Exploring the Wraparound Process through a Decolonising Lens:

Global Insights, Māori Whānau Perspectives, and Quantitative Outcomes of Engagement with Te Kahu Tōī Intensive Wraparound Service.

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Abstract

This thesis investigates the Wraparound Process as a potential framework with which equitable care and positive outcomes can be achieved for diverse populations of children, youth and whānau[1] with high and complex needs (HCN). The main objective was to contribute to the pursuit of equitable wellbeing and service experiences, particularly for children, youth and whānau with HCN in Aotearoa. The project took a decolonising research approach and prioritised obligations and duties conferred by te Tiriti (the Treaty of Waitangi). The global use of the Wraparound Process with underrepresented racial ethnic groups was explored via a scoping review, and multiple methods were utilised to explore experiences and outcomes of the Wraparound Process as delivered by Te Kahu Tōī Intensive Wraparound Service (TKT IWS; a Ministry of Education service) in two separate studies. The first study was a reflexive thematic analysis of Māori[2] whānau experiences of the Wraparound Process. The second study was a quantitative single cohort pre-test post-test outcome analysis. Overall, results demonstrated that the Wraparound Process both generally - and as delivered by TKT IWS in Aotearoa - is an effective service delivery framework that can meet the needs of diverse populations. However, service specific and systemic problems were identified. Consequently, increased investment and provision of the Wraparound Process is recommended with an emphasis on attuned, culturally responsive service design and delivery. In a wider sense, this research project adds to the growing body of evidence that calls for systemic societal reform centring decolonisation and relationality.

Keywords: Wraparound, the Wraparound Process, decolonisation, Māori, high and complex needs, emotional behavioural difficulties, SEBD

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[1] The fundamental social unit in Māori society; a conceptualisation of family broader than the European concept of a nuclear family

[2] The Indigenous people of Aotearoa New Zealand

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Chapter 1: Thesis Overview

The main purpose of this thesis is to contribute to the pursuit of equitable wellbeing and service experiences, particularly for children, youth and whānau with high and complex needs (HCN) in Aotearoa/New Zealand. This project investigates the Wraparound Process as defined by the National Wraparound Initiative (NWI; Bruns & Walker, 2008)[3] as a potential framework of care with which equitable care and positive outcomes can be achieved for children, youth and whānau with complex difficulties. The current thesis builds upon previous research exploring the use of the Wraparound Process in Aotearoa (Kirkwood, 2014; Shailer, 2015; Tamihere, 2015) and provides insights about the global use of Wraparound with underrepresented[4] populations. The use of the Wraparound Process with underrepresented communities internationally was explored using a scoping review. Both qualitative and quantitative methods were used to examine the experiences and outcomes of the Wraparound Process delivered by Te Kahu Tōī Intensive Wraparound Service (TKT IWS; a Ministry of Education service). The current project is shaped by a decolonising framework and the obligations and duties conferred by Te Tiriti o Waitangi (the Treaty of Waitangi).

Thesis structure and manuscripts

This thesis was written via publication and consists of eight chapters, five of which contributed to manuscripts written for submission to journals for publication. Chapter two provides information about the epistemological and relational foundations of the thesis; whakapapa[5], methodology, research design, ethics, and positionality. Chapter three is the first manuscript, published in a book about promoting positive youth development for youth lacking familial support or at risk of isolation (Lightfoot et al., 2023; Mozes & Israelashvili, 2023). Chapter three discusses

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[3] Unless otherwise indicated, the use of *Wraparound* (capitalised) or *the Wraparound Process* refers to the NWI definition throughout this thesis.

[4] Minoritised cultural groups underrepresented in research and academia.

[5] Geneaology/ancestry.

groups of children and youth at risk of family isolation and why the Wraparound Process may support their positive development.

Chapter four is the second manuscript. It is a scoping review of the use Wraparound with underrepresented groups worldwide. The scoping review investigates the extent and nature of the use of Wraparound with underrepresented communities and identifies trends in the literature base as well as gaps and directions for future research, which informed the studies described in the next three chapters.

The third manuscript was a multi-study exploration of TKT IWS delivered by the Ministry of Education in Aotearoa, split into three chapters for the purpose of this thesis. Chapter five introduces the third manuscript and provides the abstract, background, and rationale for the multi-study project outlined in the next two chapters.

Chapter six is the first study, which used reflexive thematic analysis to explore the experiences of Māori whānau engaged with TKT IWS. Chapter seven is the second study, which used quantitative methods (a pre-test post-test single cohort design) to examine the outcomes for a cohort of children, youth and whānau after a year of TKT IWS service engagement. Chapter eight discusses and concludes the thesis.

Because this thesis was completed via publication there is some repetition, which was inevitable to ensure each manuscript could be read outside of the context of the thesis. References for all chapters are located at the end of the thesis.

Chapter 2: Ka mua ka muri: the whakapapa, methodology, design, and ethics of the current project.

Introduction

This chapter describes the whakapapa of the current thesis in terms of the cultural, historical, and personal contexts in which it was conceived. It explains how these contexts shaped the methodological, ethical, and procedural design and execution of the project. I open this chapter with two whakataukī[6] which highlight the critical importance of engaging with the sociocultural positioning of both myself as a researcher and the thesis as a project.

Ka mua ka muri is a whakataukī which describes the notion of walking backwards into the future. It captures the notion of time as a non-linear continuum where the past, present, and future co-exist and are tethered through story-lines and whakapapa (Te Ao, 2021). Central to this concept is the importance of intentionally and thoughtfully looking backward to move forward. By doing so, we acknowledge and pay heed to the ways in which history continues to inform and shape the presence and future.

He mea nui ki a tātau ō tātau whakapapa (our genealogies are important to us) is a whakataukī that refers to the importance of whakapapa. Whakapapa is a paradigm that operates at multiple levels, linking all animate and inanimate, and known or unknown phenomena (Taonui, 2015; Te Rito, 2007). Ngata (1972) described whakapapa as “the process of laying one thing upon another. If you visualise the foundation ancestors as the first generation, the next and succeeding ancestors are placed on them in ordered layers” (Ngata, 1972, pg. 6). The constituent terms that make up the word whakapapa can also be reflected on. Whaka can mean to create, cause, action, and bring about motion. Papa can refer to a fundamental foundation and solid base. From that perspective, whakapapa refers to the foundation for continued creation, action, and motion.

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[6] Māori proverb.

Whakapapa is a useful relational framework to guide reflexivity in research, emphasising the ancestry and interactions of oneself and one's project with that of the topic being explored, the field of research and practice it is situated within, the cultural and socio-geographical context, and the overarching constructs of research and academia. Each of these entities have intergenerational histories, comprising of many layers, which collectively form the foundation for any given research project.

Whakapapa of the current thesis

This section will provide a description of three fundamental strands of the current thesis' whakapapa: the sociocultural context of Aotearoa, decolonisation and indigenisation initiatives, and researcher reflexivity. Of course, this is by no means exhaustive; other aspects of the thesis' whakapapa such as the history of the Wraparound Process; social, emotional, and behavioural difficulties in children and youth; and systemic responses are explored in the relevant chapters.

Aotearoa

It is important to acknowledge the sociocultural context in which research is situated. This project was carried out in Aotearoa (New Zealand), an island country in the southwestern Pacific ocean. As of May 2024, Aotearoa had 5.3 million residents (Stats NZ, 2024). Stats NZ states that there are six major ethnic groups in Aotearoa; European/Pākehā[7], Māori, Pacific peoples, Asian, MELAA[8], and Other. According to the 2023 census, 67.8% of the population identify as European/Pākehā, 17.8% as Māori, 17.3% as Asian, 8.9% as Pacific Peoples, 1.9% as MELAA, and 1.1% as of another ethnic descent (Stats NZ, 2023).

Māori are the Indigenous people of Aotearoa, descending from Pacific Peoples. There is considerable debate about the precise arrival date/s, but it is generally agreed upon that Māori

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[7] a light-skinned non-Polynesian New Zealander of European ancestry; of or relating to Pākehā; non-Māori; European, White.

[8] Middle Eastern/Latin American/African.

arrived in Aotearoa before 1300 CE in a series of planned migrations (Bunbury et al., 2022; Durie, 2004b; Royal, 2005). Europeans were unaware of Aotearoa until 1642, when Abel Tasman sighted the country. In 1769, Captain James Cook became the first European to visit Aotearoa, and groups of European settlers followed soonafter. In 1840, te Tiriti o Waitangi was signed by agents of the Crown and Māori rangatira[9] who represented numerous (although not all) iwi[10] in Aotearoa (Royal, 2005b; Ward, 2015). Te Tiriti o Waitangi/te Tiriti refers to the original Māori text of the agreement, which allowed the Crown to establish governance over tauiwi[11], affirmed Māori rangatiratanga[12] over their own affairs and taonga[13], and assured equal rights and privileges for Māori and tauiwi (Berghan et al., 2017).

The signing of te Tiriti marked the foundation of the modern state of New Zealand. The relationship between Māori and the Crown was formalised, settler presence was legitimised, and terms and conditions for co-existence were established (Berghan et al., 2017; Hudson & Russell, 2009). However, conflict and colonial violence continued after the signing of te Tiriti and escalated significantly shortly after, due to discordant interpretations of the treaty and clear breaches by the Crown which have persisted into the current day (Berghan et al., 2017; Came et al., 2020; Ward, 2015). Foundational to much of the conflict and controversy surrounding the treaty are inconsistencies between the te reo Māori text and the English text and interpretations of the agreement (The Waitangi Tribunal, 2024a; Ward, 2015).

The Waitangi Tribunal (2024) summarises the differences between the two versions of the treaty as following. The English version stated that the intentions of the Crown were to protect Māori interests from ongoing British settlement, to provide for British settlement, and to establish a government to maintain peace and order. The Māori text outlined similar general principles but with

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[9] Chiefs/leaders.

[10] Tribes.

[11] Non-Māori settlers in Aotearoa.

[12] Sovereignty, leadership, self-determination.

[13] Valued resources; land, culture, language, and customs.

different emphases, implying that the main promise the Crown made was to secure and protect Māori rangatiratanga[14] and land ownership. In the first article of the Māori version, Māori agreed to give the Crown *kāwanatanga*; the right of governance. In the English version Māori agreed to cede sovereignty. It is important to note there were no direct equivalents for the words sovereignty or governance in te ao Māori, which had decentralised forms of social organisation and leadership very different to British society. Kāwanatanga was a recent transliteration based on the word governor. In the second article, the Māori version uses the word rangatiratanga in reference to upholding Māori authority over lands and other cultural taonga[15], emphasising traditional Māori conceptualisations of leadership and authority. In the English text, the Crown guaranteed Māori undisturbed possession of properties (including lands, fisheries, and forests) for as long as they wished to retain them, introducing an exploitable condition to the article. Property and ownership rights were emphasised, which again are concepts that did not exist in te ao Māori[16], and fundamentally contradict Māori ways of thinking, doing, and being in relation to the natural world (Durie, 2004b; The Waitangi Tribunal, 2024). In the final article of the English version, the Crown promised Māori royal protection and full citizenship. In the Māori version, the Crown promises Māori the same rights and duties as citizens of England (The Waitangi Tribunal, 2024). The Crown's emphasis on the English version of the treaty ignores the cultural and linguistic representations of Māoritanga[17] that are embedded in te Tiriti, in favour of emphasising the contentious alleged cession of sovereignty by Māori (Came et al., 2020). Since the Māori version of the treaty is the one that was presented and signed by iwi, it should be the one that takes precedence (Berghan et al., 2017).

Despite the establishment of a treaty, and in light of continued breaches by the Crown, Māori have endured grievous ongoing harm as a result of colonisation processes (Came et al., 2020;

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[14] Self-determination, autonomy, chiefly authority, leadership.

[15] Property, goods, possession, effects, object, treasure, anything prized – including socially or culturally valuable objects, resources, techniques, ideas, and phenomena.

[16] The Māori world/paradigm.

[17] Māori culture, traditions, and ways of life.

Durie, 2004b; Ramsden et al., n.d.; Ward, 2015). As stated by Durie (2004b), the experience and consequences of colonisation for Māori are similar to that of Indigenous peoples worldwide. Their rights have been systematically dismissed, dismantled, and subjugated. Immeasurable loss has occurred; of culture, land, language, dignity, population, health, and wellbeing. As a result, Māori tend to fare worse than non-Indigenous groups on most indicators of social wellbeing, including mortality, disease, mental health, addiction, housing, income, education, employment, interactions with the justice system, and lifestyle risks. Institutional discrimination persists, generating and sustaining inequity.

Recent research has demonstrated that Māori continue to have discriminatory, inequitable experiences in the mental health system (Government Inquiry into Mental Health and Addiction, 2018), the welfare system (Fitzmaurice, 2020; Office of the Children's Commissioner, 2020) and the educational system (Agnew et al., 2022). Māori tamariki[18] and rangatahi[19] disproportionately experience expulsion and school exclusion, constituting 68% of those enrolled in alternative education compared to 24% of the national student population (Education Review Office, 2023). Research has demonstrated that negative stereotypes and discriminatory practices contribute to educational disadvantages experienced by Māori. Students' reports have revealed that the fundamental need to experience belonging, safety, and care within the educational system is disproportionately unmet for Māori students compared to their non-Māori peers (Agnew et al., 2022); a pervasive phenomenon observable throughout various systems, services and social environments in Aotearoa.

As described by Durie (2004b), it is important to note that experiencing colonisation and disadvantage is not the most defining aspect of indigeneity. While Indigenous cultures are heterogeneous and diverse, they tend to share a fundamental cultural foundation of relationality,

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[18] Children.

[19] Youth/the younger generation.

reflected in their ontologies, customs, and rituals which emphasise unity with the environment and entities within it. Fitzmaurice (2020) describes how prior to colonisation, Māori society functioned according to *tikanga*; a system of principles, values and customs that provided a framework with which to exist in the world, resolve disputes, and promote relational harmony with other humans and the wider environment. *Whānau* represented the fundamental social unit in Māori society; a conceptualisation of the family unit much broader than the European conceptualisation of the nuclear family. Whānau shared the responsibility of child-rearing and were critical in fostering personal identity and a sense of belonging. Whānau exist within *hapū* (sub-tribes), which exist within *iwi* (tribes). The existence and cohesive functioning of these social units within te ao Māori are deeply connected to individual and collective wellbeing through the maintenance of relationships to whakapapa and whanaungatanga[20].

The Crown's failure to protect and uphold tino rangatiratanga[21] (Fitzmaurice, 2020) not only resulted in the loss of land, language, and specific cultural practices, it fundamentally challenged the established structure of Māori society. Favouring of the nuclear family and individualism encouraged assimilation and urbanisation of Māori. Consequently, hapū and whānau were less able to exercise rangatiratanga and maintain their own wellbeing in traditional, culturally affirming, autonomous ways (Berghan et al., 2017; Bishop, 2019; Edwards et al., 2007; Fitzmaurice, 2020).

However, it is important to note that despite the breadth and depth of harm inflicted, Aotearoa's history of colonisation is not one of passive acceptance or submission by Māori. Māori have never ceased to resist and protest colonisation processes and breaches of te Tiriti (Came et al., 2020; Fitzmaurice, 2020). After some 150 years of protest and political agitation, the Treaty of Waitangi Act was passed in 1975, consolidating the presence of te Tiriti in public life and policy. The establishment of the Waitangi tribunal provided a forum in which treaty breaches can be raised,

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[20] The process of establishing relationships and kinship, often through shared experience.
[21] Self-determination, sovereignty, independence, autonomy.

examined and settled (Berghan et al., 2017; Bishop, 2019; Ward, 2015). The act was passed during the emergence of a pronounced revitalisation of Māori language and culture that followed rapid urbanisation of Māori in the 50s and 60s. The movement was characterised by a renewed commitment to Māori values, aspirations, and knowledge, as well as increased demands for tino rangatiratanga, and rejection of policies and societal pressures that reinforced the dominant hegemony and encouraged assimilation. Kaupapa[22] Māori approaches also emerged and proliferated during this time. Research, healthcare, and education initiatives by Māori for Māori were and are central to revitalisation initiatives, generating theoretical and pragmatic frameworks that incorporate and honour Māori perspectives (Bishop, 2019; Durie, 2004b).

By the 1980s, te Tiriti was significantly influencing policy in Aotearoa. Scope was widening for more effective assertion of Māori rights, especially in accordance with treaty guarantees of tino rangatiratanga and social equity (Came et al., 2020). Legislation was passed legitimising the importance of tikanga[23] in national law. In 1988, a governmental report formally acknowledged the impact of institutional racism within the welfare system and wider society. This resulted in significant changes to the child welfare system including increased recognition of the centrality of whānau, hapū, and iwi in ensuring the wellbeing of Māori tamariki and rangatahi, as well as legitimisation of tikanga Māori and Kaupapa approaches in social work (Fitzmaurice, 2020). In the same year, the health sector was directed to engage more authentically with their treaty obligations through partnership and recognition of Māori health as a taonga with guaranteed protection (Came et al., 2020).

Since then, the health sector has attempted to engage with and embed these responsibilities in practice. However, in 2016, a claim (WAI 2565) was opened to examine health sector grievances related to ongoing disparities in wellbeing and healthcare. The enquiry concluded that despite some

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[22] A culturally based Māori approach or way of doing something that is embedded in Māori ideology
[23] Māori customs

examples of success, the colonial system had gravely failed to uphold its promise to protect Māori health and tino rangatiratanga in the health sector. Came et al. (2020) argue that the public health system in Aotearoa has chronically and persistently neglected obligations under the treaty and undermined tino rangatiratanga. These tendencies have shaped public health policy. For example in 1907 the Tohunga Suppression Act was passed, criminalising traditional Māori wellbeing practices, delegitimising Indigenous healthcare, and removing choice and access (Came et al., 2020). These actions still have profound impacts. Recently, in 2019, protests against the Ministry of Children took place in response to ongoing, grievous harm to Māori inflicted by the welfare system (Fitzmaurice, 2020; Office of the Children's Commissioner, 2015).

Like many who take issue with the prominence of te Tiriti in public life, the current government in Aotearoa has challenged its relevance and made systematic attempts to decentre te Tiriti and remove it from public policy and legislation (The Waitangi Tribunal, 2024c, 2024b). This has included passing legislation to repeal the Oranga Tamariki Act 7AA[24] (The Waitangi Tribunal, 2024c), disestablish the Māori Health Authority (New Zealand Government, 2024), and remove Māori wards and constituencies initially established to remove discriminatory barriers to Māori political representation (The Waitangi Tribunal, 2024b). Mandatory consultation with treaty partners has been circumvented by passing bills under urgency. The Waitangi Tribunal has responded to these actions, concluding that the government 'acted in a unilateral way to prioritise its coalition agreement commitments without any discussion or consultation with its treaty partner' (The Waitangi Tribunal, 2024b), and is clearly in breach of te Tiriti by failing to demonstrate good faith and partnership, dishonouring the fundamental basis of the agreement itself (The Waitangi Tribunal, 2024c).

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[24] A section introduced to mandate a commitment to the principles of te Tiriti in child welfare practices, emphasising young people's connections to their whānau, hapū, and iwi.

Perhaps most concerningly, tribunal investigations pointed out that the government's actions contradict empirical evidence and risk causing serious irreversible harm to vulnerable children and communities, increasing prejudice, and eroding trust in Aotearoa communities (The Waitangi Tribunal, 2024c, 2024b). The actions by the current government are underpinned by a rhetoric shared by many who feel the treaty claims process fosters a grievance industry and an overemphasis on historical harm that is apparently since resolved (Ward, 2015). Despite the abundance of evidence suggesting otherwise, proponents of decentralising te Tiriti argue that Māori have equal political, linguistic, and cultural rights (Walker et al., 2006) and that colonially imposed structures such as democracy and law are sufficient and necessary tools to ensure exactly that (Ward, 2015).

As stated by Ward (2015), despite variable adherence to te Tiriti and the problems with its conception and interpretation, we are ultimately fortunate to have a statement of principles upon which a partnership can be founded. The treaty is an integral cornerstone of ethics in Aotearoa, and its interpretation and application should reflect the understandings and aspirations of both treaty partners (Hudson & Russell, 2009). In alignment with the dynamic, reflexive conceptualisation of decolonisation, Ward (2015) argues the requirement to continually review the interpretation and application of te Tiriti is a strength rather than a weakness. Partnerships, by definition, are dynamic and contextual relationships that should be continuously, reflexively engaged with. As Berghan et al. (2017) describe, breaches of te Tiriti need to be seen as what they are: unacceptable violations of the foundational contract upon which our society is built, and breaches of international human rights too. Māori should have equal and inclusive rights to the highest standards of health, education, and quality of life. Centralisation of te Tiriti in public policy, discourse, and practice across all sectors to ensure this is therefore of utmost importance in modern Aotearoa. As stated by Ward (2015); we still have a long way to go in healing the ills of colonisation, and in any setting where two or more groups co-exist it is important to have a principled basis and process to foster optimal and peaceful co-existence.

Decolonisation and indigenisation initiatives

The current thesis is informed by decolonisation and indigenisation movements. Decolonisation refers to the acknowledgement and systematic undoing of colonialism; the process by which imperial nations establish, dominate, and control foreign territories and/or peoples (Saini & Begum, 2020; Tuhiwai Smith, 2021e). Traditionally, decolonisation referred to the literal process by which a nation or state withdraws from a former colony to establish independence and self-determination. More recently, decolonisation has come to refer to the various processes by which institutions, fields of practice, populations, communities, organisations, and individuals free themselves from the cultural and/or social effects of colonisation (Brulon Soares & Witcomb, 2022; Oxford University Press, 2022). In this sense, decolonisation includes critical investigation and challenging of where, how, why, and by whom knowledge seen as legitimate is produced. Decolonisation is necessarily an ongoing, reflexive practice due to the way inequity is embedded, produced, and maintained in colonised societies (Amundsen, 2018; Saini & Begum, 2020).

Decolonisation of research and service delivery involves identifying and challenging dominant assumptions about knowledge, truth, and rationality, upon which science and services are founded. It highlights that these foundational systems of knowledge were developed within historical contexts characterised by unequal and unjust power relations (Tuhiwai Smith, 2021e). As stated by Carriere and Richardson (2020), a decolonising approach to health involves “depathologising understandable responses to colonial violence and oppression.” (Carriere & Richardson, 2020, pg. 9). In her book, *Decolonizing Methodologies: Research and Indigenous People*, Linda Tuhiwai Smith provided a critical analysis of the role of scholarly research in the colonisation of Indigenous people and spaces (Tuhiwai Smith, 2021c). She reminded us of the words of Audre Lorde: “the master’s tools will never dismantle the master’s house” (Lorde, 1984), which referred to the idea that colonial tools such as education, government, and democracy are often mistakenly thought of as generic, neutral, and unbiased. In fact, they are implicated in the establishment and maintenance of inequity and Eurocentrism (Tuhiwai Smith, 2021d).

Academia has and continues to perpetuate inequity when it fails to explicitly acknowledge or challenge the foundational assumptions and ideologies that drive academic practice. Academic research has a long history of privileging Western ways of knowing, doing, and being while denying the validity of other cultural epistemologies and ways of life (Kennedy et al., 2022; Tuhiwai Smith, 2021c). Research methodologies often reflect Western values; positioning objectivity, positivism, and distance as essential criteria for academic authority, accountability, and validity. The assumptions that research is a value-free scientific process, and that an objective universal truth exists and is discoverable are not often acknowledged as subjective beliefs themselves, grounded in Western ideology. Researchers are assumed and expected to be neutral outsiders who can remain unaffected and unaffecting as they observe, examine, and describe phenomena with sterile expertise. These assumptions clash with Indigenous ways of knowing, which centre relationality and context. The Eurocentrism of academia contributes to the exclusion of Indigenous people from meaningful participation in the construction, validation, and legitimisation of knowledge - even about themselves. (Kanaÿiaupuni et al., 2006; Robertson & Bishop, 1999; Tuhiwai Smith, 2021c).

Throughout history, scholarly research has systematically dehumanised, criminalised, pathologised, and paternalised Indigenous peoples and other subaltern[25] groups in society (Kanaÿiaupuni et al., 2006; Kennedy et al., 2022; Rogers & Lange, 2013; Tuhiwai Smith, 2021c; Yosso, 2005). As stated by Tuhiwai Smith;

> This collective memory of imperialism has been perpetuated through the ways in which knowledge about Indigenous peoples was collected, classified and then represented in various ways back to the West, and then through the eyes of the West, back to those who have been colonised. (Tuhiwai Smith, 1999, pg. 30).

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[25] In critical theory and postcolonial study, subaltern refers to any groups in society who are socially, politically, and/or geographically excluded from power hierarchies within imperial colonies.

Blame, pathologisation, and/or paternalism is often directed at disadvantaged groups for experiencing adversity and failing to conform to colonially imposed ideals and norms (Kanaÿiaupuni et al., 2006; Macleod & Munn, 2004; Mccreanor, 2009; Yosso, 2005). Research focussing on Indigenous and other subaltern groups has been largely deficit-focussed, with insufficient consideration of contextual and generative mechanisms, or unique cultural strengths, resilience, and ways of life (Durie, 2017; Durie, 1985; Yosso, 2005). Eurocentrism in academia perpetuates, legitimises, and normalises inequity by providing what is widely presumed to be indisputable scientific rationale for its ongoing existence. Additionally, research tends to frame inequity as a static and unalterable characteristic of human society (Bronfenbrenner, 1977). Ultimately, this absolves society of collective responsibility.

A long-standing contributor to Eurocentrism in scientific research is the lack of diversity in both researcher and participant populations (Rogers & Lange, 2013). Minoritised and marginalised groups have often been treated as objects of interest in research rather than active contributors and collaborators (Tuhiwai Smith, 2021b). Research has therefore often lacked adequate consent processes, meaningful engagement with participants, and/or consideration of potential ramifications. Unsurprisingly, this has caused significant harm to individuals, communities, populations and entire cultures (Kennedy et al., 2022; Rogers & Lange, 2013; Tuhiwai Smith, 2021b). Rogers and Lange (2013) describe how efforts were undertaken in the seventies to formally identify groups vulnerable to harm from research. However, an underemphasis on systemic contributors meant that groups labelled as vulnerable were then treated with paternalism and stereotyped as too vulnerable to be researched, too difficult to reach, and too difficult to include in a culturally sensitive, ethical manner (Rogers & Lange, 2013).

Underrepresentation and misrepresentation of minoritised populations in research has led to a relative lack of published knowledge about non-Western perspectives and practice, including conceptualisations of health, healing, and related practices. Most research and evidence-based practice therefore has limited relevance across diverse populations. Despite this, it shapes policy, funding allocation, and service design, where these biases are then replicated (Rogers & Lange, 2013). Racial and ethnic minoritised groups in Western societies underuse, have limited access to, and experience discrimination within health, education, and social services (Agnew et al., 2022; Education Review Office, 2023; Government Inquiry into Mental Health and Addiction, 2018; Hackett et al., 2020; Pickett & Wilkinson, 2015; Rogers & Lange, 2013; Weinstein et al., 2017). Service providers often lack the expertise required to engage in culturally responsive or culture-based ways (Cooms et al., 2024; Madden et al., 2012; Sue, 2006; Werrbach et al., 2013) due to the systemic lack of adequate information, training, resourcing, and support available to service providers regarding culturally appropriate ways of engaging (Pitama et al., 2007; Stewart, 2008). Additionally, academic and professional spaces can be hostile and discriminatory toward those of identities (Agnew et al., 2022; Berry et al., 2021a; Cooms et al., 2024), resulting in a less diverse workforce and a lack of staff who possess the intergenerational, immersive cultural expertise that comes with cultural identity and lived experience (Berry et al., 2021b; Palmer et al., 2011b).

Evidence has shown that a more diverse workforce results in better healthcare experiences for service users and improved financial performance due to an increased pool of talent, better decision-making, and improved orientation to service user experience (Berry et al., 2021). Sue (2006) presents evidence that mental health services are often inadequate for diverse cultural groups due to a lack of diversity amongst providers. Cultural, linguistic, and worldview mismatches between providers and users constitute a fundamental barrier to effective therapy and positive outcomes. These mismatches hinder rapport, alliance, and communication, reducing the effectiveness of interventions. Western perspectives and frameworks in therapeutic service delivery often contradict Indigenous worldviews (Madden et al., 2012; Werrbach et al., 2013). Some researchers suggest providing Eurocentric care to Indigenous people is therefore a continuation of oppression and colonisation, as it disregards and invalidates other cultural views and practices regarding health (Stewart, 2008). As stated by Duran and Duran (1995, pg. 6): "A postcolonial paradigm would accept knowledge from differing cosmologies as valid in their own right, without their having to adhere to a separate cultural body for legitimacy."

In response to the colonial legacy of academia, Indigenist and decolonising methodologies have proliferated over the last few decades (Evans et al., 2014; Kennedy et al., 2022; Thambinathan & Kinsella, 2021). Both approaches decentralise the dominant Western paradigm and claim space in academia for the legitimisation of other cultural paradigms and the pursuit of what has been termed by Dei (2008) as *epistemological equity* (Thambinathan & Kinsella, 2021).

Decolonising research methodologies are approaches to research that actively reveal, resist, and unsettle the colonial power relations embedded in dominant Eurocentric academic traditions (Denscombe, 2025; Thambinathan & Kinsella, 2021). There is no standard model or practice for producing decolonising research (Thambinathan & Kinsella, 2021) – in fact, this would be antithetical to the foundational plurality and situatedness of decolonial and Indigenist forms of knowledge and knowledge generation. However, there is ongoing discourse about the theoretical foundations, principal components and practical applications of decolonising methodologies. Thambinathan and Kinsella (2021) identified four practices that can be used to decolonise qualitative research: 1) exercise critical reflexivity, 2) demonstrate reciprocity and respect for self-determination, 3) embrace *other(ed)* ways of knowing, and 4) embody a transformative praxis. Similarly, Denscombe (2025) described decolonising research methodologies as those that aim to:

- Challenge the hegemony of Western epistemologies and their universal claims to truth through objectivism and positivism.
- Decentre Western epistemologies and centre the perspectives, knowledge, and lived realities of Indigenous and marginalised communities.
- Engage in research as a practice of *epistemic resistance*, rejecting colonial hierarchies of knowledge and legitimising multiple ways of knowing.

- Be relationally, contextually grounded and accountable to the communities involved, rather than extractive or imposed from the outside.
- Emphasise *praxis*; linking knowledge production to social and political transformation, particularly in the pursuit of equity, justice, and decolonisation.

In addition, Denscombe (2025) pointed out that decolonising research typically favours constructivism and qualitative methods. Quantitative methods are not excluded altogether, but are used with conscious and careful intent to promote the interests of marginalised communities. This is particularly important given quantitative research and statistics is implicated in the ongoing marginalisation of minoritised communities.

In summary, decolonising research methodologies reorient research, away from reproducing colonial dominance and towards the collective creation of knowledge that is plural, situated, and in service of decolonial futures (Denscombe, 2025). Decolonising approaches therefore allow and advocate for the resurrection and generation of Indigenous methodologies and methods which can shift the dominant paradigm and address inequity (Evans et al., 2014; Kennedy et al., 2022).

Indigenist methodologies and methods are research practices emerging directly from the culture, knowledge, values, practices, and aspirations of Indigenous communities (Tuhiwai Smith, 2021a). Because Indigenist methodologies and methods arise from, and exist within Indigenous cultures, they are distinct from Western systems of knowledge and therefore inherently decolonising (Evans et al., 2014). While Indigenous worldviews, methodologies, and methods are variable and localised (Thambinathan & Kinsella, 2021), they tend to emphasise relationality (with others, the land, knowledge systems, time, and storylines) (Durie, 2017; Kennedy et al., 2022). Indigenous knowledge is typically constructed through iterative, positioned, relational processes (Evans et al., 2014). Culturally relevant forms of knowledge construction and discovery that centre Indigenous ways are used in Indigenist research, such as yarning (Aboriginal Australian; Gidgup et al., 2022; Kennedy et al., 2022; Lyall et al., 2021), dadirri/deep listening (Aboriginal Australian; West et al., 2012), wānanga (Māori; Mahuika & Mahuika, 2020), and raranga kōrero (Māori; Ruwhiu, 2008). Conversational methods rooted in Indigenous epistemologies and oral traditions are often used (West et al., 2012). As well as being decolonising by generating and expressing distinctly Indigenous knowledge, Indigenist research often directly addresses colonial processes too. After all, colonisation shapes the contexts in which research takes place, and inequality, freedom and the fight for autonomy and self-determination are interests shared by Indigenous populations (Evans et al., 2014; Tuhiwai Smith, 2021f).

It is important to note, however, that Indigenist methodologies are distinct from and do not exist solely in response, opposition, or relation to Western systems of knowledge. Indigenous research is an expression of indigeneity, and the knowledge systems that shape reality and life for Indigenous people. It is therefore not only decolonising and postcolonial, but also affirming and revitalising (Evans et al., 2014; Thambinathan & Kinsella, 2021). As stated by Tuhiwai Smith;

> there is more to Kaupapa Māori than our history under colonialism or our desires for self-determination. We have a different epistemological tradition, one which frames the way we see the world, the way we organize ourselves in it, the questions we ask and the solutions that we seek. It is larger than the individuals in it and the specific 'moment' in which we are currently living. The significance of Kaupapa Māori for Māori language is tied to the connection between language, knowledge and culture (Tuhiwai Smith, 2021f, pg. 244).

Indigenous knowledge is often thought of as existing in conflict with Western knowledge, however, such dichotomies tend to be antithetical to Indigenous worldviews which characterise knowledge as collectively generated by an array of sources. Many researchers emphasise the importance of acknowledging and utilising the diverse strengths of different knowledge systems in thoughtful, flexible, collective manner in academia and community contexts (Evans et al., 2014; Thambinathan & Kinsella, 2021).

Revitalisation and legitimisation of cultural ways of thinking, being, and doing, is a fundamental part of equitable service delivery and health promotion (Durie, 2004a). Positive cultural identity and cultural connectedness is strongly related to increased resilience and wellbeing, via a myriad of pathways (Durie, 2004a, 2017; Wexler, 2009; Lockwood, 2011; Snowshoe et al., 2017). As Irihapeti Ramsden, a Māori nurse and academic stated; "Our culture is our health. We rely on it to find ways to be adaptive and creative when all the odds are stacked against us." (Ramsden et al., n.d., pg. 3). There is increasing recognition that traditional conceptualisations of cultural competence or responsivity are lacking. The adoption of apparently helpful protocolised cross-cultural strategies can be shallow and tokenistic in practice (Tuhiwai Smith, 2021c). Furthermore, if non-Indigenous service providers can learn a set of rules that are apparently adequate to engage with Indigenous populations in a culturally sensitive manner, the need to train, hire, and fund culturally diverse professionals and ultimately address systemic racism in the workforce is minimised (Gebhard, 2013). True cultural expertise is achieved through years of immersion and is intergenerationally acquired or possessed through ones genealogy (Palmer et al., 2011a).

Ramsden (n.d.) describes how important self-determination and autonomy is for Māori in the pursuit of wellness, explaining that for health services to be accessible for Māori, they need to have a Māori base. To be affordable for Māori, they need to have Māori control over resources; to be acceptable for Māori, they need to have a Māori perspective. She concluded that therefore, the most appropriate people to diagnose, advocate for, practice with, and teach about Māori are Māori (Ramsden et al., n.d.). Supporting this notion, a rapidly growing body of evidence demonstrates the effectiveness of culturally-based/Indigenous-led initiatives in a wide range of areas including education and health (Carriere & Richardson, 2020; Johnson et al., 2013; Kendziora et al., 2001; Martin, 2012; Murdoch-Flowers et al., 2019; Palmer et al., 2011a; Werrbach et al., 2013). On a broader scale, true partnership needs to be established, where Indigenous and non-Indigenous systems, organisations, approaches, and practitioners can exist and work alongside one another in a complementary manner that honours their respective validity and integrity (Ramsden et al., n.d.)

Ko wai au[26]: researcher reflexivity

Nō Kotarani, Ingarangi, Tarara, me Taungurung ōku tupuna

My ancestors are from Scotland, England, Dalmatia, and Taungurung country

I te taha o tōku matua ko Lightfoot tōku whānau ingoa

On my father's side, my family name is Lightfoot

I te taha o tōku whaea ko Blackett tōku whānau ingoa

On my mother's side, my family name is Blackett

I whānau ahu kei Tāmaki Makaurau

I was born in Auckland

I tipu ake ahau kei Te Whanganui-a-Tara

I was raised in Wellington

Kō Te Whanganui-a-Tara te kāinga

I call Wellington home

Kō Lucy Rose Lightfoot tōku ingoa

My name is Lucy Rose Lightfoot

Kō tēnei taku mihi ki ngā tāngata whenua me ngā tohu o te rohe nei me Aotearoa

I acknowledge and give thanks to the people and important places of this area and in Aotearoa.

I am Tāngata Tiriti[27]; my heritage is Scottish, English, Dalmatian, and Taungurung (an Aboriginal clan in Australia). My family on both sides have lived in Aotearoa for multiple generations. On my mother's side her paternal ancestors arrived in Aotearoa on the Gipsy, a ship that brought a group of assisted immigrants from the Isle of Wight to Tāmaki Makaurau in 1854. I primarily identify with and feel most connected to my identity and experience as Pākehā and Tāngata Tiriti. I grew up fairly disconnected from my genealogical roots, cultures, and lands. My position as someone who

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[26] Who am I?

[27] Translates to 'People of te Tiriti'; used to describe Non-Māori who live in New Zealand/Aotearoa by right of te Tiriti o Waitangi; acknowledges positioning as a Non-Māori treaty partner.

feels a primary belonging to Aotearoa as a result of te Tiriti is therefore a fundamental and defining aspect of my identity and many of my ancestors.

I am neurodivergent and have lived experience of emotional behavioural difficulties, chronic health issues and service use, as do many members of my family. From a very young age I was exposed to the significant difficulties individuals, whānau, and communities encounter in managing high and complex needs and how they interact with the social ecosystems in which we exist. Perhaps due to these experiences and the justice sensitivity often associated with neurodivergence, I have always been passionate about social justice and equity. Activism and allyship are important facets of my identity that have been nurtured by various members of my community throughout my life. I believe my personal and relational experiences strongly influenced the development of my interests in human development, relationships, and social, emotional and behavioural difficulties, as well as my eventual pursuit of a career in clinical psychology.

I began working at a Kaupapa Māori child and adolescent mental health service a few years ago, partway through the completion of this thesis. Working in a Kaupapa Māori environment has been monumentally influential and an enormous privilege. Being included in an Indigenous space has been affirming of my own Indigenous whakapapa which is difficult to reconnect with because of the sequelae of colonisation. It has vastly and sometimes uncomfortably confronted and challenged my assumptions and ways of thinking, being, and working as a person, a researcher, and a clinician.

Multiple facets of my identity and lived experience meant I shared commonalities with participants which fostered whakawhanaungatanga[28] directly and indirectly. However, it is important to acknowledge that power dynamics exist within any relationship and are particularly relevant in research and healthcare contexts. I hold and have always held privileges associated with various aspects of my identity, the most obvious being my Whiteness. Throughout my adulthood I have often reflected on my many expressions and experiences of being divergent and wondered if

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[28] The process of establishing relationships and kinship, often through shared experience.

others' interpretations and responses would have been the same had I not been White. Granted, there have been more than a few teachers, peers, coaches, and community members who made it no secret that they found me to be unpleasantly disruptive. But often, my divergence was interpreted in a positive or neutral light. In fact, my overzealous and uncontrollable talkativeness which often landed me in the corridor to complete my work also led to my teacher predicting I would one day become a psychologist to utilise my 'talking talents'. In difficult moments I was often extended compassion, scaffolding, and understanding. I do wonder whether assumptions about the nature of my divergent qualities and my potential would have been the same had I not been White. In light of recent research revealing underestimation of Māori students' by teachers and other aspects of discrimination (Agnew et al., 2022), I think it's fair to assume that my experience of school and academia and its potent influence on my developmental trajectory and life may have been very different.

My academic experience, qualifications, and professional status as a researcher and a clinician-in-training also confer social power and privilege and shape the way I view, interpret, and interact with the world. Although I intended to mitigate the application of this lens to whānau stories through reflexivity and research design[29] that prioritised inductive methods, the knowledge I have acquired and the cognitive/relational habits I have formed due to these aspects of my experience and identity undoubtedly were manifest to some degree throughout this project.

When I first started working on this thesis over five years ago, I unwittingly embarked on what would become the beginning of a transformative personal decolonisation journey. While I have always been passionate about social justice and equity, my engagement with te Tiriti and my own cultural positionality was fairly shallow prior to this project. Initially, this research was not going to specifically explore Māori experiences or equity of outcomes. It was not until I became aware of the

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[29] Detailed further in the methodological approach section, and in Chapter 5: A multi-study exploration of Te Kahu Tōi Intensive Wraparound Services: qualitative analysis of interviews with Māori whānau and quantitative analysis of outcomes.

overrepresentation of Māori within the population I was going to be engaging with and engaged with the implications of that more deeply that I confronted the gravity of ethical issues, duties, and obligations attached to this research project (and research more generally).

I realised that the conception, design, and funding of any research project and/or initiative in the social, health, and educational sector in Aotearoa (and globally) should be demonstrably grounded in the pursuit of equity. Attempting to figure out how to actualise that in the current project was a formative point in not only my academic career, but my life. The process of creating this thesis therefore occurred alongside a deepening and acceleration of my personal decolonisation journey.

Prior to this project, I often assumed that my good intent meant I was unlikely to misstep. I had limited awareness of the way that Eurocentrism permeated my thinking and relating; partly because I also had limited awareness of other ways of being. As stated by Margaret (2010b) becoming aware of my own colonised, Eurocentric nature has been and continues to be a sometimes deeply unsettling, uncomfortable reality to come to terms with. At times almost paralytically so, especially when first confronting the degree of harm that has and continues to be inflicted, the idea that I could potentially contribute to that, the vastness of what I do not know, and the inherent need to venture beyond the comforting confines of objectivity and positivism.

Engaging with Indigenist and decolonising frameworks, methodologies, and practice helped me to access and connect with epistemology and qualitative methods - which I had previously dismissed and avoided with conviction. Considering the nature of knowledge and truth felt prohibitively cerebral, abstract, and intimidating. In my undergraduate degree I studied biology, psychology, and statistics, which largely upheld positivist paradigms and privileged quantitative research. Letting go of the central assumption that there is an objective, discoverable truth and a correct way of being and doing has been and continues to be profoundly challenging. I do, however, consider myself to be a reformed positivist now. I can look back at my past avoidance of engaging with epistemological concepts and understand that my judgement of it as irrelevant and my pronounced commitment to being a ‘realist’ was in fact reflective of a Western epistemological framework in and of itself.

My experience of engaging in personal decolonisation throughout the current project is similar to that described by Amundsen (2018) in her publication about decolonisation through the role of Pākehā. She drew parallels between the process of personal decolonisation for Pākehā and the stages of therapeutic recovery which are cyclical and non-linear; pre-contemplation, contemplation, preparation, action, maintenance, and re(lapse). Achieving long-term maintenance of a decolonised Pākehā identity typically requires several cycles and is necessarily a reflexive and iterative process. She also emphasises that relational engagement with Māori throughout the process was a significant contributor to the development of an anti-racist Pākehā identity in her experience, which mirrored my own – working in a Kaupapa Māori space certainly broadened my horizons rapidly. She also notes that although at the outset of the journey she did not believe personal healing was required, the change process was in fact therapeutic. Indeed, there were many therapeutic aspects within my own experience. For example, having to engage with and share my positionality and whakapapa with whānau and tāngata whai ora[30] revealed to me the huge gaps in my self-knowledge, and spurred me to reconnect with my genealogy and roots, which ultimately solidified my identity and self-esteem. I also found that engaging with Indigenist theory, and existing within Indigenous spaces leant me a felt sense of knowledge which felt qualitatively different (more authentic and holistic) from that which I might have known in a cerebral sense. Much of what I have learnt from Indigenist and decolonising theory, and my exposure to those social spaces has also been profoundly affirming, exciting, and hopeful.

Amundsen (2018) describes how Pākehā have a responsibility to deliberately and consciously decolonise by connecting with one’s own identity and dismantling disturbing, prejudiced

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[30] Translates to *person seeking health*; service user, person being supported.

attitudes. This requires choosing to be vulnerable and uncomfortable in spaces that have long been comfortable for Pākehā, which is a “fragile, uncertain, and reflexive space” to be in (p. 142). I have therefore come to understand that being unsettled is a necessary part of the decolonisation process for Pākehā. To be constantly awake to one’s own fallibility, biases, strengths and weaknesses, proneness to getting things wrong, and the need to defer to those more knowledgeable, be open to other perspectives, collaborate and be humble is a necessary part of reflexive ethical conduct (Amundsen, 2018; Margaret, 2010b, 2010a). Throughout this research project I have frequently questioned my capability to conduct sufficiently ethical research, and every choice has felt weighted. Producing the current project was therefore an iterative, cyclical, and sometimes painfully ruminative process. As I learnt more about decolonisation and my positionality it often shifted my perspective and reshaped the research.

It must be acknowledged that I am early in my decolonisation journey, and of course terminally limited by static facets of my identity and lived experience. There is a lack of consensus within Indigenous academic spaces as to whether it is appropriate for members of an out-group to conduct research with Indigenous groups (Thambinathan & Kinsella, 2021; Tuhiwai Smith, 2021f). Understandably, many Indigenous researchers feel that endeavours to create or share knowledge about a group should be done by members of that in-group. Tuhiwai Smith (2021f) describes how non-Māori researchers may engage in Kaupapa or culturally responsive research and can be useful allies, but it is important they explicitly position themselves as non-Māori. She also explains how cultural safety, relevance, and mentorship is centrally important.

Ethical and Methodological Considerations

Methodological Approach

It was important that the methodological approach and tools used in this research were consistent with the pursuit of equity, wellbeing, and social justice for minoritised and marginalised groups in Western societies. This thesis is grounded in a critical realist epistemological framework, informed by decolonisation and indigenist movements and critical race theory. Critical realism treats knowledge and personal experience as constructed and mediated through language and perception while acknowledging the reality of social structures and underlying mechanisms that generate phenomena (Taylor, 2018). Critical realism accepts that reality does exist and comprises multiple levels, some of which are more easily observed than others; 1) events that are experienced and quantifiable, 2) all events whether experienced/directly observed or not, and 3) the causal mechanisms that generate events and are often difficult or impossible to observe directly. It acknowledges the matrix of innumerable, interactive social and psychological variables and processes that are constantly in operation, interacting and playing out in variable, unpredictable ways. It is therefore an approach that acknowledges and accepts the inherent complexity of human systems, and attempts to explore that complexity in a meaningful way without imposing a reductive positivist framework (Werkmeister Rozas, 2022).

Critical realism was born out of the idea that a traditional positivist approach is unsatisfactory in its ability to explore and identify underlying causal mechanisms that produce observable phenomena, while a traditional subjectivist or constructivist approach overemphasises the power of ones' perception to define their reality, and in doing so, invalidates the very real forces and consequences of a complex physical and social reality that cannot be wishfully dismissed. Critical realism's primary function and usefulness therefore lies in determining what is quantifiable truth and what is subjectively and socially accepted as truth; both of which have very real implications in terms of experience. It is described as a useful philosophical framework for social science and health research because it takes into account the systemic processes (often difficult to observe and measure) that produce and exacerbate health inequalities (arguably less difficult to observe and measure); Clark et al., 2007; Taylor, 2018).

Bhopal (2007) explains that although racial disparities in health status and service are easy to observe and describe, the causes are complex and difficult to entangle and expose. Clark et al.

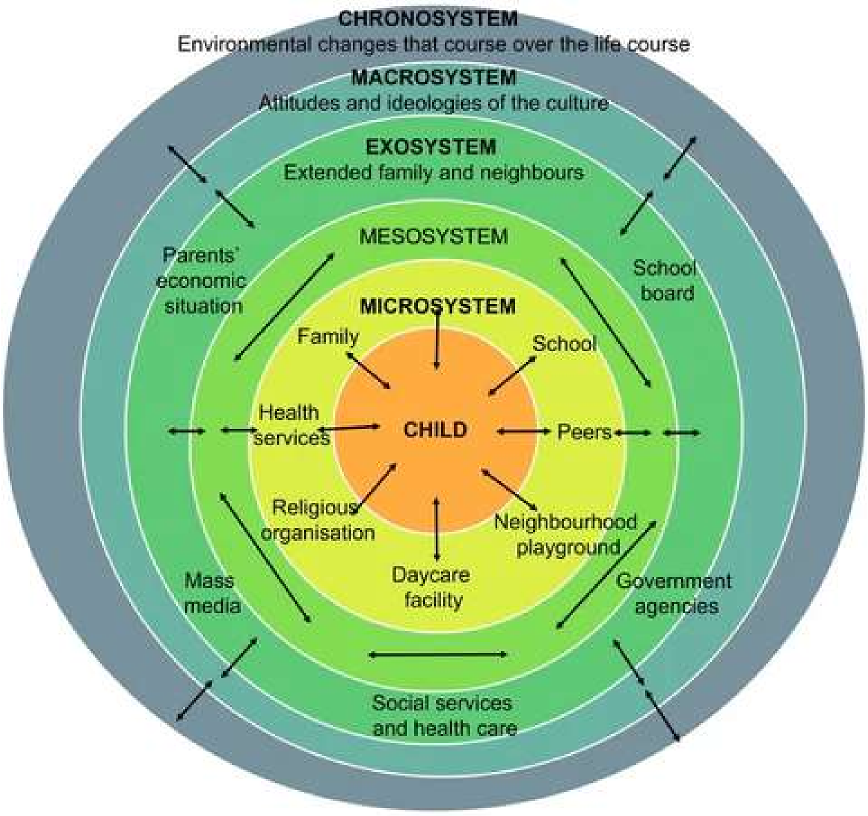
(2007) describe how useful and appropriate a critical realist approach can therefore be in social and health research, especially when assessing the effectiveness of interventions. Critical realism is a useful tool with which to understand complex outcomes, optimise interventions, and examine biopsychosocial pathways (Clark et al. 2007). Werkmeister Rozas (2022) emphasises the importance of thinking critically about whose reality is most valid and how we determine experience/reality from perception when discussing racism, discrimination, and/or inequity within a system that centres the White experience and privileges individualism. She explains that ideologies that form the basis of Eurocentrism (such as White Supremacy, patriarchy, and Christian-centrism) are unseen mechanisms which generate empirical and observable experiences and phenomena. Using critical realism as a philosophical foundation, understanding the coloniality of power, and becoming critically conscious provides a framework with which to de-centre the dominant paradigm, and is an epistemological approach often used in decolonising processes.

The current thesis took a decolonising approach in alignment with Denscombe's (2025) and Thambinathan & Kinsella's (2021) descriptions of decolonising research methodologies, outlined earlier in the chapter. In alignment with this, the current project aimed to challenge the dominance and assumptions of Western epistemologies, centre the knowledge and lived realities of Indigenous and marginalised communities, and approach the research as a relational, reflexive, and accountable process.

A commonality of critical realism, decolonising, and Indigenist approaches is they all emphasise a fundamental existence of relationality; the concept that we, our experiences, and everything exists within complex, interacting relational systems. This conceptual framework of *relationality* underpinned the thesis and provided a foundation for the research process as well as understanding, organising, and communicating findings. Bronfenbrenner's ecological systems model (Bronfenbrenner, 1977) offers one way of conceptualising relationality and systems thinking through a Western lens as depicted below.

Figure 1

Bronfenbrenner's Ecological Systems Model



Note. Sticks & Stones Education. (2023). *Schematic representation of Urie Bronfenbrenner's Ecological Systems.*

However, it is important to note Bronfenbrenner's ecological systems model does not fully align with Indigenous worldviews, which emphasise the fusion of individuals with their environment and relationships[31], rather than centring the self or even regarding oneself as a separate entity (Durie, 2004a; Fish et al., 2022; Ramsden et al., n.d.). Bronfenbrenner's model centralises the individual, which is somewhat incompatible with a collectivist worldview, and lacks inclusion of important relationships with ancestors, the spirit realm, features of the environment and so on. The differences can be observed when one compares Bronfenbrenner's model to The Indigenist Ecological Systems Model (Fish et al., 2022) depicted below, which represents Native American conceptualisations of

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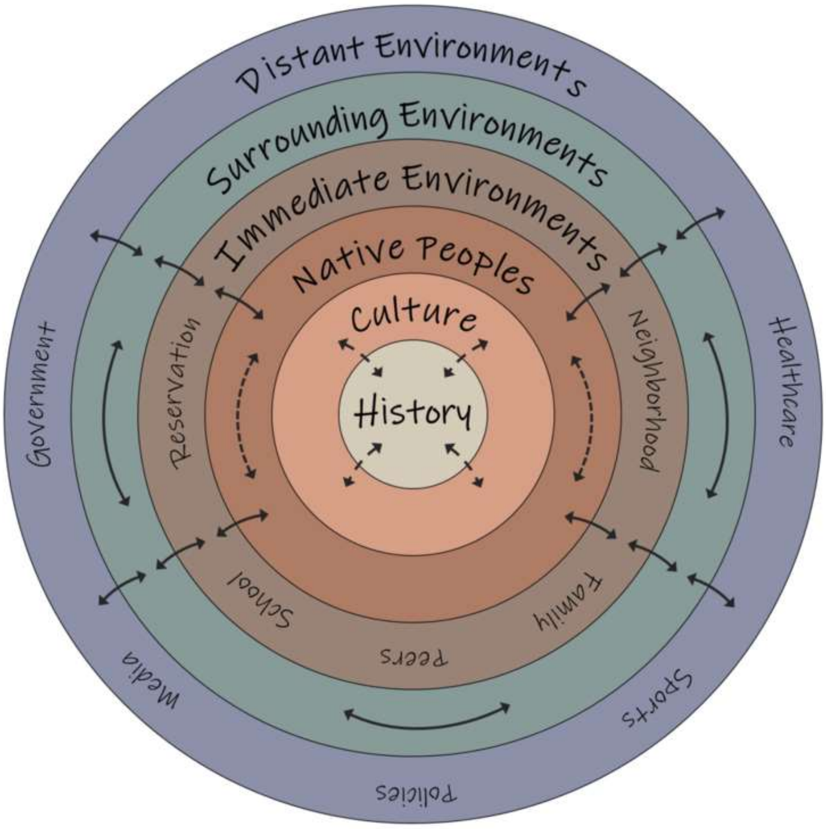
[31] Including those with ancestors, histories, culture, non-human beings and so on.

systems. For this reason, the broader concept of relationality was adopted throughout this thesis to maintain a relational, systemic lens while remaining inclusive of various conceptualisations of systems across cultures. However, Bronfenbrenner’s ecological systems model was used pragmatically to organise themes in the reflexive thematic analysis, as the phenomena described by whānau clearly mapped onto this Western model of social organisation. Indeed, the ubiquity of this individualised structure in society was reflected in their experiences and, at times, described as a force that generated and perpetuated their adversities.

Figure 2

The Indigenist Ecological Systems Model



Note. Fish et al. (2022). *The Indigenist Ecological Systems Model.*

The conceptualisation, design, and implementation of this research project was also carried out with the specific intention of honouring te Tiriti o Waitangi and fulfilling the duties and obligations it confers to tāngata Tiriti as treaty partners. Summarising how I attempted to fulfil my obligations and duties as tāngata Tiriti while producing this research project was not a straightforward task easily achieved by presenting a brief checklist, as it is not something I see (or have experienced) as being discrete, finite, task-based, or limited to the current project, nor to my conduct in the wider realms of academia and professionality that I occupy in my day-to-day life. Rather, I believe that upholding obligations as tāngata Tiriti is a dynamic and ongoing process that spans across the contexts and duration of one's life and requires deep, intentional, consistent, flexible engagement. Hudson and Russell (2009) assert that value-based engagement should be prioritised, rather than rule-based consultation when wing with Indigenous communities, as it is most likely to encourage consistency with a community and their values. I think this captures an important concept: it is not just what you do, but how you do it.

A focus on upholding the Treaty principles in the current project therefore inevitably spanned beyond the boundaries of this study, and for me meant:

- Practising cultural humility, activism, and allyship as outlined by Berghan et al., (2017) and Margaret (2010c, 2010b, 2010a).
- Engaging in ongoing reflexivity including acknowledgement and exploration of my own positioning in society, the intersectional dimensions of my identity, my whakapapa, and how my experiences influence the way I think and behave.
- Engaging in personal decolonisation. This was facilitated through engagement with Kaupapa Māori, Indigenist, and Decolonising literature (e.g. Bishop, 2019; Durie, 2004, 2011; Kimmerer, 2015; Lyall et al., 2021; Mahuika, 2008; Ramsden et al., n.d.; Ruwhiu, n.d.; Tuhiwai Smith, 1999, 2021a; Walker et al., 2006; Ware et al., 2018; West et al., 2012), exploration of my own whakapapa, working in a Kaupapa Māori setting, learning more about

mātauranga Māori[32], practicing tikanga, having frequent kōrero about these topics in my own communities, and exposure to Indigenous spaces.

- Acting in good faith and fulfilling my obligations to address inequity and challenge social injustices conferred by my positioning as a treaty partner, a researcher (Rogers & Lange, 2013), and a psychologist (Code of Ethics Review Group, 2012).
- Recognising tāngata whenua (especially those who participated in the study) as research partners with expertise. Engaging in whakawhanaungatanga in a way that reflected this, fostering safety and reciprocity, engaging in cultural supervision[33], providing opportunities for feedback and engagement, and honouring of the equivalency of diverse forms of expertise.
- Recognising Māori health, culture, and stories as taonga that are guaranteed protection under te Tiriti (Came et al., 2020).
- Recognising the historical breaches of te Tiriti in the health sector in Aotearoa as detailed by the WAI 2575 report and aligning with recommendations: compliance with te Tiriti, recognition of tino rangatiratanga (Māori right to self-determination), accountability to Māori, ensuring that investment in Māori health promotes equitable outcomes, embedding equitable and non-racist practices.
- Acting in a value-based manner with emphases on integrity, relationality, reciprocity, trust, respect, collectivism, humility, and accountability.

Research Design, Objectives, and Methods

The overarching purpose of the current thesis was to contribute to equitable, positive outcomes and experiences for children, youth and whānau with HCN by exploring experiences of the

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[32] Māori knowledge and wisdom.

[33] With Dr Simon Bennett – see Appendix B.

Wraparound Process and its effectiveness in relevant contexts. The specific objectives were as following:

1. Explore international use of the Wrapround process with underrepresented populations to establish an overview of extant literature on the topic
2. Acquire information about the experiences and outcomes of the Wraparound Process in Aotearoa as delivered by TKT IWS, with a focus on Māori experiences and adherence to te Tiriti
3. Explore Māori experiences of TKT IWS and raising children and youth with HCN using qualitative methods
4. Examine progress and outcome data collected by TKT IWS and the Ministry of Education using quantitative methods
5. Provide feedback to the Ministry of Education and TKT IWS that was useful in terms of their service development and goals
6. Use a decolonising epistemology and methodological framework

This thesis is a multi-study project consisting of three distinct studies. The studies were designed to align with my commitment to a decolonising epistemological framework as well as my obligations to communities connected to this project. I felt it was particularly important to consider how the research could best benefit children, youth and whānau with HCN and the systems they engage with. Specific information regarding each study's methods, procedures, sample characteristics, measurements, and analytical processes are outlined in detail in the relevant chapters. This section of the chapter will focus primarily on the rationale for the design and methods of each study and briefly describe them.

Manuscript 1: Use of the Wraparound Process with underrepresented groups: a scoping review

The first manuscript[34] is a scoping review of the use of the Wraparound Process with underrepresented groups globally. The purpose of conducting this scoping review was to explore and establish an overview of the literature base pertaining to the use of the Wraparound Process with underrepresented groups in research. The scoping review provided a useful synthesis of knowledge on the topic and helped to inform the rest of the thesis by 1) establishing the extent, range, and nature of research on the topic, 2) identifying trends in how the Wraparound Process has been used with and experienced by underrepresented cultural groups, and 3) identifying gaps in the literature and future directions. The scoping review was conducted in adherence to the PRISMA extension for Scoping Reviews (PRSIMA-ScR; (Tricco et al., 2018)).

Manuscript 2: A multi-study exploration of Te Kahu Tōi Intensive Wraparound Services: qualitative analysis of interviews with Māori whānau and quantitative analysis of outcomes.

The second manuscript consists of two distinct studies which utilised disparate methods to explore the experiences, outcomes, and effectiveness of the Wraparound Process as delivered by Te Kahu Tōī Intensive Wraparound Service (TKT IWS)[35]. The first is a qualitative analysis of interviews with Māori whānau about their experiences of TKT IWS, which aligns with decolonising and indigenist research methods. The second is a quantitative pre-test post-test analysis, which is more aligned with traditional research methods in social, health, and psychological sciences.

For the qualitative study, reflexive thematic analysis (RTA) as outlined by Braun and Clarke (2019) was the analytical method chosen to guide interpretation of the transcribed interviews and shape presentation of the knowledge generated in partnership with participants. RTA centres

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[34] Chapter 4: Use of the Wraparound Process with underrepresented groups: a scoping review.

[35] Chapter 5: A multi-study exploration of Te Kahu Tōi Intensive Wraparound Services: qualitative analysis of interviews with Māori whānau and quantitative analysis of outcomes.

researcher subjectivity and reflexivity. Braun and Clarke (2019) characterise research as a deliberative process involving conscious decisions about design, method, ontology, epistemology and methodology. They assert that qualitative research and analysis is about telling stories, which involves perception, interpretation, and creation. Braun and Clarke (2019) describe qualitative research as inherently creative, context-bound, and relational. Subjectivity is therefore embraced in RTA and seen as a resource to engage with and reflect upon, rather than a threat to the production of useful knowledge (Braun & Clarke, 2019). For these reasons, RTA was seen as an appropriate choice for the current project. It provides an analytical framework within which researchers can divest of dominant positivist, mono-cultural scientific thinking and processes, and be explicit and intentional in producing research that challenges pathogenic norms and processes that contribute to inequity. RTA has been used within Kaupapa and Indigenist research projects (Gidgup et al., 2022; Kanaÿiaupuni et al., 2006; Kennedy et al., 2022; Wirihana, 2012). The analytic process also was engaged with in a manner that upheld the integrity of narratives shared. This aligns with oral-based story-telling Indigenous epistemologies and the importance of stories in te ao Māori (Ruwhiu, 2008). Narratives are a common Indigenous method of codifying knowledge and engaging in the process of knowing in a way that centralises relational origins and connections. Utilisation of conversational, story-based methodologies can honour participants' voices and experiences, by seeing their story as inherently valid and focussing on its uniqueness rather than its generalisability. This is of critical importance considering Māori experiences and voices are often marginalised within research (Ware et al., 2018).

For the quantitative study, a longitudinal single cohort design was used to explore outcomes for a group of children, youth and whānau over a year of engagement with TKT IWS. Longitudinal research permits exploration of change or stability in variables of interest over time, which means inferences can be made about the direction and magnitude of potential causal relationships (McKinlay, 2011).

Using both qualitative and quantitative approaches can permit thorough, holistic exploration and understanding of phenomena at multiple levels of analysis and detail (Wisdom & Creswell, 2013). Different approaches can be brought together in decolonising research initiatives if done so with considered intentionality. Many researchers argue it is crucial to acknowledge and utilise the strengths of diverse knowledge systems and contexts in thoughtful, creative ways while critiquing and challenging the dominant paradigm (Thambinathan & Kinsella, 2021). This practice has been encapsulated by Etuaptmumk: Two-Eyed Seeing, an Indigenous approach to collaboration and co-creation of knowledge achieved through the use of *both eyes* and the *braiding* of Indigenous science and western science, as described by Kimmerer (2015) and Snively and Williams (2018). The metaphor of braiding is derived from Native American customary practices of braiding hair and weaving sweetgrass. Essentially, braiding epistemologies and approaches implies a reciprocal, mutually beneficial relationship that creates something of strength and beauty. Each strand is a separate entity, and tension is required, but all come together to form the collective whole. When Indigenous and Western science are braided, both ways of knowing are legitimised (Snively & Williams, 2018).

Additionally, the choice to use traditional quantitative methods alongside qualitative is reflective of the fact that academic, policy-making, and funding authorities tend to evaluate knowledge and interventions based on traditional scientific standards of reliability, validity, and efficacy (Chorpita et al., 2011; Thambinathan & Kinsella, 2021). Often, research approaches therefore need to be altered to meet Eurocentric standards of legitimacy (Thambinathan & Kinsella, 2021). In particular, there is a strong global pressure often backed by legislation to ensure that publicly funded interventions are evidence-based according to traditional scientific criteria that centres quantitative data, large samples, randomised controlled trials, systematic reviews, and the use of well-established measurement tools (Chorpita et al., 2011) which are not often cross-culturally relevant, applicable, or sensitive (Sue, 2006).

I therefore felt that using a traditional quantitative approach for one of the studies was an acceptable choice within the overarching decolonising framework and objectives of the thesis. By engaging critically and considering the potential limitations and problems associated with using quantitative methods and measures in this context, I felt that doing so could:

- provide meaningful data about the intervention and outcomes relative to other Wraparound approaches globally.
- strengthen advocacy for increased funding and availability of the Wraparound Process and other systemic interventions should outcomes appear to be favourable and equitable.
- facilitate and demonstrate critical exploration and reflection about the utility of quantitative methods and measurements in ethical practice and research.
- permit a clear demonstration of the added and differing benefits of qualitative decolonising methods and exploration of experiences.
- permit a synergistic exploration of the effectiveness of the Wraparound Process as delivered by TKT IWS through multiple lenses and approaches, with two separate samples.

Population, sample size, and recruitment

Participants for both the qualitative and quantitative studies were children, youth and whānau engaged with TKT IWS in 2019. Recruitment occurred via Te Kahu Tōī employees due to pragmatic[36] and ethical[37] barriers to the direct recruitment of children, youth and whānau. Recruitment via organisations who have established relationships with target populations can also reduce barriers to research engagement for vulnerable populations (Giodarno et al., 2023c; Rogers & Lange, 2013). Information about the research project was offered to all eligible children, youth and families at their regularly scheduled team meetings.

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[36] Geographical and financial limitations

[37] Confidentiality

To be eligible for the quantitative study, children, youth and their whānau had to have been engaged with Te Kahu Tōī for six months or less. This ensured a recent baseline had been taken and a second measure could be taken within the timeframe of the research project. Participation in the quantitative study for these children, youth and whānau involved providing informed consent for extra data collection and sharing and otherwise engaging with TKT IWS as normal. TKT IWS staff were required to complete extra psychometrics for these families as well as those they complete as part of their usual processes and provide results to the research team. To be eligible for the qualitative study, children, youth and whānau had to self-identify as Māori and be engaged with TKT IWS for at least six months. This timeframe ensured by the time interviews took place the whānau would have been engaged with the service for a significant period, perhaps near discharge, and likely to still be contactable. The samples for each study were distinct with no overlap, due to the different eligibility requirements regarding the timeframe families had been engaged with services.

If families expressed interest in taking part in either study, they were presented with information and consent forms[38] along with contact details for myself and my supervisors should they have any questions. Once consent had been provided, TKT IWS collected and shared baseline data for the quantitative study and families were contacted to organise interviews for the qualitative study. More detailed information about the procedures of each study can be found in Chapters 6 and 7.

From the conception of this research project, it was recognised that the sample size would be relatively small. Based on the size of the population served by TKT IWS in the previous financial year, it was estimated that 25- 35 families would be recruitable for the quantitative study. For the qualitative study, I aimed to conduct 5-10 interviews. Initially this target was based on published guidelines regarding sufficient sample sizes for small qualitative studies that could achieve theme saturation (Braun & Clarke, 2021; Fugard & Potts, 2015; Smith & Osborn, 2009) within pragmatic

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[38] Found in the appendices.

constraints given that this was one of three studies in the current thesis). Pragmatic constraints also included externally imposed timeframes by the university, limited financial resources, and having to conduct the interviews, transcription, and analysis as an individual researcher. However, as my engagement with the project progressed and my understanding of qualitative research grew, I eventually selected RTA as the qualitative approach I would take and came to understand that theme saturation was not an applicable or appropriate concept within RTA or decolonisation approaches (Braun & Clarke, 2021).

Braun and Clarke (2021) explain how the idea of theme saturation aligns with neo-positivist, discovery-based assumptions about the nature of qualitative research. It implies that codes and themes reside within data in an objective sense, separate from interpretative processes and excavatable through analytical procedures. Theme saturation also conveys assumptions about informational redundancy, implying that similar codes and themes are interchangeable, rather than unique and relationally situated in their story and context. Finally, saturation of themes implies that analysis or knowledge of a topic can be complete and reach a fixed endpoint. Conversely, Braun and Clarke (2021) explain how researchers make situated, interpretative judgements about when to complete each analytical step and eventually finalise their analysis; a process which is often circular and iterative, with no clear end.

Theme saturation is a concept often used to validate and rationalise sample size in alignment with the dominant positivist academic paradigm. However, Braun and Clarke (2021) explain that choices about sample size are inherently and necessarily relational, influenced and constrained by factors such as the diversity in the data, the demands placed on participants, the depth of the data generated, the expectations and requirements of local contexts, the scope and purpose of the project, and pragmatic constraints (Braun and Clarke, 2021). Hence, Braun and Clarke (2021) recommend researchers make a grounded decision about the final sample size in response to the adequacy of the data (in terms of complexity, richness, and depth) for addressing the research question - while still honouring pragmatic requirements. They note that Malterud et al.'s (2016) conceptualisation of information power can be useful in making such judgements, which posits that the more relevant information a sample possesses, the smaller the sample size can be. My goal of recruiting 5 – 10 families aligned with this approach and by the sixth interview my supervisors and I felt that the data collected was sufficiently complex, rich, and powerful to meet the objectives of the research project in a meaningful way.

Ethics

Careful consideration of ethical issues is critical when engaging in practice-based research with vulnerable populations (Hoagwood et al., 2014; Rogers & Lange, 2013). This section will summarise key ethical issues identified in the current research project. This research project was approved by the Massey University Human Ethics Committee (SOB 18/65). Relevant documents including information and consent forms, the interview guide, and the feedback of results to participants and TKT IWS can be found in the appendices.

Consent

Special consideration needs to be given to obtaining consent from and engaging with vulnerable populations in research and practice. Children, youth, Indigenous people, and service users are regarded as vulnerable groups (Hoagwood et al., 2014; Rogers & Lange, 2013). Ethically, informed consent requires that an individual has the capacity to give consent, has been provided with and understands information about what they are consenting to, and has chosen to participate voluntarily (Nijhawan et al., 2013).

It is also ethically responsible to recognise children and youth as capable of being partners in research. Therefore, they should be provided the right to receive information, be listened to, have their opinions and feelings considered, and give or withhold consent if competent to do so. Involving children and youth in decision-making fosters trust, engagement, and positive relationships. Although it is not legally binding, it is considered best practice to obtain child/youth assent as well as caregivers' informed consent to engage when children or youth are unable to provide informed consent (Nijhawan et al., 2013). Hence, the consent processes for both the quantitative and qualitative components of this research project sought informed consent from caregivers and assent from children/youth, who were also encouraged to take part in the interviews should they choose to.

It is important to acknowledge power dynamics in research and service delivery when considering consent in the current project. A requirement of informed consent is that participation is a choice made free from coercion and manipulation, meaning no negative consequences will eventuate if consent is withheld (Nijhawan et al., 2013). Because children/youth and their families had pre-existing therapeutic relationships with TKT IWS employees who presented the opportunity to participate in this research, there was a risk they would feel obliged to consent or have difficulty declining.

To mitigate this, the information provided made it very clear that participation was optional and choosing not to take part would not affect service provision whatsoever. The information sheets and consent forms were developed by myself and reviewed by my supervisors to ensure they provided adequate, accessible information about the research project. TKT IWS staff assisted in going through the documentation if required, and families were able to take it home to consider and discuss further. Consent forms were returned to me by TKT IWS staff. No data or information about participants was shared with me until consent had been acquired.

The information pack also clarified that consent was an ongoing, renegotiable process and participants were welcome to withdraw from the research at any stage. Participants in the qualitative study were reminded of this in person during the interview process, and consent was reconfirmed. They were also invited to review their transcripts and provide feedback on the results of the analysis.

Confidentiality

Confidentiality and privacy are also especially important in practice-based research involving vulnerable populations. Important considerations included protecting identity via anonymity, ensuring confidentiality of collected data, and ensuring that interview locations were safe and private. For the interviews, participants chose locations that were most convenient and comfortable for them. Data (including interview transcripts, consent forms, audio recordings, and outcome data) was stored and transported securely. Electronic data was sent from TKT IWS via secure email with protective firewalls and stored under password protection. Physical documents were kept in a locked file cabinet in a locked office at the Massey University campus in Wellington, accessible only by the research team.

To protect the identity of participants, identifying information was removed from transcripts. Participants were assured that participation and authenticity in interviews would not affect service provision; what they said would not be shared with the TKT IWS staff they worked with in a manner that could identify them. Once audio recordings were transcribed, they were deleted. Data will be securely held for the minimum ten-year period before being destroyed in accordance with Massey University policies.

Risk mitigation

The risk of harm to participants was deemed minimal. All but one of the interviews took place in whānau homes. To ensure the safety of myself and whānau it was important to consider and plan for potential risks. Supervision from qualified and experienced clinical psychologists was continually accessed. Practice interviews took place with clinical supervisors prior to the actual interviews to ensure that the procedures were carried out responsibly, sensitively, and ethically. Participants were reminded that they were welcome to stop the interview at any point, ask to have the recording device turned off, or refuse to answer any question.

When attending interviews, I informed my supervisor/s the time at which the interview commenced, and what the projected finish time would be. I contacted my supervisor/s when the interview was complete or if it was going to go over the estimated time. The possibility that participants could become acutely distressed during the interview was considered. In that scenario, the interview would have been ceased, the recording device turned off, and I would have offered support. If support beyond what I offered in that moment was required, I was able to facilitate access to further support through the family's TKT IWS psychologist or my supervisor (a registered clinical psychologist) if the family desired. Once immediate distress had resolved, the participant would have been reminded of their right to cease the interview and withdraw from the research or proceed at another time.

There was also the possibility that sensitive information could have been disclosed during interviews. At the beginning of each interview, a confidentiality statement was provided outlining the nature and limits of confidentiality. I ensured that at least one supervisor who was a registered clinical psychologist was available for supervision prior, during, and after interviews if required.

Cultural considerations

Cultural considerations shaped the design of the current research project from conception to write-up. Deep engagement with cultural issues was critical considering the well-evidenced culture-based disparities in wellbeing and service delivery in Aotearoa and globally. The primary ethical issue which subsumed specific cultural considerations was the potential risk of perpetuating inequity and harm by adhering to the dominant academic paradigm. This was particularly relevant due to both the objectives of the project and the socio-cultural contexts in which it was positioned; in relation to the socio-political context of Aotearoa, myself as a non-Māori researcher, and the overrepresentation of Māori labelled as HCN. Because academia, education, and the health sector have a well-documented history of enacting harm against Māori, this was the primary overarching ethical consideration within the current research project. Choices about the epistemological and methodological approach, methods, procedures, and write-up attempted to mitigate these risks as best as possible.

In addition to what has already been outlined, particular attention was given to what upholding te Tiriti and engaging in a culturally responsive manner looks like in an applied sense for researchers and providers of health and social services. Guidance was primarily taken from Māori academics (Bishop, 2019; Hudson et al., 2010; Hudson & Russell, 2009; Ramsden et al., n.d.; Tuhiwai Smith, 2021a) as well as governmental and institutional guidelines (Code of Ethics Review Group, 2012; Health Research Council of New Zealand, 2010). I found it was important to continuously engage with, reflect on, and critique my conduct and choices in relation to cultural issues as the research project progressed and new challenges, demands, and realisations arose.

Te Ara Tika: Guidelines for Māori Research Ethics (Hudson et al., 2010) and publications by Mason Durie (Durie, 2004b, 2004a, 2011, 2017) were foundational in both the initial conceptualisation and design of the current research project. Te Ara Tika outlines four tikanga based principles to consider during the conception and implementation of research: whakapapa, which refers to the purpose of the project, tika, which refers to the design of the project, manaakitanga, which refers to cultural and social responsibility, and mana, which refers to justice and equity (Hudson et al., 2010). Using Te Ara Tika as a guide when first conceiving of and designing the project facilitated identification of potential ethical concerns and provided a strong foundation with which to build an ethically, culturally sensitive project. Potential concerns outlined below were discussed with my supervisory team and Dr Simon Bennett, who provided cultural supervision. It is important to reiterate that the ethical issue of potentially perpetuating inequity and harm through upholding the dominant Western paradigm (especially as a Pākehā researcher) permeated all facets of the research and is difficult to distil down to discrete discussion points. However, specific considerations included the risk of perpetuating racist biases in research, and ensuring appropriate, positive relational engagement with Māori whānau - particularly in the interview process.

As stated earlier, my positioning as non-Māori was a central factor that needed to be acknowledged, reflected upon, and engaged with throughout the project. The extent of understanding I was and am able to achieve about Māori experiences, values, beliefs, and perspectives is limited. Regardless of my efforts, my understanding can never equate to lived experience. Being non-Māori likely shaped not only the extent of rapport and relational connection that was possible, but also the nature of it. It also increased the risk of making incorrect assumptions, engaging in a tokenistic manner, and imposing Eurocentric ideologies or interpreting phenomena through that lens. Additionally, engaging with Māori whānau who are raising children and youth with HCN as a Pākehā researcher and clinician is inevitably a social dynamic with its own whakapapa and relationality that extends beyond the room and any given moment in time. Many, if not all whānau who engaged in co-creating this research have had negative experiences with Pākehā clinicians and professionals.

Hence, prioritisation of the whakawhanaungatanga process and facilitating safe, comfortable connection was critical. The interview process was informed by decolonial and indigenist research approaches, especially conversational and narrative methods (Gidgup et al., 2022; Kennedy et al., 2022; Ruwhiu, 2008; Tuhiwai Smith, 2021d). Focussing on reciprocity, meaningful connection, and partnership was a core component of engagement. I shared information about my own identity, whakapapa, values, experiences, positioning, research approach, and personhood in an appropriate but authentic manner. I also acknowledged the potential for discomfort due to my positioning and welcomed questions, concerns, discussion, and feedback throughout the process. The Hui Process was used to guide initial engagement with whānau (Pitama et al., 2017). Questions in the interview were general and open-ended, avoiding imposing assumptions about participants' identity, perspectives, values, and lived experiences. Interviews were flexibly conducted in a manner that prioritised comfort and was underpinned by tino rangatiratanga; providing choice about how, where, and when the interview would take place. Opportunities for feedback about the research process and results were provided as well as the option to disengage at any time. Multiple whānau members were welcome to attend interviews, interviews were conducted in their chosen setting (most often their homes), sharing of kai[39] or a hot drink and thoughtful context-dependent engagement in tikanga took place where appropriate. Whakawhanaungatanga necessarily took precedence over traditional Eurocentric models of professionality and authority.

Another key ethical consideration was the potential risk of perpetuating racist stereotypes and practices in the write-up of this research by depicting Māori in a way that emphasised disparities and deficits, rather than distinction, difference, and strengths. It was important to ensure that this bias was avoided by emphasising strengths as well as disparities, avoiding negative generalisations and stereotypes, and explicitly referencing the societal and institutional conditions that produce disparities. I consulted Kaupapa Māori guidelines (Durie, 2004b; Hudson et al., 2010; Ramsden et al., n.d.; Tuhiwai Smith, 2021c) and guidelines about culturally responsible research more generally (Rogers & Lange, 2013; Saini & Begum, 2020; Werkmeister Rozas, 2022; Yosso, 2005) throughout the research process, including while working with statistics and writing up results. Consultation and supervision were sought to ensure results were reported in a culturally safe, considered, and ethical manner. Recommendations and conclusions were informed not only by traditional mainstream science and methodologies but Indigenist and decolonising schools of thought and practice too.

Learning about other cultural paradigms and methodologies during the completion of this project was powerful in deepening my reflexivity and helping me to attune to, identify, and challenge Eurocentrism in myself and the research project. For example, Ware et al.'s (2018) explanation of a Kaupapa Māori[40] approach to narrative inquiry highlights how relational, collaborative, and inherently political the construction of knowledge through narratives and conversations is in te ao Māori. To privilege marginalised voices, the storyteller and the listener must

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[39] Food.

[40] Principled Māori approach.

have some degree of shared understanding of complex experiences connected to identity. This whanaungatanga[41] is a prerequisite for ethical practice and research that is in the best interest of Māori. Related to this is the fulfilment of reciprocal obligations and duties; explicitly engaging with authenticity, accountability, and acknowledgement of power relations.

These principles are rooted in longstanding cultural histories and customs. As Ware et al. (2018) explain, storytelling is a collective act in te ao Māori. Stories are not possessed by individuals or isolated from others and the environment. Stories involve and therefore belong to multiple people and the environment in which they take place. With this conceptualisation of knowledge generation and sharing, comes the storyteller's (or researcher's) inherent relational obligation to get the story right and be open to correction by the community with whom the creation/telling of the story is shared. Retelling or sharing of a story is not seen as a simple act of recital, but rather, as an inherently relational activity where the researcher's positioning inevitably has influence. Like RTA, this is seen as an inevitable and typically useful aspect of knowledge creation and generation processes. If the world we live in is relational, and knowledge is collectively created and shared, then knowledge is richer and more useful when generated, reflected upon, and explored in a relational manner.

Conclusion

This chapter explored the positionality and whakapapa of the current project and how that shaped its design. Reflexivity, relationality, decolonisation, and social justice were foundational frameworks upon which the methodological, ethical, and procedural design choices were made. Stewart (2008) explains how relational methodologies can demonstrate how Indigenous paradigms influence knowledge and practice through co-construction and co-participation. On a related note, I am deeply grateful for what I have experienced and learnt during this project, particularly from whānau who gifted me the privilege of hearing their stories. As much as I influenced and shaped this

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[41] Kinship/relationship grounded in shared experience.

research process and project, it influenced and shaped me too, as did the participants, in quite profound and life changing ways. As stated by Wilson (2008, p. 135); “If research hasn’t changed you as a person, then you haven’t done it right.” I do not for a moment hope that this project tells a story perfectly - or even without significant faults and limitations. I do hope that my endeavours to embody allyship (Margaret, 2010a, 2010c, 2010b) and the principles of te Tiriti have allowed me to uphold the mana and experiences of the whānau that co-created this project, and ultimately offer up something of use and benefit in the pursuit of equity and wellbeing, particularly for children, youth and whānau with HCN in Aotearoa.

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STATEMENT OF CONTRIBUTION
DOCTORATE WITH PUBLICATIONS/MANUSCRIPTS

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

Student name:	Lucy Rose Lightfoot
Name and title of main supervisor:	Ian de Terte
In which chapter is the manuscript/published work?	3

Describe the contribution that the student and members of the supervisory team have made to the manuscript/published work:[1]

The candidate was responsible for the design, data collection, analysis and write up of manuscripts. Supervisors contributed to the manuscripts as usual for PhD theses; providing guidance, feedback, and input regarding decisions about the research process, analysis and formatting of the thesis.

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Chapter 3: The Wraparound Process: an adaptable, promising intervention to support isolated youth or those at risk

This chapter presents Wraparound as a promising intervention for youth who are isolated from or at risk of isolation from their family systems. The chapter was completed as a contribution to a book about the characteristics, dynamics, and development of youth (focussing on those 15-25) who lack familial support. The book took a preventative approach, emphasising the promotion of positive youth development for youth who lack familial support or who are at risk of isolation from family systems (Lightfoot et al., 2023; Mozes & Israelashvili, 2023).

Wraparound was initially designed to provide an effective intervention in the lives of children and adolescents with highly complex needs. It also targets youth who are at risk of placement, or already live, in out-of-home settings. Research continues to demonstrate Wraparound's efficacy with diverse populations, regardless of the severity and complexity of needs that children, youth and families' present with (Burchard et al., 2002; Vandenberg et al., 2003).

Wraparound offers a comprehensive framework and approach to improve youth outcomes and wellbeing and prevent or mitigate a plethora of deleterious outcomes. The chapter begins by providing a definition of youth for the purpose of the current chapter and exploring the influence of family support on the development and maintenance of wellbeing in youth. It then moves on to describe three populations of youth prone to experiencing various forms of isolation from their family systems – namely, youth with social, emotional and behavioural difficulties (SEBD), youth in state care, and Indigenous youth. The unique context, culture, and challenges faced by youth and their wider community in Aotearoa (New Zealand) will be outlined to illustrate how challenges faced by youth who are at risk, or are already isolated, are intertwined with complex personal, cultural, and societal factors - particularly for Indigenous youth in a colonised country.

The need for an approach that is intersectoral, coordinated, culturally safe, holistic, community-based, innovative, and highly adaptable to individual needs for isolated youth or those at risk will be outlined. Finally, Wraparound will be presented as a viable and promising intervention that is adaptable to diverse settings, needs, and populations.

Defining youth

Youth is a somewhat amorphous term, and definitions vary across cultures and organisations. Youth is best described as the transition from the dependence and relatively limited roles of childhood to the autonomy of adulthood, which tends to vary in timing depending on demographic, economic, and sociocultural factors (United Nations, 2014). Eccles et al. (2003) stated that youth encompasses two different developmental stages: early adolescence and emerging adulthood. It is a period often characterized by social and developmental turmoil, as the individual attempts to manage the demands of a multitude of rapid changes. They outline how from the age of 10 to 25, dramatic changes occur at all levels of life; biological, social, and psychological. Youth must navigate developmental and sexual maturation, establish social and personal identities, complete formal education, and embark on adult pursuits. These pursuits include those of a vocational nature; youth decide on a career or job, plan/make decisions regarding their futures, and find meaning and purpose in the roles they select. They also include more personal, emotional, and relational developmental tasks: acquiring awareness of their strengths and limitations, coping with unforeseen events, living more independently, and often, exploring romantic connections. They must accrue and consolidate skills, values, attitudes, and social connections necessary to develop and maintain self-reliance, wellbeing, and adult forms of interdependence. Very few periods of development are characterised by such a vast multitude of changes in so many areas of functioning. Given this, youth is a developmental period with potent potential for significant positive or/and or negative outcomes and trajectories to emerge (Eccles et al, 2003).

Burt and Masten (2010) describe developmental tasks that are seen as critical to successful transition into adulthood in most societies. These tasks include educational achievement, social competence, formation of romantic relationships, work competence, civic engagement, coherent identity formation, autonomy, and positive wellbeing. They note that autonomy and individual identity may be less salient tasks in cultures that value collectivism and belonging.

A review by Scales and Leffert (1999) outlines a comprehensive list of assets, values, and skills critical to successful development through adolescence into adulthood. Longitudinal studies have demonstrated strong relationships between the factors that they have identified and successful transition into adulthood. Of note, strong and positive connections to one's own family and to other social networks were identified as a very important factor in healthy development and in the successful transition to adulthood.

Arnett (2000) coined the term *emerging adulthood* to conceptualise the age period between late adolescence and the mid-late twenties (approximately 18-25). He asserted that it was a useful way to conceptualise a new life stage with distinctive characteristics in modern industrialised societies. Emerging adulthood is a highly variable life stage without clear normative expectations, developmentally distinct from both adolescence and adulthood. Research has shown that in alignment with this theory, emerging adults tend to view themselves as neither adolescents nor adults, as do their parents (Arnett, 2007, 2015). Arnett (2000) explains that this ambivalence is due to the delay in achieving milestones perceived as integral to reaching adulthood compared to previous generations. Emerging adulthood is characterized by role and identity exploration (Arnett, 2000). Although individuals become more independent in emerging adulthood, they also tend to rely on their families for emotional and material support for longer than previous generations and reside with their parents for longer too (Oliveira et al., 2020).

While there has been an increase in awareness and attention pertaining to the mental health and social issues that affect youth, there continues to be a lack of early identification and effective intervention in practice. Research has shown that youth have different challenges and needs than children and adults. However, this is not clearly demonstrated in service delivery (Malla et al., 2018; Patel et al., 2007).

In terms of specific age parameters, The World Health Organisation (WHO) defines *children* as those under 18, *young people* as those aged 10-24 years, a*dolescents* as those aged 10-18 years, and *youth* as those between the ages of 15-24 (World Health Organisation, n.d.). In Aotearoa, youth have been defined as those between the ages of 12-24 (Ministry of Youth Affairs, 2002). UNICEF defines those under 18 as children (United Nations, 2014). For the purpose of this chapter, a wide net will be cast to allow for cross-cultural and contextual variance. Research cited in the current chapter will include children, adolescents, and emerging adults up to mid-twenties. Risk and protective factors relevant to navigating the transition into adulthood have often been present throughout childhood and adolescence, highlighting the importance of considering research that focusses on children and adolescents when concerned about the wellbeing of emerging adults (Patel et al., 2007a). Early intervention reduces the severity and/or risk of mental health difficulties later in life and has beneficial effects on developmental, emotional, academic, and social outcomes. Research has shown that the earlier the intervention occurs, the greater its positive effects are (Manning, 2017; Manning et al., 2010)

The obvious implication of the abundance of challenges faced by youth in their transition to adulthood, and the skills required to navigate them, is that there should be a focus on early intervention and support for youth, particularly for those at risk of poor outcomes, to foster skilful transition into adulthood.

The influence of family support on the healthy development and maintenance of wellbeing in youth

Parents are highly influential throughout the lifespan and increasingly, research is exploring the effects of wider family system dynamics on youth development (Kaniušonytė & Žukauskienė, 2018). Lerner et al.'s (2002) strengths-based Positive Youth Development (PYD) Framework proposes five specific traits that facilitate positive development in the transition to adulthood: caring, confidence, competence, character, and connections of a positive nature with institutions and people. Lerner (2005) states that these traits protect youth from developmental trajectories characterised by problems and risks, such as smoking, drinking, bullying, delinquency, high risk behaviours, and poor mental health. Furthermore, their presence is predictive of the emergence of a sixth trait; contribution to the self, family, community, and society, which indicates successful transition into adulthood and society. Lerner's framework (2002) outlines how youth develop into healthy, fulfilled adults when their peer groups, parents, and communities act as promotive influences. The importance of the family context and parent-child relationships is emphasised. Lerner (2005) states that people are the most important asset to PYD, and family members, more than school or community members, play the most significant role in the youth development. His research found one of the strongest predictors of PYD to be regular family dinners.

Social Support Theory outlines how families might provide support to children and youth. Often the very existence of a social network is assumed to be positive, but social networks can be detrimental if they include harmful dynamics such as neglect, conflict, or modelling/reinforcement of antisocial and/or problematic behaviours (Chu et al., 2010). The evidence suggests that while children and youth may not be observably isolated, they can still experience social and emotional isolation within their family or social systems. Social support is defined as the provision or inferred availability of material and psychological resources that help individuals to cope with stress (Armstrong et al., 2005; Chu et al., 2010), which is not always present within a social network.

Social support can take several forms; instrumental, informational, emotional, and tangible support (Armstrong et al., 2005). Cohen and Wills (1985) proposed that social support is related to wellbeing because it facilitates positive emotions, a sense of self-worth, and predictability in life. It also has a stress buffering effect through reinforcement of self-esteem, self-efficacy, and problem-solving skills. Armstrong et al. (2005) described two pathways through which social support is associated with wellbeing: firstly, through the main effect, whereby the presence of social support has a positive effect on wellbeing regardless of whether an individual is under stress. The second is the buffering model, whereby social support acts as a protective buffer against the potentially detrimental effects of stressful events. Specifically, social support has been shown to act as a buffer at two points between stress and wellbeing: between the stressor and the manifestation of distress, and between stress and health/mental health outcomes.

Research corroborates these theories, emphasises the importance of social support, and elucidates specific pathways through which family support and social connection foster healthy development and wellbeing in youth. Chu et al. (2010) conducted a meta-analysis exploring the relationship between social support and wellbeing in children and adolescents. Wellbeing outcomes included academic achievement, conduct issues, psychological adjustment, self-concept, social adjustment, health and health behaviours, coping skills, and establishment of a career. They found a positive relationship between perceived support and wellbeing outcomes. Perceived support refers to the perception of available support, which was a stronger predictor of positive wellbeing than social network density (suggesting that it is the quality of the connections that matters, rather than the quantity) or enacted/actual support (this may be because those who access/need high levels of enacted support may have lower levels of wellbeing, and receiving actual support frequently may reduce self-efficacy or be seen as intrusive). Furthermore, Chu et al. (2010) found that there were three main sources of support for youth: family, educational staff, and friends. Interestingly, the associations between teacher/school support and wellbeing were stronger than for any other source (followed by family, then friends). This emphasizes the potential power of compensatory connections when youth have difficulty accessing support in their family of origin.

Lerner (2005) emphasised the particular importance of parental support, outlining how parents help youth to navigate the transition into adulthood by supporting their identity formation and autonomy. More so than the school or the community, he stated that family members play the most important role in positive youth development. Armstrong et al. (2005) provided a detailed description of how this takes place, asserting that the quality and characteristics of parenting interact with children and youths' personal characteristics, behaviours, and the wider sociocultural context to shape the course of the transition into adulthood. Caregiving dynamics contribute to the development of resilience; the ability to adapt and cope with adversity. It is within parent-child relationships that children and youth learn how to regulate behaviour and emotions and establish coping patterns, through parenting factors such as adequate supervision, consistent structure and discipline, parental attitudes, active involvement, and clear patterns of communication.

Wider systemic consideration of family dynamics and structure, both within and beyond the immediate family unit, is also important in conceptualising the effects of social support among youth. Armstrong et al. (2005) state that familial wellbeing and functioning as a structural unit affect youths' social-emotional functioning and development, through influential factors such as inter-parental conflict and broader familial characteristics such as cooperation, cohesion, harmony, expressiveness, and conflict. Additionally, the authors state that parenting quality is affected by the embeddedness of the family unit and parents in wider support systems. This is particularly pronounced when raising a high needs child or a child with a disability. Self-reported parental satisfaction with social support has a positive effect on parental wellbeing, family functioning, and parental perception of difficulties with their child.

In the twenty years since the conceptual establishment of emerging adulthood as a distinct developmental life stage, research has examined how social and familial support influences navigation of emerging adulthood, and the eventual outcomes. Oliveira et al. (2020) reviewed 50 studies published since 2000 that explored family dynamics during emerging adulthood. They found that emerging adulthood is a stage characterised by change in family relationships, and that healthy family systems anchor both individual and family development during these years. Additionally, family systems were found to help to foster a sense of identity and belonging, which are critical aspects of successful transition into adulthood. Kaniušonytė and Žukauskienė (2018) studied Lithuanian youth transitioning from adolescence into emerging adulthood and found that later success in navigating the transition[42] was predicted by supportive positive relationships with parents. These relationships were characterised by emotional warmth, trust, and communication, as well as autonomy supportive parenting styles. Similarly, García Mendoza et al. (2019) investigated the link between Spanish undergraduate students' family relationships and students' psychological wellbeing and distress. They found that emerging adults still received considerable social support from their parents. Families in the study were categorized into three clusters: high-quality family relationships, intermediate-quality family relationships, and low-quality family relationships. The clustering was based on five variables: parental involvement, parental support of autonomy, parental warmth, behavioural control, and psychological control. Higher levels of warmth, affection, closeness, and support of autonomy were associated with higher levels of wellbeing and lower levels of distress, whereas those who perceived family relations negatively demonstrated higher rates of distress and adjustment problems.

Where family support, community, and connection can confer developmental benefits and protection, a lack of these factors or problems within social and familial networks are significant risks to healthy development and successful transition into adulthood. Family problems, high levels of conflict, low parental engagement, greater use of invalidation, and harsh, inconsistent discipline are all factors associated with heightened difficulties and poorer outcomes in the transition into adulthood (Armstrong et al., 2005). A study of Nigerian emerging adults found that early vulnerabilities and a difficult developmental transition into adulthood, characterised by reduced social support and pervasive changes in social connections, made emerging adults more susceptible to suicidality (Olatunji et al., 2020).

In terms of experimental research, interventions that target familial and social connections to facilitate the establishment or improvement of positive supportive relationships demonstrate

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[42] as conceptualised by the young person's contribution to themselves, their family, and their community, in line with Lerner's PYD framework (2002).

benefits. Positive, sustained relationships between children, youth and adults tend to be a key factor in the effectiveness of positive youth development programs (Lerner, 2005). Behavioural family interventions that target modifiable family factors such as parental warmth, conflict, and encouragement of autonomy have been shown to be reliably effective in the prevention and treatment of negative outcomes for youth (Chand et al., 2013).

In summary, the importance of familial and social support for youth is undeniable. Interventions should therefore focus on preventing isolation from familial systems, improving and strengthening family dynamics and systems, and creating compensatory relationships where needed. The evidence base also highlights the need to consider youth and their families within a multitude of dynamic systems. It is crucial to consider the dynamics and stressors that may be affecting the family of the child or youth and intervene systemically.

Children and youth who are isolated from or prone to isolation from family systems

Children and youth can become isolated from family systems or have difficulty accessing family support for a wide variety of reasons. For the purpose of the current chapter, three groups of vulnerable children and youth will be focused on, who are highly represented in populations served by Te Kahu Tōī Intensive Wraparound Services (TKT IWS) and other Wraparound interventions worldwide: children and youth with serious emotional and behavioural difficulties, children and youth in state care, and Indigenous children and youth. These three populations are somewhat overlapping and intersect with one another but also have their own distinct needs and pathways to social and familial isolation, which will be briefly outlined below.

Children and youth with SEBD

The term *social, emotional and behavioural difficulties* (SEBD) is used primarily in education to refer to behaviours and emotions children and youth demonstrate that constitute significant barriers to personal, social, cognitive, and emotional development. Relationships with others are often negatively affected by SEBD. Challenges associated with SEBD typically impact the individual's own education and/or that of their peers (NEPS, 2010). SEBD encompass both internalising[43] and externalising behaviours[44] (Lund, 2014; Zhang et al., 2013) and a wide, varied range of phenomena: disruptive, antisocial, and aggressive behaviour; hyperactivity, attention, and concentration problems; somatic and emotional problems; interpersonal problems, and poor school attendance.

Macleod and Munn (2004) describe the difficulties regarding conceptualising and working with SEBD, given the lack of consensus as to the actual definition of SEBD. There is consensus in the literature that the definition of SEBD is problematic. The term is over-inclusive and replaces the term maladjusted, to describe any student experienced as troubled, troubling, disruptive, or generally problematic by staff and peers. The authors also stated that the process of acquiring the label of having SEBD is generally agreed to be far from objective, with terms such as naughty, disaffected, delinquent, SEBD, and those describing serious mental illnesses used indistinctly. They state that the label SEBD essentially functions as an administrative or organisational device in to identify children and youth who educational providers find difficult to manage, and who may require extra support, rather than being clinically descriptive or explanatory.

Furthermore, Macleod and Munn (2004) describe how the term SEBD is rooted in a history of conceptualising and treating these children and youth according to the Individual Medical Deficit (IMD) model. The IMD model developed from the medicalisation of disabilities. It assumes a standard of normality to which all should aspire, and that any deviance from this represents a personal deficit with a medical or organic cause that should be treated. The adoption of the IMD legitimised the establishment of a separate education system for divergent individuals, creating views of normality and abnormality which have informed wider societal discourses about who does and doesn't belong in society. More recently, an interactionist explanation of SEBD has garnered increasing support. Interactionist theories consider the interaction of individual, familial, social,

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[43] Directed inwards, including emotional and somatic problems such as anxiety, depression, and stomach aches.

[44] Directed outwards, including social and behavioural problems such as aggression, hyperactivity, and fighting.

environmental, and broader structural factors in producing symptoms often labelled as SEBD. This conceptualisation is supported by the fact that changing systemic factors[45] can result in the disappearance of SEBD, discrediting the idea that SEBD are attributable to an individual deficit. However, such explanations are less attractive to practitioners, parents, and policy makers who prefer simple, direct interventions often derived from biomedical theories. Unfortunately, any explanations that solely focus on the individual and neglect to consider wider causes will inevitably be inadequate, and interventions based upon such suggestions will be unsuccessful (Macleod & Munn, 2004).

As Macleod and Munn (2004) described, despite problems with the definition of SEBD, the term has utility in its inclusiveness and non-clinical nature. Retaining the label enables recognition that there are children and youth experiencing significant difficulties which may be related to loss, abuse, family relationships, poverty, learning difficulties, self-esteem, systemic adversity and so on, without requiring a clinical diagnosis for identification and treatment. It is useful to have a term that describes children and youth with ongoing issues that have been noticed by multiple adults and recognises that the problem may not only stem from within the individual.

SEBD can and does lead to social ostracisation and isolation for those that do not conform to normative expectations. Evidence has suggested that those with SEBD are more likely to experience school exclusion (Caslin, 2021). Given the systemic nature of SEBD and the frequency of issues in wider familial and social systems, school exclusion is likely put further strain on already stressed systems, worsening problematic dynamics and outcomes. Research has demonstrated a bidirectional relationship between mental health issues (and related risk factors, such as family conflict) and school exclusion. Mental health issues heighten the risk of school exclusion substantially, and being excluded often results in the deterioration of mental health and family functioning. Mental health

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[45] by providing a tailored curriculum, positive role models, relief from poverty, and improvements in family systems.

issues influence school attendance, academic achievement, and social communication skills. Permanent school exclusion from school disrupts peer relationships, removes access to an environment that often has positive factors and opportunities, affects self-image, places strain on the family system, and increases social isolation (Tejerina-Arreal et al., 2020). In addition, school exclusion demarcates a shift towards exclusion from wider society, or *deep exclusion*. Deep exclusion describes a systemic lack of or denial of access to relationships, activities, resources, rights, goods, and services available to the majority of society. Deep exclusion affects not only the individual's and family's quality of life, but also the cohesion and harmony of society as a whole. Describing this, it becomes obvious how social isolation and SEBD, can become a bidirectionally bound, intergenerational feedback loop in families over time (Daniels, 2011).

Although SEBD is not a clinical or diagnostic entity, Visser (2003) pointed out the significant overlap between diagnosable mental health conditions and SEBD. Supporting this, Macleod and Munn (2004) note that children and youth with SEBD often acquire psychiatric diagnostic labels such as oppositional defiance disorder, conduct disorder, depression, bipolar disorder, Tourette syndrome, obsessive compulsive disorder, dyslexia, autism, and attention deficit hyperactivity disorder (which tends to be the most common).

Within the population of youth who experience SEBD exists a smaller group characterised as *high and complex needs* (HCN). This term refers to children and youth who present to services with a complex of interrelated unmet needs and severe difficulties. Difficulties and unmet needs present across a wide range of areas and may include: social, emotional, and behavioural difficulties; physical, developmental, and neurological conditions/difficulties; and familial, social, environmental, societal, and financial disadvantages (High and Complex Needs Unit, 2005; Social Policy Evaluation and Research Unit, 2015). This group posits a significant challenge to services and communities. Individuals with HCN often display extremely challenging behaviours (e.g., suicidality, risk-taking, absconding, and illegal behaviour), substance use, and aggression. The needs of these children and youth are often inseparable from the needs of their wider family, who often can also be described as having HCN. The wider family system may experience issues related to trauma, addiction, disability, and mental/physical health issues which are often intergenerational. They are typically situated within a context of social exclusion and deeply entrenched disadvantage and have both a marked breadth and depth of unmet needs. In line with Maslow's hierarchy of needs (Maslow, 1943), it is of utmost importance to first acknowledge and attend to the safety and survival needs of vulnerable families for any other intervention to be effective (Social Policy Evaluation and Research Unit, 2015). The Wraparound Process was initially conceived of to address the needs of this population effectively; however, evidence will be presented later in the chapter to demonstrate its effectiveness across diverse populations with differing levels of needs.

Youth in state care

As previously outlined, the transition from adolescence to adulthood is a challenging and demanding developmental stage. This transition is particularly difficult for youth who are disconnected from their family systems because they are in state care; living in foster placements or residential settings. Greeson and Thompson (2016) state that when foster youth age out of the child welfare system, they often transition into adulthood with very little, or no family support, typically further complicated by the presence of risk factors associated with a difficult developmental history. Premature adoption of adult roles and responsibilities often takes place without adequate support. As outlined earlier, access to resources and protective factors helps to shape a successful transition during this period. As Greeson and Thompson (2016) state, unfortunately youth aging out of foster care often have grown up with severe, ongoing adversity in their families and communities, and are therefore at heightened risk of poor outcomes.

Jones and Kruk (2005) conducted a study among youth aged 17 – 24 years who had lived in foster care. Youth identified their birth family as their primary object of attachment, despite also identifying them as those they were least likely to turn to in times of sickness or talk about their feelings to. Youth described feeling that although they wanted to stay in touch with their family of origin, they were not supported to do so. As youths' successive foster placements increased, their sense of being part of a family decreased, with youth who lived in many foster homes reporting they did not feel a part of any family system. Transiency and instability of placements contributed significantly to poor outcomes. Similarly, Collins et al. (2008) found that youth who grew up in state care tended to reunite with their family of origin in emerging adulthood, despite the fact that typically, their family was at some point deemed unsafe or incapable of caring for them, and tended to be characterised by high levels of conflict, and parental dysfunction. Macleod and Munn (2004) pointed out that while residential care may provide an environment that is consistent and predictable, more consideration needs to go into increasing family involvement. Additionally, they stated that in line with Collins et al. (2008), individuals often return to their original family, and residential programs had the greatest impact and benefits for positive adjustment when they were congruent with the environment youth were discharged to. Finally, they described how family involvement is associated with a better transition into adulthood. These studies demonstrate the importance of connection to and support from family, even for those youth who have been separated from or had significant difficulties within their family systems.

Therefore, where possible, interventions should focus on preventing out of home placement and supporting families to address difficulties in order to provide nurturing consistent care. Alternatives to state care should be prioritised, especially culturally significant options that are often well-established and highly effective (Bronsard et al., 2016; Humphreys, 2019). For example, whāngai is a customary Māori practice whereby children are cared for by someone within their wider whānau, hapū, or iwi other than their birth parents. This practice prioritises links to whakapapa and culture, safekeeping children and youths' embeddedness in their culture, strengthening a positive sense of identity, and fostering wellbeing (McRae & Nikora, 2006). When placement within the family system is not possible, a focus on establishing sustained, positive relationships with adult mentors is protective. Greeson and Thompson (2016) state that the involvement of a caring adult who offers social support is both normative and protective for a healthy transition into adulthood, including for those in foster care. Furthermore, they describe natural mentoring as an increasingly recognised, promising approach, in which important adults in a child or youth's natural environment and community provide support.

Indigenous youth

Indigenous youth are another population at heightened risk of isolation from family systems. Indigenous people are affected by intersectional disadvantage due to discrimination, colonisation, displacement, genocide, and forced assimilation. The profound intergenerational trauma that these processes inflict cannot be understated (Patel et al., 2007a; Snijder et al., 2020). The results of colonisation for Indigenous peoples have been catastrophic, resulting in loss of culture, land, voice, population, dignity, health, and wellbeing. Similar consequences can be seen in Indigenous communities globally. In relation to almost all indicators of wellbeing such as disease, malnutrition, substance use, mental health, and suicide, Indigenous people tend to fare far worse than their non-Indigenous counterparts (Durie, 2004b). While Indigenous youth may not have directly experienced initial colonisation events, the consequences and ongoing effects of colonisation that they experience are well documented (Wexler, 2009). Durie (2004) states that suicide and distress in Indigenous peoples are strongly linked to group dispossession and disempowerment; disconnection from family, tribes, traditional social structures, and homelands; and damage to cultural identity, which can lead to insecure, negative, or confused identity and sense of self. Indigenous youth are prone to experiencing not only isolation from their own immediate family, but also from their wider family, genealogy, land, language, and culture.

Indigenous youth also tend to be overrepresented in state care. Krakouer et al. (2018) state that Indigenous Australian youth represent 35.6% of youth in care of the state, despite only making up 5.5% of the wider population, with similar trends being seen in North America and New Zealand. During the process of colonisation in New Zealand, British laws and welfare practices were imposed without consideration of Māori cultural values or needs. *Uplifting* occurred on a macro level – with Māori uplifted from their land and traditional ways of living, healing, and being, and a micro level - with Māori children being placed in institutional care or with Pākehā families, depriving them of connection with their family, culture, community, and environment, and enforcing abrupt assimilation (Worrall, 2001). The Tohunga Suppression Act in 1907 banned traditional Māori healing practices, which was not repealed until 1962 (New Zealand Government, 1907; Te Puni Kōkiri, 1962). Te reo Māori[46] was prohibited in schools to ensure assimilation. Māori students were punished for speaking te reo. Pākehā did not understand the centrality of te reo to the expression and transmission of Māori culture (Ministry for Culture and Heritage, 2017). The ramifications of these practises are still felt today. Experiencing socioeconomic disadvantage, welfare care, and being Māori are all factors associated with higher suicide rates among children and youth in New Zealand (Oakley-Browne et al., 2006)). A report released in 2015 revealed that Māori children were still significantly over-represented in child welfare statistics, making up 58% of youth in state care (Office of the Children's Commissioner, 2015). Troublingly, strong links have been shown between being in state care and later incarceration. Sixty nine percent of incarcerated adults, and 83 percent of those incarcerated under the age of 20 in Aotearoa have a history of state care (L. Mitchell, 2018).

However, as stated by Durie (2017), Indigenous populations are far too often characterised in the literature through a deficit lens. He described how according to Indigenous peoples themselves, the fundamental commonality that unites Indigenous populations is not disadvantage or a history of colonisation. Rather, Indigenous cultures are almost universally characterised by a strong notion of unity with their environment and land. This is often reflected in tradition; customs, songs, knowledge, conceptualization of wellbeing, and approaches to healing, birth, and death. Along with being separated from their land, Indigenous people have also been separated from traditional knowledge and wellbeing practices, which are typically not represented or even considered within

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[46] The Māori language.

mainstream frameworks and practices. Indigenous peoples' concepts of health span beyond the individual and are collective and intergenerational. Indigenous models of wellbeing tend to incorporate four core dimensions: the spiritual, intellectual, physical, and emotional. If any of these dimensions are compromised, so too is the integrity of the entire structure (Durie, 2017; Health Navigator NZ, 2020). More recent models such as the Meihana Model (Pitama et al., 2007) also incorporate wider ecological and historical forces that impact the wellbeing of Māori, such as migration, colonisation, marginalisation, and racism, as well as aspects of Māoritanga that bolster or increase wellbeing (such as connection to whenua/the land, the practice of tikanga, cultural and spiritual practices, and so on).

Consistently, studies have found associations between positive affiliation and engagement with one's own culture and Indigenous youths' wellbeing and resilience (Wexler, 2009). For example, Clark et al. (2013) found that having a positive family connection reduces the risk of suicidal ideation and attempts for Māori youth. An extensive review of Indigenous youth in Canada conducted by Toombs et al., (2013) found that factors which increase resilience included engagement with one's own culture, positive peer and family relationships, and a positive self-identity. Cultural interconnectedness in the form of connection to one's homeland, a collective identity, nurturance and support from one's own community, an ability to remain non-conforming and autonomous, and access to culturally meaningful services within one's own community were related to community-based resilience.

The Children's and Young People's Wellbeing Act (also known as the Oranga Tamariki Act), passed by the New Zealand Government in 1989 and amended in 2017, marked the first official recognition of the importance of continuity in terms of keeping children within their whānau, community, and wider cultural network. It recognises that the primary role in caring for and protecting a child should lie within the child's whānau, hapū, and iwi. The Act outlines the responsibility of service providers in supporting, assisting, and protecting families as much as possible, in accordance with the Treaty of Waitangi. The Treaty of Waitangi is relevant to all social policies and services, and the principles of partnership, participation, and protection need to be reflected in service development and provision (Government Inquiry into Mental Health and Addiction, 2018).

For our services and society to support the wellbeing and empowerment of Indigenous peoples, we must take a multi-level approach. Socioeconomic and macro-political interventions are necessary to address the social processes that produce systemic disadvantage (Chirgwin & D'Antoine, 2019). Indigenous culture, knowledge, and practices regarding healing and wellbeing need to be acknowledged as strengths and represented in service delivery (Social Policy Evaluation and Research Unit, 2015). Funding and training accessible to Indigenous people needs to be offered to increase the representation of Indigenous people in service provision, as they are obviously best placed to provide culturally sensitive care.

The Wraparound Process: A promising intervention for isolated youth or those at risk

A description of the Wraparound Process

The Wraparound process is a team-based, collaborative approach to service delivery and support planning. An individualised team made up of the identified youth, family and community members, mental health professionals, educators, and other relevant supports meet on a regular basis to design, implement, and continuously monitor an intervention plan responsive to the individualised goals of the youth and their family (VanDenBerg et al., 2003)

Wraparound is often geared toward children and youth who have multiple child-serving agency involvement, and whose families would benefit from coordination between such systems. It also often serves youth who are at risk of placement in out-of-home or out-of-community settings, or who are already in these settings and are transitioning back. The Wraparound Process achieves positive outcomes through several mechanisms. Compared to traditional treatment planning, it provides a more comprehensive yet structured, creative, and individualised process that results in plans that are more relevant and therefore effective for the identified youth and their family (Burchard et al., 2002).

The Wraparound Process is an ecologically based approach to care planning and service delivery that acknowledges the embeddedness of children and youth within wider socioecological systems, and the need to view and address children and youths' difficulties in a holistic manner. The Wraparound Process intentionally produces plans that address the needs of caregivers, siblings, and other community supports, as well as those of the child/youth. This is in recognition of the aforementioned evidence that interventions have the greatest long-term effects if the post-intervention environment is coherent with the intervention, and if family support or compensatory relationships are maximised. Through team-based planning and intervention, Wraparound focuses on developing the problem-solving skills, coping skills, and self-efficacy of the entire team, including family and other natural community supports (Burchard et al., 2002).

The Wraparound process is built upon ten principles and four phases that outline the philosophy and values of Wraparound and provide guidelines as to what needs to be done. The table below outlines the ten philosophical principles regarded as the active defining ingredients of Wraparound:

Table 1

Ten Principles of the Wraparound Process

Family voice and choice	The family and child/youths' perspectives are intentionally elicited and prioritised during all phases of the Wraparound Process. Planning is grounded in the family's perspective, and the Wraparound team strives to provide options and choices that reflect and respect the family's values and preferences.
Team-based	The Wraparound team is made up of people agreed upon by the family including informal, formal, and community support/service relationships.
Natural Supports	The Wraparound team seeks out and encourages the full participation of team members drawn from the family's community networks. The Wraparound plan incorporates activities and interventions that draw on and strengthen sources of natural support.
Collaboration	Team members work cooperatively, and the responsibility for developing, implementing, monitoring, and evaluating the plan is shared. The plan incorporates all the team members' perspectives, values, wishes, and resources. The plan specifies and coordinates each team member's role in meeting goals.
Culturally competent	The Wraparound Process demonstrates respect for and builds on the values, preferences, beliefs, culture, and identity of the child/youth, their families, and communities.

Community-based	The Wraparound team implements strategies that take place in the most inclusive, responsive, accessible, and least restrictive settings possible, safely promoting child/youth and family integration into home and community life.
Individualised	The Wraparound team implements a customised set of strategies, services, and supports to achieve goals.
Strengths-based	The capabilities, knowledge, skills, and assets of the child, the family, the community, and the Wraparound team are identified, acknowledged, utilized, and enhanced.
Persistent	Despite challenges, the team persists in working toward the goals detailed in the Wraparound plan until the team reaches agreement that a formal Wraparound process is no longer required.
Outcome-based	Progress in relation to goals and strategies is monitored using measurable indicators of success, and the individualised plan is continually revised and tailored accordingly.

Note: adapted from Bruns et al. (2008).

Burchard et al. (2002) also describes three essentials of implementing Wraparound effectively. The first essential factor is system and community level support. Wraparound is designed to ensure that youth benefit from coordinated care planning and intervention that is responsive to their unique needs. It produces a single, comprehensive plan that integrates the efforts of multiple agencies and providers in collaboration with the youth's family and/or natural community supports. It aims to ensure that youth receives the support required for them to live successfully in their community, at home with their family or otherwise, in the most home-like and least restrictive setting possible. To do this, the team must establish and maintain access to a flexible, diverse set of community supports. The second essential factor is organisational support. The plan must ensure that the team is made up of the right people, with the right skills for the job, and adequate working conditions to ensure they can be effective and available. This is achieved through regular, evidence-based training, supervision, and support. The final essential factor is that Wraparound must be outcomes-based in the sense that it is an approach that is evidence-based, accountable, and demonstrates measurable improvement in pursuit of goals.

A brief history of Wraparound

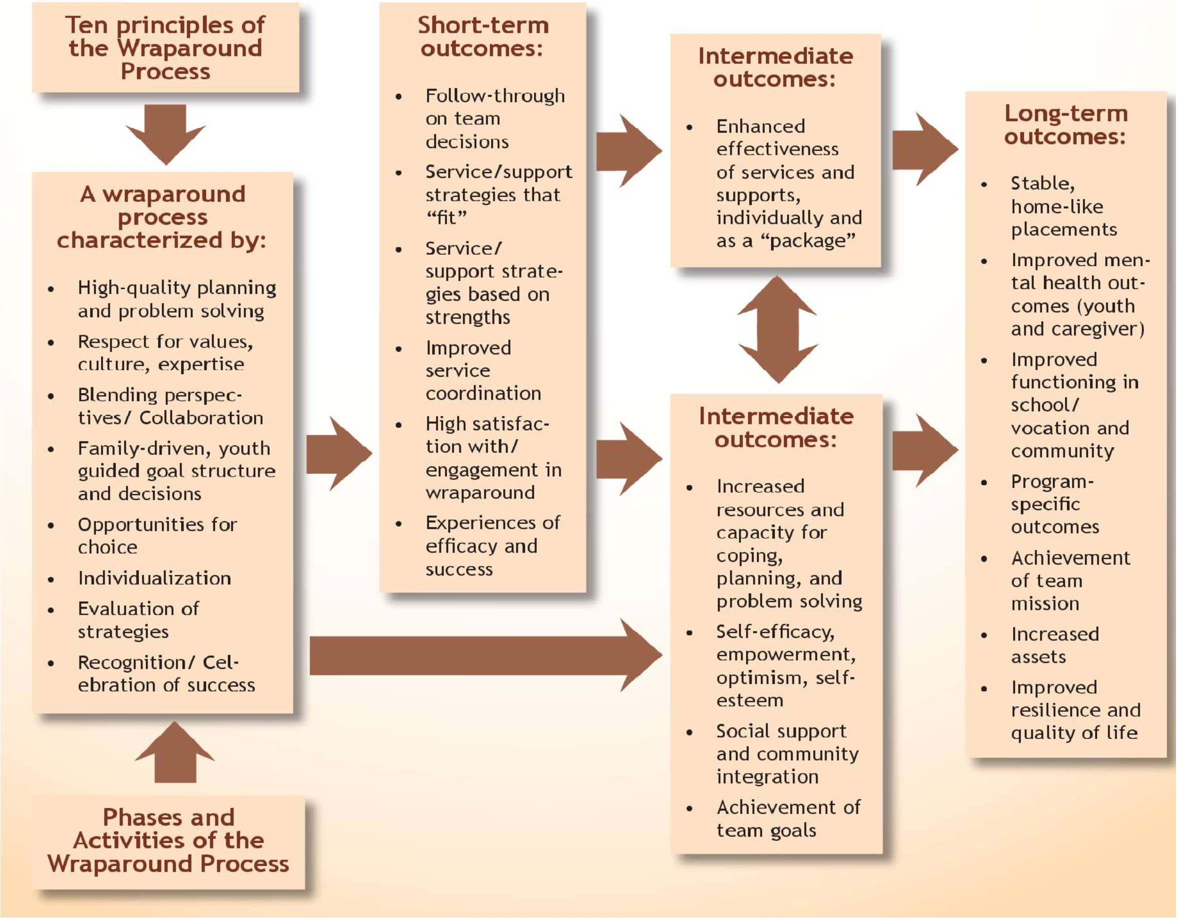
The history of the Wraparound process is described by VanDenBerg et al. (2003), who stated that Wraparound was coined in the early 1980s to describe the provision of a range of comprehensive community-based services to families, as an alternative for institutionalisation. It then became shorthand for service delivery that is comprehensive and flexible, and aimed to help keep children and youth in their family and community systems. The early work on Wraparound focused on children, youth and families with HCN. However, it has since been proven useful with children, youth, families, and adults with various needs, including those whose needs are just emerging.

Formative work on the establishment of the Wraparound process was conducted in Canada through the Brownsdale Programs, which aimed to provide unconditional, needs-based, individualised services. During this time, similar movements were also occurring elsewhere, such as the establishment of family group decision-making in North America; a process rooted in Māori traditions. In 1985, a coordinated effort was conducted which returned almost all children and youth who had been placed in out of state institutions to Alaska. This kicked off more than 30 replication efforts across the Americas, and inspired funding to accelerate the study and implementation of Wraparound type interventions. In 1998, following an upsurge in the popularity and utilisation of the Wraparound Process, a group of family advocates, Wraparound trainers, and providers met to define the core components and processes of Wraparound in response to concerns about the lack of specification and definition of Wraparound as a modality (VanDenBerg er al., 2003).

The aforementioned principles provide a foundation with which to work from. Based on these principles and the Practice Model of Wraparound (Bertram, Suter, Bruns, O'Rourke, et al., 2011; Schutte & Walker, 2004a), the National Wraparound Institute (NWI) proposed a theory of change to describe how and why Wraparound works:

Figure 3

A theory of change for the Wraparound Process (Walker, 2008)



Walker (2008) noted that this diagram is a highly simplified representation of an inherently complex process. The routes to change are not independent, they interact and strengthen one another and may not occur in a linear chronological way. Walker (2008) asserted that the

Wraparound process essentially establishes an iterative positive spiral, whereby the process of creating, implementing, evaluating, and adjusting a collaborative plan leads to a multitude of improvements and benefits (e.g., improved natural supports and coping skills), influencing other factors (e.g. increased self-efficacy and opportunities to contribute to the community), which then feed back into the positive spiral. This dynamic is not attributable to discrete intervention techniques, but rather, is attributed to the Wraparound Process as a whole, and the way it provides a coherent form of support that at its very core is respectful, optimistic, and empowering of natural social systems (Walker, 2008).

Evidence Base

A comprehensive review of studies regarding Wraparound care was conducted by Coldiron et al. (2017). Among the 206 studies reviewed, 40% were non-empirical and focused on defining the Wraparound Process and advocating for increased use and exploration of the modality. Among the remaining empirical studies, 22 were controlled studies, most of which found positive or mixed evidence for the effectiveness of the Wraparound Process compared to a control group (either receiving treatment as usual or no treatment). Of these 22 studies, 14 found some evidence that favoured the Wraparound Process, and none found better outcomes in the comparison group or for treatment as usual. Other empirical studies explored necessary system conditions, measurement methods, and the influence of fidelity on the Wraparound model. It was concluded by the authors that the extant literature provides useful information about core components, implementation supports, and the applicability of Wraparound across diverse systems and populations. They also concluded that the review provided promising information regarding effectiveness and cost-effectiveness.

However, significant limitations were also identified. The authors noted that it was interesting that there was a large portion of research still going into model definition and utility, which may in some ways be encouraging in that it may represent continual refinement of the model and its application in real world contexts. However, there were major gaps in the literature regarding rigorous testing and identification of change mechanisms, workplace models, peer support, and description of specific treatments used. Additionally, only 17.8% of empirical studies attempted to measure fidelity, which muddies findings and makes it difficult to establish the true relationship between the Wraparound Process and outcomes. They concluded that future research should focus on more rigorous effectiveness studies, identification of specific intervention and implementation components, and pathways of change. This will help to provide increased guidance on populations most suited to the Wraparound Process, what version should be delivered, and the types of implementation support which should be employed. Despite the limitations, Coldiron et al. (2017) highlighted a strength of the existing research; the majority of controlled Wraparound studies are effectiveness studies implemented in real world settings, in complex situations, with highly representative children and youth. We know that many evidence based treatments efficacious in controlled conditions prove to be far less effective in the real world, so while more rigorous research needs to be conducted, Wraparound does demonstrate positive outcomes.

Yu et al., (2020) conducted a review of school-based Wraparound programs. Their results suggest the Wraparound Process is a promising and cost-effective way to support students' success. Positive outcomes from large school-based Wraparound programs, such as improved graduation rates, academic achievement, more equitable and accessible education, higher staff satisfaction, and lower rates of mental health problems, dropout, and absenteeism were found. They outline how school problems are often problems that affect the wider community and the child/youth's family too, and how the Wraparound Process provides educational staff with a framework with which to conceptualise students as existing in a wider context, which facilitates the implementation and connection to accessible community-based resources. In agreement with the previous review, the authors state that existing literature could be criticised for several reasons: mixed findings, inadequate measurement of fidelity, limited experimental studies, and small effect sizes. However, they concluded that overall, the evidence suggests that integrating Wraparound into schools is good practice.

Similarly, Hill (2020) conducted a recent literature review of the Wraparound model as applied in schools. Based on a review of community school models that based their approach on Wraparound, the author stated that the use of Wraparound is a proven method to overcome socioeconomic barriers and move beyond normal confines of schooling to establish partnerships with the wider community and provide immediate, direct solutions to students' complex problems. Students can then receive integrated support and develop well despite out-of-school factors that risk being detrimental to their learning and development. Furthermore, Hill (2020) found student outcomes such as attendance, social-emotional functioning, and academic achievement were more attainable in community schools, which could potentially address racial and economic gaps in achievement. They suggested that governments, schools, and communities should therefore consider incorporating Wraparound services.

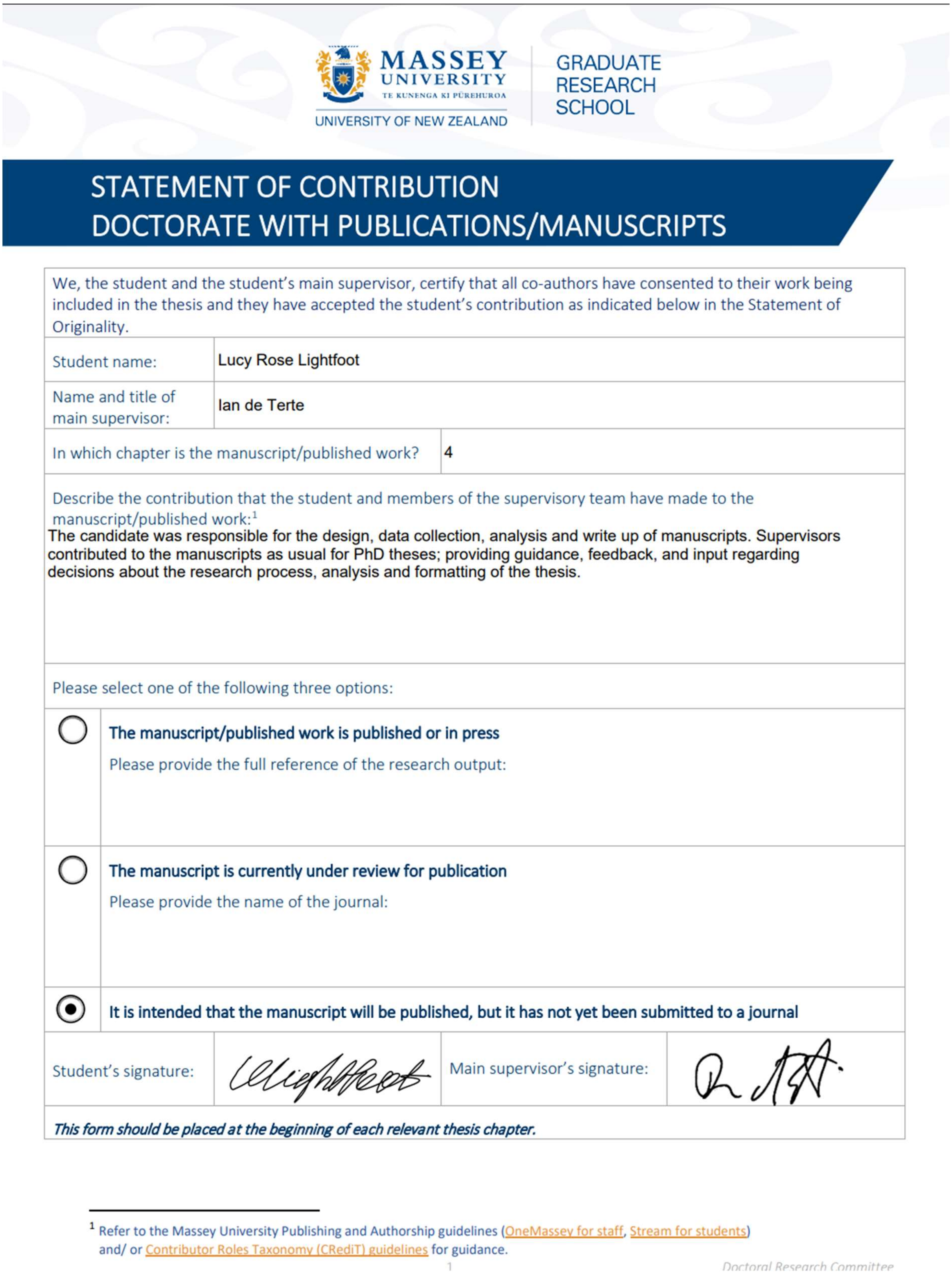
In terms of addressing the needs of diverse populations, Palmer et al. (2011) describe the development of culture-based Wraparound. Wraparound already embraces cultural competence as a core principle of care; however, culture-based Wraparound is an approach that expands on the original Wraparound model by establishing a higher standard of cultural competence. The model ensures that families receive an intervention that is grounded in their culture, provided by culturally matched staff, and designed by members of their culture. Culture-based Wraparound was established in response to concerns that high rates of African American and Native-American children and youth were being placed in residential or foster care, and Latino-American and Hmong-American children and youth were often not accessing services due to communication difficulties secondary to language barriers and profound cultural differences. Culture-based Wraparound ensures that children, youth and their families can access professionals who are culturally and linguistically matched to them, who see culture and healing traditions as wisdom, who embed

Wraparound in their culture rather than the other way around, and who understand that perceptions of and trust in staff from other another culture may impair the relationship, regardless of the professional's competence. Preliminary outcomes suggest that this approach ensures culturally competent services and is effective in reducing problems for culturally diverse children and youth. Compared to 29 other systems of care funded communities it was found that the culture-based Wraparound was experienced as more culturally sensitive. Satisfaction with culture-based Wraparound was higher, and outcomes were found to last longer. Respondents reported that they experienced a safe environment, positive regard, and non-judgemental support, which was delivered in their language, and underpinned by their cultural belief systems. Fidelity scores were also higher than national means, suggesting that fidelity can be maintained effectively while also establishing culture-based processes.

Wraparound training has also been incorporated throughout Indigenous communities in Canada and Australia and has been effectively modified to incorporate Native American perspectives and best practices according to tribes (Kendziora et al., 2001; Palmer et al., 2011a). It has been used in New Zealand, and more recently adapted to include Māori models of wellbeing. Kirkwood (2014) describes how the ten principles of Wraparound align well with the principles of the Treaty of Waitangi, and how he, as a Māori practitioner, incorporates Māori values, narratives, and practices under the overarching Wraparound framework in order to provide tailored, culturally competent care.

Conclusion

In conclusion, Wraparound is a highly promising intervention that should be considered in supporting youth at risk of isolation, or who are already isolated, to best support a successful transition into emerging adulthood. Several defining characteristics of the Wraparound Process suggest that it would likely be beneficial across diverse populations for this purpose. As mentioned, one of the foundational aims of the Wraparound Process and original reasons for its conception was to prevent and remediate the isolation of children and youth from their family and wider social systems and the causal problems. Wraparound's systemic focus: from the way it conceptualises difficulties, to the way that the intervention is carried out, is designed to meet the needs of isolated youth through the establishment and/or strengthening of natural sources of support. Additionally, the centrality of the child/youth and their family's voice and choice in the practice model strengthens autonomy and identity development – fundamental developmental tasks associated with healthy transition into adulthood. As outlined in the description of youth populations prone to isolation from their family and social systems, social and emotional isolation in childhood and youth is a complex phenomenon associated with a wide range of risk factors and difficulties. The holistic nature of Wraparound ensures that youth are viewed in their entirety, and that all relevant factors associated with their isolation from family and wider social systems are considered and addressed in the intervention.



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Chapter 4: Use of the Wraparound Process with underrepresented groups: a scoping review

Abstract

Background:

Wraparound is a widely used service delivery model for developing and implementing individualised care plans that are comprehensive, holistic, and driven by the service user and their family. Wraparound was originally designed to support children and youth with complex emotional and behavioural needs (and their families) who require multi-agency input. Foundational principles and tenets of the Wraparound practice model indicate it could be used effectively cross-culturally, incorporating and complementing cultural beliefs, ways of living, and healing practices, without compromising on fidelity to the model and positive outcomes. Diverse cultural populations are underrepresented in psychological and health science research currently; this likely contributes to well demonstrated inequities in service provision, accessibility, experience, utilisation, outcomes, and ultimately wellbeing for underrepresented populations.

Objective:

The purpose of the current scoping review was to provide an overview of the existing literature regarding the use of the Wraparound Process with underrepresented groups and more specifically, to: 1) Establish the extent, range, and nature of existing research on the topic; 2) Identify trends in the literature regarding how Wraparound has been used with and experienced by underrepresented groups; and 3) Establish what gaps exist in the research area on this topic and make recommendations for further research and practice development.

Method:

A scoping review was conducted using the PRISMA extension for Scoping Reviews (PRISMA-ScR). A search was conducted in the following databases to identify sources for the review: Social Sciences Citation Index, Scopus, Medline, Science Citation Index, APA PsycINFO, APA PsycArticles, PsychiatryOnline, Psychology and Behavioural Sciences Collection, and CINAHL Complete (EBSCO). During the process of reviewing articles for inclusion, further articles of interest were identified and

considered for inclusion by hand searching of journals and their respective reference lists. The first search was conducted in June 2019 and the last in September 2022. No limits were placed on date or type of publication.

Results:

A total of 46 publications were included in the final review. The majority originated from the USA, and all publications were based in Western-colonised countries. Most interventions targeted emotional behavioural symptoms in childhood and/or youth; however, both interventions and target populations were diverse. Most sources used quantitative methods. Outcomes were largely collected via surveys, clinician observation, and administrative data. About a fifth of the publications measured fidelity to the Wraparound model. A significant proportion of the publications showed no evidence of any cultural considerations and adaptations, while a small sub-group described culture-based Wraparound. Outcomes were generally positive, but interpretative power was constrained by poor fidelity or the absence of fidelity measurement and methodological concerns. Outcome equity (when measured) indicated that well designed and delivered Wraparound is a potentially effective modality to combat cultural-ethnic disparities in service delivery and outcomes.

Conclusions:

The review evidenced that Wraparound is currently used across diverse populations and shows promise in terms of demonstrating equitable, positive outcomes cross-culturally. Future research should focus on identifying barriers to fidelity measurement, avoiding ambiguous use of the term *wraparound*, and incorporating culturally relevant measures of impairment, wellbeing, and success for the purpose of eligibility, progress monitoring, and outcome measurement. In a broader sense, it is of crucial importance to explore and identify culturally significant outcomes, acknowledge, measure and report potential disparities, and widen the scope of conceptualisation, measurement, research methods and service delivery to best serve underrepresented populations and address inequity.

Introduction

The Wraparound Process: what is it, and why might it be promising cross-culturally?

The Wraparound Process is a team-based, collaborative approach to planning and provision of care (Vandenberg et al., 2003). It was initially created to serve children and youth with complex emotional behavioural needs (and their families) who require coordinated multiple agency involvement. The Wraparound Process provides a clear framework and practice model with which to form an intervention team and guide service delivery. Such a team is typically made up of the identified child/youth and their family, intervention staff, community members, educational staff, professionals and any other relevant supports identified by the child/youth, their family, and the wider team. This team meets on a regular basis to design, implement and continuously monitor an individualised plan designed to meet the goals of the child, youth and their family (Vandenberg et al., 2003). The Wraparound practice model describes the core principles, phases and activities, and implementation essentials that define Wraparound, providing a clear framework for practice while still maintaining enough flexibility for a highly tailored and adaptable approach (Bruns & Walker, 2008; Burchard et al., 2002).

The foundation of the Wraparound approach is 10 core philosophical principles that guide practice and service delivery. One of these is *cultural competence*, defined in the approach as; “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” (Bruns et al., 2008, p.7). Bruns and Walker (2004) expanded on this to explain that individual and familial perspectives and belief systems are shaped by culture, identity, and their unique experience. Therefore, to collaborate with families, service providers must be able to interact in a way that demonstrates respect for diversity of opinions, expressions, and preferences. Additionally, Wraparound’s conceptualisation of cultural competence acknowledges that cultural traditions, values, and heritage are sources of strength. An individual’s and family’s culture and community can offer support professionals cannot, that will endure far beyond formal support offered by an intervention. The role of providers of the

Wraparound Process is to embrace, nurture, and strengthen these connections and resources regardless of their own background and perspective, and this is seen as an integral part of the approach.

At face value, many of the other principles also seem to be conducive to culturally competent care. For example, the principle of family voice and choice is intended to ensure the approach and goals are grounded in child/youth and their families' perspectives, thus encouraging self-determinism. Similarly, the principle of using natural supports involves seeking out and encouraging full participation from team members drawn from families' networks of interpersonal and community relationships. The principle of collaboration requires partnership and shared responsibility. The community-based principle means the intervention takes place in the most inclusive, most accessible, and least restrictive settings possible, to promote sustainable community integration. The individualised principle mandates that Wraparound approaches are uniquely tailored to fit the child/youth and family. Additionally, the strengths-based principle; emphasises identification, validation, and enhancement of strengths and assets the child, family and their community already possess.

In support of this, emerging evidence indicates that the Wraparound approach has been effectively used in culturally responsive or culturally based ways to produce positive outcomes (Kirkwood, 2014; Palmer et al., 2011a). As mentioned earlier, Olson et al. (2021) found larger effect sizes for populations with a higher percentage of children and youth of colour. Palmer et al. (2011) described the development of *culture-based Wraparound*; an approach that takes the principle of cultural competence that already exists within the Wraparound model and expands upon it to establish a higher standard of cultural competence. The authors also describe several Indigenous and racial ethnic minoritised groups with which this approach has been used effectively, garnering higher ratings of cultural sensitivity and service satisfaction, and longer lasting positive outcomes.

The evidence base for the Wraparound Process

To establish an overview of the literature on the use of Wraparound with underrepresented communities, it's essential to first understand the general evidence base for the Wraparound Process. Wraparound has been adopted globally across a wide range of contexts and treatment populations. It is funded by Medicaid in the United States, used in almost every state in the country (Olson et al., 2021), and has been formally classified as an effective or promising practice (California Evidence Based Clearinghouse for Child Welfare, 2007; Washington State Institute for Public Policy., 2012). Olsen et al. (2021) stated that the evidence base regarding Wraparound has not historically kept up with the widespread adoption of the approach. Therefore, until recently, the evidence base for Wraparound was seen as poorly developed.

However, over the last 15 years the literature on Wraparound has grown significantly, comprising descriptions and applications of the practice, the development of implementation standards, required system conditions, a practice model, empirical studies, and further development of training material and fidelity measures. In 2017, a comprehensive narrative review of Wraparound studies was published by Coldiron et al. (2017). They identified 206 peer-reviewed publications about the Wraparound Process. Almost half the publications were not empirical, largely focussed on describing the model and advocating for its use. Of the 60% that were empirical, the majority explored necessary system conditions, measurement methods, cost-effectiveness, and fidelity. Only 22 publications were controlled (experimental or quasi-experimental) outcome studies, of which 63% favoured Wraparound. None favoured treatment as usual (TAU). It was concluded that the review provided useful information about the definition and potential applicability of Wraparound across diverse systems and populations, along with promising information about effectiveness and cost. However, the review emphasised significant gaps in the literature. Specifically, the evidence base lacked rigorous high quality outcome studies, evidence about mechanisms of change, and specific interventions used within the approach. Additionally, only 17.8% of empirical studies attempted to measure fidelity.

A few years after this narrative review, Olson et al. (2021) conducted a systematic review and meta-analysis with more stringent inclusion criteria and analyses to determine the significance and size of treatment effects associated with the Wraparound Process. The inclusion criteria required that studies: 1) examined outcomes for youth[47], 2) examined outcomes commonly addressed by Wraparound[48], 3) used an experimental or quasi-experimental design, 4) were published after 1991[49], and 5) were either published in a peer-reviewed academic journal, non-peer-reviewed grey literature or a dissertation/thesis. In this review, medium sized effects were found in favour of the Wraparound Process for cost, residential outcomes, and school functioning. Small sized effects were found for improved mental health symptoms and functioning. Larger effect sizes were found in peer-reviewed studies, quasi-experimental designs, interventions with higher fidelity, and populations with a larger proportion of youth of colour. It was concluded that the systematic review indicated that the Wraparound Process demonstrates positive outcomes, particularly in supporting youth with serious emotional disturbances (SED) to remain in their home and community. However, Olson et al. (2021) also stated that many of the studies demonstrated methodological weaknesses and fidelity measurement was mostly absent.

Trends in implementation science: evidence-based treatments and common elements.

In 2005, the World Health Organisation stated that the estimated worldwide burden of mental health disorders was currently well beyond the treatment capacities of both high- and low-income countries and was continuing to grow. In response, global authorities mobilised to initiate scientific trials and evaluations, collect evidence, develop policies, and implement programmes to prevent mental health difficulties and maintain or improve mental wellbeing (World Health Organization, 2005). Identifying and providing evidence-based, high-quality mental health care

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[47] 3 – 21 years.

[48] Mental health, mental health and academic functioning, justice, residential restrictiveness, and cost.

[49] When the Wrapround Process was formally defined as a care coordination model.

became a public health priority. The mental health field focussed on identifying evidence-based treatments (EBTs) with replicable and reliable results, requiring a well-specified treatment protocol (often guided by a treatment manual) with demonstrable efficacy and internal validity in repeated randomised control trials (RCTs) (Chorpita et al., 2011).

In these efficacy studies, clients with a specific type of problem (and no comorbid difficulties or extraneous circumstantial factors that may contribute to or exacerbate the problem) are assigned to a treatment or control group. The treatment group receives a pure, potent form of the intervention delivered in ideal conditions to an ideal standard. Service providers are typically highly trained and intensively supervised. Fidelity is usually monitored in reference to a manualised protocol. Clients are carefully selected to meet stringent exclusion and inclusion criteria. Efficacy studies therefore provide information about how well treatments work in addressing the target problem in a homogenous population under ideal conditions.

Effectiveness studies lie at the other end of the spectrum from these efficacy studies. They tend to be conducted in routine settings, with clients who are representative of typical referrals. While manualised approaches and supervision are often used, there is a greater degree of flexibility as dictated by the demands of a real-world setting. Effectiveness studies therefore provide information about the actual impact of treatments under usual conditions. These studies demonstrate how interventions work when flexibly implemented by regular service providers with normal levels of supervision to typical client populations. Clients who have the presenting problem often experience other complex difficulties too (Carr, 2007).

As described by Chorpita et al. (2011), the emphasis on establishing EBTs based on efficacy studies and randomised control trials has resulted in impressive innovations in the area. However, implementation and effectiveness studies have been relatively neglected. This “almost singular emphasis on knowledge proliferation” (Chorpita et al., 2011, pg. 1) and the generation of novel interventions has produced a knowledge base far too large for any one service provider to comprehend or apply optimally, resulting in a gaping science-practice divide. At the time of their publication, Dorsey et al. (2016) found over 500 EBTs for child and adolescent mental health disorders, yet few were being implemented in public health settings. In an exploratory attempt to choose a set of EBTs to best fit an organisation's service population and needs, Chorpita et al. (2011) found that selecting a set of no more than 12 treatments from all EBTs for children yielded over 67 sextillion possibilities. They proposed that selecting an ideal set of EBTs for any given client or population in the real world was a problem approaching insolvability. While we have succeeded in producing research demonstrating what works in controlled conditions, the volume of that knowledge has entirely eclipsed our ability to apply it effectively and responsively.

Chorpita et al. (2011) defined this challenge as a knowledge management problem. Continued growth of knowledge about treatment modalities will not be helpful if we fail to vastly improve our ability to summarise, synthesise, integrate, and deliver what we already know. Additionally, the way that the knowledge has been synthesised and presented for practice is problematic. Treatment manuals typically offer a specific protocol to address a specific problem with little to no guidance on how one might integrate said protocol with another protocol which targets highly prevalent comorbid issues. Often, the best that can be offered is a sequence of two EBTs designed separately, which may not be cohesive in actual delivery or offered by the same service. Given EBTs are typically designed based on populations without comorbid issues, the effectiveness of them in real-world settings is questionable, and the interference of comorbid issues could very well be detrimental to effectiveness. Trans-diagnostic models that provide guidance on how to combine scientific expertise on multiple conditions to provide high-quality, cohesive, evidence-based care are emerging (e.g. Modular Approach to Therapy for Children with Anxiety, Depression, Trauma and Conduct Problems (MATCH-ADCT) (Hagen et al., 2019).

Out of this challenge in the field, the *common elements* approach has emerged. The common elements framework conceptualises clinical work as composed of core elements present across numerous effective treatment approaches (Barth et al., 2014). Development of a common elements framework involves aggregation of knowledge; noting which practice elements (e.g.

relaxation techniques, use of rewards, cognitive restructuring, and so on) are commonly associated with desirable outcomes for which symptoms in clinical trials, and how those elements are associated with service user and context features (e.g., age, setting, population, target problem) (Chorpita et al. 2011).

Converse to this efficacy focussed trend, the majority of controlled studies of the Wraparound Process are effectiveness studies, implemented in real world settings with children/youth who have highly complex issues and needs (Coldiron et al., 2017). The dearth of rigorous controlled experimental studies of the Wraparound Process contributes to the perception of it as having an unsatisfactory evidence base, particularly when the emphasis on efficacy studies has been so strong. Researchers have called for efficacy studies of the Wraparound Process under more ‘ideal’ conditions, where delivery reflects full fidelity to the model and service providers partner with clinicians and psychiatrists who use evidence-based treatments to determine the ‘full potential’ of Wraparound (Olson et al., 2021). However, as Silva et al. (2020) outlined other researchers call for reconsideration of how the Wraparound Process should be evaluated. Because Wraparound is a process model of care coordination and delivery, rather than a manualised treatment protocol or a specific intervention modality, application of the same standards across clients and settings to determine its status as evidence-based may be inappropriate. As Bruns (2008) stated, once a fidelity measure has been created, a challenge then exists in determining when adherence scores are sufficient. He goes on to note that this is particularly difficult for a model designed to be individualised, not strictly manualised or delivered in a standardised way, and representative of processes rather than procedures.

These differing views draw attention the idea that running rigorous, standardised randomised control trials of the Wraparound Process may significantly compromise the philosophies that underpin and define it (e.g., being flexible and individualised, centring family voice and choice in defining the process). Inherent to the evaluation and implementation of Wraparound exists a core tension. Measures of success as defined by the dominant social or scientific paradigm may differ from that of the recipient child/youth and their family. Typically, programme evaluation favours quantitative data, which may in turn minimise the importance of qualitative information about child, youth and family experience, satisfaction, and outcomes, creating conflict with the client-driven foundation of the Wraparound Process. Other researchers have suggested evidence for the Wraparound Process should also be examined through a systems lens, emphasising its impact on communities, organisations and systems rather than just individuals (Silva et al., 2020).

Chorpita et al. (2011) acknowledged that there are different types of evidence; all of which have value and contribute to the development, evaluation, and delivery of effective community interventions. When integrating evidence about efficacy and effectiveness, researchers interested in modes of delivery rather than treatment modality may further study EBTs as they are applied in the context of the Wraparound Process, which would contribute to the knowledge regarding effectiveness of the EBT. This would also further Wraparound research by demonstrating how EBTs can be utilised within the approach. Collaborating and integrating knowledge about implementation, service delivery, and treatment development dissolves barriers that limit the effective application of knowledge to the communities that should be served by it.

Ensuring fidelity to the Wraparound Process and measuring it effectively is however crucial for maintaining the integrity of the model. As Bruns (2015) stated; “Wraparound applied inappropriately or implemented in name only may represent a waste of our increasingly scarce behavioural health dollars” (Bruns, 2015, pg. 6). Fidelity ensures that the intervention is being implemented as intended, which is crucial for achieving desired outcomes. Maintaining fidelity to the Wraparound model ensures key principles integral to the intervention’s success are consistently upheld, leading to more effective and sustainable outcomes (Bruns, 2015). In their study on Wraparound fidelity in Aotearoa New Zealand, Shailer et al. (2017) highlighted that monitoring fidelity can lead to better service delivery, ensuring that families receive the full benefits of Wraparound. They also emphasised that fidelity measurement allows for the identification of specific areas where services may be lacking. This is crucial in preventing drift, whereby interventions evolve in ways that no longer align with the practice model, potentially reducing effectiveness. Fidelity to the practice model is key to achieving positive outcomes for children, youth and families. Bruns (2008) explains how when the Wraparound model is followed with high fidelity, it leads to more positive outcomes in areas like family functioning, child/youth behaviour, and community integration. In contrast, low fidelity can lead to inconsistent practices that undermine the model's potential. For example, a lack of consistent family involvement or community coordination can limit the benefits of Wraparound, ultimately resulting in reduced engagement and worse outcomes. Fidelity checks provide the evidence necessary to support continued improvements in service delivery, ensure that the model is being implemented correctly, and ultimately help to achieve the best outcomes for the families and communities being served.

The importance of diverse representation in research, and cultural competence in research design and service delivery.

Health and social inequity are well-established global problems. Racial ethnic minoritised groups within and between nations experience poorer outcomes across a broad range of health and social markers such as income, lifespan, disease, physical health, stress, education, employment, housing, incarceration and negative interactions with the justice system (Fryer & Beren, 2010; Nkansah-Amankra et al., 2013; Pearce & Dorling, 2009; Penner, 2014; Saluja & Bryant, 2021; Sue, 2006; Weinstein et al., 2017). While inequities based on ethnicity and race are easily observed and thoroughly evidenced, the causes and contributors are diverse, complex, and interdependent. They feed into one another, and exert themselves intergenerationally, at multiple levels of social ecology.

Rogers and Lange (2013) described three potential sources of vulnerability for any person: inherent, situational, and pathogenic. Inherent vulnerabilities are shared by all humans, rooted in our embodiment and inherent biological nature as human beings. They may vary between cultural-ethnic groups based on genetics; for example, some cultural groups have higher rates of anaemia. Situational vulnerabilities are created by the specific economic, social, or political contexts that shape an individual's circumstances and vary from person to person. They may exacerbate or ameliorate inherent vulnerabilities; for example, being able to earn a sufficient income facilitates access to healthcare and adequate nutrition which may affect the expression of genetic vulnerabilities. Finally, pathogenic vulnerabilities are situational vulnerabilities that generate poor outcomes and exist due to adverse social phenomena. They include vulnerabilities created by injustice, domination, discrimination, colonisation, and repression. Pathogenic vulnerabilities also arise when actions intended to alleviate vulnerability actually exacerbate problems and cause iatrogenic harm. Although we may not have clearly mapped all the causes for cultural-ethnic disparities, it is evident that inherent, situational, and pathogenic causes of vulnerability interact to produce the observable disparities.

Penner (2014) and Weinstein et al. (2017) explained that inequity operates across multiple levels of social ecology: intrapersonal[50], interpersonal[51], institutional/organisational/structural[52], societal/systemic[53] and historical/intergenerational. At the intrapersonal level, individuals hold culturally influenced beliefs and attitudes about healthcare, seeking help, and different groups of people. These beliefs, whether conscious or subconscious, shape how individuals interact with services, service users, and staff, affecting the nature of care they receive and provide. The complexity of these forces is clear, as inequity at one level often reinforces inequity at another.

Weinstein et al. (2017) goes onto explain how inequities function as social determinants of health and contribute to the development of health disparities. The interacting multi-level mechanisms that sustain inequity distribute power and resources differentially according to culture, ethnicity, gender, sexual orientation, gender expression and other dimensions of identity. The unequal allocation of power, resources, societal attention, and valuing dominant cultural narratives creates conditions that shape disparities. Nkansah-Amankra et al. (2013) explained that advantaged groups in society have more political power and influence public policies to disproportionately

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[50] within a person, e.g., personal attitudes and beliefs of service users and providers.

[51] between interacting individuals.

[52] within organisations and institutions e.g. the culture of an organisation, institution, or field.

[53] Within society e.g. the systemic mechanisms and norms that define and characterise it.

benefit them at the expense of less privileged groups. Interventions that target these systemic mechanisms alongside individual factors are the most promising in terms of promoting health equity.

While personal responsibility and individual poor decision-making are often emphasised, evidence has shown the existence of a class gradient in personal responsibility; environmental insults and pathogenic situational vulnerabilities make unhealthy choices more likely, worsen the effects of them, and magnify deleterious outcomes, further feeding into inequity. For example, as one moves down the social hierarchy, the severity of illnesses related to smoking increases significantly. Weinstein et al. (2017) described demonstrating how race and class differences in adverse childhood experiences, chronic stress, trauma, and lead exposure affect children and youths' ability to engage with education. Additionally, racial ethnic minoritised students tend to be disproportionately affected by discipline policies ultimately associated with school drop-out. Nkansah-Amankra et al. (2013) asserts that public health research which selectively focusses on individual and cultural risk factors and neglects to explore systemic factors is overly simplistic, condescending, paternalistic, and potentially pathogenic.

Underrepresentation of non-White populations in research is one of many well-recognised culminations of cultural inequity that leads to a number of significant and impactful problems, well described in a summary piece by Rogers and Lange (2013). The Belmont Report (1979) included *minority populations* among their list of vulnerable research participants, which included racial ethnic minorities, economically disadvantaged groups, chronically and severely ill people, and those who were institutionalised. This was done to draw attention to groups that may have been vulnerable to exploitation or overrepresentation in research due to their dependent status or impaired capacity to give informed consent. However, Roger and Lange (2013) argued that the report overlooked various types of vulnerability (as previously mentioned) and overemphasised informed consent, which led to paternalism, stereotyping and the underrepresentation of diverse racial ethnic groups in research. They identify several socio-ecological mechanisms rooted in systemic inequity that contribute to this underrepresentation, including reluctance to participate, lack of opportunities, practical barriers (e.g., childcare and work hours), lack of cultural expertise in researchers, and exclusionary recruitment practices. They also highlight factors such as resource shortages, difficulties reaching diverse populations, and discrimination. Success in recruiting underrepresented groups was linked to personal relationships with members of those groups and language fluency, while failure was often due to time constraints, assumptions about interest, and the inability to extend culturally appropriate invitations.

While the introduction of identified vulnerable populations was intended to protect people, and signal extra care should be taken, it culminated in a lack of equal opportunity to participate. This lack of opportunity is the main barrier to adequate representation. The underrepresentation of racial and ethnic minoritised groups in research results in a lack of understanding of how cultural identity impacts health and limits the applicability of clinical research to these populations. This, in turn, results in reduced access to appropriate interventions, undertreatment, and negative service experiences, further exacerbating the vulnerability of these groups to poor health outcomes. Essentially, the research base as it stands contributes to pathogenic vulnerabilities and inequity. Roger and Lange (2013) concluded that researchers have an obligation to conduct research that intentionally mitigates inherent vulnerabilities and works to eliminate pathogenic vulnerability by not generating or exacerbating pathogenesis through research itself.

A significant area in which disparities manifest globally is emotional behavioural health. Disparities are evident across the determinants and risk factors that shape emotional behavioural health, emotional behavioural problems, access to and experiences of services, unmet needs, and outcomes. Research has shown underrepresented groups experience these disparities even after controlling for income, insurance, age, and symptom expression. Barriers to service engagement for underrepresented groups with emotional behavioural difficulties include cultural differences in understandings of mental health and wellbeing, racism and discrimination, cultural differences in help-seeking and expression of difficulties, language and communication barriers, and fear/mistrust of treatment and authorities. Service providers often view all service users through the same cultural lens, which can limit the capacity for shared understanding of the problem and collaborative care (Alegria et al., 2010; Simmons University, 2024).

Kolluri and Tichavakunda (2023) emphasised the importance of taking a counter-deficit approach when conducting research, designing interventions that will be used with, and engaging with underrepresented populations. They explain that mainstream research has typically reported on underrepresented communities through a deficit lens. In searching for the cause of inequities, research has historically looked first to marginalised people and their families to find the locus of the issue. In doing so, adverse outcomes have been attributed to inherent characteristics of disadvantaged individuals, families, or cultural communities. This tendency has upheld societal power imbalances, perpetuated stigmatising belief systems and attitudes, and circumvented critical analysis or challenging societal norms that generate inequity and adversity. The over focus on deficits exacerbates paternalistic attitudes towards underrepresented groups and characterises them as perpetual victims. Yosso (2005) noted that mainstream research typically characterises communities of colour as places full of cultural poverty and disadvantage, and neglects to focus on the array of cultural knowledge, skills, abilities, and connections uniquely possessed by marginalised groups.

In conclusion, inequity is a global problem that leads to poor health outcomes and diminished quality of life in vulnerable communities, significantly contributing to the global health burden. As it currently stands research, service design, and service delivery has not adequately addressed inequity. As Fernando (2012) stated, structural and societally sanctioned racism now primarily takes a less overt form, but still permeates diagnosis, risk assessment, service planning, and service delivery in mental health. Governmental strategies and service providers have failed to do much about the presence and impact of racism in service delivery, bar some minor adjustments. The racism that has been long embedded in institutional practice, psychiatry, and mental health treatment is intact. Research and academia should attempt to challenge inequity in a systemic manner, addressing barriers to engagement for underrepresented populations and ensuring diverse representation in research and professional contexts.

The current study

The current scoping review was conducted as part of a larger doctoral research project exploring the use, experiences, and outcomes of the Wraparound Process delivered in Aotearoa. There was a particular focus on equity and the experience of Māori whānau. The original aim of this scoping review was to establish an overview of the extant literature about the use of Wraparound with Indigenous communities globally. However, an initial exploratory search revealed little material on the topic. Hence, the population of interest for the current review was widened to include any underrepresented groups, with the hope that this would provide enough material to form a meaningful analysis of existing research on how Wraparound has been used with underrepresented groups globally. More specifically, this review explores how widely the Wraparound Process has been used across culturally diverse populations, including whether it has been adapted and how it has been evaluated. In the conception of the current review, the authors were unable to find any literature summarising the research about the use of the Wraparound Process with underrepresented groups. Hence, the underpinning rationale of the current study is to provide that summary to date.

It is important to address the terms used in the current study to refer to non-dominant and non-White groups in research and Western societies. Initially, the term minority was identified as a common descriptor of such groups in research when broadening the scope of the target population beyond Indigenous populations to find target sources. An important question then emerged - what is a minority and what would the term mean in the specific context of this study? The term minority has different usages depending on context. In its most basic sense, it can be understood in statistical terms: a minority group is a group within a population with the least number of individuals. However, in sociopolitical and academic contexts it typically is used in reference to a group's positioning within hierarchical societal power structures, denoting those who experience marginalisation and exploitation due to power imbalances that favour a dominant group. Minority group identification is often based on differences in observable characteristics or practices relative to dominant groups, such as ethnicity, race, religion, sexual orientation, gender identity, disability, health status, and so on. Such groups often face multiple forms of discrimination (overt, covert, individual, structural) across areas of life such as housing, employment, healthcare, and education (Healey et al., 2018). Additionally, White people (especially men, heterosexual, and cisgender White people) are overrepresented in health and social wellbeing research (in terms of producing it and participating in it), meaning that non-White (and other non-dominant) groups are underrepresented in research (Cundiff, 2012; Rogers & Lange, 2013). For all these reasons, minority was a term that had utility in the current study as a search term. However, more recent guidelines criticise the term, highlighting valid concerns. Namely, the use of minority to refer to diverse groups of people neglects to acknowledge that people of colour are actually the global majority. Also, minority is a term often equated with being less than, oppressed, or deficient compared to the majority (that is, White people) which may perpetuate the deficit lens bias which already exists in research involving underrepresented groups. Essentially, the use of the term minority (or minorities, or minority groups) may perpetuate stigma and inaccurate perceptions by implying diverse racial ethnic groups are primarily identified by their relation to White people, and as lesser than. Hence, the term underrepresented was primarily used in line with recent guidelines regarding ethical, inclusive discussion of racial groups in research (American Medical Association, 2024; American Psychological Association, 2024). As these resources suggest, the term *racial and ethnic minoritised groups* was also used, to specifically denote how racial and ethnic groups have and are actively minoritised because of social constructs that grant some groups less power and representation than others in society.

Objectives

The aim of the scoping review was to:

1) Establish the extent, range, and nature of existing research on the topic. Multiple questions were subsumed by this overarching objective, including:
    - how much research has been done on this topic?
    - what methods have been used?
    - Was fidelity measured?
    - How were outcomes measured?
    - Are underrepresented groups served by the Wraparound Process currently?
    - Is there evidence of cultural considerations and adaptations in research[54] and/or service design?
2) Identify trends in how the Wraparound Process has been used with and experienced by underrepresented groups. Again, there were multiple areas of interest encompassed by this objective:
    - Does the research suggest Wraparound is a promising approach for underrepresented populations?
        - According to who? Are outcomes measured in culturally relevant ways that centre service user perspective and experience?
    - Has Wraparound been adapted for underrepresented groups?
        - If so, how?
    - When a Wraparound service serves a population comprised of different groups including minoritised and dominant groups, are outcomes equitable?
        - Are potential disparities examined and reported?

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[54] including conceptualisation, theorising, measurement, and interpretation/discussion.

3) Establish what gaps exist in the literature and make recommendations for further research and service development related to the use of Wrapround with underrepresented populations, with a view to ultimately improve culturally appropriate care and pursue equity.

Methods

Search Strategy

In conducting this review, publications describing best practice for scoping reviews were reviewed (Arksey & O'Malley, 2005; Peters et al., 2015; The Joanna Briggs Institute, 2015; Tricco et al., 2018). A preliminary exploratory search of *Wraparound*, *Indigenous* and *minority groups* was undertaken using the Massey University search engine, Discover (which searches a wide range of databases), in May of 2019 which resulted in 23 records. The search strategy was formulated based on this exploratory search. Relevant databases and keywords to use in the final search were identified. The first search was conducted in June 2019 using the following databases: Social Sciences Citation Index, Scopus, Medline, Science Citation Index, APA PsycINFO, APA PsycArticles, PsychiatryOnline, Psychology and Behavioral Sciences Collection, and CINAHL Complete (EBSCO). These databases were selected to be comprehensive and cover a range of potentially relevant disciplines. No limits on date or type of publication were placed.

Given the scarcity of results in the initial search, and the intention to map what is known (rather than formally and stringently assess the quality of records or ask a specific question), an *a priori* decision was made to broaden the scope in terms of databases searched, nature of publications investigated (e.g., published, peer-reviewed, grey literature, annual reports) and keywords. It was important in a cross-cultural sense for the review to be inclusive of different forms of knowledge. Results were limited to the English language given the limits of the researchers' own abilities and the lack of access to translation services. A topic librarian assisted with selecting terms for the final search which was as follows: (Wraparound) AND (racial OR race OR ethnicity OR ethnic OR culture OR cultural OR culturally OR refugee OR immigrant OR "multi-cultural" OR multicultural OR "multi cultural" OR african OR "cross-cultural" OR underrepresented groups OR minority OR Indigenous OR Native OR "Native American" OR Black OR Asian OR "African American" OR Latino OR Hispanic OR "First Nation" OR "First Nations" OR LGBT OR Gay OR Queer OR disabled OR disability OR disabilities OR Chinese OR China OR Japan OR Japanese OR India OR Indian OR Pacific OR Pasifika OR "New Zealand" OR Māori OR Hawaii OR Hawaiian OR "Middle Eastern". Follow-up searches were conducted in May 2022 and again in September 2022. These were undertaken using the same databases with the same parameters but limiting the date range to span from the time of searching to that of the last search, to pick up any new records listed since. A snowball technique was adopted throughout the screening and full-text review process, whereby any potentially relevant citations were noted down and later accessed and reviewed for inclusion. Due to permissions afforded by Massey University's subscription (or lack of) to various databases, a small proportion of records from the search were found to be inaccessible. When the abstract suggested that the record was likely to meet inclusion criteria and not accessible via the database, efforts were made to contact authors and access the record.

Citation Management

All citations were imported into the web-based bibliographer manager Mendeley for screening and data characterisation of full articles. Duplicate citations were removed at three points; automatically by search engines, automatically upon import into Mendeley software, and manually when further duplicates were found during the screening process.

Screening and Eligibility

A two-stage screening process was used to assess the relevance of studies for inclusion in the review. In the first stage, the title and abstract of each record was reviewed. Articles that clearly met exclusion criteria or did not meet inclusion criteria were excluded at this stage. Those that were unclear were retained for the second stage, where the full articles were read and included or excluded based on the established criteria. Defining the inclusion criteria was an iterative process, particularly when determining what constituted the target recipient population. Since the review aimed to examine Wraparound's use with underrepresented groups, it was crucial to avoid including studies where Wraparound was delivered traditionally to a population with only a small proportion of underrepresented service users. After further discussions and readings, the final criteria were determined.

A record was included if it met the following two criterion:

1) Recipients of the Wraparound intervention were Indigenous and/or belonged to an underrepresented community. This criterion could be met if either of the following were true:
    1. Over half of population belonged to underrepresented groups.
    2. Less than half were, but differential outcomes were explored.
2) The record either:
    1. Reported outcomes for service users OR
    2. Described how the approach had been adapted or delivered in a culturally relevant way.

A record was excluded if any of the following criterion were met:

1) The topic was irrelevant. For example, many papers about surgery techniques, physics, and funding/policy models which used the term wraparound were excluded.
2) The record did not describe outcomes or specific cultural adaptations to service design and/or delivery.
3) Less than half of the participant population were of underrepresented identities or differential outcomes were not explored.
4) The record did not explore actual application of the Wraparound Process and was a theoretical piece; for example, recommendations or advocacy for how Wraparound could theoretically be delivered or adapted for underrepresented communities.

5) The record focussed solely on outcomes unrelated to service user experiences and outcomes. Usually, these sources focussed on organisational outcomes, such as cost analyses, service provider and team member experiences, and implications for policy and reform of health care.

Data Charting Process

Data charting was an iterative process. Features to chart were added and changed as trends emerged throughout the charting process. A table was developed (see Appendix F) to chart relevant study characteristics in a comprehensive, structured, consistent manner. The table was reviewed by and discussed with supervisors/co-authors regularly. The use of a form or chart is common practice for scoping reviews (Tricco et al., 2018). The final characteristics extracted were: author/s, year of publication, service user population, description of intervention, research design, evidence of cultural considerations and adaptations in the source[55], fidelity[56], method/s of outcome measurement, outcomes, and whether potential disparities in outcomes were explored[57]. A document was used to denote further details of these characteristics, qualitative results, and examples of emergent trends for reflection and discussion in the current study.

Critical Appraisal of Evidence

Critical appraisal of evidence is typically reserved for systematic reviews and is an optional step in a scoping review that requires a clear rationale. A key difference between systematic and scoping reviews is that typically the latter are intended to provide an overview of existing literature regardless of methodological quality or risk of bias (Tricco et al., 2018). This review examines methods, quality concerns, and potential biases - particularly those affecting underrepresented groups - for two key reasons. First, as highlighted in the introduction, existing narrative (Coldiron et al., 2017) and systematic (Olson et al., 2021) reviews have identified

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[55] in the theory/introduction, research design, and/or service delivery

[56] mentioned and/or measured

[57] if the service user population was comprised of both over- and underrepresented identities

trends and concerns about the Wraparound evidence base, including methodological issues. A central concern has been the lack of demonstrable fidelity, which remains a point of contention. The current study seeks to determine whether these concerns are also present in the literature on Wraparound's use with underrepresented groups. Second, the main purpose of the current review is to provide an overview of the literature on Wraparound's use with underrepresented populations, set against the backdrop of systemic inequity, as discussed in the introduction. It is crucial to critically examine biases and trends in research and service delivery that may contribute to these inequities. While this review does not assess quality with the rigor of a systematic review, it aims to identify trends in research design and highlight key concerns and future directions for both research and practice.

Synthesis of Results

To answer the review's questions, records were grouped based on intervention characteristics, populations served, research design, cultural considerations and adaptations, fidelity measurement, outcome measurement[58], outcome nature[59], and outcome equity[60]. Results are presented in a narrative format. Percentages are used to provide an overview of the representation of each characteristic in the identified literature and are rounded to the second decimal place. Examples are summarised to illustrate the findings. The chart used to extract and display data can be found in the Appendix.

Results

Search and selection of records

Following PRISMA guidelines, Figure 4 provides a flowchart of the search and selection process. The original search conducted in June 2019 yielded 1002 potentially relevant sources. A

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[58] clinician, service user, or caregiver rated

[59] favourable, mixed, or unfavourable

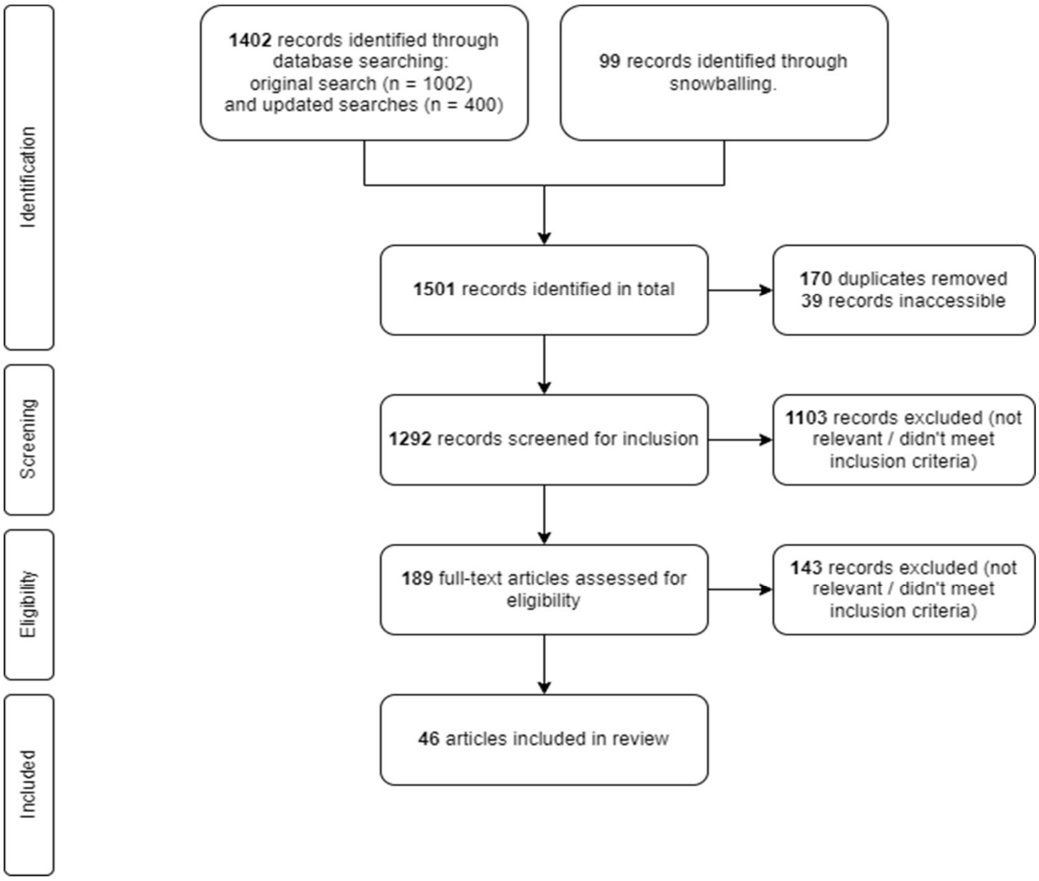
[60] including exploration of outcomes in mixed populations of underrepresented and overrepresented identities

repeated search in May of 2022 yielded 320 results published since the last search, and a final search in September 2022 produced an additional 80. A total 39 records were inaccessible. They either appeared to be irrelevant or were unable to be procured and were therefore not included for screening. After full-text review, 38 records met inclusion criteria. A total of 99 additional sources of interest were identified during the full-text review, and eight of these were eventually included, resulting in a total of 46 records.

A large proportion of records were excluded upon screening the title and abstract as *wraparound* is a term used widely across disparate disciplines. For example, several articles described *wraparound reconstruction surgery,* a surgical method used to restore a severely injured digit (Zang et al., 2017). A number of physics, chemistry, and biology articles also used the term *wraparound* in contexts irrelevant to the current review (e.g., Gonzalez et al., 2015; Khan et al., 2022; Saijyou & Yoshikawa, 1998). Many records were excluded in the first and second stages of screening as they focussed on implementation science (e.g., Bertram et al., 2011; Bruns et al., 2008), explaining the model (e.g., Schutte & Walker, 2004), describing theoretical applications of Wraparound and future directions (e.g., Lloyd et al., 2018), and discussing implications and recommendations for policy and government funding (e.g. Bruns et al., 2016; Gettens et al., 2016). Many papers briefly mentioned or cited a paper about Wraparound but were not actually about Wraparound (e.g., Jones, 2013). Some sources compared Wraparound to other approaches (e.g., Clark & Hieneman, 2007). Other articles reviewed several Wraparound programs but provided insufficient information about any one service (in terms of outcomes, demographic information and so on) to meet inclusion criteria (e.g., Goodwill & Giannone, 2017). However, publications about the interventions cited in such papers were reviewed for inclusion. Finally, some articles were excluded as they primarily looked at the outcomes and experiences of service providers and collaborating stakeholders (Matthews et al., 2019).

Figure 4

Selection of sources for scoping review



General characteristics of included records

All included sources were published between 1996 in 2022, with 78.26% (36/46) published since 2011. Most sources were journal articles (86.95%, 40/46). The remaining sources were governmental or service provider reports (13.04%, 6/46). Most of the sources were from the USA (78.26%, 36/46), and all sources originated from Western-colonised countries. Of those that were not from the USA, four were conducted in Canada (8.70%), three in Australia (6.52%), two in Aotearoa/New Zealand (4.35%) and one in Alaska (2.17%). See Appendix F for a table of the 46 included sources and all key information charted.

Characteristics of interventions and their target populations

In terms of the target problem that interventions aimed to address, the majority targeted emotional behavioural difficulties (26/46, 56.52%). A small proportion of these interventions (3/46, 6.52%) also targeted challenges and barriers to reunification with primary caregivers for children and youth with emotional behavioural difficulties. Other target issues included offending behaviours (and co-existing issues; 4/46, 8.70%), substance use (and co-existing issues; 4/46, 8.70%), gang involvement (and co-existing issues; 3/46, 6.52%), post-traumatic stress (2/46, 4.35%), engagement with education (2/46, 4.35%), unaccompanied youth homelessness (1/46, 2.17%), sexual offending (1/46, 2.17%), child maltreatment (1/46, 2.17%), inequities in pre- and post-natal care and vaccination of infants (1/46, 2.17%) and general markers of marginalisation (out of home care, justice involvement, homelessness and/or disconnection from education/employment, 1/46, 2.17%).

True to the philosophy of Wraparound, most interventions were entirely community-based and delivered in natural community settings (41/46, 89.13%). Six of these community-based interventions were school-based (6/46, 13.04%). A small number of interventions were delivered in a mixture of inpatient/residential and community settings with the aim to support transition into the community and the least restrictive setting possible (4/46, 8.70%). One intervention was delivered in a residential setting; a home that was set up for unaccompanied homeless youth who wanted to stay in school (1/46, 2.17%, Raffaele Mendez & Randle, 2021).

Over a third of the interventions in the review combined Wraparound services with another intervention, modality, or service (17/46, 36.96%). Typically, this was done with the intent of improving outcomes, accessibility, and service utilisation. For example, one study delivered in home Parent Child Interaction Therapy within a Wraparound framework (Fowles et al., 2018) and an anti-gang project integrated aspects of the Wraparound Process with Multisystemic Therapy, harm reduction, and cultural/faith based therapies (National Crime Prevention Centre, 2012a).

In terms of target populations, 82.61% (38/46) of the interventions served children or youth. Adult populations engaged with included: pregnant or parenting women (3/46, 6.52%), homeless veterans (1/46, 2.17%), adults with intellectual/developmental disabilities (1/46, 2.17%), young adults (1/46, 2.17%), refugees (1/46, 2.17%), and families/caregivers of children/youth who were the subject of a welfare report (1/46, 2.17%).

Slightly over a fifth of the interventions in the review targeted exclusively underrepresented and minoritised groups in their community (21.74%, 10/46). The largest proportion of interventions within these sources engaged with children/youth of minoritised racial ethnic identities (17.39%, 8/46). Four (8.70%) exclusively served children/youth from Indigenous populations (Passamaquoddy, seven tribal groups across the USA, Aboriginal children/youth in Canada, and tribal communities in San Felipe and North Dakota respectively). The other four interventions (8.70%) served Latinx children/youth, Mexican children/youth, African American children/youth and a diverse population comprising African American, Latino American, Hmong American and Native American children/youth. The other two interventions designed specifically for underrepresented service users both targeted Indigenous pregnant or parenting women (in Australia and Aotearoa/New Zealand; 4.35%).

Research design characteristics

Most sources included in the review were quantitative studies (30/46, 65.22%). Just over a fifth of sources used qualitative research design or presented qualitative information (10/46, 21.74%), and the remainder were mixed methods (6/46, 13.04%). Of the 30 quantitative studies, only four used an experimental design with randomised assignment to groups (4/46, 8.70%; Bruns et al., 2014; Carney & Buttell, 2003; McCarter, 2016; Siennick et al., 2020), 25 were quasi-experimental research projects (25/46, 54.35%), and one study was a descriptive cross-sectional multi-cohort study (1/46, 2.17%, Hyde et al., 1996).

Of the 11 qualitative sources, six analysed interviews using the following methods: thematic analysis (Raffaele Mendez & Randle, 2021; Shailer et al., 2018), narrative inquiry (Lyall et al., 2021), a priori content analysis (Painter et al., 2011), and unspecified interview analyses techniques (Madden et al., 2012; Rutman et al., 2020). Four of the remaining qualitative sources provided case studies/series (Kendziora et al., 2001; Madden et al., 2012; Méndez & Cole, 2014; G. Werrbach et al., 2013) and three provided a description of the design and application of culture-based or culturally modified Wraparound (Méndez & Cole, 2014; National Indian Child Welfare Association, 2015a; G. Werrbach et al., 2013).

Of the six mixed-methods sources, two were quasi-experimental single group pre-test post-test designs and reported both quantitative and qualitative data extracted via purpose-made surveys (Behnke et al., 2020; Champine et al., 2020). The remaining four used diverse methods. Ward and Bosek (2002) described the intervention and provided observational data and case series. Fletcher and Tan (2021) presented qualitative analysis of interviews (analysed using constant comparison analysis) with stakeholders and quantitative results from a survey. Simmons et al. (2008) presented quantitative descriptive data and case studies. Finally, National Crime Prevention Centre (2012a) presented a descriptive overview of the intervention and preliminary results.

In total, 15 studies compared recipients of the intervention to a control group (15/46, 32.61%). As stated earlier, only four studies were experimental and utilised randomisation, one of which (McCarter, 2016) had problematically small sample sizes and high attrition from the control group. Of the other studies that utilised a control group, most were grouped non randomly into treatment as usual (TAU) or intervention[61]. Some studies aimed to improve group equivalency using various methods, such as treating clinics in the same region (offering Wraparound or not) as the unit of randomisation (Lawton et al., 2021), selecting a local school with a similar population but no demographic details for the actual control group (Fletcher & Tan, 2021), or separating populations into high and low service use groups (National Crime Prevention Centre, 2012a). Only two studies reported using propensity scoring to match populations when they clearly differed on key characteristics (Blizzard et al., 2017; D. Evans et al., 2017). Some studies reported significant

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[61] based on factors such as archival data, location/availability of interventions (e.g., relevant local provider, school, or region which provided Wraparound), or pre-existing needs/situational circumstances.

preexisting differences between groups on relevant characteristics such as ethnicity, childhood adversity, gender, legal and mental health contacts, and so on (e.g. Hyde et al., 1996; Smelson et al., 2013).

Outcome measurement

Quantitative data was collected via surveys, clinical observation, clinical judgement, and administrative data while qualitative data was gathered via interviews, open-ended survey questions, and clinical observation. Most sources measured outcomes in multiple ways, combining reports from service users, caregivers, clinicians, and administrative data (27/46, 58.70%). In total, 58.70% (27/46) of the sources included reports from service users, caregivers, or both, whether used alone or alongside other outcome measurements. About a third used caregiver ratings and reports (15/46, 32.61%) and slightly more used service user reports (18/46, 39.13%). Just over two fifths of the studies did not include caregiver or service user reports or ratings (19/46, 41.30%).

A small group of sources used purpose-made measures were designed for the project (5/46, 10.87%; Behnke et al., 2020; Champine et al., 2020; Hyde et al., 1996; Syvertsen et al., 2021; Totten & Dunn, 2011). Both Totten and Dunn (2011) and Behnke et al. (2020) reported significantly reducing the size of their measurement tool in follow up as it proved too lengthy for participants to fill out. Some surveys were administered via interview, and researchers acknowledged that this may have introduced social desirability bias (National Crime Prevention Centre, 2012a), while others noticed that some service users were reluctant to discuss sensitive issues with researchers (Simmons et al., 2008). Evidence from studies that collected both caregiver and service user report demonstrated that the ratings and feedback provided by caregivers and children/youth were not necessarily consistent in terms of level of reported impairment, experience of the intervention, and outcomes (e.g., Painter, 2012; Painter et al., 2011; Shailer et al., 2018). Almost half of the sources used administrative data to measure outcomes (22/46, 47.83%). Administrative data collected included contact with the justice system, hours of service engagement, residential restrictiveness, treatment completion, graduation from school, truancy, welfare reports, suspension, crime, and engagement in desired/prosocial/health behaviours.

Fidelity measurement

Concerns about the lack of fidelity measurement in Wraparound, highlighted in previous reviews (Coldiron et al., 2017; Olson et al., 2021), are supported by the current review's findings. Over two-thirds of the sources did not mention or measure fidelity to the Wraparound model (32/46, 69.57%) while a small number of studies mentioned it but did not measure it (5/46, 10.87%). The remaining sources both mentioned and measured fidelity (9/46, 19.57%). Seven of the studies that measured fidelity used a standardised, psychometrically validated measure[62] and two used fidelity measures developed specifically for their service. For the latter two, it was unclear whether and/or how the measures were standardised and validated.

A significant proportion of studies also did not explicitly mention or describe the Wraparound practice model or any aspects of it. Some of these studies appeared to use the term *wraparound* in a colloquial manner to describe any approach that is multi-pronged, incorporates more than one intervention or service, and/or meets multiple needs (e.g. Behnke et al., 2020; Champine et al., 2019, 2020; Lawton et al., 2021; Lyall et al., 2021; Raffaele Mendez & Randle, 2021; Raghavan et al., 2013; Syvertsen et al., 2021; K. M. Ward & Bosek, 2002).

Four studies explicitly stated intentional nonadherence to key aspects of the Wraparound Process (typically stating it was too difficult or not beneficial to adhere) or provided strong evidence of non-adherence. For example, Siennick et al. (2020) did not include children/youth’s families in treatment planning, and in only 42% of cases teams met more than once. Ward and Bosek (2002) argued the *voice and choice* principle was not suitable for their population (adults with intellectual

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[62] six studies used the Wraparound Fidelity Index, 4th Edition (WFI-4), and one used the Wraparound Fidelity Index, 3rd Edition (WFI-3).

disabilities and a history of sexually inappropriate offending behaviour); Feely et al. (2022) stated that while the Wraparound process guided service delivery, a specific model was not used. Raffaele Mendez and Randle (2021) described an intervention in a residential setting with many prescriptive, non-individualised features.

Some studies that did not mention or measure fidelity nevertheless demonstrated clear understanding of the Wraparound practice model (e.g., Carney & Buttell, 2003; Fletcher & Tan, 2021; Fowles et al., 2018; Klayman & Crawford, 2007; Madden et al., 2012; National Crime Prevention Centre, 2012b; Painter et al., 2011; Simmons et al., 2008; G. B. Werrbach et al., 2013; Wu et al., 2018). Other authors recognised the importance of fidelity and adhering to the Wraparound practice model, and/or monitored adherence in non-standardised ways, but did not formally measure fidelity. For example, Wu et al. (2018) partnered with the National Wraparound Intervention for support and coaching to ensure high quality service. Klayman and Crawford (2007) noted that although the intervention’s evaluation team attended multiple meetings and trainings on the Wraparound Fidelity Index, they chose not to use it due to the evaluation staff being overburdened. The team held regular staff meetings to address service delivery issues, conducted focus groups with families, gathered client satisfaction surveys, monitored team meetings, provided clinical supervision, and included unspecified measures of impact and implementation in evaluations. The National Crime Prevention Centre (2012b) described the Wraparound practice model including principles and activities of the intervention. However, they stated it was not possible to formally assess fidelity of their service as staff lacked the necessary training.

Cultural concerns about fidelity measurement were raised in two publications on culture-based Wraparound. Kendziora et al. (2001) proposed that language in the original Wraparound model and its fidelity measures can be irrelevant or inappropriate for Indigenous people. Traditional formal protocol for seeking help within one's cultural group, may contradict the *informal supports* terminology in the Wraparound Model. In the context of Indigenous tribal communities in North Dakota, requesting help follows a formal process with specific protocols, making the term *informal* inaccurate (Kendziora et al. 2001). Palmer et al. (2011) stated that while accountability to funders and agencies is important, primary accountability lies with the cultural community served. They noted that measuring fidelity in culturally relevant ways is challenging due to the lack of normative data and argued that prioritizing cultural relevance should not compromise adherence to the model. Strengthening their argument is the results of their own formal measurement of fidelity, demonstrating scores above national means for their culture-based Wraparound Process.

Of the nine publications that formally measured fidelity, four reported high or above average fidelity scores (Anderson, 2011; Painter, 2012; Palmer et al., 2011b; Shailer et al., 2018), three reported moderate or adequate fidelity (Blizzard et al., 2017; Cox et al., 2009; Yohannan et al., 2017), and one did not present results of fidelity measurement but described intervention as high fidelity and did measure it (National Indian Child Welfare Association, 2015a). Yohannan et al. (2017) used a measure developed by the Department of Health and Human Services and all other studies that measured fidelity used standard measures of Wraparound fidelity.

Cultural considerations and adaptations

Each source was examined for evidence of cultural considerations and/or adaptations in three broad areas: theory, research design and service delivery. Some of the cultural considerations or adaptations were coded as *minimal*, indicating minor adjustment/s or consideration/s were made. Such adjustments included using a measurement that was cross-culturally validated or translated, briefly acknowledging inequity in theory without reference to contributing factors and history, and emphasising cultural competence or sensitivity but providing no description of how it is or was demonstrated.

Approximately a fifth of the publications did not demonstrate evidence of cultural considerations or adaptations in any of the three areas (9/46, 19.57%). This group contained all four interventions that solely focussed on addressing offending behaviours. Almost two-fifths of the publications described cultural adaptations and considerations in all three areas screened (18/46, 39.13%). Of the remaining studies, six showed evidence of cultural considerations and adaptations in research design and theory but not service delivery (13.04%), six showed evidence of cultural considerations and adaptations in research design only (13.04%), five showed evidence of cultural considerations and adaptations in theory and service delivery but not research design (10.87%), one showed evidence of cultural considerations and adaptations in service delivery only (2.17%) and one showed evidence of cultural considerations and adaptations in theory only (2.17%).

Most studies that met criterion demonstrated relatively minor cultural considerations or adaptations set within a traditional intervention/research project. On the other end of the spectrum, some research projects and/or interventions were entirely culture-based; founded within and shaped by an underrepresented cultural paradigm and worldview. Palmer et al. (2011), one of the included publications, outlines a comprehensive list of defining features of culture-based Wraparound which provides a useful (albeit non-exhaustive) framework with which to classify and report the types of cultural considerations and adaptations observed in the current review. The following list of features of culture-based Wraparound research and service delivery is based on Palmer et al. (2011) and expanded with additional examples or features observed in other sources from the current review:

1. Interventions and research projects were often designed and delivered by (or at least in partnership with) members of the underrepresented cultural group that was receiving the service (Fletcher & Tan, 2021; Kendziora et al., 2001; Lyall et al., 2021; National Indian Child Welfare Association, 2015a; Palmer et al., 2011; Werrbach et al., 2013). There was a spectrum in terms of the relative ownership of research and interventions by in-group members. Some interventions used a cultural consultant or Indigenous program coordinator to identify and meet cultural needs; provide cultural training, consultancy, and supervision; and facilitate connection to cultural resources or figures. Other research projects/interventions were entirely founded and delivered by members of the in-group.
2. Researchers and staff members accepted that members of cultural communities may not trust them exist regardless of their competency or intent, which alleviated inappropriate

labelling of individuals and families as resistant. Simmons et al. (2008) demonstrated this by hiring culturally responsive engagement specialists that did not meet clients at the service provider building (the Department of Children and Families) due to the recognised likelihood of negative connotations and mistrust.

3. Cultural expertise was recognised as was the idea that true cultural competency requires full immersion, and intergenerational wisdom. This was demonstrated through prioritising culturally-led research, service design, and delivery that upheld cultural ways of knowing, healing, and living as being just as valid and important as traditional Western ways (Kendziora et al., 2001; Palmer et al., 2011a). For example, Totten and Dunn (2011) highlighted the importance of cultural programming for Aboriginal children/youth, emphasising the central role of elders in high-quality service delivery for Indigenous populations. They demonstrated this by integrating cultural connections and programming into their intervention and paying a cultural expert a salary equal to that of full-time clinical staff, recognising cultural and clinical expertise as equally valuable.
4. Researchers and services ensured access to culturally and linguistically matched staff, thereby minimising the chances of misinterpretation and judgement resulting from cultural mismatches (Palmer et al., 2011). There was some evidence within the review that when this did not happen, there were indeed adverse consequences. For example, Madden et al. (2012) emphasised cultural competency in research and service delivery, particularly as the majority of service users in the intervention belonged to racial ethnic minoritised groups. Despite this explicit consideration and training, none of the individual caseworkers belonged to these groups themselves. Madden et al. described occurrences where caseworkers misinterpreted and misunderstood children/youth and families because they lacked cultural understanding. Similarly, Werrbach et al. (2013) described how their community, the Passamaquoddy First Nations people, experienced a history of culturally incompetent services, where interventions and communication often conflicted with their cultural values.

There was an underemphasis on the expected role and impact of extended family and misunderstandings of cultural practices and beliefs culminating in the misinterpretation and pathologisation of culturally normal phenomenon. Consequently, the tribe had been labelled by local authorities as resistant to treatment, which further increased distrust of services.

5. Interventions facilitated access to culture-based services and practises, strengthened connections to cultural elders, leaders, and role models, and were delivered in culturally safe environments (e.g., homes, reservations, meeting houses). When service providers or researchers could not address a cultural need, they partnered with others who could. (e.g., home, on a reservation, in meeting houses, and so on) (Kendziora et al., 2001; Palmer et al., 2011a; Totten & Dunn, 2011; Werrbach et al., 2013).
6. Inequities affecting underrepresented groups were acknowledged without focusing on deficits, recognizing the complex factors that contribute to inequity and respecting the unique cultural context and history of the community involved. For example, Totten and Dunn (2011) provided a comprehensive context and history of the local tribal community when explaining disproportionate incarceration of Indigenous people in the area. Kendziora et al. (2001) described the cultural and historical context of the local reservation, the specific impact of colonisation on local peoples, and how that connected to individually experienced issues.
7. Wraparound was integrated into their culture, rather than the other way around (Palmer et al., 2011). A traditional approach to cultural competence retains a fundamentally Eurocentric foundation. Interventions designed by Westerners, based on evidence from Western populations and informed by Western values, are adapted by adding features to make them more culturally appropriate. Conversely, culture-based interventions founded service design and delivery in the culture of those receiving and often delivering it. A service-provider quoted in Kendziora et al. (2001) explained that the Wraparound Process delivered in their tribal community has validated their culture and provided a framework with which

to bring traditional cultural interventions back and allow for tribal variation in approaches. Werrbach et al. (2013) used culture-based Wraparound in a community previously labelled resistant to services. As well as reporting positive outcomes, they describe how previous service users have been supported into professional training and returned as staff. The program mission states: "Kmihqitahasultipon intervention recognises that our community holds up the sky for our children. It is our belief that the answers for our children and our family challenges will not come from a program imported to the reservation, but it will come from our hearts, our memories and from our combined efforts. It comes from our tribe, and it is given in our homes in a manner that has been handed down through generations' (Werrbach et al., 2013g, p. 4).

8. Interventions and researchers emphasised accountability to service users, their families, and their communities as well as local and governmental agencies (Palmer et al., 2011). This was demonstrated through collective ownership of the intervention, prioritisation of service user/community perspectives, and partnership and collaboration across research, service design, delivery, and evaluation. Transparency of outcomes should also be evident. For example, Totten and Dunn (2011) presented results to service users and community members frequently in sharing circles, and Eadie (2022) established an Indigenous program coordinator advisor group to provide feedback.
9. Culturally relevant measurements of progress and outcomes were used in research and service delivery which centred service user, family and community perspectives. For example, Totten and Dunn (2011) used a quantitative psychometric survey that assessed for risk factors in adolescence[63] but also conducted focus groups and talking circles to elicit service user perspectives in a culturally appropriate way. Outcome tools were selected to be culturally responsive, and pilot surveys were reviewed by target children/youth. Lyall et al.

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[63] Rutger's Teenage Risk and Prevention Questionnaire: not a single, standardised instrument but rather a collection of questionnaires and measures (some of which have proven psychometric reliability and validity) to assess various aspects of risk behaviour and prevention in adolescence.

(2021) selected narrative inquiry as their research method because it closely aligned to *yarning;* a traditional Indigenous Australian way of generating knowledge. However, identification and use of culturally appropriate outcomes and measures can be difficult. Werrbach et al. (2013) highlighted the absence of established culturally competent measures for assessing outcomes in Native American communities' systems of care. Eadie (2022) stated that clinician-rated measures generally do not tend to have strong cultural validity and may bias findings. While diversifying and broadening methods of measurement, eliciting information, and measuring it is important cross-culturally, some culturally relevant markers of wellbeing may be difficult or even inappropriate to attempt to quantify – as quoted in Kendziora et al. (2001) 'We don't want no White people measuring us spiritually'.

10. Researchers and intervention staff acknowledged cultural differences in beliefs and attitudes about confidentiality and dual relationships and were flexible in response. Under a traditional clinical lens, dual relationships are seen as risky, potentially bringing in concerns regarding confidentiality, professional conduct, and safety. However, multiple publications in the current review noted that often having staff or research members known to participants was extremely helpful if not necessary for successful engagement. Werrbach et al. (2013) stated that for the population of First Nation service users, dual relationships were not an issue, and it was culturally important not to separate family and community identity from mental, professional, and spiritual expertise. In fact, some historically 'resistant' families benefited from the trust that shared ancestry and community connections conferred.

Outcomes of interest

Outcomes of interest covered were diverse: emotional behavioural symptomatology and risk factors, substance use, treatment completion, community engagement, positive relationships, offending and risk factors, violence, caregiver stress, caregiver interactions, educational/vocational, residential restrictiveness, reunification with family, reported experience of intervention, truancy, suspension, goal achievement, welfare reports, gang affiliation, attitudes, interactions with justice system, adaptive functioning, and functional impairment.

Publications were grouped into four groups according to whether reported outcomes favoured the intervention in comparison to baseline, treatment as usual, or a control group: favourable[64], mixed[65], unfavourable[66], or not measured. Just over a half of the publications reported favourable outcomes (25/46, 54.35%). About a third of the publications reported mixed outcomes (15/46, 32.61%). Only four studies reported unfavourable outcomes (4/46, 8.70%) and two studies did not report outcomes (2/46, 4.35%): Lawton et al. (2021) are yet to collate all outcomes and National Indian Child Welfare Association (2015) described culture-based applications of Wraparound without reporting specific outcomes.

Of the publications that did reported unfavourable outcomes, Bruns et al. (2014) attributed the lack of success in part to poor fidelity as did Siennick et al. (2020). Champine et al. (2019) reported that despite positive ratings of the service and their cultural competence, there was no observable effect on the target outcome; parental stress. Although Champine et al. (2019) found caregivers who experienced more frequent discrimination demonstrated higher service use, they still demonstrated worse stress related outcomes. They hypothesised that for marginalised families, participating in an intensive intervention may increase stress for already overburdened parents. Wu et al. (2018) found no difference in the changes over time for polypharmacy between a Wraparound intervention and a control group. All publications that primarily focussed on justice-based outcomes had mixed or unfavourable findings (Carney & Buttell, 2003; Feely et al., 2022; McCarter, 2016; National Crime Prevention Centre, 2012a, 2012b; K. M. Ward & Bosek, 2002). There were some musings that this could have been due to the relatively low base rate of reoffending.

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[64] Evidence of a positive difference in target outcomes either in comparison to baseline or compared to TAU/a control group.

[65] Evidence of positive difference on some target outcomes but not others (i.e. no evidence of a positive difference on some target outcomes compared to baseline/control and for some studies, evidence of a negative difference).

[66] No evidence of a positive difference in any target outcomes compared to baseline/control, or evidence of a negative difference.

In terms of the publications that reported mixed results, all 15 reported some favourable outcomes accompanied by either some null effects or negative outcomes. For example, Feely et al. (2022) reported no significant change in subsequent child welfare reports post intervention, but the Wraparound group had significantly less reports substantiated than the control group, indicating the reports were probably less serious. McCarter (2016) found significant differences in improvements on various target outcomes for the Wraparound group compared to control, but no difference in recidivism. Cox et al. (2009) reported a significant reduction in emotional behavioural problems, but only 51% of children/youth met their goals and sustained a low restriction home setting, 16% did one or the other, and 33% achieved neither.

Many of the qualitative studies were classified under mixed outcomes, as participants typically highlighted both positive and negative aspects of the intervention and their experience. The positive features of interventions commented on in qualitative sources emphasised the importance of holistic approaches, positive relationships with staff and community, flexibility, individualised care, cultural emphases and programming, unconditional positive regard, trust, support, non-judgement, developing skills and adaptive strategies, increased empowerment and hope, advocacy, navigation, and the positive impacts of the intervention.

The following unfavourable features and experiences were reported in qualitative sources: not feeling ready for discharge when it occurred, frequent staff turnover disrupting care continuity, difficulty coordinating services, being rushed through the process, interpersonal conflicts with staff, unclear staff roles, limited service accessibility, difficulties with gang-affiliated peers and engaging in cultural activities due to trauma, and a lack of natural supports after service termination.

Outcome Equity

Outcome equity was assessed by screening whether publications explored comparative outcomes when populations comprised both overrepresented and underrepresented groups. Publications were assigned to one of three groups; outcome equity measured and reported, not measured or reported, or not applicable (because the entire population belonged to one underrepresented group). Just under a quarter (11/46, 23.91%) of publications measured and reported equity of outcomes. Over half of the publications included in the current review did not measure or report outcome equity (25/46, 54.35%) and the remainder (10/46, 21.74%) were not able to, as they served an entirely underrepresented population that was relatively homogenous in terms of cultural identification.

Of the publications that measured and reported outcome equity, seven (7/11, 63.64%) found no differences in treatment participation, completion, or outcomes based on racial ethnic identity. The remainder (4/11, 36.36%) did find differences as following:

1. Stenersen et al. (2021) found that at intake, caregivers of White children/youth reported higher levels of overall caregiver strain, significantly more problem behaviours and lower functioning in than caregivers of Latinx and Black children/youth. There was no difference in reported trauma symptoms or number of traumatic events experienced across racial ethnic identity, but White children/youth had significantly a higher likelihood for a reported history of trauma. White children/youth also had significantly more meetings compared with their Black and Latinx peers. At follow-up and discharge, there were no racial ethnic disparities in outcomes after controlling for intake scores. Caregivers of Black children/youth reported significantly less satisfaction with staff in respecting their religious beliefs compared to their White and Latinx counterparts. Given the lack of difference in the rate of change on target outcomes, the number of days enrolled, and mutual discharge, authors concluded the intervention did not further contribute to racial ethnic disparities and therefore effectively contributed to rectifying them.
2. Yohannan et al. (2017) separated participants into four groups: White higher socioeconomic status (SES), African American higher SES, White low SES, African American low SES. Children/youth were placed in various categories based on whether they received free lunch services. Those who completed treatment were reported to demonstrate significant improvement in emotional behavioural health and functioning. However, authors also

reported a high rate of attrition; over half of entire population did not complete treatment. Attrition was significantly higher in the African American low SES group compared to the White low SES group. Those who completed services were more likely to experience improvements than those who did not. However, the authors failed to comment on the fact that their data demonstrated African American children/youth had significantly lower scores on the CAFAS (indicating better functioning and lower impairment) than their White peers regardless of SES and treatment completion. The authors also did not explore or comment on why low SES African American children/youth may have had more difficulty with treatment completion.

3. Eadie et al. (2022) reported Indigenous children/youth showed a significantly greater improvement than non-Indigenous peers in three domains emotional behavioural outcomes: emotional symptoms, antisocial behaviour, and peer relationships. Non-Indigenous consumers had more difficulties with self-care and independence at baseline but there were no other baseline differences. There was no overall difference in changes in scores based on Indigenous or non-Indigenous status. Authors attributed this finding to the provision of specialist Indigenous trainings for staff, cultural consultation, guidance, and support.
4. Anderson et al. (2003) found that African American females and White males were more likely to be in a restrictive residential setting at the 6-month point, by 12 months there were no significant differences between groups. Men who belonged to a racial ethnic minoritised group were also less likely to complete treatment, and recidivism was more likely in non-completers.
5. All publications presenting interventions that engaged with entirely underrepresented and minoritised groups in their community reported positive outcomes.

Discussion

Overview

The current paper provides an overview of the use of the Wraparound Process with underrepresented populations. Formally assessing the quality of included publications is beyond the remit of the current review. However, reflections on the results, implications, and recommendations are provided, guided by the objectives of the current study.

The overwhelming majority of included publications came out of the USA, and all were from Western-colonised countries. Many of the trends in the review mirror those in the wider Wraparound evidence-base (Olson et al., 2021; Coldiron et al., 2017), including a relative absence of fidelity measurement, a lack of experimental research designs, and concerns about methodological weaknesses.

In terms of the extent, range, and nature of existing research on the use of Wraparound with underrepresented groups, this review demonstrated Wraparound is already being provided to diverse populations of underrepresented groups in Western-colonised countries. Most interventions targeted emotional behavioural difficulties in children/youth, but overall, the target populations and problems varied significantly. In alignment with Wraparound's philosophy, most interventions were community-based. A significant number of interventions were solely designed for and serving underrepresented populations. Most studies were quantitative, and studies used diverse research methods. There were very few experimental research designs.

Existing concerns about fidelity in the wider Wraparound evidence base were replicated in this review. Most publications did not measure or even mention fidelity. Some authors described a theoretical commitment to fidelity but still failed to formally assess it. Reasons were sometimes provided and included difficulty accessing formal trainings or being under-resourced in terms of staff, funding, and availability of training opportunities. Concerns were identified about the cultural relevance of fidelity measurement and how high-fidelity Wraparound is defined particularly in terms of language used. However, evidence was also provided to demonstrate the existence of culture-based Wraparound that was also high fidelity.

There were overt issues regarding the use of the term *Wraparound* in the literature; many publications used the term colloquially when referring to multi-pronged, holistic care, sometimes without any reference to the Wraparound practice model. Others selected some aspects of the Wraparound Process to utilise but did not adhere to others.

In terms of measurement, outcomes were mostly measured and collected via standardised and validated psychometric tools, purpose-made surveys, clinician observation and administrative data. There was a relative lack of measurements that centred service user, family, and community perspectives. The importance of using culturally significant measures was emphasised by those who delivered culture-based Wraparound. Often measurement was an area where otherwise culture-based or culture informed interventions used clinical, traditional measures of phenomena that do not capture service user experience or culturally relevant descriptors of wellbeing and success. Such practices risk contributing to the deficit lens through which underrepresented populations are often defined in academia. A core tension seems to exist between the required accountability to governmental and funding stakeholders and affected communities and service users who have different perspectives. Studies that elicited feedback from clinicians, caregivers, and service users evidenced how their experiences and perspectives can vary, emphasising the importance of collecting various perspectives.

Given the current review selectively included sources describing interventions for underrepresented populations, it is concerning that a significant proportion did not report any cultural considerations or adaptations whatsoever. Most publications reported some adjustments or theoretical considerations related to culture, but these tended to be minor add-ons (e.g., a culturally validated measure) to fundamentally traditional research or service design. Conversely, some studies demonstrated culture-based intervention and research design, providing guidance and frameworks in terms of how it can be done.

In terms of outcomes, just over half of the sources reported that results on all target outcomes were favourable. Almost 90% of interventions represented in the current review reported some favourable outcomes. A very small minority reported unfavourable outcomes. However, as mentioned earlier, poor fidelity and potentially questionable methodological quality limits the confidence with which these outcomes can be interpreted.

Of the studies that explored outcome equity, most demonstrated equitable outcomes and some even showed better outcomes for underrepresented groups within their research population (Eadie et al., 2022; Stenersen et al., 2021). This finding supports Yosso's (2005) assertion that underrepresented cultural groups have unique strengths, characteristics, and community connections that contribute to wellbeing and success and can be drawn upon therapeutically. Although Stenersen et al. (2021) did not hypothesise about why White children/youth demonstrated higher trauma symptomatology despite higher service use, it is possible that cultural factors underpin the finding. Perhaps the Western tendency to prioritise individualism and the nuclear family means White families and children/youth had less access to natural supports, which impeded their resilience and ability to cope with and recover from traumatic events. Or perhaps Western norms and values regarding social, emotional, and behavioural functioning meant that White caregivers had a higher tendency to pathologise or view phenomena negatively. Eadie et al. (2022) primarily attributed better outcomes for Indigenous children/youth to cultural trainings provided to staff. It may very well be that these trainings assisted staff in being more culturally responsive and mitigated the barriers that can be caused be cultural mismatches. However, it is difficult to see how this would result in superior results for minoritised children and youth and overlooks the potential contribution of strengths and protective factors located in the child/youth, their family, and community that may be associated with culture. Studies that showed inequities for underrepresented identity service users often identified connected factors (e.g., higher attrition, lower satisfaction with services) that likely represent systemic and institutional dynamics that can be explored and targeted in research and service delivery.

Limitations

A key limitation of the current study is that the primary researcher is English-speaking and therefore, some studies may have been excluded that were not available in English. Certainly, the lack of publications from non-Western countries constitutes a significant gap in the literature if it is not partially explained by this limitation. This review also could have missed some sources in the available literature despite efforts to be as comprehensive as possible. Relevant terms that were not used in the search strategy may have identified more sources.

The scoping review method inevitably privileges Western and mainstream frameworks of knowledge and practice. There are likely effective, important Wraparound approaches in cultural communities that would be impossible or difficult to learn about via an electronic search strategy. In fact, a conversation with John VanDenBerg (one of the founders of the Wraparound Process) confirmed exactly this. He described being invited to work with over 200 Indigenous groups since the Wraparound Process was first being established in the eighties, many of which responded to the Wraparound Process by saying things like “that’s the way we have always done it”. Not all these engagements were documented or published. Indigenous populations often understandably had apprehensive attitudes about researchers, mental health, and social services. Hence, engagement with the Wraparound Process was often directed by Indigenous groups and leaders who invited VanDenBerg to their community. There was less of a focus on producing publications and more of a focus on relational engagement and grounded application (personal communication, April 5, 2023).

Grouping and making generalisations across diverse underrepresented groups can be problematic, given each culture and community is unique and distinct in innumerable ways. Using the terms minority, racial ethnic minoritized, and underrepresented when referring to these groups had utility in the current study in terms of exploring the use of the Wraparound Process with underrepresented communities, especially because there was little research that directly explored this topic. However, it is important to acknowledge that grouping diverse cultural groups together is inherently reductivist and may erase important differences and various phenomena that are important in both theory and practice.

Conclusion and Recommendations:

In conclusion, this review demonstrates that Wraparound is used effectively with underrepresented groups and can be entirely based within and shaped by the cultural community it serves. Most studies demonstrated equitable outcomes and some even showed better outcomes for underrepresented groups within their research population (Eadie et al., 2022; Stenersen et al., 2021). This finding supports Yosso's (2005) assertion that underrepresented cultural groups have unique strengths, characteristics, and community connections that contribute to wellbeing and success and can be drawn upon therapeutically. It is therefore a promising service delivery model for diverse underrepresented groups, demonstrating positive outcomes and providing a framework that may combat inequity.

In the future, research should identify and address barriers to fidelity measurement and high-fidelity Wraparound. Clearer definitions and descriptions of the Wraparound Process need to be used in the literature, and colloquial use of the term *wraparound* should be avoided. Research should also explicitly consider, measure, and report potential disparities. The tension between accountability to governmental funding agencies and service users, families, and communities needs to be resolved. Definitions and measurement of problems, wellbeing, and success should be defined collaboratively; prioritising what is most important to the communities, families, children, and youth who are struggling and need support. Palmer et al. (2011a) and other publications about culture-based Wraparound provide useful exemplars and guidelines to inspire culturally responsive, ethical Wraparound delivery and research.

In a wider sense, academia and service delivery needs to be decolonised. It is important to use the scientific method to identify and characterise problems and effective interventions while remaining aware of and responsive to potential cultural biases within ourselves, our services, our disciplines, and our society. This means widening the scope for what we consider to be evidence, and adjusting practice, measurement, conceptualisation and communication in a manner that honours the rich diversity of knowledge, wisdom, and experience across different cultures. Furthermore, combating the deficit bias in academic and research reporting about underrepresented groups is essential. This can be achieved by both acknowledging and investigating the unique strengths inherent in cultural communities, highlighting resilience, agency, and cultural assets, and considering how these elements can and do contribute to successful interventions.

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Chapter 5: A multi-study exploration of Te Kahu Tōi Intensive Wraparound Services: qualitative analysis of interviews with Māori whānau and quantitative analysis of outcomes.

Abstract

Background

Unmet mental health needs are one of the most significant global public health challenges and a leading cause of disability. Children and youth are disproportionately affected yet have the poorest access to services. Within the population of children and youth with mental health needs, there is a smaller population referred to as having high and complex needs (HCN). These children and youth present with chronic, complex, unmet needs[67] that significantly impact their wellbeing and functioning and are difficult for standard services to address. Indigenous, minoritised, and marginalised children and youth tend to be overrepresented within those deemed to have HCN. Globally, system responses have been inadequate, failing to address the intersectional nature of the problem. In Aotearoa, these trends are replicated. Due to a history of colonisation (and despite ongoing resistance and cultural revitalisation movements), Māori experience disparities across all indicators of social wellbeing in Aotearoa. International evidence supports the need for a system reform, centring holistic systems of care. However, the same problems systems of care were designed to address also act as barriers to their implementation. Decolonisation and indigenisation of systems, research, and practice can shift the dominant paradigm in pursuit of equity.

Objective

The overarching purpose of this research project was to contribute to the pursuit of equity in service provision, access, and research both generally and more specifically; for children, youth and whānau with HCN and particularly for those in Aotearoa, with a focus on adherence to the Treaty of Waitangi. The study explored the outcomes and experiences of the Wraparound Process as

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[67] That can relate to social, emotional, behavioural, and/or developmental factors and often interact with each other and require intensive support.

delivered by Te Kahu Tōī Intensive Wraparound Service (TKT IWS), provided by the Ministry of Education, to assess its potential as an effective approach for achieving equitable service provision, experiences, and outcomes.

Methodology

The project is grounded within a critical realist epistemology informed by critical race theory, as well as decolonising and Indigenist ontologies, epistemologies and methodologies. The current project consists of two separate related studies. The first is an exploration of Māori experiences of TKT IWS and raising children and youth with HCN using reflexive thematic analysis (RTA). The second is a quantitative analysis of outcomes using longitudinal single cohort design to compare outcomes at baseline and one year of engagement.

Results

Results from both studies demonstrated convergent evidence of increased functioning and decreased impairment, demonstrating the effectiveness of Wraparound with a diverse population in Aotearoa.

Study 1

Results demonstrated Māori caregivers' experiences of Wraparound were positive. This was attributed to aspects of service delivery such as partnership, increasing access to resources, reducing familial stress, and improvements in functioning and quality of life for children, youth and whānau. Societal problems and systemic contributors to problems experienced by children, youth and whānau with HCN (including those related to engaging with TKT IWS and other services) were emphasised.

Study 2

A paired samples t-test revealed a significant difference between CAFAS scores at T1 and T2. The effect size was large and the observed overall improvement in functioning according to the CAFAS was clinically and statistically significant. Outcome scores on the Special

Education (SE) Outcome Tool revealed that after a year of engagement, most of the sample were still functioning at below the expected level[68]. Little change was observed in ratings of caregiver resources, and there was a small increase in the number of children and youth in residential placements.

Conclusions

These findings add to a growing evidence base which demonstrates Wraparound can be effectively and equitably used across diverse populations. Importantly, they also demonstrate how Wraparound (as delivered by TKT IWS) centred partnership, and add to assertions that the philosophical foundation of Wraparound naturally aligns with principles of te Tiriti. Consequently, these studies suggest Wraparound is a promising approach for addressing inequities experienced by Māori children, youth and whānau with HCN in Aotearoa. They also add to the literature indicating Wraparound can be used in culturally responsive and based contexts globally to combat inequity and provide more holistic, effective care. Limitations of the project are outlined and recommendations for future research and practice are made, including; 1) further identification and investigation of outcomes of concern (educational, caregiver resources, residential placements, and culturally significant outcomes) and equity of outcomes across gender and cultural groups utilising a larger sample, 2) increased adoption of Kaupapa Māori/Indigenist approaches in research and practice, 3) critical analysis of measurement strategies alongside development and implementation of culturally relevant, collaborative measurement tools, 4) partnership and cultural responsivity throughout all levels of service design and delivery, 5) increased recruitment and representation of children and youth in research, and 6) acknowledgement, critique, and challenging of societal norms, dynamics, and systems that generate inequity.

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[68] The SE Outcomes Tool uses numerical ratings to provide an indication of poor, moderate, or engagement and achievement at the expected level for three areas: presence, participation and wellbeing, learning and achievement.

Introduction

This chapter provides the abstract, background, methodology, and objectives for the multi-study project described in the following chapters.

Unmet mental health needs in children and youth

Mental health problems are one of the most significant public health challenges we currently face as a global society (Whiteford et al., 2015; WHO, 2021). This is especially true for children and youth. For those aged 10-24 years, mental health difficulties account for 45% of the overall *burden of disease*[69]. Neuropsychiatric[70] disorders are the leading cause of disability in this age group (Kieling et al., 2011a; United Nations Children's Fund, 2021), and suicide is the second most common cause of death (McGorry et al., 2022). Recent international research has estimated at least one in seven youth aged 10-19 live with a diagnosed mental health difficulty (United Nations Children's Fund, 2021), and by the age of 25, more than 50% do (McGorry et al., 2022).

Mental health difficulties that arise in childhood and youth are often chronic and persist into adulthood (Prince et al., 2007). Mental health problems in childhood and youth are strongly associated with a broad array of difficulties that increase the likelihood of cumulative negative experiences throughout the lifespan; poorer overall sexual, emotional, social, and physical wellbeing, increased behavioural issues, and problems with education, employment, and the justice system. These difficulties often put enormous strain on family systems, and place youth at heightened risk for out-of-home placement (Patel et al., 2007; Shailer et al., 2017) and exclusion from school (Education Review Office, 2023; Tejerina-Arreal et al., 2020; Wynne et al., 2013). Ultimately, mental health difficulties that arise in youth can thwart positive developmental trajectories if they are not identified and addressed in a timely, effective manner. This comes at a high social and economic cost

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[69] This term refers to the impact of any given health issue on a population, as measured by the prevalence, severity, and consequences of the condition. It is important to note that the use of this term in reference to mental health difficulties does not imply they are *diseases* in the traditional biomedical sense but highlights their significant impact.

[70] emotional, behavioural, substance-related, and neurodevelopmental.

not only to affected individuals and families, but communities and society too (Kieling et al., 2011b; Prince et al., 2007; United Nations Children's Fund, 2021). As stated by Kieling et al. (2011), regardless of the well-evidenced argument that investing in early intervention would benefit the economy, our health system, and society at large (well described by McGorry et al., 2022), we also have ethical and statutory obligations to protect children and especially those who are most vulnerable. Children have a universal right to experience wellbeing and achieve their full developmental potential, which is not currently upheld by our society (Kieling et al., 2011b; United Nations Children's Fund, 2021).

Baranne and Falissard (2018) analysed data from the global burden of disease study (WHO, 2015) to investigate the burden of mental health problems in children from 5-14 years. They found mental distress to be a leading cause of disability in this age group and one that was likely to increase in relevance. Due to medical advancements, the burden of chronic and mental health conditions surpasses that of acute infectious disease in many high-income countries. Baranne and Falissard (2018) stated this transition is likely to eventuate across the entire globe, making mental health one of the most pressing public health challenges of the twenty-first century. Given this, they made the following call to action:

> This paper is intended as an urgent signal of alarm to national and international public health institutions and policymakers. The world is experiencing an epidemiologic transition. The relative burden of disease of mental disorders among children aged 5–14 years is increasing and will accelerate even more in the near future. This change and the problems accompanying it will require specific responses. Psychiatric diseases in children must be considered specifically. Planning a vaccination program or an antibiotic prescription is very different from organising a global policy for mental health and psychiatric care. It requires a long-term perspective, specially trained professionals, and careful preparation in view of the numerous obstacles that must be anticipated, including local representations of psychiatric diseases, the time necessary for effectiveness, and the

extensive resources, financial and human, that will be required. This is a major challenge. (Baranne & Falissard, 2018, pg. 8).

Such compelling evidence should inspire rapid, significant societal responses in the form of development, establishment, and optimisation of targeted services, policies, and resources. Almost two decades ago the World Health Organisation stated that the global mental health burden was beyond the treatment capacity of nations worldwide irrespective of wealth, and was continuing to grow (World Health Organization, 2005). Despite this, inadequate systemic responses persist globally, and the morbidity and mortality associated with mental health difficulties remains largely unchanged (Mei et al., 2020). This is in part due to the pervasive societal stigma regarding emotional behavioural problems. Commonly held beliefs about the validity, controllability, causes, and actual day-to-day impact) of mental health difficulties permeate society and contribute to relative systemic neglect of mental health needs, despite an abundance of research demonstrating the comparable impact (and connection) of neuropsychiatric disorders to physical health problems (Baranne & Falissard, 2018).

Concerningly, the treatment gap for mental health difficulties is especially pronounced for youth, who are also the most affected (Kieling et al., 2011b; McGorry et al., 2019; Prince et al., 2007). The age-of-onset for most mental health disorders fall within a narrow timeframe (12 – 24 years) with 75% of diagnosable mental health issues emerging by the age of 25, making it a critical period for intervention. Paradoxically, those between 12 and 25 also have the worst levels of access to mental health care (McGorry et al., 2019; Prince et al., 2007). Research conducted in high-income countries (HIC) has shown 70-80% of youth do not seek professional support for their mental health concerns, and when they do, it is often inadequate and does not adhere to evidence-based approaches. This treatment gap is even higher in low-middle income countries and marginalised communities within HIC (Mei et al., 2020).

McGorry and Mei (2018) argued that health services are often poorly designed, severely under-resourced, and typically uninviting and mistrusted by youth. Service design and resource allocation has not reflected the disproportionate burden of mental health difficulties carried by youth, nor their unique and complex developmental needs. Traditional models of care offer paediatric and adult services, designed primarily for young children or adults with severe, persistent mental health disorders. Such services are typically narrowly bound within a biomedical framework, inaccessible in terms of eligibility criteria and navigation, developmentally inappropriate and ultimately ill-fitting for youth presenting with complex, emerging difficulties. It is therefore unsurprising that low rates of treatment engagement and high rates of attrition persist for this age group (McGorry et al., 2019).

In Aotearoa/New Zealand a recent report (Controller and Auditor General, 2024) demonstrated global trends of unmet mental health needs in youth and inadequate system responses are mirrored nationally. The report focussed on youth from 12-24 years of age, noting that nationally representative prevalence data for mental health issues in youth was outdated and unavailable for younger children in Aotearoa, an issue that should be promptly addressed to better guide funding, service design, and provision. Available data from a recent nationwide health survey demonstrated over a fifth of those aged from 15-24 reported high or very high levels of mental distress in a recent four-week period (Controller and Auditor General, 2024). Additionally, a cross-sectional youth health survey conducted in 2019 representing 2-4% of the Aotearoa secondary school population demonstrated significant increases in self-reported mental health difficulties since 2012. When reflecting on the past year, 23% of youth in the 2019 survey reported significant depressive symptoms, 38% reported periods of low mood lasting two weeks or longer, 24% reported deliberate self-harm, 21% reported serious thoughts about suicide, 6.3% reported suicide attempts, and 42% reported anxiety symptoms. The rate of youth suicide in Aotearoa/New Zealand remains amongst the highest in HIC countries (Sutcliffe et al., 2023).

Wait times for services continue to increase, and many youth are unable to get help when they need it. In alignment with global trends, in Aotearoa most mental health needs remain unmet for youth, who also experience the highest levels of unmet need for mental healthcare relative to other age groups. Funding models that shape resource allocation and eligibility criteria for publicly funded mental health support in Aotearoa are based on outdated Australian data from the 1990s which estimated 3% of the population will experience serious mental health issues. More recent data demonstrates 4.7% percent of the population meets this threshold. In addition, the report urged governmental powers to reconsider current funding models based on such high eligibility thresholds, given the robust and ever-growing evidence-base demonstrating the benefits of early intervention (Controller and Auditor General, 2024).

The need for reform of social and healthcare systems and services is well-substantiated given systemic failure to respond to population needs and provide equitable experiences and outcomes. In the last two decades, advocacy for systemic reform has gained traction as the importance of effective early intervention and addressing unmet needs in youth is increasingly recognised as a top societal priority. However, this transformation is in its infancy (McGorry et al., 2022; Mei et al., 2020). As described by Malla et al. (2018), reform is not a short-term or straightforward task. Steadfast commitment and prioritisation of youth mental health is required across all levels of government, academia, and service providers. A different conceptual framework of mental health needs in youth is required to facilitate exploration and addressing of the generative mechanisms of unmet needs in a meaningful manner responsive to political, cultural, and geographical context. Malla et al. (2018) asserted that service delivery reform should address what impedes timely access to adequate appropriate services for youth based on international evidence. They provide the following set of guiding principles:

- Services should be designed specifically for and with target youth to address their multiple intersecting needs.

- Services should be sensitive to cultural, historic, and geographic context.
- Evidence-based approaches should be utilised while also centring service user preference.
- Services should be easily accessed by youth and families, without need for referral and including drop-in.

Services should be well-connected both vertically to other specialist services and authorities, and horizontally to other social and health services.

High and complex needs exist within and as a result of intersecting systemic problems.

The principles outlined by Malla et al. (2018) for service reform shed light upon what has been relatively neglected in conceptualisations and approaches to mental health problems to date: intersectionality. Mental health difficulties, and perhaps more broadly, social-emotional behavioural difficulties (SEBD) in youth typically arise from and exist within a matrix of interacting problems, adversities, and unmet needs. Children and youth with diagnosable mental health difficulties present to services with high levels of comorbidity, complexity, and unmet needs across a range of areas (Patel et al., 2007a) including physical health, behaviour, cognition, development, interpersonal, familial, discrimination, marginalisation, and disadvantage (Fergusson & Horwood, 2001; Kessler et al., 2005; P. F. Mitchell, 2011; Oakley-Browne et al., 2006; Prince et al., 2007).

The term *high and complex need*s (HCN) is used to denote the severity and breadth of unmet needs a small group of children and youth present to services with. These children and youth have chronic, persistent, highly complex unmet needs, and often engage in behaviour that puts themselves or others at risk. Typically, their caregivers are under extreme stress and struggle to cope with the severity of their child or youth's difficulties. Often this means children and youth with HCN are already in (or at-risk of being placed in) residential care, often at specialist facilities. The unmet needs and difficulties these children and youth experience are systemic; intertwined with the unmet needs and difficulties experienced by their family, community, and society systems (High and

Complex Needs Unit, 2005). Some researchers have questioned the appropriateness of the HCN label as it implies the problem or pathology is located in the individual whose needs are exceedingly difficult to meet. While it is clear these children and youth have significant unmet needs and difficulties that can complicate treatment engagement, it has been suggested a more accurate term might highlight the pathology within a social system that generates and is then unable to address these unmet needs and difficulties, rather than placing the burden solely on the individual (Social Policy Evaluation and Research Unit, 2015).

Systemic conceptualisations of SEBD and systems-based service delivery are not new. *Ecological systems theory* is a systems-based bioecological theory of human development which has gained widespread acceptance since it was established in the seventies (Ashiabi & O'Neal, 2015; Bronfenbrenner, 1977). Ecological systems theory emphasises interactions of different developmental processes with contextual factors in the multi-level social environment an individual is embedded within which is divided into nested, interacting systems (Ashiabi & O'Neal, 2015). Bronfenbrenner placed emphasis on the centrality of *proximal processes*: the enduring, complex, reciprocal interactions that take place between an individual and their environment over time. The trajectory, nature, and power of these processes vary as a combined function of the characteristics of the individual and their environment (Ashiabi & O'Neal, 2015).

By drawing attention to context and environment, ecological systems theory diverges from traditional conceptualisations of SEBD which medicalise difficulties, framing them as pathological individual deficits (Macleod & Munn, 2004). Ecological systems theory provides a framework with which to zoom out and consider the contribution of environmental and societal factors to developmental pathways. Alongside the development of the ecological systems theory, the systems of care (SOC) approach arose in the mid-1980s to address the well-documented problems in systems and services for children and youth with SEBD and their families. SOC is a service delivery approach and philosophy of care (rather than a specific intervention or model) formally defined as:

An adaptive network of structures, processes, and relationships grounded in system of care values and principles that provides children and youth with serious emotional disturbance and their families with access to and availability of necessary services and supports across administrative and funding jurisdictions. (Hodges et al., 2007, pg.2).

Rather than treating mental health needs in an isolated manner, SOC comprises overlapping dimensions of infrastructure[71] to address the comprehensive needs of children and youth who with or at risk of SEBD (Stroul et al., 2018). The core values of the philosophy specify that SOC should be 1) child-centred and family focussed, 2) community-based, and 3) culturally competent. Furthermore, the guiding principles of systems of care emphasise interagency collaboration, comprehensive care, an individualised strength-based approach, cultural sensitivity, involvement of youth and their families, community-based supports in the least restrictive environment possible, and maintenance of accountability through constant evaluation of services and outcomes (Child Welfare Information Gateway, n.d.).

The SOC approach has been widely adopted, particularly across the United States, and an extensive body of research has documented its effectiveness (Stroul et al., 2018). However, there are significant barriers to the expansion and optimal implementation of SOC. At the macro or systems level, meeting the needs of a high-risk, complex population often in crisis is a formidable challenge, as is securing the necessary collaboration and cooperation from multiple child-serving systems. At the micro and service-provider level, barriers to implementation include funding SOC approaches, service and staff shortages, and incorporating traditional psychiatric approaches into community-based treatment models (Biebel & Geller, 2006).

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[71] e.g. early childhood services, recreational services, social and welfare services, educational services, effective system and data management, quality improvement practices, workforce development and interagency partnerships.

Challenges to implementing systems of care

The systemic problems that SOC was intended to address have limited the implementation of it. Such problems have persisted in mental health systems since the beginning of the community mental health movement, when transitioning from psychiatric institutionalisation to community-based care became a global priority (Cook & Kilmer, 2004). Many critics of the movement (e.g., Szasz, 2009) have argued that this reform was incomplete and problematic; although there was indeed a move away from institutionalisation, the establishment of a functional, cohesive, empowering community system has been largely unsuccessful to date. As stated by Szasz (2009), the reform did not significantly shift underpinning ideologies, such as the medicalisation of problems that are often actually public health/social problems. While services may primarily be provided in the community now, medical conceptualisations and treatments are still dominant. Involuntary treatment and admissions remain commonplace for those in serious distress, high needs service users remain dependent on the mental health system without effective treatment, and many fall through the cracks of a siloed system riddled with gaps. Organisational and systemic fragmentation means mainstream services struggle to meet complex needs (High and Complex Needs Unit, 2005). Services are typically specialised to address a singular issue - substance use, welfare, education, housing, family functioning, and so on. While this may be a convenient and efficient way for providers to operate, it is not effective in terms of experiences, outcomes, or costs for service users and society (B. D. Miller et al., 2012). Nor is it conducive to successful implementation of SOC.

Converging evidence has shown both service providers and service users find the mental health sector disjointed and confusing. Youth in Aotearoa have reported feeling the emphasis is on whether they meet criteria for a given service, rather than whether their needs are being met (Controller and Auditor General, 2024). An Irish study described care systems as traumatised and traumatising; describing the frustration, helplessness, and vicarious trauma that service providers experienced due to what they described as chronically inadequate system responses and poor interagency coordination (McElvaney & Tatlow-Golden, 2016).

Reform of the educational system alongside the health system is also important, as international and national evidence demonstrates children and youth with SEBD and racial ethnic minoritised children and youth are disproportionately excluded from school, subjected to punitive disciplinary measures, and over-represented in alternative education (Agnew et al., 2022; Education Review Office, 2021; Gebhard, 2013). International and national legislation and policies clearly mandate the provision of equitable, inclusive, and free education to children regardless of their needs and difficulties. This makes it unlawful to exclude individuals from (or reduce their access to) local mainstream education on the grounds of discrimination (Bill of Rights Act 1990, 2013; Human Rights Act, 1993; Ministry of Education, 2020; United Nations General Assembly, 1948). However, as stated by Community Law (Community Law, 2024), current legislation about discrimination in the public education system is messy and largely unenforceable.

This is partially due to the double-bind imposed by the legal prohibition of discrimination paired with the somewhat vague obligation of educational bodies to make *reasonable attempts* to accommodate students (Human Rights Act 1993). What is reasonable is contextual and subjective; partially dictated by how much funding and resourcing can be accessed as well as the perspective of individual providers. The legislation also states accommodations must not impose a disproportionate or undue burden on the education provider, which again is subjective and difficult to assess (Community Law, 2024).

The Education Review Office (2021) highlighted evidence indicating children and youth with special needs are not included in mainstream schooling in Aotearoa. They found most issues relate to enrolment problems (e.g. schools' refusal to enrol children and youth with high needs or only offering limited hours), the disproportionate exclusion of disabled children and youth, insufficient funding for teacher aides and resources, and inadequate accommodations for children and youth with disabilities to participate in school activities, such as trips and camps. The Education Review Office (2023) emphasised that alternative education providers do not generally provide good outcomes for children and youth. Even though students are often engaged and attending, the current model of provision is inadequate and fails to deliver equitable education, contributing to inequitable outcomes. A reform of the education system has been recommended, prioritising inclusion, early identification, intervention, and meeting diverse needs within mainstream. As the educational system currently stands, many schools in Aotearoa act in breach of human rights and are not fulfilling their basic obligations. This is an observation made internationally too (Caslin, 2021; Cole, 2015; Cortis, 2012; Welsh & Little, 2018).

These problems in education are intertwined with those of the health system, underpinned by the dominance of the individual medical deficit model which legitimises paternalistic practices including the segregation of children and youth for failing to conform to an ideal norm and having needs that cannot be met by mainstream services (Macleod & Munn, 2004). Mental health issues are especially strongly associated with exclusion. A systematic review by Whear et al. (2014) demonstrated that children and youth who are excluded from school may be up to 31.9 times more likely to have mental health problems.

Persistent negative educational experiences, particularly exclusion, are powerfully pathogenic forces which exacerbate and multiply developmental risk factors and negative outcomes. The link between exclusion and later incarceration is well-established. Biased use of disciplinary measures and separation of children and youth into alternative education or streams limits their opportunities and demarcates select populations of children and youth as requiring increased surveillance and containment. In turn, this shapes societal and personal perspectives, legitimising further discrimination and damaging children and youths' self-esteem, efficacy, and attitudes about learning (Gebhard, 2013). School exclusion is risk factor for lifelong exclusion from beneficial relationships and activities available into the majority of society and chronically limited access to resources, rights, goods, and services. This is a bidirectional interaction between the individual and environment, which can become intergenerational (Daniels, 2011). A recent study by Obsuth et al.

(2024) that examined the impact and causal effects of school exclusion demonstrated strong evidence that permanent school exclusion had broad negative impacts on wellbeing in the mid-twenties. Those who experienced exclusion were significantly more prone in adulthood to experience severe mental health problems, chronic physical health problems, life dissatisfaction, poorer sleep, smoking, and reduced engagement in sports. The authors, along with an abundance of published evidence, concluded there is an acute need to eradicate school exclusion as a disciplinary strategy, and implement new educational models.

The problems with the education system are closely related to those in the health system. Unsurprisingly, evidence-based recommendations and initiatives to address problems in education also emphasise systemic approaches. The Education Review Office (2023) in Aotearoa recommended increasing: early identification and responses to prevent mainstream exclusion, funding and resources, choice and flexibility, clear and consistent referral criteria, partnership with families and children/youth, inter-agency co-ordination, service provider accountability, and the availability of Kaupapa Māori (Indigenous) approaches. Comprehensive school mental health systems, which provide an exemplar of how this can be done, provide an array of supports that promote a positive atmosphere, social-emotional learning, mental health and wellbeing provide. These initiatives can reduce the prevalence and severity of SEBD (Stroul et al., 2018), demonstrating the importance of co-ordinated multisystem solutions.

For systems of care to cross-sect siloed systems and provide truly integrative care, a cultural and societal paradigm shift is needed. Currently, public mental health systems provide treatment to those who clearly meet diagnostic criteria and present with severe issues, despite a wealth of evidence demonstrating the superior benefits of early intervention (Stroul et al., 2018). Early intervention can reduce the severity and/or risk of certain mental disorders later in life and has beneficial effects on children’s developmental, emotional, academic and social outcomes. Research has shown that the earlier the intervention occurs, the better the improvements are (Manning, 2017). Children and youth who present to services with severe problems are at heightened risk of attrition and families who do not complete treatment demonstrate greater socioeconomic disadvantage, heightened levels of stress, multiple intersecting adversities, and familial dysfunction (Kazdin et al., 1990). This highlights the importance of intervening early in a holistic manner that addresses barriers to engagement.

To resolve the incongruence between the evidence base and the current system, some experts have argued for the adoption of a public health approach. Public health approaches integrate prevention and health promotion practices into health systems and communities for the general population and those at-risk, as well as providing treatment to those already experiencing difficulties. There is an increased focus on generating resilience and optimising population wellbeing in addition to treating problems. A public health approach may provide a framework with which to transition to a new system and alleviate systemic problems such as overburdening, fragmentation, high costs, unmet needs, and inequity (Stroul et al., 2018). Such a shift must be driven and scaffolded by public policy and legislation, which can break through the institutional, fiscal, and political barriers that stand in the way of establishing sustainable infrastructure and communities centred on the values, principles, and practices that comprise SOC (B. D. Miller et al., 2012; Stroul et al., 2018).

Recent updates to the SOC framework emphasise the necessity of societal collaboration, public health strategies, and policymaking in the global pursuit of equitable care (Stroul et al., 2018). Bronfenbrenner himself was a strong advocate for the use of social policy interventions as a scientific method of improving wellbeing (Bronfenbrenner, 1977). The paradigm shift required to establish a functional system of care spans beyond the mental health system. At all levels of social ecology, it requires widespread acknowledgement and acceptance of systemic problems and the need for change, as well as sustained commitment to prioritising equitable and optimal wellbeing for all. Governments, institutions, primary care settings, schools, service providers, recreational community services, and early education providers can all play important roles in implementing positive change (Stroul et al., 2018).

Decolonisation and indigenisation of systems, research, and practice.

Decolonisation refers to the acknowledgement, critique and systematic dismantling of colonialism; the process by which imperial forces establish and maintain dominance and control over foreign territories and populations (Saini & Begum, 2020; Tuhiwai Smith, 2021c). In relation to academia and service delivery, decolonisation draws attention to the contexts in which knowledge, academia, social systems, and fields of practice were developed, and challenges their universal legitimacy, objectivity, and neutrality. Decolonisation initiatives explore how these social constructs are rooted in a colonial history, and therefore privilege Eurocentric assumptions, ideologies, and epistemologies, and delegitimise other ways of knowing, being, and doing (Kennedy et al., 2022; Tuhiwai Smith, 2021c). Colonisation has and continues to contribute to inequity and ill-health through a matrix of interactive pathways that pervade social systems in Western societies.

Academia is one such pathway. Research has a long history of inflicting harm by pathologising, dehumanising, and paternalizing non White racial ethnic groups in research (Kanaÿiaupuni et al., 2006; Kennedy et al., 2022; Rogers & Lange, 2013; Tuhiwai Smith, 2021c). Attempts to recognise and correct this have been largely unsuccessful in increasing equitable representation, resulting largely in avoidance of recruitment and engagement of minoritised racial ethnic groups in research endeavours, further perpetuating the underrepresentation of racial ethnic minoritised groups and perspectives in research and academia (Rogers & Lange, 2013). The lack of diverse representation in research culminates in a dearth of knowledge about culturally relevant phenomena in academia which permeates societal systems, fields, and practice. Inevitably, this sustains inequitable, discriminatory experiences within educational, health, and social systems (Agnew et al., 2022; Hackett et al., 2020; Pickett & Wilkinson, 2015; Weinstein et al., 2017).

Over the last few decades, decolonising and Indigenist research methodologies have proliferated in response to and recognition of Eurocentrism and systemic inequity (Evans et al., 2014; Kennedy et al., 2022; Thambinathan & Kinsella, 2021). Both methodologies decentre the dominant Eurocentric paradigm in academia. Decolonising approaches to research do so by design, and when adopted, intentionally challenge the dominant paradigm. While Indigenous inherently challenge Eurocentrism by centring Indigenous epistemologies, perspectives, and method, they are not necessarily designed to do so. Indigenous approaches exist independently from Western systems of knowledge and practice, and represent revitalisation, expression, and affirmation of Indigeneity (Evans et al., 2014). Both decolonising and Indigenous methodologies tend to emphasise relationality in the construction and discovery of knowledge (Durie, 2004b; Evans et al., 2014; Kennedy et al., 2022).

Decolonisation and Indigenisation of systems, research, and practice are vital processes in the pursuit of equity and increasing wellbeing and positive outcomes for minoritised groups. Decolonisation and Indigenisation initiatives not only hold promise in addressing inequity but also providing a wealth of wisdom, methodologies, and innovations to academia that support and contribute to a shift away from the current dominant paradigm with all its shortfalls. Due to the centralisation of relationality, Indigenist epistemologies tend to align with systemic and critical theory and practice, expressing well-established ways to understand and work within complex relational systems. As evidenced earlier, Eurocentric societal systems and structures such as the health, education, and welfare systems are not adequately, equitably, or sustainably meeting population needs. Evidence based recommendations for improving systems emphasise systemic and relational solutions, focusing on empowering service users, fostering true partnerships, enhancing connectivity and collaboration across societal entities, and strengthening natural community supports (Malla et al., 2018; B. D. Miller et al., 2012; Stroul et al., 2018). Indigenist and decolonial epistemologies may provide guidance on how to actualise these solutions.

Bronfenbrenner (1977) noted our resistance as a society to experiment with social systems as potent contexts for the optimisation of human development and wellbeing. Most scientific explorations of social realities perpetuate the status quo. When ecological contexts and dynamics are included in research, they are often regarded as fixed variables rather than dynamic socioecological factors susceptible to significant transformation. While he acknowledged the unorthodox nature of the proposition, Bronfenbrenner recommended that:

> Research on the ecology of human development should include experiments involving the innovative restructuring of prevailing ecological systems in ways that depart from existing institutional ideologies and structures by redefining goals, roles, and activities and providing interconnections between systems previously isolated from each other (Bronfenbrenner, 1977, pg. 528).

Given current global circumstances, it seems a more pressing proposition than ever.

Context of the current study

Aotearoa

The current study was carried out in Aotearoa/New Zealand, a country with 5.3 million residents (Stats NZ, 2024). In terms of cultural composition, 67.8% of the population are European/Pākehā, 17.8% are Māori, 17.3% are Asian, 8.9% are Pasifika, 1.9% are Middle Eastern/ Latin American/African, and 1.1% are of another racial ethnic identity (Stats NZ, 2023). Māori are the Indigenous people of Aotearoa. Aotearoa was first colonised by the British in the 18th century and became a British colony in 1840, officialised by the signing of a treaty[72] between agents of the crown and Māori rangatira[73] representing many (though not all) iwi[74] (Berghan et al., 2017). Despite the signing of te Tiriti and due to continued breaches by the Crown, Māori have experienced and

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[72] Te Tiriti o Waitangi.

[73] Chiefs/leaders.

[74] Tribes.

continue to endure a great deal of harm inflicted by colonisation processes (Came et al., 2020). The experience of Māori is unique, but similar in many ways to other colonised Indigenous populations across the globe. Their rights and ways of life were systematically dismantled and dismissed, and grievous loss was experienced; of culture, language, land, population, and wellbeing. As a consequence, Māori continue to experience disparities across various indicators of social-wellbeing (Agnew et al., 2022; Durie, 2004b; Fitzmaurice, 2020; Government Inquiry into Mental Health and Addiction, 2018; Office of the Children's Commissioner, 2015). It is important to note that adversity and colonisation is not the most definitive or uniting aspect of indigeneity and being Māori, as representation in mainstream media and research may imply. Rather, a defining Indigenous populations tend to share is a foundational emphasis on relationality; with each other, the environment, and all entities within it. This is reflected in Indigenous and Māori tikanga (customs) and knowledge systems, and the sustenance and revitalisation of these worldviews and practices are centrally important in the maintenance and pursuit of wellbeing for Indigenous populations (Durie, 2004b; Fitzmaurice, 2020).

Adherence to te Tiriti by the Crown been variable, and it has by no means prevented colonial harm. However, it is unquestionably a useful foundation upon which a meaningful, functional partnership can be worked towards. The adoption and continued relevance of te Tiriti in guiding policy and cross-sector conduct in Aotearoa is crucial in the pursuit of an equitable, harmonious national society. As stated by the Code of Ethics for psychologists in Aotearoa, considered application of the principles of partnership, protection, and participation is vital to engagement with Māori populations (Code of Ethics Review Group, 2012). In light of a recent Waitangi Tribunal (WAI 2575) report, this is of particular relevance in the development and evaluation of any services and processes in Aotearoa related to the wellbeing of Māori. The report concluded despite formal attempts to engage with Treaty obligations since 1988, the Crown has systematically contravened treaty obligations and duties across the health sector and failed to deliver equitable health outcomes. The following recommendations were made, of relevance to the current project; 1) adoption of Tiriti-compliant legislation and policy, 2) recognition of Māori political authority/tino rangatiratanga; 3) strengthening accountability mechanisms, 3) investment in Māori health, and 3) embedding of equity and anti-racism in the health sector.

Te Kahu Tōī Intensive Wraparound Service

TKT IWS is a Wraparound programme offered by the Ministry of Education in Aotearoa. They serve a small population[75] of children/youth (and their whānau) with highly complex and challenging behavioural, social, and/or learning needs who require significant support at school, home, and in the community. The program was developed for children and youth who had fully utilised available local services[76] which were found to be unable to meet their needs. This population represents some of the most vulnerable children and youth in Aotearoa in that they tend to experience serious ongoing barriers to safe participation and inclusion in education, home, and community life which are difficult to address through traditional service approaches and systems(Gammon, 2018; Ministry of Education, 2024).

TKT IWS uses the Wraparound Process as defined by the National Wraparound Initiative (NWI; Bruns & Walker, 2008). The Wraparound Process is a systemic approach to care planning and service delivery originally designed for children and youth with highly complex needs and difficulties. These challenges are difficult for traditional services and systems to address because they require highly integrated multi-agency and multi-system coordination. Wraparound is designed to facilitate this coordinated approach. In collaboration with children, youth and whānau, the Wraparound approach identifies and mobilises resources from various sources and supports (both formal and informal) in the community, creating an individualised team and care plan that honours the aspirations, preferences, strengths, and needs of the children, youth and whānau, and is regularly evaluated by the team (Ministry of Education, 2024). The Wraparound Process aims to establish

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[75] Increased to 365 children/youth and their whānau in 2018

[76] Such as learning support services, the Resource Teacher Learning and Behaviour (RTLB) service, day specialist schools, other Ongoing Resourcing Scheme fundholders, mental health services, developmental services, and so on.

support in the least restrictive settings possible, maximising natural supports and the safe inclusion of children, youth and whānau in their community (Bruns & Walker, 2004). Details of the Wraparound model as delivered by TKT IWS are further illustrated in the graphic below.

In Wraparound we help your child and your family/whānau to realise your hopes and dreams and for your child to grow up in their home and community.

Family Voice and Choice: *Family and child/ youth perspectives are intentionally elicited and prioritised during all phases of the Wraparound process. Planning is grounded in family members' perspectives, and the team strives to provide options and choices such that the plan reflects the family's values and preferences.*

Individualised: *To achieve the goals laid out in the wraparound plan, the team develops and implements a customised 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.*

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.*

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.*

Community-based: *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.*

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.*

Outcome based: *The team ties the goals and strategies of the wraparound plan to observable steps towards success. Progress is monitored and the plan is changed as needed.*

Note. Graphic from TKT IWS flier produced by Ministry of Education (2018)

Program fidelity is essential in Wraparound service delivery. Monitoring and maintaining Wraparound fidelity maintains the integrity of the model, ensuring it is delivered as it was intended to be (Bruns, 2015; Gammon, 2018). It also produces an overview of the service's approach, including strengths and areas that need improvement (Shailer et al., 2017). Research has demonstrated that when Wraparound is adhered to with high fidelity, better outcomes are observed (Bruns, 2008; Bruns, 2015; Shailer et al., 2017). Ultimately, maintaining fidelity increases the likelihood that children, youth and their families will experience the positive outcomes and benefits specifically associated with the impact of adhering to Wraparound principles and activities throughout service delivery.

A fidelity review conducted in 2018 found that TKT IWS demonstrated above average fidelity to the Wraparound practice model[77]. Program fidelity was assessed using the *Wraparound Fidelity Index: Fourth Edition (WFI-4)*, at the time the most widely used Wraparound fidelity tool (Gammon, 2018; Ministry of Education, 2023). Combined respondent scores averaged 80, considered above average fidelity and comparable to national means of well-established providers in the U.S (Gammon, 2018).

The WFI-4 is a 40-item interview measuring adherence to the 10 Wraparound principles across the four phases of the process, with versions for facilitators, caregivers, youth, and other team members. Items are scored on a *yes/sometimes/no* scale with opportunities for elaboration. The WFI-4 demonstrates good internal consistency, inter-rater reliability, and construct validity (Pullmann et al., 2014; Shailer et al., 2017; Wraparound Research and Evaluation Team, 2010). However, critiques note potential differences in how respondent groups interpret items, limited sensitivity at the highest and lowest ends of fidelity, some redundancy among items, and the burden of administration (Pullmann et al., 2014).

Respondents were recruited from 26 different Wraparound teams, aiming for a representative cross-section of TKT IWS psychologists/providers. Caregivers, facilitators, and team members participated, but children/youth were underrepresented. Of 64 total respondents, only three were children/youth. Factors such as age, residential placement, or developmental challenges reportedly meant most children/youth could not provide feedback, and their data was excluded because of the small sample size (Gammon, 2018). Notably, child/youth ratings were markedly lower than those of other respondents, however, this is a pattern often observed in WFI-4 and Wraparound research (Shailer et al., 2017; Wraparound Research and Evaluation Team, 2010). The review also identified areas for improvement, including increased attendance and participation of

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[77] See Gammon (2018) for full report.

the child/youth, increased use of natural supports, and stronger transition planning; an area often rated lower as families may feel unready to move on from Wraparound (Gammon, 2018).

Recommendations from the review included ongoing supervision, training, and quality assurance to sustain high fidelity, with external fidelity reviews suggested every one to two years. Feedback loops had been put in place within TKT IWS to support continuous monitoring (Gammon, 2018).

Flexible service delivery that is contextually responsive is the fundamental foundation of the Wraparound Process. Because of this, an increasing evidence base demonstrates utilisation of the Wraparound Process in a culturally-based manner (Palmer et al., 2011b) without compromising fidelity to the evidence-based model (National Indian Child Welfare Association, 2015a). The goals of Wraparound, as described by TKT IWS, align with the principles of the Treaty of Waitangi by emphasizing partnership, participation, and protection. The process ensures children, youth and whānau have access to the necessary resources and services that enable them to make informed decisions about interventions and support, allowing them to truly have ownership over decision-making processes. It also promotes whānau as full decision-makers in their lives and ensures they have ownership of the planning process, in partnership with the Wraparound Team, with all parties committed to the plan (Ministry of Education, 2018). In fact, Kirkwood (2014); a Māori social worker and family therapist, described how Wraparound principles align with and can be used in a synergistic manner with te Tiriti principles in practice. Similarly, Tamihere (2015) describes how Wraparound principles and practice parallel values in te ao Māori. TKT IWS has engaged in ongoing efforts to honour diversity, equity, and te Tiriti (Ministry of Education, 2024) in their work; Sonja Macfarlane, a specialist in the development of culturally responsive evidence based approaches to education, health, psychology, and counselling, has provided significant guidance to the service regarding Kaupapa Māori methods of case conceptualisation and care (A. Macfarlane et al., 2020; S. Macfarlane, 2009, 2012; Ministry of Education, 2021).

Referrals to TKT IWS occur through Ministry of Education support staff, resource teachers of learning and behaviour (RTLBs), and the student's ongoing resourcing scheme (ORS) fund-holding school. Referrals must meet the following three criteria to be considered for prioritisation by TKT IWS: 1) the child/youth must be between 5 and 14 years of age, 2) they must have complex and challenging unmet needs that require substantial support across multiple settings, and 3) locally available support services must have been fully utilised and unable to meet their needs (Ministry of Education, 2024). Regional panels meet about once per school term to consider all referrals, determine whether they meet criteria, and then prioritise cases for service based on the region's priority hierarchy. When a referral meets criteria but is not prioritised for service by the regional panel, the child or youth continues to receive existing learning support service and can reapply to future panels. TKT IWS has been offered in its current form for about 15 years, and has consistently demonstrated demand exceeding service capacity which has enabled the service to expand significantly (Ministry of Education, 2024; R. Etheredge, personal communication, November 19, 2020).

Once a child/youth and their whānau are accepted for service, a Wraparound facilitator works closely with them to conduct a collaborative assessment. After the assessment and clarification of goals, TKT IWS collaborates with the child/youth, their whānau, and other community supports to develop a personalised plan that outlines specific goals, team member responsibilities, and clear pathways to achieve those goals.

The current research project

Background

The current research project builds upon research by Shailer (2015) which was the first independent evaluation of the Wraparound Process in Aotearoa/New Zealand. Shailer (2015) explored fidelity to the practice model and the experience of Wraparound team members from 2012-2013. At that point, Wraparound was being implemented on a very limited basis by a small regional intensive clinical support service (ICSS) team. Overall, Shailer (2015) found that the Wraparound process offered by that ICSS team was experienced as positive, helpful, and was implemented consistently with above average fidelity. Authors concluded that Wraparound is a viable and useful intervention for children, youth and whānau with HCN in Aotearoa. Several recommendations for future research were made including using larger, more representative samples, and analysing quantitative outcome data. In terms of limitations, and of crucial importance considering the sociocultural context and history of Aotearoa, there was no direct exploration of Māori experiences of Wraparound or its alignment with te Tiriti. Because results demonstrated high fidelity to the Wraparound principle of cultural competence, it was inferred that Wraparound may be promising cross-culturally in Aotearoa. However, Shailer (2015) admitted this assumption should be made with caution. A specific recommendation to explore the experience and applicability of Wraparound for Māori whānau in Aotearoa was made. Additionally, their research project primarily focussed on the fidelity of the Wraparound Process; that is, whether the Wraparound Process was being delivered in adherence to the practice model. Outcomes and effectiveness of the intervention were not central to the focus of the project or directly explored, though high fidelity Wraparound is robustly associated with improved outcomes for children and youth (Effland et al., 2011).

Prior to the conception of the current project and other than the intervention Shailer (2015) evaluated, Wraparound was a term often used to describe various services in Aotearoa that were *wrapping* multiple services around families and providing some form of intensive case management. Few programs were using a research-based approach with fidelity to the Wraparound practice model (Gammon, 2018). Hence, there was a clear rationale for investigating the applicability of Wraparound in Aotearoa further; particularly in terms of effectiveness, quantitative outcomes, and experiences of Māori children, youth and whānau.

Additionally, a scoping review was conducted prior to the multi-study exploration of experiences and outcomes associated with TKT IWS. The scoping review established an overview of existing literature about the use of Wraparound with underrepresented populations. All papers were based in Western-colonised countries. Most interventions targeted emotional behavioural problems in children and youth, and the majority of publications used quantitative methods to determine outcomes. Only a fifth of publications in the review demonstrated evidence of measuring fidelity to the Wraparound process. A significant proportion of did not demonstrate any evidence of cultural considerations or adaptations. When measured and reported, analyses of outcome equity indicated the outcomes associated with Wraparound show promise in combatting disparities. It was concluded that future research initiatives should explore barriers to fidelity measurement, avoid colloquial use of the term *wraparound* when not referring to the Wraparound Process, use culturally relevant measures and outcomes, and examine/report potential disparities in service experiences and outcomes. In addition, the academic scope needs to widen to legitimise and validate diversity in terms of conceptualisations of wellbeing and success, measurement, research methods and service delivery in the pursuit of equity (Lightfoot et al., 2024).

Objectives

The overarching purpose of this multi-study exploration of TKT IWS was to 1) contribute to the pursuit of positive intervention experiences and outcomes for children, youth and whānau with HCN and 2) target inequitable experiences and outcomes in this population, particularly for Māori children, youth and whānau in Aotearoa. To do this, the research explored child, youth and whānau experiences of TKT IWS through multiple methods to examine whether it demonstrated promise as an effective approach through which equitable service provision, experiences, and outcomes can be achieved. The project aimed to do this by:

1) Collecting information about the experiences and outcomes of the Wraparound Process as delivered by TKT IWS for children, youth and whānau in Aotearoa, with a particular focus on Māori experiences and adherence to te Tiriti.

2) Qualitative exploration of Māori whānau experiences of TKT IWS and raising children and youth with high and complex needs.
3) Quantitative analyses of progress and outcome data collected by TKT IWS and the Ministry of Education.
4) Providing feedback to the Ministry of Education about experiences and outcomes that was useful in relation to their goals and ongoing service development.
5) Adopting a decolonising epistemology and methodological framework.

Methodology

The current project was approved by the Massey University Human Ethics Committee (SOB 18/65). It was conducted through a decolonising lens, grounded in the active pursuit of equity and social justice for Indigenous and underrepresented groups in Western society. Research is inevitably situated in relation to various influential contexts and stakeholders. The methodology of the current project was designed to fulfil the various obligations conferred formally and informally by my positioning in society as Tāngata Tiriti, a researcher, a psychologist, an activist, and a human being and my relationships to various research partners, stakeholders, and communities. These obligations included those to;

1) Tāngata whenua/Māori
2) Participants
3) Children and youth, particularly those with high and complex needs
4) Massey University and the wider academic community
5) The Ministry of Education and TKT IWS Intensive Wraparound Service

The current research is a multi-study project that utilised a combination of methods to fulfil obligations to these various parties, and commitment to a decolonising epistemological framework. The first study is a reflexive thematic analysis of Māori whānau experiences of TKT IWS services. This study uses methods in line with decolonising research approaches. The second study is a quantitative pre-test post-test analysis of outcomes for a sample of children, youth and whānau that been engaged with TKT IWS for at least 6 months in 2019. It uses more traditional scientific methods and measurement tools.

As stated by Thambinathan and Kinsella (2021), different ontologies and epistemologies can be brought together in decolonising research initiatives if done so with intentional awareness. Research design can acknowledge and utilise the strengths of various knowledge systems while remaining critical of the dominant paradigm and endeavouring to shift it (Thambinathan & Kinsella, 2021). It is important to acknowledge that knowledge and interventions are currently generated, evaluated, and funded within a Western system and therefore primarily judged against traditional scientific Eurocentric standards and measurements of reliability, validity, and efficacy (Chorpita et al., 2011; Thambinathan & Kinsella, 2021).

The design of the current project reflects the recognition of the pragmatic need to collect and present data in a traditional manner in light of the potential applied benefits. This research project exists within a system that often demands such data in exchange for funding. Ultimately, the goal is to increase access to effective, equitable service provision that can support underserved communities in need. However, it also acknowledges the limitations and potential harm of over-reliance on quantitative data and indicators of wellbeing and effectiveness that are reductivist, Eurocentric, and have limited applicability cross-culturally. While a generic, internationally used measurement of emotional behavioural difficulties and functioning was used in the quantitative study (CAFAS; Hodges, 2019), TKT IWS uses a range of other measurements to gauge progress and outcomes, some of which are grounded within Kaupapa Māori frameworks (A. Macfarlane et al., 2020; S. Macfarlane, 2009, 2012). TKT IWS and the Ministry of Education have undertaken significant efforts to engage in professional development and adopt approaches that reflect the principles of te Tiriti and Māori perspectives and models of wellbeing. In doing so, they have recognised that widely used behavioural questionnaires may be inappropriate to use with Māori children, youth and whānau who require culturally relevant measures of change, and efforts to ensure their measurement and evaluation approaches are culturally appropriate and explore meaningful dimensions and values within a Māori worldview are ongoing (The Ministry of Education, 2020).

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Doctoral Research Committee

Chapter 6: A reflexive thematic analysis of interviews with Māori whānau who engaged with Te Kahu Tōī Intensive Wraparound Service

This chapter describes the first study in a multi-study investigation of outcomes and experiences associated with Te Kahu Tōī Intensive Wraparound Services (TKT IWS).

Method

Participants

Participants were seven whānau members of six children/youth who were engaged with TKT IWS. All the participants were caregivers of children/youth engaged with TKT IWS; four mothers (three of which were solo parents), a grandmother, and a mother and father who were interviewed together. None of the children/youth in these whānau elected to participate.

Procedure

Participants were recruited by TKT IWS employees who offered information about the research project to whānau at their regular team meetings. Whānau/caregivers and children/youth who self-identified as Māori and had been engaged with TKT IWS for at least six months were offered the opportunity to participate. Caregivers were invited to bring whānau and support people to the interview and youth were encouraged to take part too. Volunteers received remuneration for participation in the form of a grocery voucher for a local supermarket of their choice. It was made clear that participation in the research was optional; choosing not to take part would not affect provision of services, and all information would be anonymised and kept confidential to the research team. If participants expressed interest, they were provided an information sheet and consent forms to read and consider before consenting to participate.

The information sheet introduced the research team and shared information about them. It also described the purpose of the project, what participation would involve, information about data, privacy, and participant rights, and contact details for the research team. Finally, specific supports that would be made available and contacts for support services were provided along with a reminder that they could halt the interview at any time and/or withdraw their participation in the study.

Once informed consent had been attained, I (the lead researcher) made contact to organise an interview with myself at a location and time convenient for the whānau. The interview process was informed by decolonial and indigenist research methods, particularly those describing conversational and narrative methods of collaborative knowledge creation and sharing (Gidgup et al., 2022; Kennedy et al., 2022; Ruwhiu, 2008; Tuhiwai Smith, 2021d). The kōrero (conversation) could take place at their home, a community venue, or a local Ministry of Education office. Providing choice was intended to mitigate identified barriers to engagement in research for underrepresented populations (Rogers & Lange, 2013), and ensure interviews could take place wherever whānau felt comfortable, safe, empowered, and in control. Tikanga[78] were adhered to where appropriate and I collaborated with whānau to ensure the process felt tika[79] for them. For example, all but one whānau elected to have the kōrero at their home. One caregiver could not get childcare, so their young children were present and kai[80] was provided and shared prior to the kōrero and breaks were taken as needed.

Interviews took place in late 2019 and were conducted using a semi-structured exploratory approach. An interview guide was written consisting of open-ended questions to encourage kōrero about their experiences of TKT IWS and more generally, while still allowing for prompts, clarifications of answers, and exploration of any topics raised by participants. Interviews were not time-limited, and caregivers were encouraged to speak freely. The interview guide for the current research was adapted from research conducted by Shailer et al. (2018) to provide comparability of results, explore topics relevant to the current project not explored previously (e.g. cultural meaning and experiences), and to facilitate more flexibility and open-endedness as to the direction and length of

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[78] Cultural processes and practices.
[79] Correct, right, fair, appropriate.
[80] Food.

the interview. At the end of the interview, caregivers were asked whether they wanted to talk about anything else or any questions or concerns. They were provided with my contact details and encouraged to make contact should they want to after the interview.

All whānau who participated were offered the opportunity to review the transcript of their interview and a summary of the results prior to publication and provide feedback. The intention was to include feedback in the final publication. All participants elected to have the results sent back to them, and only one whānau did not want their transcript. Results and transcripts were sent out to participants, and no feedback was provided in response – although whānau were phoned before it was sent out and reminded of their right to give feedback.

Analytical approach

Reflexive thematic analysis (RTA) as outlined by Braun and Clarke (2019) was the analytical method chosen to guide interpretation of transcribed interviews and ultimately help tell the story that was built in partnership with participants. RTA was chosen due to the way it centres researcher subjectivity and reflexivity and demands deep engagement with one's own positionality. It provides a framework with which researches can diverge from dominant ideologies and practice, and has been used in a number of Kaupapa and Indigenist research projects (Gidgup et al., 2022; Kanaÿiaupuni et al., 2006; Kennedy et al., 2022; Wirihana, 2012). The analysis also focussed on upholding the integrity of intact narratives, grounded in the belief that people make sense of their world best and generate knowledge by telling stories. Emphasising and upholding narratives within the RTA aligned with the tendency of Indigenous cultures to have oral storytelling traditions and methods of knowledge creation. Narrative inquiry has been described as a relational methodology, where the embedded process of co-construction of stories and co-participation generates continual, relational knowledge that aligns with Indigenous worldviews (Stewart, 2008).

An inductive or bottom-up approach to coding was undertaken, meaning that the analytic process was data-driven rather than guided by preconceptions and hypotheses about what themes may arise and how they might align with pre-existing knowledge and theory (Braun & Clark, 2006). This was critical to the current study for the following reasons: 1) the relative lack of research exploring Indigenous and Māori experiences of Wraparound upon which to base theoretical assumptions, 2) the exploratory nature of this project, 3) the importance of ensuring that the analytic process aligned with the principles of te Tiriti. An inductive approach helped to protect the integrity of stories shared and the right of whānau to determine and define their own realities, therefore honouring their status as partners in co-creating the results of this study. Using inductive analysis also provided a protocol with which to emphasise listening to what was being said and being curious about what might arise, rather than imposing my own pre-conceptions, hypotheses, theories, and ideas onto the data initially. In saying that, it is important to acknowledge that researchers cannot free themselves from theoretical and epistemological leanings, and analysis is never undertaken in an epistemological vacuum (Braun & Clark, 2006).

Positioning Statement

In the spirit of self-reflexivity and transparency, I acknowledge the intersecting facets of my own identity and experiences which are relevant to this project and inevitably influenced it. I am tāngata Tiriti and mostly of European descent; my heritage is Scottish, English, Dalmatian, and Taungurung (an Aboriginal clan in Australia). I am neurodivergent and have lived experience of emotional behavioural difficulties, complex health issues, and service use, as do multiple members of my family. From a young age I was exposed to the challenges caregivers and whānau face in dealing with complex needs. For the past few years, I have worked at a Kaupapa Māori mental health service. While facets of my identity and experiences fostered connection, understanding, and an increased ability to relate to whānau who participated in this project, I also acknowledge that I hold and have always held privilege inherent to moving through the world as Pākehā. I must also acknowledge my ability to understand and communicate about te ao Māori or Māori experiences is seriously limited by being non-Māori. Despite these limitations, I do hope that my endeavours to embody partnership in this project mean that I have upheld the stories as they were told and captured their essence/mauri, as well as the mana, expertise, and lived experience of the whānau and their tūpuna who were co-creators of this project.

Analysis

Coding and analysis was an iterative process guided by the six phases of reflexive thematic analysis (V. Braun & Clarke, 2006, 2019).

Phase 1: Data familiarisation

I was continually immersed in the data from the moment data collection commenced. Conducting the interviews was particularly impactful. The experience of interviewing participants allowed me to engage in whakawhanaungatanga[81] with participants and experience a rich account of their stories which can only be achieved kanohi ki te kanohi[82]. Face-to-face communication is a core tenet of human behaviour and community functioning and is especially important in te ao Māori[83]. The term kanohi ki te kanohi refers to the way that we experience social relations in person using all the senses we possess to hear, feel, and smell the encounter through sharing of the same air (W. Ngata, 2015). Additionally, the act of storytelling and sharing is an important form of knowledge creation and synthesis in many Indigenous cultures including te ao Māori, so engaging in the actual interviews was an integral part of both data collection and analysis.

Flexibility was important during the interviews in terms of being able to go off-script and follow caregivers' stories. Active and careful listening involving clarifying questions, summarising what had been shared, and sharing my own thought process and impressions also important, as it gave caregivers the opportunity to correct me if I had misunderstood and for us to begin to generate ideas together. Immediately after each interview I noted my initial impressions and what stood out to me experientially during the interview. Factors that could only be experienced kanohi ki te kanohi

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[81] The establishment of relationships.
[82] face to face.
[83] the Māori world.

such as gestures, posture, eye contact, emotionality, and interactions with others in the room informed these impressions. When it came to transcribing the interviews shortly after conducting them, I was then able to recall and draw from these rich relational experiences. During the transcription process I developed an intimate familiarity with the data through listening to interviews repeatedly.

Throughout data collection and transcription, I used a reflective journal to record my thoughts, which included personal reflections, strong impressions that I got from the content and the way that participants expressed it, and what the data linked to or led me to think about. I also had multiple detailed discussions about the data material and the associated thoughts and ideas I had with my supervisors, and about more general concepts with colleagues, peers, and my own community.

Phase 2: Generating initial codes

Once transcribed, all six interviews were collated into one document, producing a 44,000-word transcript. I began coding by going through the transcript line by line and attaching codes to anything that seemed meaningful. This was a highly inclusive process, given the richness of the stories gifted to me, and the importance as tāngata Tiriti working with tāngata whenua of ensuring I did my best to uphold and capture what was most important to participants, rather than what was most important to me. To support this intention, coding was largely semantic initially, adhering closely to participants' directly conveyed experiences. It felt crucial to establish a comprehensive, grounded sense of the data in its' entirety before moving onto more interpretative stages of the analysis.

Due to the care with which coding was done, and the sheer volume of data, the coding phase was a slow and rigorous process. One small segment of data often had several attached codes. Extracts of data were coded inclusively, as recommended by Braun and Clarke (2019), to retain surrounding context. This proved useful later on when linking and organising themes, as an important point made in one extract often connected to a point made in an extract directly preceding it. Additionally, the codes themselves tended to be phrases that summarised concepts and experiences participants had shared, rather than a single keyword or a few keywords. While it was labour intensive, coding in this way helped me to retain some fidelity to the hearty, complex, and uniquely personal narratives that participants shared. I felt that if I coded in a more systematic manner and attempted to neatly categorise aspects of the dataset into keywords or look for what was most often mentioned across all interviews I would have risked losing the heart of the stories shared. Additionally, I would have risked losing the forest for the trees by focussing on specific experiential phenomenon. It became increasingly clear throughout the analytic process that across interviews participants were speaking to their experiences within in relation to wider societal phenomenon. Given the importance of oral tradition and narratives in te ao Māori (Ware et al., 2018), protecting the integrity and relationality of the narratives shared with me was of utmost importance.

Coding was an iterative process. I frequently went back over the transcript to review and adjust links and patterns that began to emerge. Over time, I began to code at a more latent level too, looking for the deeper meaning and implications of what had been shared. Latent coding was strongly informed by the emphasis and frequency with which certain topics were raised, and the links between topics made by participants and/or me. During this process I also had many conversations with my supervisors, peers, and community, particularly regarding relevant cultural and societal phenomenon, theory, context, and concepts. I did a lot of freewriting during this time and mapping of ideas. Once the entire transcript had been coded, I exported codes into an excel document along with the corresponding transcript extracts, where I further developed the wording of codes and developed a keener sense of the patterns I observed in the data.

Phase 3: Generating themes

The initial step in the generation of themes initially involved reviewing and clarifying codes alongside their transcript extracts and then combining codes into overarching themes. An initial mind map was drawn up after reviewing all codes and developing an immersive, deeply familiar sense of the data's topography. There were many commonalities in participants' stories, some of which were frequently repeated and emphasised strongly. However, I had significant difficulty separating themes and subthemes given the ecological nature of the identified components of the story I felt was being told. Each theme felt inextricably and reciprocally embedded in the overall narrative and typically contained or intimately linked to other themes. The initial mind map and concepts were presented to my supervisors who provided feedback and ideas regarding how to organise the ideas best. Particularly helpful was the suggestion to consider organising the themes within an ecological systems framework. With this guidance, a series of mind maps were generated until I felt one satisfactorily presenting a cohesive narrative that meaningfully represented the individual stories and overarching narrative.

Phase 4: Reviewing themes

Theme development involved reviewing sequential mind maps and identifying which concepts could be absorbed into overarching themes. Keeping an ecological systems framework (Peppler, 2017) in mind was helpful, as it allowed me to identify which concepts might belong together within an overarching theme, and how these themes might be organised meaningfully within a system. For example, I was able to recognise that several phenomena raised or alluded to by participants related to characteristics of Western capitalist society and were therefore situated at a macrosystem level. While these societal phenomena directly shape more localised, personal experiences described by caregivers (such as those involving schools and services) they differ meaningfully in terms of the level of social ecology they are situated within and from which they exert influence. This difference affects the type of impact they have, and the meaning made of them. Organising concepts in reference to where they were situated in the wider ecological system allowed for meaningful organisation of concepts while still retaining the reciprocal, interconnected nature of the concepts described. Once six main themes had been identified and colour coded, data extracts and associated codes were printed off, cut out, and highlighted to denote which themes each one related to. This ensured that all coded excerpts were captured by the identified themes. Initially, each theme had its own mind map with possible subthemes and associated codes. As the codes were organised into groups, each theme became further defined as areas of overlap were identified and addressed, and potential subthemes were identified.

Phase 5: Defining and naming themes

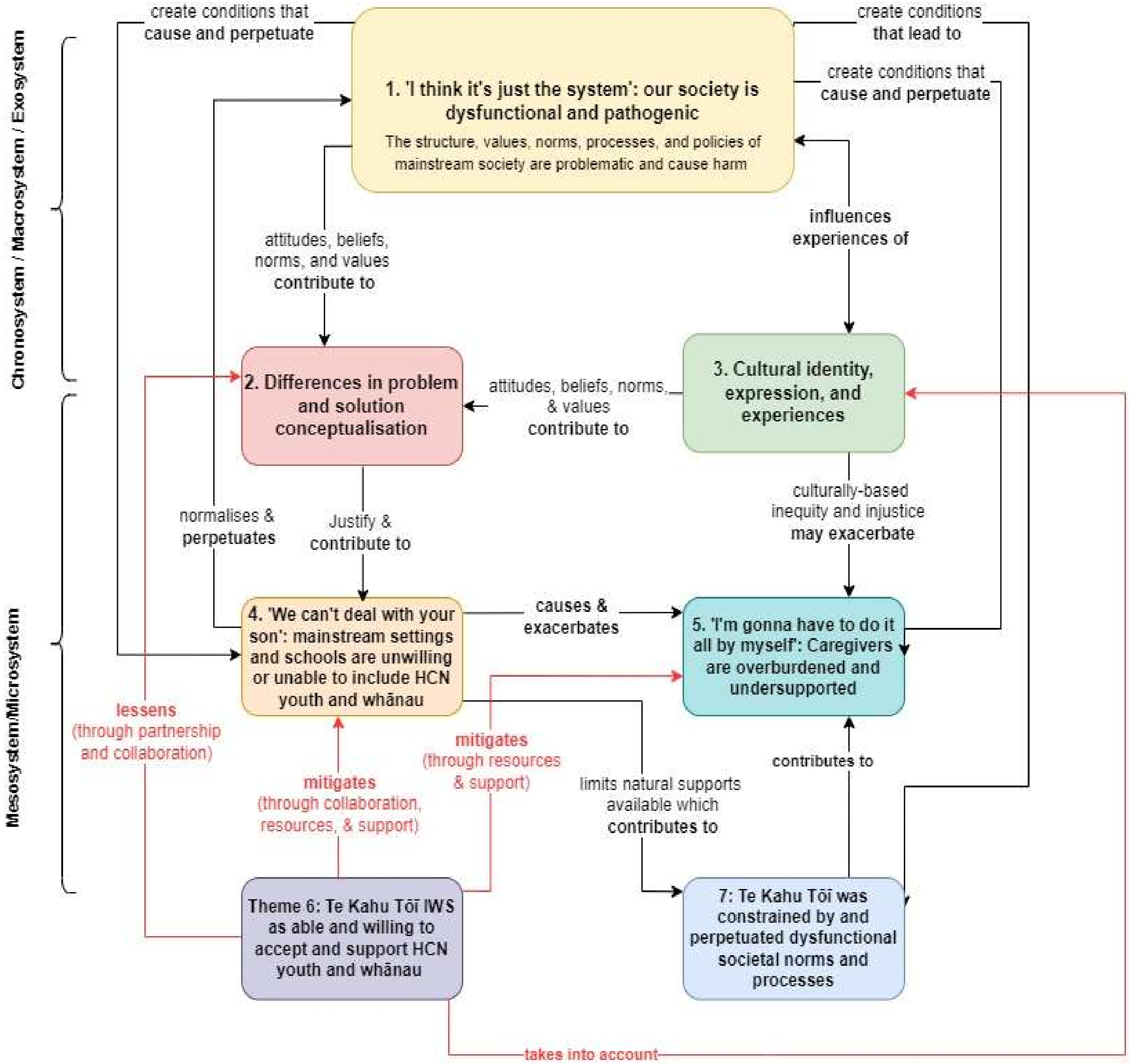
During the previous themes, quotes which captured themes best were highlighted as potential titles for the theme to centre the voice of caregivers' and how they defined their experiences. Mind maps and groups were analysed and rearranged iteratively until I felt that collective and individual narrative/s were optimally represented by the number and general definition of themes. When looking through highlighted quotes for ones that exemplified the themes or subthemes, I noticed that there was still some overlap or over-inclusivity within some of the themes. This led to further fine-tuning, where some themes were separated, and others were collapsed together.

Phase 6: Producing the report

Writing the results the last step of the analysis. During write up, I noticed still that some themes were too large, homogeneous, and inclusive, and needed to be separated out. Designing the diagrammatic figure of the themes for publication and labelling their relationships was a particularly helpful process that assisted me in zooming out and assessing the overall coherence and impression of the results. In my first draft, seven themes were developed as seen below in figure 5. I found write up (and particularly, writing a summary of themes to feedback to participants) was a process that highlighted any uncertainty or lack of clarity in the results.

Figure 5

First draft of themes



After submitting my first draft and reflecting on it in supervision, it was agreed the themes could be further condensed to convey results in a more concise, analytical manner. I went back to the fourth phase of analysis and rereviewed, redefined, and rewrote the analysis to produce the final three themes described in the result section.

Results

Three themes and two subthemes were developed through reflexive thematic analysis as shown in Figure 6. Table 2 provides reference information for participants. As outlined in the analysis section, it became increasingly evident that the themes I identified represent descriptions of aspects, dynamics, and phenomena within a broader socioecological system, all of which are inextricably interconnected. Hence, themes were organised within an ecological system context (Peppler, 2017) as indicated in the flowchart below. This approach and conceptualisation are reflective of the critical realist and decolonial frameworks that underpinned this thesis and encourage critical analysis of systemic phenomena.

Figure 6

Final themes

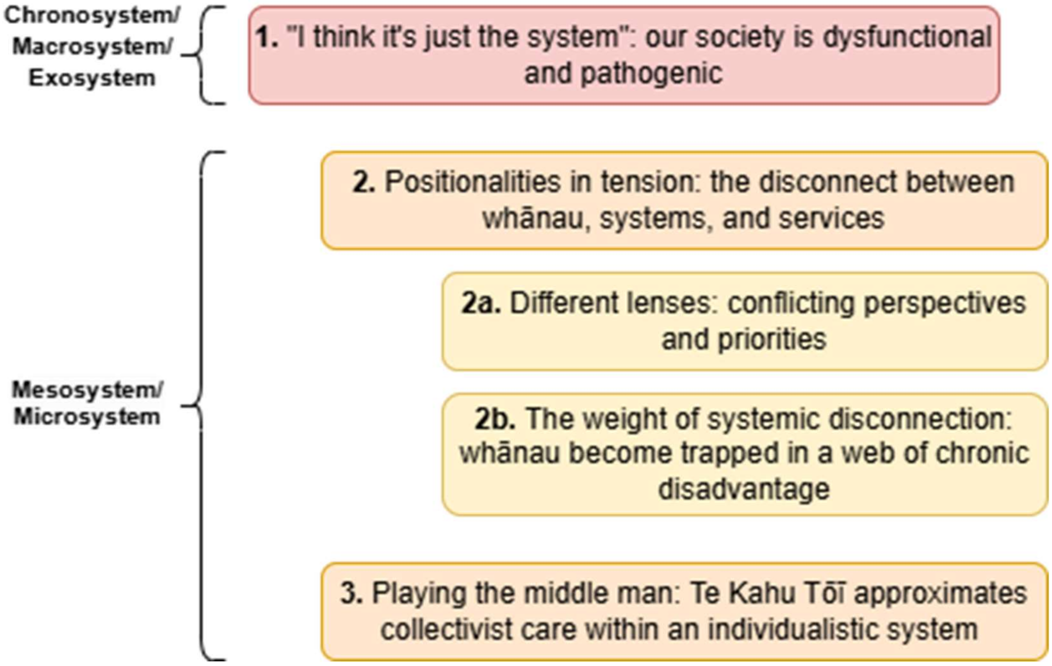


Table 2.

Participant information

Participant code	**Relationship to child/youth receiving TKT IWS**
P1	Grandmother
P2	Mother
P3 + P4	Mother and Father
P5	Mother
P6	Mother
P7	Mother

Theme 1. "I think it's just the system": our society is dysfunctional and pathogenic.

Across and throughout all conversations, participants emphasised the overarching presence and influence of pervasive societal dysfunction. The ubiquitous prominence of this idea and it's socioecological positioning in the macrosystem makes it a megatheme: it encompasses and links the other themes, describing the context in which they exist. Participants' stories illustrated how society prioritises and operates according to Western norms and values such as capitalism, competition, individualism, efficiency, profit, professionalism, bureaucracy, and conformation to an idealised norm (Arun & Kahraman Gedik, 2020). These values are often prioritised at the expense of compassion, cooperation, collective wellbeing, and inclusion. Participants explained how these societal norms create barriers to support, with resource scarcity, complex bureaucratic systems, and high eligibility criteria making it difficult to access timely, effective support. For example, P3 stated *"I know this becomes a business - but at the same time, we're dealing with people who are cold-faced to what the issues are."* Her quote captures how the centrality of capitalist values and norms creates systems and services that feel impersonal and unresponsive to whānau needs.

In a wider sense, these values and norms generate a fragmented, siloed, and competitive social environment where accessible resources are scarce and heavily contested. Participants described how this fosters competition between not only individuals, but services and schools too, creating barriers to effective collaboration, resource-sharing, and care. For instance, P3 said *"we're fighting different divisions, because everyone's got ten dollars, ten dollars, ten dollars, but they won't share…nobody talks to each other.'* Systemic fragmentation meant that services were overwhelmed and under resourced in similar ways to the whānau who required their help. Existing within the same competitive, siloed social system made it difficult for service providers to access the support, resources, and interagency collaboration needed to provide effective support and function well themselves.

Resource scarcity forces services to act as an ambulance at the bottom of the cliff. Participants described how services were often unwilling or unable to provide support until significant harm or crises had occurred. A systemic lack of and need for early intervention was emphasised: '*Some of the rules are that they have to be excluded from school. If they've been excluded from school? It's too late. Get in early…When they see that there are issues. Don't wait til they're excluded to get them help. Make it easy to access*.*'* Meeting eligibility criteria and accessing formal support was described as unduly difficult. As P1 asserted; *'I think it's just far too late and you have to jump through far too many hoops.'*

Whānau often identified and communicated their needs early, but resource constraints and bureaucratic delays meant their needs were left unmet until circumstances had deteriorated significantly. Participants described how this reactive approach contributes to harmful outcomes with severe and chronic effects; school exclusion, out-of-home placement, exacerbations of social emotional difficulties and antisocial behaviour, and involvement of the justice system. While harm impacts affected individuals and whānau most directly, the effects of delayed or insufficient support impacts communities and society too, as described by P1: *"If these kids don't get helped and* *assisted, they will be the ones that end up in prison. And again, if we wanna talk about money? How much does it cost to keep a prisoner? A lot of money. And what's the damage that they do outside before they go into prison?"* Unfortunately, her emphasis on potentially catastrophic long-term social impacts due to delayed intervention is a valid concern. Research in Aotearoa has demonstrated that children and youth excluded from mainstream education face significantly worse outcomes (even when well engaged in alternative education), including higher rates of unemployment, long-term welfare dependence, and involvement with the justice system (Education Review Office, 2023). This emphasises the hypocrisy of systems that prioritise cost-cutting in the short-term over long-term outcomes. As P1 also described, costs of delayed or insufficient intervention accumulate, such as loss of parental income, family strain, and increased reliance on social services and systems. Her story illustrated how delayed intervention underpinned by a short-term, individualistic approach leads to greater systemic costs over time by increasing the severity and chronicity of unmet needs (in both individuals and communities) and their wide-reaching effects. This perpetuates overburdening of services and cycles of disadvantage.

Participants also highlighted how power and privilege in professional and financial domains are valued by societal systems and create inequities in navigating societal dysfunction. Because professional/educational status or experience is valued, it enabled some caregivers to challenge systemic barriers and advocate effectively, while lived experience expertise was undervalued. For example, P1 credited her professional background with helping her advocate for her whānau but acknowledged the inequity of needing such privilege: *"We're lucky because I played the system. But I shouldn't have had to."* Financial privilege also mitigated the impact of societal dysfunction and barriers to care by granting access to private assessments and care when public pathways were inaccessible. P1 expressed concerns for those without this advantage; *"We got him assessed privately. But again, some people can't afford to pay five hundred dollars for a specialist."*

In conclusion, participants described how values, norms, and processes of Western capitalist society create a hostile and inequitable social environment that hinders the ability of individuals, families, and communities to thrive. Their stories highlighted the ways in which society generates scarcity and adversity, perpetuated by fragmented systems who cannot or will not provide effective, timely, and accessible support. Their stories illustrated how societal scarcity and adversity not only affects whānau and their communities, but also educational, health, and social services, emphasising the intrinsic relationality of human social systems. Unmet needs in the community are high, and services present as overburdened and under resourced themselves; with eligibility criteria and processes that were sometimes seen as purposefully functioning to guard resources, and at other times seen as the inevitable consequence of difficulty accessing and mobilising resources required for provision of support. Appropriate care was described as extraordinarily difficult to access until multiple crises or significant harm had occurred. Within this environment, services and whānau are trapped in crisis management, with resources disproportionately allocated to tertiary prevention, leaving little capacity for early intervention, preventative action, or systemic reform. This perpetuates inequity, harm, and societal dysfunction while undermining kotahitanga, unity, and collective wellbeing.

Theme 2. Positionalities in tension: the disconnect between whānau, systems, and services

Positionality and worldviews shape how we experience the world, make sense of it, and behave within it. Participants' stories evoked stark differences in the positionality and worldviews of whānau, services, and systems, which made it hard to communicate and collaborate effectively. Whānau were described as having a collectivist, relational, long-term worldview while services tended to have a more individualist, short-term worldview. This theme is broken down into two subthemes. The first covers what was said about the differences between the perspectives of whānau and services and the second covers the impact of that disconnect for whānau.

Subtheme 2a. Different lenses: conflicting perspectives and priorities

Worldviews shape how we make sense of problems and determine solutions. Participants described how the conflicting perspectives and priorities of whānau and services culminated in differences in the ways problems and solutions were conceptualised. Conceptualisation of problems appeared to culturally influenced; problem conceptualisation was linked to culturally based norms, values, and knowledge.

Two core differences in the perspectives of whānau and services were evoked in relation to conceptualising HCN. These differences related to the locus of the problem, its definition, and its causes; that is, what the problem and its associated causal factors are, and where and when the problem and its associated causal factors exist.

Individual versus collective perspectives

The first key difference pertained to different conceptualisations of where the problem of HCN was located socially and how it was defined in relation to this. Services were described as conceptualising the problems whānau were facing in an individualistic way. Social, emotional, and behavioural problems were typically described as located within the child and often pathologised: attributed to a diagnosis or disorder, a genetic or biological difference, a personality deficit, poor decision-making, and so on. The immediate family was also often identified as the locus of the problem, due to assumed deficits in parenting, role-modelling, and/or a lack of effort or commitment as described by P4,*“we used to get these meetings of: You guys must be shit parents, you guys must be alcoholics, you guys must be... what we were told once… we're not feeding them properly, we should dig a garden and stop spending our benefit and I'm like holy shit - if we even had half that much fun, it'd be brilliant - you know, we both worked full time - so the assumptions were always on us as being shit parents.”* In describing this experience, P4 exemplifies how individualist conceptualisations of problems can foster stigma, discrimination, and shame. She also describes how individualistic conceptualisations of problems prevents collaboration, and provision of effective support, creating negative associations with providers that may lead to disengagement and wariness of support services more generally.

Individualistic conceptualisations of social, emotional, and behavioural problems characterise them as discretely contained within the child and/or their direct relatives, overlooking the contribution of wider social influences and contexts. This model of thinking is called the individual medical deficit (IMD). It has two key tenets: a judgement in which individuals are measured relative to the population norm, and a value judgement about divergence. It assumes the existence of an ideal norm to which all should conform or aspire to - regardless of the cost. Identifying divergence within this framework is therefore not a neutral acknowledgement of difference but also a value judgement of worth; you are different, and therefore, you are inferior (Macleod & Munn, 2004; Mowat, 2010).

In contrast to this IMD model, whānau typically characterised their difficulties in a collectivist manner; related to or stemming from collectively owned systemic problems. For example, P6 stated *"At the end of the day, it was the school's responsibility as well to say 'Look, we need help'. Instead of saying 'Look - this boy needs medication"*. P6's statement frames her son's difficulties, and the causes as collectively located and owned. She pointed out the school was also struggling and needing support. Given the problem was seen as a shared experience and responsibility, she prioritised systemic collaboration as a solution rather than individual approaches like medication.

While some caregivers acknowledged the presence and helpfulness of understanding individual contributing factors like neurodivergence and cognitive difficulties they also identified a multitude of systemic factors that contributed to their difficulties, such as resource scarcity, stigma, discrimination, social exclusion, and a lack of inclusive education. P5 lamented the lack of low-cost prosocial activities for youth in small towns and explained how it predisposed them to problematic choices and behaviour: *"Unfortunately for [small town], they have nothing for the youth. Absolutely nothing. They got what - a two-million-dollar frickin library, you know, and a - I think it was a five-*

million-dollar - park that is for toddlers and kids to ten. I mean, what's there for the youth? There's absolutely nothing. Nothing. Now they've just got methamphetamine and weed." Caregivers also tended to frame divergence and difficulties less pathologically, accepting diversity and variance and acknowledging strengths rather than attributing it entirely to a biomedical deficit. For example, in describing her son's difficulties in social and educational contexts, P5 said *"He'd rather be on a horse in the middle of a paddock, you know, doing that sort of stuff".* Similarly, P7 described her son's difficulties in social and educational contexts but also highlighted his interests and strengths *"He likes to build things, so, you know, that's really cool."*

Chronic versus short-term perspectives

The second key difference between the views of whānau and services related to the chronological locus of the problem; that is, where it is in time. Given services were primarily oriented toward identification of and intervention for urgent problems, they tended to characterise the problem as limited to the time-period in which a crisis threshold was met. Conversely, caregivers had often identified the problem and contributing factors as chronic, existing throughout the child's lifetime, as described by P1: *"So my grandson started playing up pretty early at school. Actually, he was six when he started and within six months we knew there were issues - actually, within about six weeks we knew there was something not quite right".* Some caregivers identified the problem as intergenerational in timespan and described how multiple members of their whānau or community struggled with similar difficulties and unmet needs throughout their lives. P7 spoke about social and educational difficulties in her own childhood due to significant hearing impairment that wasn't identified until she was an adult. The lack of early identification and intervention severely limited her ability to engage with education and later support her son to do the same.

Caregivers were typically only able to access short-term support which they knew would be insufficient to address their chronic, complex difficulties. The prioritisation of short-term results and crisis resolution rather than addressing the long-term needs of whānau and building a foundation for sustained positive outcomes, created a strong sense of misattunement and frustration for caregivers. As P1 explained, *“He's got a long way to go, and the school are being clear about that too, they said he's barely on the start of the pathway. Cos one of my things - and I'm sure it won't happen (cos I will make sure), but, one of my things is yes, I signed up for one year, but I don't think he's gonna be done in one year”.* Participants’ conceptualisations of their difficulties as a chronic, complex, and systemically generated and therefore requiring systemic, long-term, responsive action aligns with recent research (Malla et al., 2018; Social Policy Evaluation and Research Unit, 2015) but is not reflected in services predominantly individualistic, short-term perspectives and approaches.

The influence of culture

The differences between whānau and services perspectives and priorities seemed to be in part linked to culturally based norms, values and knowledge. Participants’ descriptions of their cultural identity and being Māori were diverse. As P6 noted after explaining why she thought Wraparound may align with ways of knowing, being, and doing in Te Ao Māori, *“But that's only just me though, like I'm not speaking for every Māori person.”* Regardless of how caregivers described their personal connection to Te Ao Māori, all consistently emphasised the importance of values and practices rooted in Māoritanga (Māori culture, traditions, and ways of life), including kotahitanga[84], whanaungatanga[85], manaakitanga[86], pono[87], and increasing wellbeing through Māoritanga (by connecting with tūrangawaewae/whakapapa, accessing Kaupapa Māori services, being involved in Kapa Haka, and so on).

P1 described how kotahitanga was clearly evident in the Māori side of her whānau which functioned very differently from the Pākehā side, providing insight into the different worldviews, perspectives, and priorities; *“your Pākehā side it's like that's your child, that's my child… Māori's are*

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[84] collective responsibility and unity.
[85] the establishment and maintenance of connection and relationships.
[86] care and reciprocity.
[87] integrity, honesty, and directness.

not like that. They'll all come together, all take an interest, all take a part, because it's like a family. It's not just your immediate family, it's the whole: my brothers, my sisters, and my grandchildren, their children's children, and my cousins, and my nieces, and they all pull together…So, yeah, it's very very different, a very different approach, and very different cultural - you know, how we are culturally." P3 and P4 made similar statements when they were reflecting on why Wraparound may resonate with Māori whānau, *"It involves all… Like, we were asked if we wanted to bring our family in… the wider community like friends, family, cousins, uncles, so you get everyone's buy into it… it's not just one person raising a family, it's a community raising a family."*

The collective strength and willingness to help that characterises kotahitanga provided significant social support for whānau. Needing, seeking, and providing help as well as taking collective action were described as more normalised in te ao Māori and less associated with shame than in te ao Pākehā. P5 described how the centrality of kotahitanga and collectivism in te ao Māori creates a safer space for honest and direct communication about difficulties. In contrast, individualism in te ao Pākeha means that admitting a problem may bring shame upon the affected family or individual and be associated with a sense of personal failure, which makes problems harder to talk about. As P5 stated; "*We know how to open up. I'm not being racist or anything, but I know that Pākehā's hold - they're too proud. They're too proud to talk about their son… where we actually - we're happy to get that support. We know how to open up, and we know how to ask*". Caregivers also described the benefits of having access to Kaupapa Māori services and other modalities of healing and restorative practices, including connecting with tūrangawaewae, whakapapa, and visiting their marae, which some described as integral to stabilising their situations and improving wellbeing and outcomes for them and their children. Culturally based values and practices are strengths and resources for whānau to draw upon, which is important for services to be aware of to engage in effective partnership.

However, caregivers noted that the values and practices most important to them were often lacking in systems and services, contributing to misunderstanding. For example, caregivers frequently described services as lacking integrity and directness, which they saw as essential. Some caregivers experienced services being taken aback by their own directness, as P6 described: *"I walked in there, because I'm just honest, and said, 'Look, this is what my son is, this is what's happened, and this is what I need for him, what can you offer me?' And the principal was like, 'Woah, I've never had a parent come in and be so forward.'"* These mismatches underscored the importance of services understanding and aligning with whānau values in a genuine and respectful way.

While shared values were observed across participants, the diversity of cultural identities, experiences, and preferences was also demonstrated. This consolidates the importance of service providers taking time to understand and respond to each whānau's unique needs and values in a way that is authentic, not tokenistic or one-size-fits-all. Participants shared examples where a failure to attune to their specific cultural identities led to impersonal, problematic responses. For instance, P1 described her concern when a SENCO[88] suggested placing her grandson in kura kaupapa[89] to alleviate issues he was having at school: "*I said, 'Well, I'm a bit worried about that, cos he's never… been brought up in a Māori environment. Māori schools speak Māori. My grandson doesn't know this.'"* The assumption of this being appropriate because they were Māori overlooked the complexity and diversity of cultural identities and experiences, creating tension and mistrust. Examples of cultural misalignment underscored the importance of approaching cultural identity with curiosity and responsiveness and genuinely engaging with whānau values, experiences, and needs. Attuning to these complexities helps create trust and builds meaningful, culturally aligned partnerships between services and whānau.

Establishing shared understanding is a critical prerequisite for effective partnership. This is even more important when working with Māori whānau given ongoing disparities in service utilisation and outcomes, treaty obligations, and cultural values including whakawhanaungatanga and kotahitanga. Conceptualisation of a problem informs attitudes and beliefs about it; how

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[88] Special Educational Needs Coordinator.
[89] Kaupapa Māori language immersion school.

important and urgent it is, whose responsibility it is to solve, and what actions and solutions are seen as appropriate and potentially effective. Without agreement across these domains, it is very difficult, if not impossible, to create and carry out a collaborative plan. If a problem is seen as chronic and systemic, then the associated solution may reflect this by being holistic, systemic, long-term, inclusion-focussed, and community-based. An intervention based on this conceptualisation would occur across levels of the social system, targeting multiple causative pathways. When a problem is seen as individually located and only necessary to address when crises occur, the associated intervention may focus solely on the child/youth and their immediate family, place the bulk of responsibility on them, be short-term, and exclude the child/youth from community until crises have abated and the problem is seen as resolved with little change in systemic factors that may create more sustainable improvement. Without establishing shared understandings, services risk perpetuating disconnection, inequity, and failing to address the factors that generate and sustain HCN.

Subtheme 2b. The weight of systemic disconnection:

As previously outlined, the systemic disconnection between whānau and services and the predominance of individualistic, short-term perspectives do not exist in a vacuum. They are phenomena with very real consequences, shaped by a social system characterised by resource scarcity, competition, and fragmentation. This theme describes what was said about the actual impact of these phenomena on the lived reality of whānau.

Participants described the fundamental lack of accessible, available support appropriate for Māori whānau with HCN. As P5 described, *“We sorta just were in limbo. Like my son was just getting worse and worse and worse and - we didn't know what to do. There was nothing.”* Mainstream services and schools were ubiquitously described as either unwilling or unable to help. While some were seen as deliberately uncooperative or discriminatory, others were viewed as well-intentioned but constrained by resource scarcity and systemic limitations. This is reflective of the individualistic norms embedded in our society. The unwillingness and inability to include Māori children, youth and whānau with HCN can be seen as symptomatic of the broader tendency to view such challenges as individual rather than collective responsibilities, especially when they challenge other people or institutions in the community and exceed their capacities.

Due to the fragmented, siloed nature of services, support became less available and was often withdrawn when a child/youth's unmet needs grew more complex and severe. This reflected primary consideration and implicit prioritisation of the service or school's needs and capacities rather than the needs of the child/youth, as described by P1: *"When I was dealing with the school, it started with being all around the child, and then when it got a bit hard? It went away from being around the child to really - about them."* This implied that the responsibility to change lay with the individual child/youth rather than the school or system, reinforcing individualistic norms and the widely accepted perception of society and institutions as static, unchangeable, and acceptable in their current form (Bronfenbrenner, 1977). The expectation that the child/youth must adapt, rather than the system evolve to meet their needs, upholds the status quo and perpetuates inequity and HCN.

Participants described how the systemic lack of support exacerbated and multiplied adversities their whānau experienced, entrenching them in a matrix of intersectional disadvantage. Although individual whānau circumstances varied between those represented in the current study, many described a chronic lack of access to and possession of resources (financial, social, and local) including P6: *"it's expensive to have a boy that wants to do a lot of things, y'know? But you don't actually have the money for him to do it."* Many caregivers had few, if any, feasible pathways available to them to alleviate their struggles and fulfil their child's unmet needs, even though they were often very capable of identifying what would work. As a result, their right to exert self-determination and tino rangatiratanga was not fulfillable across multiple domains of their life including child-rearing. This is an incredibly important finding in relation to te Tiriti o Waitangi and the centrality of tino rangatiratanga to increasing wellbeing for Māori. Research also highlights the fundamental role of autonomy and self-determination in wellbeing (Chirkov et al., 2011)..

School exclusion was a key manifestation of systemic failure, reinforcing the broader lack of support and dramatically deepening intersectional disadvantage. For whānau in this study, exclusion was not just a bureaucratic process, it was a profoundly distressing and destabilising event that placed immense strain on children, youth and their families. All children and youth represented in this study had chronically negative experiences at school that ultimately led to exclusion. Exclusion disrupted the fulfilment of fundamental developmental needs: belonging, safety, acceptance, care, and mastery. Without these foundational needs met, it is incredibly difficult for fulfilment of higher order needs such as learning and growth which education should foster. Participants described exclusion was not just about losing access to education – it was an intensely personal rejection that damaged children and youths' sense of self-worth and belonging. Rather than being places of support and growth, schools became sources of deep emotional pain, as described by P5; "*They told my son that they don't want him, that's their exact words, were 'we don't want you'. When you tell a kid that's ADHD - or you know, any kid - 'we don't want you'? You're literally just ripping his heart out... I talk about it I cry".* Rejection is devastating for any child, but particularly for those already struggling with emotional behavioural challenges. Participants described how children and youth internalised these messages, which fostered self-doubt, disengagement, and further difficulties. This aligns with previous research showing Māori children and youth report lower belonging and safety in schooling and are overrepresented in alternative education and exclusion statistics (Agnew et al., 2022; Education Review Office, 2023) which increases their risk of long-term negative outcomes (Daniels, 2011).

Noguera (2003) explains that schools operate under an implicit social contract whereby students are expected to comply with rules and norms in exchange for the benefits of an education. However, some children and youth become aware through repeated negative experiences that these benefits are not available to them. In response, they disengage or act out, rejecting the system that is rejecting them. P5 described how this dynamic affected her son: *“My son knows that he can’t learn. Putting him in a classroom with thirty other kids and twenty-eight of them are tens at learning and there’s the other two, that are only at either one or two. It’s just… their self-esteem’s just not going to do them any good. And kids like that—the only way they can get attention is by doing something naughty.”*

School exclusion placed enormous, sudden demands on whānau who were already struggling to cope, further embedding them in intersectional disadvantage and stripping them of the resources needed to improve their situation. Five of the six children and youth represented in this study were excluded for six months or longer. Once excluded, re-enrolment in another school was often impossible, as P6 described: *"I homeschool my son, cos it's really difficult to get him into school, cos he's been expelled from two primary schools already. So, when I go to a school and try to enrol him, they're like - wait up… We can't deal with your son."*

This left whānau with no choice but to take on full-time care and education - an expectation that felt impossible and unfair. Schools provide childcare as well as education, and caregivers, who were already under-supported, were then required to fulfil the role of trained educators while managing the pre-existing demands of employment and their daily life. This caused immense strain, disrupting family structures and livelihoods. As P1 explained: *"What are we gonna do with him? And where are we gonna send him? Because we all work, and so none of us can take time off… does it mean that his dad has to come off work and go on a benefit? Cos that's the only option that's available. And then he's not the right person, because he's not very good at schooling and things like that."*

Despite attempts to reorganise their lives and whānau, this was essentially described as a completely untenable situation. Caregivers reported job loss, financial instability, and relational breakdowns as they scrambled to meet impossible demands. P5 captured the cascading impact of exclusion: *"Son got expelled, I had to give up my job, I lost my house, my partner had an affair, CYFS*[90] *got involved, so yeah. I think I had like six shit go down in like—that one month."*

Beyond economic hardship, exclusion forced whānau into desperate attempts to protect their children from accelerating towards negative life trajectories. P5 described trying to prevent her son from becoming involved with gangs during his prolonged exclusion: *"Our street's fully Black Power, so I don't want him to be in that, so I've got my cousin that's out in a farm… I've asked him to come and get boy on the weekends, cos he does horses… I need to find shit for my son, cos I don't want him in Black Power. I'd rather him be in Mongrel Mob than Black Power. But you know, I don't want him in anything."* This highlights how a chronic lack of available resources and choices can force people into extraordinarily difficult positions where they have to reckon with reality of their children and youth entertaining the only options available to fulfil their fundamental needs.

For many whānau, exclusion ultimately led to out-of-home placement because no appropriate, capable community-based services existed to support their child. With schools unwilling or unable to meet their needs and no viable alternatives available, caregivers had to send their children away to ensure their safety, inclusion, and education**.** P1 noticed that Māori were overwhelmingly overrepresented in these facilities: *"Of the fourteen kids out there—you'd be lucky if there's one that's not Māori."*

Out-of-home placement strips whānau of their tino rangatiratanga, diminishing their ability to determine how they raise their children within their own communities. When no other options exist, this becomes not a choice but an inevitability, further entrenching systemic inequities. The fact that Māori children and youth continue to be disproportionately removed from their communities and placed in institutional settings mirrors the long history of state intervention in Māori whānau

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[90] *Child, Youth and Family Services*; the previous title of *Oranga Tamariki: Ministry for Children,* which is primarily referred to as Oranga Tamariki (which translates to child wellbeing). However, many challenge the appropriateness of the new te reo Māori title, given the history of institutionally entrenched racism and inequity.

life, from colonial land confiscation to the forced removal of tamariki through the child welfare system.

Caregivers had little control over their children's experience in residential care. P1 illustrated the difficult reality of having their child/youth's safety and wellbeing entirely in the hands of the institution: *"Well they're all a bunch of kids with the same thing, aren't they. Anger issues, so there's a bit of fighting going on.. Whereas he stood out at his last school. I have asked the school, extremely clearly… he should never be left on his own. Because he is the smallest, the youngest, and he's naughty. Like he's really smart. So I've asked them - please don't leave him on his own. Cos they will kill him. Or they will belt him. Cos they're a lot bigger…. And we've had one incident where that's happened. He came home all scratched up."*

This highlights the risk that placing vulnerable children and youth in residential facilities may expose them to further harm and chronic institutionalisation. Multiple caregivers expressed pessimism within their whānau about whether mainstream environments could ever meet their child's needs. Concerningly, they also predicted their children and youth would do whatever they could to return to residential environments in the future, given they were the only contexts in which their needs were attuned to and met. This was described by P5: *"All this good work that [residential specialist school] has done, all the support that they have given my son, is all gonna be undone in one week of being at highschool. I said - my son's not gonna like it. I said - he's gonna deliberately get suspended, or expelled, just to get back up to [residential specialist school]. You know, that's how my son will think, cos he loves it up there".*

The idea that Māori children and youth with HCN learn that they can only get their needs met in segregated, specialist environments raises serious concerns about the lack of kotahitanga, acceptance, and support available to them in wider society. Although there was an array of benefits, these placements do isolate children and youth from their communities and diminish tino rangatiratanga. Even when experiences are positive and students are well engaged, a recent review clearly demonstrated that alternative education providers do not provide equitable outcomes for children and youth (Education Review Office, 2023). Ensuring inclusion and adequate support is available within children and youths' communities is of critical importance. Without systemic change, this cycle of exclusion, segregation, and intergenerational harm will continue.

Theme 3. Playing the middleman: Te Kahu Tōī Intensive Wraparound Service approximates collectivist care within an individualistic system.

This theme describes observations about the impact, positioning, and role of TKT IWS within the dysfunctional societal context, as drawn from kōrero with participants. TKT IWS functioned as a bridge between whānau and the wider service landscape, mitigating the disconnect between individualistic, fragmented systems and the collectivist values and needs of Māori whānau. By providing relational, flexible, and holistic support, TKT IWS offered an approximation of collectivist care within an individualistic society. However, participants highlighted that while it was largely successful in fostering partnership and improving outcomes, it was also significantly constrained and shaped by the systemic issues it aimed to address.

In stark contrast to other services, TKT IWS was experienced as genuinely willing and able to support children, youth and whānau with HCN in the current study. Caregivers' ratings of the service ranged from 7/10 out of 10 to 10/10, with positive evaluations attributed to what TKT IWS did, how it was done, and the tangible impacts of engagement. Caregivers' descriptions highlighted how TKT IWS's approach strongly aligned with collectivist conceptualisations of wellbeing and HCN, emphasising shared responsibility, relational connection, and holistic, tailored support.

Te Kahu Tōī Intensive Wraparound Service was able and willing to support Māori children and youth with HCN and their whānau

Caregivers' described how TKT IWS access to support and resources that were previously unavailable or inaccessible due to structural barriers and systemic neglect. This was achieved through the provision of comprehensive, tailored support that centred the needs, expertise, and perspectives of whānau. The following forms of support were described:

Instrumental and material support: Financial support in the form of the flexible funding was described as especially important for whānau and a point of difference compared to other services. P6 described how other services often provided recommendations and informational support but no other types of support. Knowing what would be helpful and therapeutic was unhelpful when whānau lacked the means to actualise these recommendations, and services did not acknowledge that, as described by P6: *"The funding is the biggest part, because a lot of other services are just there to support you, there to help give you ideas and stuff on what you might need… but it's really the [TKT IWS] IWS that comes through with funding. To be able to do stuff for him."*

Informational support: Caregivers described how TKT IWS's provision of advocacy, system navigation, information, and facilitation of access to specialist services and assessment ensured whānau were well informed and connected to relevant resources. As P5 described, *"They helped us get up to [residential specialist school] and do the enrolling and all that. The funding side of it for son. And just the – oh like, [IWS worker] comes across as a real nerdy guy - but he explained everything really good… Like he came down to my level. Yeah, so that's what I liked about it."*

Emotional and social support: TKT IWS promoted social inclusion, and provided unconditional positive regard, acceptance, encouragement, validation, and reassurance.

The combination of these forms of support culminated in a deeply felt sense of functional support expressed by participants; that is, the sense that the support they received was actually helpful and making a difference in their lives.

Caregivers highlighted that it was not just what TKT IWS did but how they did it that was important. TKT IWS's service provision was underpinned by collectivist principles that aligned with Māori values and Te Tiriti obligations, as highlighted by P1, *"Māori come together as a group. And how they live and how they do things as a family… they'll come together, and they'll all wraparound* *to see: what can we do, what shall we do, how can we help? I think that might be why the two get on - because it's the same - a similar kind of approach."* This aligns with research by Kirkwood (2014) proposing alignment between Wraparound, Māori values, and Te Tiriti principles. Demonstration and appreciation of the following values were particularly emphasised:

Kotahitanga (unity, collaboration, and shared responsibility): Caregivers valued the centrality of kotahitanga in TKT IWS's approach. Their focus on establishing and maintaining a cohesive, collaborative support network with a shared understanding and strategy was highly valued and effective, as described by P5; *"We had a big support system. It was mean. You know, once we started, there was no stopping us."* P3 and P4 described the power of working as a collective and noted it was a point of difference for TKT IWS, *"One-stop shop - everyone works together. You don't know what you could have, they've got an idea for you."*

Whānau-centred approach*:* TKT IWS recognised that a child does not exist in isolation and supporting the entire whānau was essential to positive outcomes. Caregivers' appreciated this systemic focus: *"Even though the funding is specifically for [child/youth] and his needs, they also included my daughter as well… They're not just worried about [child/youth]—they're worried about the whole family."* [P5].

Similarly, P6 described how receiving support alleviated her own stress, allowing her to better care for her child: *"It was really good that they not only supported my son, but they were also supporting me… At the end of the day, if the mother's not right, then the kid's not right."*

Whanaungatanga and pono (genuine relations characterised by integrity and honesty): Caregivers appreciated that TKT IWS staff demonstrated authenticity, genuine goodwill, and commitment to shared goals. They described how staff did not act out of their own individual or organisational interests or prioritise bureaucractic convenience. Rather, they were described as maintaining a clear, sustained focus on the best interests of the child. P1 described the unfaltering clarity and commitment to her grandson's best interests as her favourite thing about TKT IWS*; "They put my grandson first. It's all about him. IWS is all about - and that's what I like, cos at the end of the day, that's why we're here. We're here for him…. No agendas. No politics. No political - 'Oh I can't be bothered with it, it means more work for me' or anything like that - it's all around the child."*

The impact of TKT IWS was described as profoundly positive, reducing burdens and increasing quality of life for whānau, children and youth. By holistically addressing the systemic burdens and barriers that had immobilised them, caregivers described how TKT IWS helped them become unstuck. Removing barriers such as navigating complex systems, accessing necessary resources, and coordinating appropriate supports that would meet whānau needs reduced strain on whānau and increased stability, as described by P3, *"We can release a bit of the control. We got somebody else, as in [the TKT IWS] IWS team—coming in and saying 'Right, don't try to organise it—we'll sort it for you.'."* This meant whānau could shift out of survival mode and chronic crisis management. This restored mobility within the whānau system and increased stability of caregivers' wellbeing and employment, which meant they could better support their children. As P3 explained, TKT IWS relieved her stress about frequent school suspension *"I'm not stressed - every time my phone rings, I would just be bursting into tears at work… So, it's been sanity."*

Participants described how the stability and security provided by TKT IWS positively impacted children and youths' self-esteem, wellbeing, and behaviour. Increased access to prosocial activities, structured support, and opportunities for success reduced children and youths' unmet needs, improved their functioning, and helped to reshape self-concept and future aspirations. As P5 shared: *"He's socialising more… he's slowly learning responsibilities, and just responsibility of his own actions, and his learning has been amazing."*

Whānau described feeling more supported, in control, and hopeful, contributing to improved wellbeing, stronger relationships, and a greater sense of possibility for the future. P5 reflected on the impacts of TKT IWS as following; *"We're here. We're here, we're happier. You know, son's happier. Son is so much happier."*

Collectively, caregivers reported improvements across multiple domains, including:

- Increased understanding of the child/youth's difficulties.
- Better communication and stronger whānau relationships.
- Increased belonging, inclusion, and engagement in educational and social environments.
- Decreased emotional and behavioural difficulties.
- Greater access to prosocial activities and environments which fostered skill development and self-esteem.

Te Kahu Tōī Intensive Wraparound Service was constrained and shaped by the dysfunctional societal context it exists within

As described, TKT IWS provided effective support that aligned with the collectivist perspectives of whānau. However, it was also constrained and shaped by the individualistic, bureaucratic, capitalist system it operates within. Caregivers' critiques related to the ways in which TKT IWS was influenced by and at times perpetuated the very systemic problems it is designed to address. This tension underscores a fundamental limitation of TKT IWS (and perhaps Wraparound more generally): while it approximates a collectivist approach, it is still restricted by an individualistic, capitalist society that does not prioritise communal wellbeing or long-term, systemic change. This creates a core tension between service goals and the societal barriers it encounters.

The most commonly reported frustration about TKT IWS related to delays, bureaucracy, and high eligibility criteria. Caregivers felt it was too hard to access TKT IWS services in a timely and transparent manner. After being approved, whānau often waited months during periods of extreme stress for actual intervention to begin. For example, when she was asked what she would change about TKT IWS, P5 said *"The enrolment process. And I think this would have to be the number one. It takes too long."* Many caregivers believed opportunities for early intervention were lost due to restrictive entry criteria, reinforcing the reactive, crisis-driven nature of support systems. P1 felt that considerable harm could have been prevented if intervention was earlier, and criteria were lower: *"I understand that it's for the kids at that extreme end. But it's unfortunate that they have to wait til that to get it. Because they could have got it - if they got in earlier, we might've been able to prevent some of it."*

Caregivers' descriptions of navigating complex bureaucratic processes implied they were detrimental to partnership. Some caregivers described feeling they were not seen as trustworthy or competent, particularly when it came to managing flexible funding which went through schools rather than directly to whānau. This meant caregivers were put in difficult positions, sometimes having to pay for approved services themselves and wait for reimbursement as described by P6: *"I had to pay the [sports] fees… I can't just be like 'Oh, the fees will be paid, I'm not sure when, but, the school's gonna pay them'… Soccer clubs don't rely on people saying 'Oh yeah, the fees will be paid'—because then they don't, and then I have the shame of turning up to the game knowing that his fees ain't been paid yet."*

Most caregivers reported strong partnerships with TKT IWS, but ruptures occasionally occurred when bureaucracy, staffing changes, or interpersonal conflict disrupted collaboration. The under resourced nature of the service sector meant that staff turnover and scarcity sometimes dismantled the sense of kotahitanga caregivers had built with the team, as described by P3: *"That's the other problem we actually had, was the psychologist change on us. [City team] decided that they didn't wanna share him up in the North anymore, so we actually had the person who was really trying to bond everybody removed."*

P7 described feeling dismissed when she raised an issue that was important to her. This made her feel hesitant to voice her needs and concerns later on and underscores the crucial importance of having your perspective heard and validated within a partnership to establish shared understanding: *"I brought that up in the meeting… and I got shot down. I got told to 'sort that out in* *your own time.' And, I didn't like that, you know? I just thought—you're not getting where I'm coming from."*

Caregivers expressed anxiety about what would happen once support from TKT IWS ceased. Many felt discharge decisions were not collaborative, primarily based on service capacity and constraints rather than whānau readiness. Facing discharge that felt premature caused considerable stress and uncertainty. This aligns with previous themes regarding chronic versus short-term conceptualisations of problems. Often, caregivers also reported a lack of post-intervention planning and support in the form of referrals to other services and follow up, which they felt would mitigate their fears somewhat. As P3 stated, *"I guess my fear is that [TKT IWS] IWS, to me, shouldn't come with a timeframe? Cos his timeframe doesn't change. His life … you know. Yeah, that scares me. Terrifies me."*

For caregivers, discharge and mainstreaming meant having to face the overwhelming challenge of managing significant burdens with little support. Additionally, they would have to re-integrate their child/youth into an unchanged pathogenic social environment that remained largely hostile, had failed to meet their needs in the past, and was generative of their difficulties. It is understandably not within the scope of TKT IWS to engage a child/youth and their whānau indefinitely. However, it does not seem reasonable either to temporarily alleviate significant adversity and hardship only to discharge youth and whānau into the same or similar circumstances that generated their difficulties when they are demonstrating budding progress. Like a bud, new growth can be vulnerable and requires extra nurturance and care to grow into all it can be. However, within an individualistic capitalist society where people and services are chronically overburdened and under-resourced, that extra nurturance and care is hard to come by. P7's words capture the profound grief and uncertainty caregivers faced when a service that had finally met their child's needs was no longer an option, forcing them back into an environment that had failed them before:

“He’s really good at [residential specialist school]. Like he just fits in there. It's not that great having him away from home, but I've got used to that now. I feel like they're pushing us into getting him into normal school, and I just don't see why he can't stay where he is. I really don't understand that. Cos he's doing alright where he is. And it's not like he can't stay there, cos he can. Is it - if it's because the government funding - I don't know why, it's just that there's no - there's no answers. I've asked them to give me a 'What if' plan. You know, like what if it doesn't work? Because my problem is - when I found out that they were looking, that they found a couple of schools for him and stuff like that, I was just not sleeping. Cos I'm the one who goes to the school, and takes lunch to my son, cos he wouldn't eat. And I'd get there a little bit early, and I'd see him walking around, by himself. You know, with his head down... it's just sad”.

More difficult to address than specific service delivery critiques is what caregivers raised about the reality of the surrounding socio-cultural ecosystem in which TKT IWS is inextricably situated within and therefore shaped by. The hostility of the wider societal context exacerbated caregivers’ experiences of TKT IWS intervention timelines as being too short and too rigid, and is implicated in their critiques about service access, bureaucratic processes, and ruptures in partnership. TKT IWS was often a lifeline for whānau, lifting them out of hostile, pathogenic circumstances. However, TKT IWS is ultimately only able to offer a temporary salve for adversities generated and perpetuated by the surrounding socio-cultural ecosystem. As a systems-focussed modality that is designed to identify and mobilise natural, community-based supports to create sustainable change, Wraparound relies on the assumption that those supports exist and have the capacity to engage. The reality, as described by caregivers, is that we live in an individualist, capitalist society where that is not necessarily the case. These findings align with international and local research that has identified chronic inadequacies in systemic responses and societal efforts to prevent and address inequity and social-emotional-behavioural difficulties (Government Inquiry into Mental Health and Addiction, 2018; Kieling et al., 2011a; McElvaney & Tatlow-Golden, 2016; Weinstein et al., 2017).

In summary, TKT IWS offers a more humane, relational, and collective model of care within a society that emphasises individual responsibility. The service was described as valuable and transformative by whānau, but it's functionality and impact were constrained the faults in the system it seeks to address and improve. To truly create sustainable, meaningful change for whānau, society (and all services within it) needs to shift towards more collective, community-centred approaches, which would allow services like TKT IWS to work more effectively in the long term.

Limitations

In alignment with the epistemological framework and statements made by by caregivers, the stories and results in the current study are not necessarily generalisable to all Māori children, youth and whānau with HCN who have or have not engaged with TKT IWS. The aim was to explore the experiences of a group of Māori whānau raising children and youth with HCN who were engaged with TKT IWS, to generate and contribute knowledge about Māori whānau experiences of the Wrapround Process. It is important to reflect on the limitations that exist in relation to the research design and execution when interpreting findings.

Due to pragmatic (geographical, financial) and ethical (confidentiality) barriers to directly approaching children, youth and whānau, recruitment of participants occurred via TKT IWS employees. Participation was voluntary. The use of self-selection may mean that those who took part were especially impacted (whether positively or negatively) by their experiences and therefore felt they had a story to tell. Their willingness to engage may also have been influenced by various contributing factors such as their attitudes towards research and capacity to participate in terms of possessing sufficient time, commitment, and emotional resources.

It is important to note that the research relationship with TKT IWS was characterised by goodwill and commitment to the goals of the project. Conversations were had and documentation was given to TKT IWS to guide them in the recruitment process. However, I had little control over exactly how and to whom the opportunity to participate was offered. It is possible that staff made judgments about who would be most able, willing, helpful and desirable to recruit for the study which affected recruitment. Recruiting children and youth through organisations that have existing relationships and access to them is a commonly recommended strategy (Giodarno et al., 2023c, 2023a). Despite being invited to participate, no children or youth chose to take part in the study. Hence, only caregivers' experiences and perspectives are represented in the current study. Research has demonstrated that there are often discrepancies between caregiver and child/youth reports of emotional behavioural issues (Bonadio et al., 2022), and that caregivers tend to be perceived as more credible informants (Youngstrom et al., 2011) which likely contributes to the underrepresentation of children and youth engaged in health research (<1%; Giodarno et al., 2023b). The dynamic between participants and I would have influenced how conversations unfolded and stories were told. Innumerable aspects of my own and participants' positioning, identity, and communication styles inevitably shaped the data in an interactive, relational manner. This brings me to arguably the most significant limitation of the current study; my positioning as Tāngata Tiriti/non-Māori, a clinician, and a researcher. Although I made significant efforts to mitigate biases associated with those facets of my identity and positionality, particularly those that could be harmful, my identity inevitably will have influenced the research. To some degree I represented the various communities I belong to and the experiences participants had with them when I engaged in interviews, as evidenced by one caregiver referring to service providers and the Ministry of Education as *you guys* in our conversation. My membership to several social groups that have enacted and continue to enact systemic and institutional racism may have understandably influenced participants' comfort and in turn what they shared, and how they shared it. Despite my efforts to encourage caregivers to speak freely and share what they felt was most relevant, my own background and identity undoubtedly influenced how I responded verbally and non-verbally to aspects of their stories which would have shaped them to some extent.

Being non-Māori significantly limited and limits my awareness and understanding of culturally rooted phenomena within te ao Māori. Due to this, it is highly likely that I failed to pick up on culturally relevant phenomena and nuances. More generally, being non-Māori exerts limits on the depth of communication, connection, and understanding that can be achieved with Māori. As stated by Palmer et al. (2011b) true cultural expertise and fluency is acquired intergenerationally, through identity, and/or decades of immersion. Some Indigenous academics take the position that studies such as the current one should be Kaupapa Māori, undertaken by Māori researchers. Others emphasise the importance of all researchers engaging thoughtfully and collaboratively with inequity and issues affecting non-dominant groups, due to the harm caused by failing to do so (Hudson & Russell, 2009; Thambinathan & Kinsella, 2021; Tuhiwai Smith, 2021f). I do hope that the decolonising framework and intentional centring of allyship, activism, and partnership in the current study has created something of use, meaning, and benefit in the pursuit of equity. However, I do not think these endeavours negate the proposition that a Kaupapa Māori approach led by a Māori researcher would be especially valuable in this area.

All analytical processes and the outcomes they produce are inevitably reductionist and imperfect representations of complex realities. I conducted the analysis in adherence to Braun and Clarke's (2019) conceptualisation of reflexive thematic analysis. It was an intensive process carried out by myself as the sole coder and analyser, supported by theoretical discussions with supervisors. Inevitably, the analysis and results are reflective of the intersect between stories told by caregivers; the meaning collaboratively created through conversation; and my own theoretical, interpretive, and creative engagement with the data. Analysis was an area in which partnership was lacking. Transcript checking and feedback of results prior to finalisation was intended to mitigate this lack of participation in analysis somewhat, by offering participants the opportunity to review their transcript and results and provide their feedback and reflections. Due to multiple delays in the completion of the project, there was a lengthy interval between the interviews and the opportunity to review transcripts and provide feedback of results. The considerable passage of time may have contributed to a lack of feedback from participants when results were sent through.

Summary

This RTA study explored the experiences of Māori whānau engaged with TKT IWS who were raisingr children/youth with HCN. The findings were presented across three interconnected themes.

First, societal dysfunction emerged as a core problem that generated and maintained whānau difficulties, with participants describing an inequitable and fragmented service landscape shaped by Western norms that prioritise competition, resource guarding, and bureaucratic complexity over collective wellbeing. The resulting scarcity and inaccessibility of support was described as leaving both whānau and services overburdened, reinforcing systemic disadvantage, and creating an environment in which only the most urgent cases received attention.

Second, the disconnected worldviews of whānau and services was a major barrier to effective collaboration. While whānau viewed their difficulties as part of a broader, systemic issue requiring collective responsibility and holistic solutions, services often framed problems as individual and discrete, locating responsibility within the child or immediate family. Whānau described how misalignment shaped service functionality and responsivity, leading to short-term, reactive interventions that failed to address root causes or provide sustained, meaningful support. School exclusion was one of the most damaging consequences of this disconnect, further entrenching disadvantage by isolating children and youth and increasing whānau burden.

Finally, the role of TKT IWS within this dysfunctional system highlighted both the strengths and limitations of collectivist care in an individualist society. TKT IWS was widely experienced as a rare and valuable service, providing holistic, tailored, and relational support that aligned with collectivist Māori values and upheld tino rangatiratanga through shared decision-making. However, despite its successes, TKT IWS was still constrained by the broader system it operated within. Bureaucratic delays, resourcing limitations, and limited intervention timelines undermined its functionality and impact. Many caregivers feared what would happen after discharge, as their children and youth were often returned to the same underresourced, exclusionary environments that had contributed to their difficulties.

These findings underscore the need for systemic change. While services like TKT IWS can provide crucial, temporary relief, sustainable, long-term solutions require a shift away from individualistic, crisis-driven approaches towards a collectivist, community-centred model of care. Only by addressing the underlying structural inequities that shape service provision can meaningful and lasting change be achieved for children, youth and whānau with HCN.

Chapter 7: A quantitative analysis of outcomes for children and youth who engaged with Te Kahu Tōī Intensive Wraparound Service

This chapter describes the second study in a multi-study investigation of outcomes and experiences associated with TKT IWS. Study two used quantitative descriptive research methods to explore patterns of change for children and youth and whānau who engaged with TKT IWS. A longitudinal single cohort design was used to compare measures taken at baseline (T1: in mid – late 2019) and after one year of engagement (T2: in mid – late 2020). Longitudinal research enables the observation and description of change or stability over time, which allows for inferences to be made regarding the direction and magnitude of causal relationships (McKinlay, 2011). It was hypothesised that scores on measures of interest at T2 would be significantly better than scores at T1, indicating improvement over the year long period of engagement with TKT IWS. The quantitative study was designed to contribute to the overarching research aims[91] by critically examining quantitative data about the outcomes of TKT IWS. Aligning with academic discourse on decolonising research methodologies, which emphasise praxis and the generation of knowledge that is directly useful in practice (Denscombe, 2025; Thambinathan & Kinsella, 2021), the quantitative study was designed not only to meet overarching research objectives of the thesis, but also to address the pragmatic goals of TKT IWS. These goals included exploring the potential validity of their newly developed IWS?, Life Predictors measure and assessing intervention effectiveness specifically using the Child and Adolescent Functional Assessment Scale (CAFAS), given it is widely recognised and used to assess the efficacy of Wraparound interventions globally (Bates, 2019). Undertaking this work in a critical manner while also incorporating pragmatic goals of the service allowed the study to generate meaningful information to support service improvement and development, while also providing evidence that could be used by TKT IWS in seeking government funding and improving access to, equity, and effectiveness of their services.

Participants

Based on the population served by TKT IWS in the previous financial year, it was expected that up to 25 – 35 families would be recruitable for the quantitative analysis study. A total of 24 children/youth and their families initially volunteered to take part. However, one family disengaged with TKT IWS during the research period. Another provided verbal consent but not written consent

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[91] See Chapter 5, pg 166

and was not included in the study. This left a total of 22 participants. For each child/youth the following data was provided by TKT IWS for analysis: a) demographic data (age and ethnicity), b) CAFAS score at baseline and one year (Child and Adolescent Functional Assessment Scale; Hodges, 2019), c) IWS Life Predictors score at baseline and one year (The Intensive Wraparound Service: Te Kahu Tōī, 2016). Of the 22 children and youth in the group, nineteen were male and three were female. Racial ethnic identity was categorised by TKT IWS into the six main ethnic groups in Aotearoa; Māori, NZ European/Other European, Pacific Peoples, Asian, MELAA (Middle Eastern/Latin American/African), and Other as is usual practice for them in alignment with governmental procedures (Stats NZ, 2018). In terms of ethnicity, 11 children/youth were NZ European, eight were Māori, two were MELAA, and one was Pacific Peoples. Participants ranged in age from 8.25 to 13.75 years (*M* = 11.02, *SD* = 0.42).

In terms of representativeness, the group was comparable in demographics to the wider population of children, youth and families engaged with TKT IWS. The typical age range of children/youth engaged with TKT IWS is 5-18, and with a small sample, a truncated range and reduced standard deviation as observed is typical. The mean age is typical of the wider population. Regarding racial ethnic identity, the group was relatively representative of the wider population though a slight underrepresentation of Māori children/youth and overrepresentation of MELAA youth was observed (R. Etheredge, TKT IWS psychologist, personal communication, August 5, 2025).

Design

Measures

The Child and Adolescent Functional Assessment Scale (CAFAS)

The CAFAS (Bates, 2019; Hodges et al., 1998) is a standardised assessment which measures the degree to which a child/youth’s challenges interfere with their overall everyday functioning. It has been widely adopted in case management, assessment, eligibility determination, and measurement/documentation of outcomes and treatment effectiveness. Widespread adoption of the CAFAS is in part due its clinical utility, ease of use, and the increased emphasis on outcome monitoring procedures in clinical practice (Bates, 2019). In the US, many states have mandated the use of the CAFAS statewide, and it has been used extensively to evaluate Wraparound services. The CAFAS is clinician-rated; scoring is based on practitioners' judgement of clients' functioning. Test-retest reliability, interrater reliability, and concurrent validity has been demonstrated. Evidence has also shown that the CAFAS predicts service utilisation, restrictiveness of care, and costs at 6- and 12-months post intake better than other commonly used tools, particularly when combined with psychiatric diagnostic information (Bates, 2019). Hodges (2006) suggested that the CAFAS is valid cross-culturally, as it has been used with large, diverse populations and does not demonstrate significant differences between groups (Bates, 2019). However, the CAFAS has not been adapted or normed for children and youth in Aotearoa or Māori children and youth.

The CAFAS consists of several separate subscales. Behavioural descriptions for ratings against several psychosocial domains of youth functioning are provided; school/work role performance, home role performance, community role performance, behaviour towards others, moods/emotions, self-harmful behaviour, substance abuse, and thinking. Two subscales (material needs and family/social support) measure caregiver resources and produce a score from 0 – 60 that does not contribute to the total youth functioning score. Each subscale is rated on an interval scale; 0 points represents minimal/no impairment, 20 points represents mild impairment, and 30 points represents severe impairment. The most severe rating of impairment within each domain is scored, based on an elected period (past month, past three months, or other). Certain items are flagged as risk behaviours. A total score for youth functioning can range from 0 to 240, indicating the following:

- 0–10: minimal/no impairment
- 20-40 mild impairment: can likely be treated on an outpatient basis provided risk behaviours are not present
- 50-90 moderate impairment: may need additional services beyond outpatient care

- 100-130 marked impairment: likely needs care more intensive than outpatient and/or which includes multiple sources of supportive care
- 140 and over severe impairment: likely needs intensive treatment, the form of which would be shaped by the presence of risk factors and the resources available within the family and community

The CAFAS was chosen in addition to TKT IWS's usual measures due to its psychometric properties, extensive use across relevant and comparable contexts, ease of use, predictive validity, and concurrent validity. Most importantly in an applied sense, the CAFAS is particularly useful because its extensive use in Wraparound research provides a strong evidence base for comparison. This is useful when seeking funding for and evaluating service delivery and development. Situating TKT IWS outcomes within the literature by using the CAFAS enables a clearer understanding of how the service aligns with patterns associated with positive outcomes internationally, while also identifying areas where improvement may enhance effectiveness. This linkage offers the service both a benchmark and a guide, ensuring that local data can be interpreted in light of established knowledge about what contributes to successful Wraparound delivery. CAFAS scores were also correlated with the IWS Life Predictors Form used by TKT IWS to determine the degree to which outcomes on the IWS Life Predictors Form aligns with those on the CAFAS, a well-established, and widely used psychometric measure.

The IWS Life Predictors Form

The IWS Life Predictors Form was developed by TKT IWS with the intent of tracking change and measuring outcomes in a manner more relevant to children and youth in Aotearoa with increased long-term predictive validity (The Intensive Wraparound Service: Te Kahu Tōī, 2016). It was designed to meet specific criteria. Concepts assessed by the tool were intended to be familiar to and easily understood by the general population, clearly applicable to TKT IWS and the population they work with, and based on established predictive factors susceptible to intervention. Use of the tool was intended to produce reliable results, utilise specialist skills and knowledge possessed by TKT

IWS psychologists, align with the Ministry of Education outcomes reporting framework, and minimise time and effort for staff, children, youth, and whānau.

The form was therefore developed based on predictive factors for relevant life outcomes identified in studies utilising data from the longitudinal Dunedin Multidisciplinary Health and Development study (Olsson et al., 2013; Poulton et al., 2015). Other resources that informed development of the measure included procedures used in the assessment of the likelihood of future outcomes by the Department of Corrections (Forth et al., 2003; Hodge & Andrews, 2002), reports regarding antisocial behaviour and development (Church, 2003, 2013; Church et al., 2006), a meta-analysis of risk factors for delinquency (Assink et al., 2015), and a review of social-emotional childhood skills and their long-term associations in adulthood (Goodman et al., 2015). A wide range of static and dynamic predictive factors were identified culminating in the selection of five broad constructs consisting of nine items each: 1) self-control of behaviour and emotions, 2) social competence and interpersonal skills, 3) attitudes, values, and perceptions, 4) relationships with families and/or caregivers, and 5) access to and achievement in safe and prosocial environments. TKT IWS's aspiration is that children and youth they engage with experience improvements in each key area.

Like the CAFAS, the IWS Life Predictors Form is clinician-rated. The IWS psychologist scores items based on their own knowledge of a child/youth and clinical judgment. Each item within each of the five constructs is accompanied by a behavioural description and scored on a three-point scale: 0 – not at all applicable, 1 – somewhat applicable, 2 – definitely applicable. Item scores are summated and translated into an overall rating for the corresponding construct, made on a five-point Likert scale ranging from 1 (a minimal degree) – 5 (a very high degree). The overall score can therefore range from 5 – 25, indicating the degree to which positive factors are judged to be present.

The Special Education (SE) Outcome Measurement Tool

The SE outcome measurement tool is administered alongside the IWS Life Predictors form and is also included in its appendix. The SE outcome measurement tool is clinician-rated. The tool was designed to gather sufficient evidence to demonstrate the impact of learning support services, rather than collect detailed information about student progress. Three areas of educational engagement are scored and described as following:

1. Presence: the student is enrolled, attending and included. They have equitable access to local education services, attend as expected with no limitations placed on attendance, and their needs are met.
2. Participation and wellbeing: the student is accepted and supported by the school/service community, positively engaging in an enriching shared learning environment, accepted and supported in peer groups, and demonstrates self-determination.
3. Learning and achievement the student has access to teaching/learning, believes they are capable, and can acquire and use skills.

Each area is scored on a 9-point subscale; scores of 1-3 indicate poor outcomes, 4-6 indicate moderate outcomes, and 7-9 indicate engagement and achievement at the expected level. In addition, the lead TKT IWS worker in the Wraparound team makes a judgement about progress given their knowledge of the child/youth and whānau and their circumstances; less than expected, as expected, or more than expected. The SE outcome measurement tool is only rated after engagement with TKT IWS, it is not used at intake (The Intensive Wraparound Service: Te Kahu Tōī, 2016).

Procedure

Participants were recruited through TKT IWS. TKT IWS staff invited children, youth and whānau engaged for at least six months to participate at one of their monthly Wraparound meetings. Staff communicated that participation was optional and choosing not to take part would not affect service provision. If interest was expressed, TKT IWS provided children, youth and their whānau with an information sheet and consent forms. The information sheet shared information about the research team; the purpose of the study; what participation would involve; information about data, privacy, rights; and contact details for the research team. If children, youth and their whānau chose to take part, they simply consented for TKT IWS to share the data collected as part of their usual processes (as well as extra clinician-rated data collected via the CAFAS) with the research team. If the prospective participants did not take part in the research project, this did not affect the clinical services they received.

Measures are taken at three stages by TKT IWS during services provision. The measures are taken at baseline (T1), after one year of engagement (T2), and at discharge. The current study examined changes between measures at T1 and T2. TKT IWS uses multiple assessment tools and strategies to monitor outcomes and progress. At the time the project commenced, they were using the IWS Life Predictors Form, The SE Outcomes tool, collaborative Wraparound team ratings of individualised goal achievement (including ratings by the child/youth and their whānau), teacher ratings of school engagement, and measures of programme enrolment. The current study focusses on outcomes according to scores on the IWS Life Predictors Form, the SE Outcomes tool, and additionally, the CAFAS.

Data Analysis

Data were analysed using IBM SPSS Statistics V.29. An a priori power analysis was conducted for sample size estimation. Effect sizes for Wraparound interventions are variable in the literature, ranging anywhere from very small to large (Bruns & Sather, 2008; Bruns & Suter, 2010; Painter, 2012). A recent meta-analysis of Wraparound evaluation studies concluded that effect sizes are heterogeneous, likely as a result of variability in methodologies, demographics, and outcomes across studies (Olson et al., 2021). Olson et al. (2021) found a small average effect size across 17 studies ($d = 0.277$, CI = 0.119 - 0.435, $p = .001$) using Cohen’s criteria (1988). Hence, the power analysis in the current study assumed a moderate effect size would be present (*d* = 0.5). The results of the power analysis indicated the required sample size to achieve 80% power to detect the presence of a medium effect (*d* = 0.5), at a significance of α = .05, was *N* = 27. However, only 22 participants were recruited which meant the actual power of the analysis was 0.734. This is below the typically recommended value of 0.8 and translates to an increased risk of a type 2 error (failure to detect a significant effect). Low power also can increase effect sizes and compromise precision of estimates, reducing generalisability of findings (Field, 2009). For this reason, the current study functioned primarily as a pilot study for TKT IWS.

Results

The table below provides a summary of descriptive statistics for variables in the current study.

Table 3

Descriptive statistics for study variables

Measure		**T1**			**T2**	
	n	***M***	***SD***	***n***	***M***	***SD***
CAFAS						
Total Youth Functioning	22	110.45	7.94	22	73.64	9.48
Caregiver Resources	22	13.63	3.05	22	11.36	2.89
Risk Behaviours	20[a]	1.65	1.14	20[a]	0.59	0.854
IWS Life Predictors						
Total Score	22	8.91	0.63	22	12.91	1.05
SE Outcomes[b]						
Presence	-	-	-	22	5.64	3.09
Participation	-	-	-	22	4.64	2.42

Learning Achievement	-	-	-	22	4.41	2.48
Residential placement[c]	1	-	-	3	-	-

[a] missing data for two participants

[b] measure only taken at T2

[c] missing data for four participants at T1 and T2

A paired samples *t*-test was performed to evaluate the hypothesis that there would be a significant difference between Total Youth Functioning Scores on the CAFAS at baseline and after a year of engaging with TKT IWS. Assumption testing confirmed that the necessary assumptions were met to conduct the analysis. The results indicated that the CAFAS: Total Youth Functioning Scores were significantly lower at T2 (*M* = 73.64, *SD* = 9.48) than they were at T1 (*M* = 110.45, *SD* = 7.94), *t*(21) =, *p* = <.001. The effect size was large with a Cohen's d of 1.197. The observed reduction in the mean CAFAS score is clinically significant, supporting the hypothesis and shifting the mean score from indicative of marked impairment at T1 to indicative of moderate impairment at T2 (Hodges, 2006; Hodges et al., 1998). The table below displays the proportional shifts in impairment levels within the sample according to CAFAS scores.

Table 4

Level of impairment indicated by CAFAS scores

Level of impairment	**T1** **% of sample**	**T2** ***% of sample***
none – minimal	0	9.09
mild	0	31.82
moderate	40.91	31.82
marked	36.36	18.18

severe	22.73	9.09

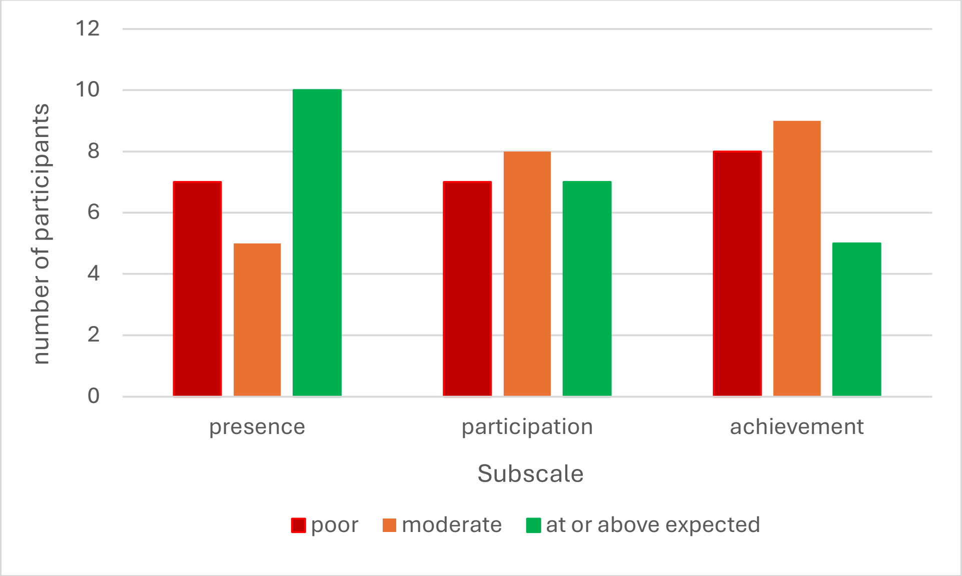
Assumption testing revealed that conducting paired samples *t*-tests for risk behaviours and caregiver scores recorded by the CAFAS was not appropriate due to violations of the normality assumption for both sets of variables. Non-parametric tests were considered but the datasets violated assumptions for these tests too. The descriptive statistics for these variables are listed in Table 1. A very small reduction in means for both variables were observed from T1 – T2, however, no conclusions about the significance of these findings can be made.

However, it is important to note that the majority of caregiver resources scores at T1 indicated mild to severe difficulties (17/22; 77.27%) and by T2, the majority of these scores remained unchanged (16/22; 72.73%). A small proportion of scores improved (4/22, 18.18%) or worsened (2/22, 9.09%).

Descriptive analyses of the SE Outcomes scores revealed that after a year of engagement, mean scores on each subscale were indicative of moderate presence, participation, and achievement below the expected level in educational contexts. The graph below displays the relative proportions of the sample who were rated as achieving educational outcomes that were poor, moderate, and at or above the expected level by T2.

Figure 7

Educational outcomes at T2 according to the SE Outcomes Tool



Across all measures of educational engagement and achievement, the majority of the sample were functioning below the expected level at T2.

A Pearson correlation coefficient was computed to assess the linear relationship between CAFAS Total Youth Functioning scores and IWS Life Predictors scores. CAFAS and IWS Life Predictors were found to be moderately negatively correlated, $r(21) = -.521$, $p < .01$. This means that there was a significant correlation between reductions in impairment as measured by the CAFAS and increases in positive factors as measured by the IWS Life Predictors Form.

At T1, one participant was living in a residential care setting. By T2, three participants were living in residential care settings.

Limitations

The first significant limitation of the current study is the sample size. The sample size resulted was restrictively small, meaning analyses could be performed for some variables. Significance of differences in variables such as caregiver resources and residential placements could not be determined. Equity of outcomes across genders and cultural identities also could not be explored. As stated earlier, the small sample size also reduced the power of the analyses. This increased the risk of failing to detect a significant effect in the population, inflating effect sizes, and compromising precision and therefore generalisability. For this reason, and of particular relevance given the large effect size in comparison to other Wraparound studies, results should be interpreted with caution in terms of magnitude and generalisability.

The duration of the study limits conclusions that can be made about the longevity and stability of the observed outcomes. It is difficult to speculate about the longevity of positive change after discharge, particularly because at T2 children, youth and whānau were still engaged TKT IWS. The development of the IWS Life Predictors Form was intended in part to introduce some predictive power to outcome measurement by basing the constructs on well-evidenced predictive factors associated with positive developmental experiences and outcomes throughout the lifespan. However, it is yet to be validated.

This leads to the next significant limitation of the current study: the tools used to measure change and outcomes. None of the measures employed have been cross-culturally validated or normed, limiting their applicability, relevance, and appropriateness across diverse cultural identities and contexts. All measures were quantitative and rated solely by clinicians, with no direct input from children, youth, or their whānau. The focus of these tools was predominantly individualistic, with the exception of the SE Outcomes Tool, which included some items regarding the extent to which a child's needs were met in social and educational environments. However, the SE Outcomes Tool was only administered at T2 (which is how it is typically used by the Ministry of Education) preventing assessment of change over time, and its items often relied on subjective judgments about a child's functioning in educational contexts that clinicians may not have observed directly.

The CAFAS, though widely used for assessing outcomes and service eligibility, carries limitations particularly relevant to this research. In Aotearoa, and within a decolonising project with Māori whānau, the CAFAS's Eurocentric, objectivist, and positivist assumptions constrain how functioning is evaluated, understood, and communicated. Its reliance on Likert-scale ratings reduces complex lived realities into narrow categories, obscuring cultural and relational dimensions of wellbeing.

In terms of psychometric reliability and validity, Wraparound clinicians may only see the child/youth intermittently (e.g., once a month at Wraparound meetings), relying largely on second-hand information from schools or caregivers (who may have their own biases) rather than direct observation. The rating descriptors in the CAFAS are fairly vague and broad, leaving substantial scope for subjectivity and imposition of the clinicians' own values, beliefs, and interpretations. These issues align Bates' (2019) findings of limited evidence for structural validity, unclear correspondence between scores and functional impairment, and insufficient reliability, including inter-rater consistency across contexts.

Bates (2019) described how the scoring method itself is problematic in terms of critiques weight equivalence and subscale distortion. The highest rating within a domain determines the overall score, risking overweighting isolated difficulties and biasing results more generally toward deficit. This is particularly relevant when considering the findings about caregiver resources in the current study. An item in the caregiver resources subscale assesses financial/material resources. The design of this subscale paired with scoring methods risks portraying caregivers as inadequate overall solely due to limited material or financial resources, individualising blame for structural inequities and perpetuating stigmatising narratives. The finding in this study that caregiver resources did not appear to improve over time may partly reflect this structural bias, although it also aligns with qualitative findings where many parents expressed concern about inadequate systemic support and access to necessary resources once Wraparound services ended.

In terms of validity, CAFAS evidence for clinical and social validity has been criticised as limited, with scores insufficiently reflecting meaningful change or family priorities (Bates, 2019). Its limited cross-cultural equivalence raises particular concerns for Māori whānau, as Eurocentric indicators of caregiving inadequately capture relational strengths, resilience, and culturally grounded wellbeing.

Collectively, these psychometric, scoring, validity, and cultural limitations raise concerns appropriateness of the CAFAS as a primary measure of Wraparound outcomes in contexts such as TKT IWS, particularly when aiming for equitable, culturally responsive assessment for Māori children, youth, and whānau. While these limitations must be acknowledged, the CAFAS was used in this context because of its extensive adoption in Wraparound research and practice, as well as the pragmatic implications of this. Its widespread use provides a benchmark for comparison, supporting interpretation of outcomes and advocacy for funding or expanded service delivery. Situating TKT IWS outcomes within this literature enables a clearer understanding of how the service aligns with patterns already associated with positive outcomes internationally, while also highlighting areas where improvement may enhance effectiveness. This offers the service both a benchmark and a guide, allowing local data to be interpreted in light of established international knowledge about factors contributing to successful Wraparound delivery, though it is important to note that this body of literature is inherently Eurocentric in its current state. Using the CAFAS alongside a high level of critical reflection provides a clear rationale for developing culturally affirming measures that centre youth, child, and family voices, are culturally affirming, and more relevant to local contexts. As noted in earlier chapters, adopting a traditional quantitative approach alongside/within decolonising methodologies can be necessary to align with academic, policymaking, and funding expectations, which often prioritise evidence-based interventions evaluated via established quantitative standards (Chorpita et al., 2011; Thambinathan & Kinsella, 2021). In this way, the CAFAS is not used uncritically but strategically, providing both a benchmark for comparison and a rationale for the development of culturally responsive, locally relevant measures in future work.

The IWS Life Predictors Form was developed by TKT IWS with the aim of providing a tool specifically relevant to an Aotearoa context with high predictive validity. However, many of the same limitations observed in the CAFAS appear relevant to this measure. As noted, the IWS Life Predictors Form has not yet been validated. Comprehensive empirical analysis of its psychometric properties was beyond the scope of the current project, as best practice recommendations for validation would require either approximately 10 respondents per survey item (N ≈ 450) or 200–300 observations (Boateng et al., 2018) thresholds not achievable given the size of the TKT IWS population.

At face value, several concerns are apparent. Many items use vague descriptors and are susceptible to rater bias, reflecting similar issues to those identified in global functioning measures such as the CAFAS (Bates, 2019). While the constructs and items are derived from empirical evidence, the operationalisation of items was often unclear, limiting potential inter-rater reliability. It is also unclear which specific adult life outcomes are being targeted by the predictive factors included in the measure. Furthermore, many items reflect Eurocentric norms and assumptions about wellbeing and positive indicators of functioning; e.g., valuing a positive attitude toward the police and justice system, assuming schools are inherently safe and pro-social, and using reading fluency as a proxy for academic achievement. A strong emphasis on compliance and conformity is present throughout the measure, with little evidence of cultural relevance or responsiveness in its design.

Significant research into the psychometric properties of the IWS Life Predictors Form is required to determine whether it is truly more predictive or locally applicable than internationally used measures such as the CAFAS. Given the similarity in weaknesses at face value including construct validity issues, Eurocentrism, vague descriptors, and likely low inter-rater reliability, future measure development is likely better directed toward approaches that are defined and evaluated by children, youth, and families themselves, and that are culturally relevant, affirming, and contextually grounded.

Summary

As hypothesised, a paired *t*-test revealed that total CAFAS scores decreased significantly after a year of engagement with TKT IWS. The effect size was large and at the upper end of effect sizes reported by previous Wraparound evaluation studies (Bruns & Sather, 2008; Bruns & Suter, 2010; Olson et al., 2021; Painter, 2012). The magnitude of the effect size may have been inflated due to lower power and a small sample size, but also may be in part attributable to the above average fidelity Wraparound approach TKT IWS provides (Ministry of Education, 2018), and the high representation of racial ethnic minoritised children and youth - both factors are associated with greater effect sizes for Wraparound (Olson et al., 2021). The decrease in CAFAS scores from T1 to T2 was statistically and clinically relevant, representing a generalised reduction in impairment and improvement in functioning. A shift of this magnitude translates to a significant reduction in the level of support required according to the CAFAS, reducing the requirement for intensive multisystem involvement.

The current findings are promising in terms of the effectiveness and value of using the Wraparound Process with diverse populations of children and youth with HCN in Aotearoa to improve socio-emotional functioning, consolidating findings of previous research on the topic (Olson et al., 2021; Shailer, 2015).

In terms of educational outcomes, data from the SE Outcomes Tool demonstrated that educational engagement and achievement remained below the expected level for the majority of the sample at T2. Because there was no data for SE Outcomes at T1, it is unclear to what extent these ratings may have changed over the study period. However, it does suggest that engagement with TKT IWS Intensive Wraparound Service did not produce normative levels of inclusion, participation, and achievement in the educational system according to the measures scale.

The correlation between scores on the IWS Life Predictors Form and the CAFAS suggest they are measuring similar phenomena and that the IWS Life Predictors Form is capturing changes in constructs that are associated with increased functioning and decreased impairment. There was little change in caregiver resource scores on the CAFAS, the number of risk behaviours displayed, and the proportion of the sample in residential care settings by T2, though none of these outcomes could be tested for statistical significance. However, the proportional lack of change observed in caregiver resource ratings within the sample is of concern, as is the observed increase in residential placements.

Chapter 8: Discussion

This thesis was driven by an overarching aim to contribute to the pursuit of equity in wellbeing and service delivery. The Wraparound Process is a systemic, holistic, coordinated service delivery approach that has been identified as a useful framework with which to meet the needs of children, youth and whānau with HCN (Olson et al., 2021; Coldiron et al., 2017; Shailer, 2015; Suter & Bruns, 2009). A growing body of evidence has suggested Wraparound can be used to produce equitable outcomes and incorporate or be entirely based within diverse cultural worldviews and ways of life (Kirkwood, 2014; Olson et al., 2021; Palmer et al., 2011a).

The current research was designed to increase knowledge about the Wraparound Process in terms of its applicability, equity, and effectiveness cross-culturally, especially in Aotearoa, and with Māori. Previous research regarding the use of the Wraparound Process in Aotearoa has been conducted (Shailer, 2015; Tamihere, 2015). Limitations and recommendations outlined in these research endeavours informed the current project. For example, Shailer (2015) recommended exploring of quantitative outcome data, cross-cultural validity, and Māori experiences of the Wraparound Process. Tamihere (2015) investigated a Kaupapa Māori Wraparound approach using Kaupapa Māori research methods. However, she raised concerns regarding the infidelity to the Wraparound practice model as described by the National Wraparound Initiative (Bruns, 2008; Bruns & Walker, 2008). The current research project addressed these gaps in the literature by exploring recommended phenomena within a research-based Wraparound approach that has demonstrated fidelity to the service delivery model as defined by the NWI (Bruns & Walker, 2008). In this chapter I will summarise and discuss the key findings from each of the three studies in this thesis. I will then discuss general implications and recommendations in relation to the literature, TKT IWS, service delivery, and the surrounding social ecosystem.

Use of the Wraparound Process with underrepresented groups: a scoping review

The first study presented in the current thesis was a scoping review of the use of the Wraparound Process with underrepresented groups. The review aimed to investigate the extent and ways in which Wraparound has been used with underrepresented groups, and establish trends, limitations, and recommendations drawn from the review of the evidence base. These findings informed the design of the studies in this project thereafter.

In terms of the extent, range, and nature of existing research on the use of Wraparound with underrepresented populations, the review demonstrated that Wraparound has been used extensively across diverse cultural groups. However, in alignment with general trends and biases in academia, all sources in the review came from Western-colonised countries (Cundiff, 2012; Rogers & Lange, 2013; Tuhiwai Smith, 2021c).

Many of the trends evident in the evidence base about the use of Wraparound with underrepresented groups replicated trends in the general evidence base of the Wraparound Process (Coldiron et al., 2017; Olson et al., 2021). Most sources did not mention or measure fidelity to the Wraparound Process practice model, and there was a general lack of adherence to the approach. Wraparound was frequently used colloquially to denote a multipronged approach to service delivery or treatment. Those that did measure fidelity reported moderate to above average fidelity, suggesting that those who measure it tend to be those who also adhere to the practice model. However, concerns regarding the cross-cultural validity of standard fidelity measures were raised (Kendziora et al., 2001; Palmer et al., 2011b). Some interventions explicitly and intentionally omitted core aspects of the Wraparound practice model. The principle of fostering and involving natural supports was often not prioritised or effectively upheld. This is of significant concern given the centrality of natural supports and community to the Wraparound Process and the achievement and sustenance of wellbeing/positive outcomes more generally (Chu et al., 2010; Cox et al., 2009; Lerner, 2005; Painter et al., 2011).

A significant proportion of studies in the review demonstrated no cultural considerations or adaptations in any of the three areas screened (theory, research design, or service delivery). This is a serious concern given the review selectively included interventions serving culturally diverse or minoritised populations. Most of the studies that did demonstrate cultural considerations or adaptations made relatively minor adjustments in one or more areas within a traditional intervention and research framework. Conversely, a small group of research projects and interventions were culture-based, emerging from a distinct cultural paradigm. Useful information was extracted from these studies which can be used to guide culturally responsive and/or culture-based service delivery.

There was a dearth of culturally relevant measurements used to evaluate outcomes and intervention success. Measurements used were often based on Eurocentric standards of wellbeing and progress, and overly reliant on professionals' judgements and opinions.

In terms of research design, trends mirrored that of the general evidence base regarding the Wraparound Process. Most studies used quantitative research techniques, although a significant proportion used qualitative or a mixed methods approach. There were very few experimental research designs. Identified outcomes of interest varied, typically relating to improved functioning, decreased impairment/pathology/antisocial behaviour, treatment completion, and/or reductions in punishments from the justice system or educational sector. Outcomes of interest were mostly identified and defined by researchers or service providers and there was an implicit emphasis on compliance and conformity to expected norms. Very few studies focussed on outcomes defined and desired by service users. A significant proportion of studies did not use any outcome measurements that elicited caregiver or service user perspective. The majority used standard psychometrics, clinician observation and judgement, and/or administrative data.

The majority of studies in the review reported favourable outcomes. A very small group reported unfavourable outcomes which authors linked to poor fidelity, systemic issues beyond the scope of the intervention (e.g., unmet caregiver needs that made engagement with an intervention taxing, the inability of the intervention to mitigate or protect against discrimination), or the outcomes of interest being poor indicators of actual treatment success/improvements (particularly when related to interactions with the justice system).

Regarding equity, just under a third of sources with populations comprising both underrepresented and overrepresented groups explored outcome equity. Most of these studies found no differences in participation, completion, or outcomes based on cultural-ethnic identity. Of the four studies that did find differences between cultural-ethnic groups, three found underrepresented cultural-ethnic groups to have better functioning, less impairment, and better outcomes than White youth (Eadie et al., 2022; Stenersen et al., 2021; Yohannan et al., 2017). Two studies found underrepresented groups were more likely not to complete treatment (Anderson et al., 2003; Yohannan et al., 2017). One also found that caregivers of Black youth had lower satisfaction with staff in respect of religious and cultural beliefs (Stenersen et al., 2021). Interestingly, there was a lack of explicit acknowledgement of and reflective discussion about underrepresented groups having better wellbeing and/or outcomes in these studies, and why they might have experienced higher attrition. Additionally, none mentioned the potential existence of culture-specific strengths associated with resilience.

A reflexive thematic analysis of interviews with Māori whānau who engaged with Te Kahu Tōī Intensive Wraparound Service

The second study presented in the thesis was a reflexive thematic analysis of interviews with Māori whānau who had been engaged with TKT IWS for at least six months. It explored their experiences of engaging with TKT IWS and raising children/youth with HCN. The stories caregivers told emphasised the prominence of societal dysfunction, injustice, and personal experiences of intersectional adversity. Caregivers described defining aspects of Western society that contributed to pathogenesis and the intersectional difficulties affecting their whānau; resource scarcity, fragmentation of services and communities, and a generalised lack of unity/kotahitanga.

This converges with evidence regarding the societal systemic problems that act as barriers to meaningfully addressing the growing burden of emotional behavioural issues in youth (B. D. Miller et al., 2012; Patel et al., 2007b; Stroul et al., 2018; Szasz, 2009). It also aligns with the Conservation of Resources (CoR) theory, which posits that many families live in chronically dire circumstances characterised by intersectional disadvantages that are externally imposed, interrelated, and often inherited. For these families, their resources are entirely consumed by their efforts to stay afloat, making it incredibly difficult to improve their circumstances and quality of life (Hobfoll, 2012).

Society, authorities, institutions, and services within the health, education, and welfare sector were typically experienced as unwilling and/or unable to provide effective support. Mainstream education providers were experienced as hostile environments for children, youth and whānau with HCN; they were often ill-equipped and therefore unable and unwilling to support and include them. Hence, contexts and services that are often framed as protective and supportive actually exacerbated families' difficulties and contributed to pathogenesis.

Lengthy periods of school exclusion with little support were ubiquitous, increasing the demands and stress families were experiencing, which were already unsustainable. Exclusion and negative experiences within the educational, welfare, and health systems exacerbated their difficulties and further isolated children/youth and their whānau.

Children and youth were often placed in alternative education and residential settings. These settings were often more able to meet the needs of whānau and children/youth with HCN than mainstream settings and relieved stress and pressure on whānau systems. However, placement of Māori children and youth into specialist settings where they are separated from their natural supports, communities, and culture is not a sustainable or ethical solution, particularly in consideration of the evidence demonstrating poor long-term outcomes of those in alternative education (Education Review Office, 2023). The overrepresentation of Māori in alternative education and school exclusion is a continuation of colonial harm, institutional racism, and discrimination (Agnew et al., 2022; Education Review Office, 2023).

The burden associated with HCN was disproportionately carried by affected children/youth and their caregivers, who described a severe lack of systemic support. Their stories implied that education, health, and welfare providers are often not fulfilling their intended duty or meeting their legal and/or human rights obligations, a finding that is supported in the literature (Community Law, 2024; McElvaney & Tatlow-Golden, 2016; Education Review Office, 2021; Bill of Rights Act 1990, 2013; Human Rights Act, 1993; Ministry of Education, 2020; United Nations General Assembly, 1948). Caregivers described service providers as overburdened, under resourced, and undersupported themselves, due to also being embedded within and constrained by the dysfunctional, individualistic societal system.

Caregivers described important aspects of their cultural identity, expression, and experiences. They described values and practices associated with te ao Māori, including ways of relating, understanding and conceptualising, and seeking/sustaining wellbeing. The importance of kotahitanga and collectivism permeated their stories and shaped their conceptualisation of problems and solutions. This often led to conflict or disharmony between services (who tended to have more individualistic, pathological conceptualisations of the issue) and whānau regarding the nature of the problem and the appropriate solution. This disconnect was a core trend throughout the RTA.

The importance and power of partnership and collaboration was emphasised strongly throughout caregivers' stories, aligning with principles of te Tiriti. In contrast to many services caregivers had interacted with, TKT IWS was experienced as genuinely able and willing to support them. Underpinning service delivery was a collectivist philosophy and approach that aligned with whānau perspectives and was consistently demonstrated through factors such as genuine and persistent commitment to partnership. Engaging in a genuine supportive, reciprocal partnership with a service was a healing and empowering experience for caregivers and resulted in improved functioning and quality of life for children, youth and whānau in numerous ways that were meaningful to them.

Relational and pragmatic aspects of TKT IWS facilitated partnership. The flexible funding offered by TKT IWS was a significant part of this; a very literal example of putting your money where your mouth is. TKT IWS increased access to resources in a responsive, tailored way that was empowering, increasing autonomy and self-efficacy. The availability of instrumental and material support as well as informational and emotional support increased caregivers' sense of TKT IWS's integrity. Prioritising partnership, reciprocity, and unconditional positive regard in all aspects of service delivery (even bureaucratic and administrative processes) fostered whanaungatanga, trust, and a positive partnership in alignment with te ao Māori and well-established concepts of therapeutic alliance which is the most predictive factor in generating positive change through intervention (Yao, 2023).

However, a fundamental limitation of TKT IWS was described. TKT IWS approximates collectivist care, and in doing so, provides a service that whānau described as highly effective. However, it is still restricted by an individualistic, capitalist society that does not support collective wellbeing or long-term, systemic change. Participants' critiques of TKT IWS tended to relate to how the service was shaped and constrained by the wider pathogenic social context.

Lapses in partnership, staff turnover, and premature non-collaborative discharge with insufficient transition support were challenging, which converged with the results of an evaluation of Wraparound by Painter et al. (2011). Caregivers expressed serious concern about what would happen to them after discharge due to chronically adverse conditions and a lack of sufficiently resourced natural supports within their communities. This finding replicated observations made by Gammon (2018) who described that the transition phase of Wraparound is often rated lowest, as families do not feel ready to move on. This strengthens the fundamental collective assertion of whānau in the RTA, and this thesis – that systemic problems in our society, beyond the remit of any one service or field of practice, generate and maintain problems experienced by children, youth, and whānau.

To conclude, TKT IWS provided a valued, relationship-based support system that aligned with collectivist values, offering whānau much-needed relief within an individualistic society. However, its impact was constrained by the broader systemic issues it aimed to navigate. Sustainable change requires a societal shift towards collective, community-centred approaches, enabling services like TKT IWS to operate more effectively in the long term and strengthening social environments to be more conducive to wellbeing.

A quantitative analysis of outcomes for children and youth who engaged with Te Kahu Tōī Intensive Wraparound Service

The third study examined quantitative outcome data for a cohort of children, youth and families engaged with TKT IWS for one year. A longitudinal single cohort design compared measures taken at baseline and after one year. Results demonstrated that the mean decrease in total CAFAS scores from baseline to one year was statistically and clinically significant, likely representing increased functioning and decreased impairment. According to CAFAS scoring, the degree of change demonstrated translates to a reduction in level of required support, reducing the need for intensive multisystemic involvement. The effect size was large and bigger than most found in Wraparound evaluation studies (Bruns & Sather, 2008; Bruns & Suter, 2010; Olson et al., 2021; Painter, 2012) but the precision and generalisability of the effect size should be interpreted with caution given the small sample size. It is possible that the large effect size may also be influenced by TKT IWS's practice of monitoring and ensuring fidelity to the Wraparound practice model, and the high representation of racial ethnic minoritised youth in the population, both of which are factors associated with increased effect size in the literature (Olson et al., 2021).

There was a slight increase in the number of children and youth in residential placement after a year of engagement. This contradicts the usual finding that Wraparound tends to demonstrate highest effect sizes for reducing residential restrictiveness (Olson et al., 2021; Suter & Bruns, 2009). It is important to note that at the time of this study, TKT IWS was the only pathway through which residential schools could be accessed in Aotearoa, which has since changed (R.

Etheredge, TKT IWS psychologist, personal communication, December 9, 2024). Additionally, residential education facilities are not a core feature of the government's strategy to support children and youth with HCN in Aotearoa in the way they have been in other nations and are typically only accessible in exceptional circumstances. The number of residential beds available across educational, justice, social and mental health services are relatively low. Hence, it would be unreasonable to expect similar reductions in residential placement observed in other nations as a result of Wraparound (R. Etheredge, TKT IWS psychologist, personal communication, December 9, 2024). However, it is important to note the substantial impact of placement in residential care facilities for children, youth and whānau who experience it, as well as the overrepresentation of Māori children and youth in those statistics. Increases in the restrictiveness of settings and removal from one's community contradicts the core philosophy and aims of the Wraparound Process (Bruns & Walker, 2004) and community-based support should always be prioritised.

Caregiver resource and problem scores largely stayed the same; indicating that there was little change in home circumstances and the relevant resources that caregivers possessed according to clinician scoring. Although the statistical significance of the difference between caregiver resources from baseline to one year could not be analysed in the quantitative study, the lack of observed change for most of the sample is of concern given it is an area that should be targeted by Wraparound and has significant associations with children and youths' difficulties, intervention engagement, and outcomes (Cook & Kilmer, 2010; Kilmer et al., 2010; Marcenko et al., 2001; Pullmann et al., 2010; The Intensive Wraparound Service: Te Kahu Tōī, 2016). This notion was corroborated by caregivers in the qualitative study, who expressed concern about the finite nature of TKT IWS involvement and the lack of resources and support they would have when discharged.

Educational engagement and achievement remained low for majority of sample after a year of engagement, suggesting that TKT IWS engagement did not generate normative levels of inclusion, participation and achievement in the educational system. However, the tool used to measure educational outcomes had clear flaws and this should be examined further. Systematic review of the

Wraparound Process has demonstrated medium-sized effects favouring Wraparound for improvements in educational functioning, indicating that generally the Wraparound Process is effective in increasing educational outcomes (Olson et al. 2021). Further research should explore the effects of TKT IWS on educational functioning and identify barriers to normative levels of inclusion, participation and achievement.

The correlation between scores on the CAFAS and the IWS Life Predictors Form designed by TKT IWS suggest that they are measuring related phenomena and the IWS Life Predictors Form designed by TKT IWS is capturing meaningful change. All of the measurement tools were quantitative and clinician rated. None were cross-culturally validated or normed. The measures were individualistically focussed and emphasised conformity and compliance to Western norms and values.

In conclusion, the results of this study indicated that the Wraparound Process as delivered by TKT IWS was associated with significant positive change in terms of emotional behavioural functioning. However, it was unclear from this study whether there were any beneficial outcomes in terms of educational and caregiver functioning/home circumstances. It also seemed that there was a small increase in out of home placements.

Implications

This thesis highlights significant systemic issues affecting Māori children, youth and whānau with HCN and engaging with services like TKT IWS. The findings reinforce the urgent need for systemic change to ensure services align with collectivist values and uphold the obligations of te Tiriti o Waitangi. The findings of both the RTA and the quantitative study indicate that the Wraparound Process is an effective service delivery modality with which to meet the needs of diverse children and youth with HCN in Aotearoa, including Māori whānau. Results from both studies demonstrated evidence of increased functioning and decreased impairment. The two studies were conducted separately, with different samples, and utilised disparate analytical methods and approaches. The convergence of the results therefore strengthens their validity, demonstrating that the effectiveness of the Wraparound Process as delivered by TKT IWS is evident through different methodical lenses (Evans et al., 2014).

These findings add to a growing evidence base which demonstrates how the Wraparound Process can be effectively used across diverse populations in a manner that produces equitable outcomes (Kendziora et al., 2001; Kirkwood, 2014; Lightfoot et al., 2024; Palmer et al., 2011b; Werrbach et al., 2013). The systemic philosophy of Wraparound aligns with global recommendations and evidence regarding best practice approaches to addressing social, emotional and behavioural difficulties in children and youth (Malla et al., 2018; Stroul et al., 2018).

Importantly, the findings also indicate that the Wraparound Process as delivered by TKT IWS is an approach that naturally aligns with te Tiriti, embodies partnership, aligns with the perspectives and needs of whānau, and may be useful in combatting inequitable experiences and outcomes for Māori children, youth and whānau with HCN in Aotearoa. This aligns with emerging evidence about the use of Wraparound with Māori populations (Kirkwood, 2014; Tamihere, 2015) and contributes to a growing body of evidence supporting the use of the Wraparound Process with diverse cultural identities globally (Lightfoot et al., 2024; Olson et al., 2021; Palmer et al., 2011b). Furthermore, it emphasises the value of culturally aligned, collectivist support models. TKT IWS was described in the RTA as a rare example of a service that genuinely partnered with whānau, demonstrating a collectivist, relationship-based approach. This was experienced as empowering, healing, and effective, reinforcing the importance of services aligning with Māori values such as kotahitanga, whanaungatanga, and tino rangatiratanga. The experiences of whānau powerfully emphasise the importance of service design and delivery that centres Māori perspectives, collective responsibility, and relational approaches rather than continuing to impose individualistic, deficit-based models

The personal experiences described by caregivers' sheds light on the lived reality of Māori whānau raising children and youth with HCN. Staying afloat within a society that fosters inequity, and engenders scarcity of resources, support, and opportunities is incredibly difficult. Caregivers' stories demonstrated how scarcity disproportionately disadvantages minoritised and marginalised groups, generating interlocking matrixes of disadvantage and perpetuating systemic discrimination and inequity. Lacking support is both an adversity and makes it harder to cope with adversity. Social belonging, support, and inclusion is critically important for children and youth but also for the whānau that support them. Caregivers described feeling repeatedly abandoned and rejected within society, which left them untethered, lost, and hopeless at times, despite their commitment and determination to improving their circumstances. It is important too, to emphasise the resilience, persistence, and skilfulness of caregivers and whānau that was clearly evident in their management of chronically and extremely difficult circumstances.

The entrapment and lack of autonomy caregivers described is deeply concerning. Caregivers' experiences of being overburdened and under supported draws attention to the pressing need for systemic and theoretical reform with intersectionality, relationality, and shared responsibility at the centre of change. Collaborative, proactive, community-based actions need to be taken to ensure families and communities are adequately resourced and empowered to live well. It is important to note that addressing income inequality and resource deprivation should be a priority for all, not just the disadvantaged, due to its diffuse negative impacts. Social and income inequality has a negative impact on population health worldwide and is associated with higher rates of mortality (Dorling et al., 2007). Income inequality is representative of a social climate of competition rather than co-operation. Even in countries where relative deprivation may not directly and imminently threaten life (e.g. through malnutrition, poor sanitation, and lack of shelter), the detrimental physiological consequences of chronic psychosocial stress incited by competitive hierarchical societies are well-evidenced. The relationship between income inequality and health extends to social problems such as violence, conflict, and incarceration (Pickett & Wilkinson, 2015). The evidence that inequality has deleterious health and social consequences is robust and further strengthened by this thesis. Any actions by governments to oppose or impede interventions and legislation that target inequity by increasing access to essential resources for disadvantaged groups (e.g. Ka Ora, Ka Ako, the Healthy School Lunch Programme in Aotearoa; (Garton et al., 2024) should be seen as and challenged for what they are according to evidence; a direct threat to our collective wellbeing, harmony, and happiness.

As described in the introduction, socioemotional difficulties in children and youth often have a chronic course if effective intervention does not occur in a timely manner. This comes at a great cost (economically, socially, emotionally, and in terms of health) not only for affected children, youth and whānau but also the nested systems they are situated within and interact with. Results emphasised how addressing structural barriers and systemic inequities is a critical endeavour to address HCN and unmet emotional behavioural needs in children and youth. While the Wraparound Process may be resource intensive in the short-term, there is a clear rationale for increasing the adoption and availability of high-quality Wraparound services. As the RTA demonstrated, Wraparound can address HCN in a systemic manner and mitigate systemic barriers. Effective intervention can break the cycle of chronically unmet needs, reducing long-term reliance on multiple services and alleviating economic, emotional, functional, and social burdens on individuals, whānau, services, and systems.

Strengthening preventative and early intervention pathways is a crucial part of establishing effective systems of care. Whānau described how high eligibility thresholds and crisis-driven intervention models resulted in children and youth only receiving support once their difficulties had escalated to extreme levels. This was widely regarded as a missed opportunity to prevent worsening challenges.

Despite its strengths, TKT IWS was still constrained by the wider sociocultural ecosystem and sometimes perpetuated problematic norms. Caregivers expressed concerns about the short-term nature of support, difficulties accessing the service, and the lack of sustained transition support after discharge. These concerns highlight the need for long-term, community-based systems of care that ensure ongoing access to support (whether formal or informal) beyond time-limited interventions.

There was little improvement in caregiver resource scores over the year of engagement with TKT IWS for participants in the quantitative study. Similarly, caregivers in the qualitative study expressed concerns about premature discharge and a lack of sufficient support in their community after discharge. This suggests that many caregivers still felt (or were judged by clinicians to be) lacking necessary resources to support their child/youth. Given the well-established contribution of caregiver resources and familial factors in shaping youth development, it is of critical importance that these factors are considered and addressed by interventions serving children and youth. This is particularly pertinent for Wraparound, as holistic family support is a core tenet of the practice model (Bruns & Walker, 2008).

The scoping review in the current project also found natural supports tended to be a principle that was often relatively neglected by Wraparound interventions or inadequately adhered to. This may reflect the influence of the individualist Western cultural paradigm which underemphasises the crucial contribution of social connection, relationships, and harmony to general wellbeing. Doing so also may reduce fear about discharge and the perception of being insufficiently resourced post-discharge. However, systems of care such as the Wraparound Process can only mobilise resources that exist in the local community. It is reasonable to hypothesise that it may be difficult for any intervention, no matter how well delivered and designed, to sustainably improve access to community resources and natural supports within a social system that does not foster or sustain abundant relational support or community-based resources.

Similarly, a core intention and principle of the Wraparound Process is to deliver services and meet needs in a manner that minimises the restrictiveness of settings and maximises community integration. Typically, Wraparound interventions are reasonably successful at achieving this and tend to demonstrate the largest effect sizes in residential restrictiveness outcomes (Olson et al., 2021; Suter & Bruns, 2009). However, there was a small increase in out of home settings for children and youth engaged with TKT IWS in both the quantitative and qualitative studies. Typically, these placements were part of the services facilitated by TKT IWS. Caregivers stories suggested that outside of these specialist facilities, it was incredibly difficult if not impossible to 1) access sufficient support to safely manage their child/youth at home and/or 2) access educational environments that were willing and able to include their child/youth and meet their needs. Again, this emphasises the dire lack of available, adequate supports and services Wraparound and other systems of care are realistically able to draw on.

Mainstream education was experienced as a hostile environment for many children and youth with HCN, and school exclusion was a common and harmful outcome. The quantitative study demonstrated that the majority of the sample demonstrated poor educational attendance, participation, and achievement after a year of engagement with TKT IWS. It is unclear why and to what extent they may or may not have improved, as there was no baseline measure taken for educational engagement. Regardless, a year of TKT IWS service provision was not resulting in normative educational engagement. This implies that systemic barriers in the educational system exist that TKT IWS was not able to overcome. The overrepresentation of Māori children and youth in alternative education and exclusion pathways constitutes ongoing institutional racism and colonial harm. Systemic efforts must be made to ensure mainstream education is truly inclusive, with appropriate adaptations, resources, and supports in place to prevent exclusion and promote success for all learners.

Commonly used measures including some used in the quantitative study imply that educational settings are unquestionably prosocial, positive environments. By this reasoning, any issues that manifest there are reflective of problems located within the child and their family, not the school environment. A significant evidence base, supported by the current thesis, indicates that in actuality, mainstream educational settings and systems can be pathogenic environments that cause harm and perpetuate inequity through institutional discrimination. Disabled, HCN, and racial ethnic minoritised children and youth are disproportionately excluded, ostracised, and discriminated against in mainstream education (Agnew et al., 2022; Macleod & Munn, 2004; Noguera, 2003). Marginalised children and youth are often labelled as SEBD early in their academic career which becomes a self-fulfilling prophecy, resulting in increased monitoring and punitive treatment, and negative experiences at school that shape students perceptions of themselves and their potential

(Noguera, 2003). Negative experiences in the educational system, particularly involuntary exclusion and placement into alternative education settings is a formative and powerful predictor of a host of negative long-term outcomes (Education Review Office, 2023; Gazeley, 2010; Noguera, 2003; Tejerina-Arreal et al., 2020). This is particularly important for Māori children and youth (Education Review Office, 2023). Prioritising inclusion in mainstream education and ensuring providers have sufficient resourcing to do so is crucial.

Recommendations

This section will first cover recommendations specific to TKT IWS. It will then go on to explore general recommendations generated from the findings of the current thesis.

Recommendations for Te Kahu Tōī Intensive Wraparound Service

The first set of recommendations for TKT IWS relate to measurement of outcomes, impairment, functioning, and progress. It would be useful to administer the measure of educational engagement and achievement at baseline as well as at one year and discharge, so that the degree of change can be evaluated. As part of TKT IWS measurement of progress and outcomes, they also rate individualised Wraparound goals developed by children, youth and whānau in collaboration with their Wraparound team. Future research should explore these outcomes as they are likely to be more meaningful indicators of success and progress to whānau than standardised psychometric measures, clinician judgement, and administrative data. TKT IWS also collaborated with Sonja Macfarlane to develop strategies and measurements for their service based on Kaupapa Māori approaches to education and supporting students with HCN (The Ministry of Education, 2020). Exploring outcomes and intervention experiences as defined and measured by these specific tools would be especially useful in relation to ethical measurement and reporting of Māori whānau outcomes. Future selection and utilisation of outcome and progress measurement methods should prioritise cross-culturally relevant and systemic conceptualisations of difficulties, progress, treatment completion, and success, which examine contextual factors that may contribute to the child or youth’s difficulties. It would also be useful to engage children and youth more in outcome measurement and evaluation of the intervention. This was identified as an area for improvement in TKT IWS service delivery in 2018 (Gammon, 2018), and in a wider sense is an ongoing difficulty in both research and practice (Giodarno et al., 2023c) but is of critical importance given the discrepancies often observed between caregiver and child/youth reports issues (Bonadio et al., 2022).

Concerns and recommendations regarding progress and outcome measurement were discussed with TKT IWS, who expressed interest in both seeking cultural consultation to validate the IWS Life Predictor measure and diversifying assessment methods. In particular, increasing the use of the *Journey to Tino Rangatiratanga* (JTTR) tool (The Ministry of Education, 2020) was identified as a meaningful way to capture outcomes and changes from a whānau perspective. TKT IWS staff have already received training in this kaupapa Māori case management and outcome measurement tool, and its integration could provide a more culturally responsive approach. However, the challenge remains in balancing government expectations for statistical change with the need for measures that genuinely reflect whānau experiences - an issue best explored in collaboration with experts in kaupapa Māori measurement.

The Wraparound Process practice model is designed to increase caregiver resources, improve home situations, and prevent or reduce placement in restrictive settings. This is particularly important given the abundance of research demonstrating how increasing caregiver resources and strengthening healthy connections within families and their communities improves parenting, family functioning, caregiver wellbeing and and is associated with positive youth development. Of note, this research emphasises ensuring the caregivers and whānau themselves are embedded within supportive networks and feel well-resourced (Armstrong et al., 2005; Lerner et al., 2002). If the intervention is not achieving those outcomes, it is important to identify why. CAFAS scores suggested that there may not be significant change in caregiver resources, though this could be due to biases inherent to the scoring process. Caregiver resources should be further investigated in a more sensitive and thorough manner. It would be useful to identify what the unmet needs are, and why they might persist despite TKT IWS support. As previously stated, this may be due to the influence of systemic issues and disadvantage that is difficult for a single service such as TKT IWS to address. However, it is important to generate this knowledge to advocate for change, and there may be useful actions that TKT IWS could take. This recommendation aligns with previous findings and recommendations by Gammon (2018) in a fidelity review of TKT IWS. At that time, it was identified that use of natural supports should be improved, and transition planning strengthened. Research should also investigate patterns of placements into residential and alternative education settings during engagement with TKT IWS. It would be useful to explore further what specific factors are being met for children, youth, and whānau in residential and alternative education settings that are not able to be met in mainstream, and why.

Results of the current project suggest that factors such as whanaungatanga, relational attunement, acceptance, inclusion, belonging, and care may be important. This aligns with previous findings that have shown that the need for belonging, safety, and care is disproportionately unmet for Māori students in mainstream education settings (Agnew et al., 2022) and that that Māori are often more engaged in alternative settings, have less behavioural difficulties, and describe feeling cared for and less lonely (Education Review Office., 2023). Because placement in alternative education settings is still associated with far poorer outcomes long-term generally and for Māori children and youth, it is important that significant efforts are undertaken to ensure that mainstream settings meet the needs of Māori children and youth and do not operate in a discriminatory manner.

The problems caregivers described in their engagement with TKT IWS should be examined, reflected upon, and addressed. The most prominent issues related to process and bureaucracy: it took too long to get support; relevant services and community providers had little knowledge of TKT IWS; the eligibility criteria and application processes were convoluted and confusing; there seemed to be staffing issues which resulted in frequent turnover impeding whanaungatanga, partnership, and continuity of care; the funding process was inefficient and for some caregivers implied a lack of trust and reciprocity. There were also lapses in partnerships and instances where caregivers felt invalidated, unheard, or misunderstood.

The eligibility criteria requires complex exhaustion of local services. This contributes to the accumulation of significant harm and negative support experiences over long periods as whānau attempt to engage with various services that cannot meet their needs. This exacerbates difficulties and increases stress significantly. Perhaps there could be another way of recognising HCN that could streamline access to ensure adequate support is extended faster. Ultimately, this would be more cost effective and likely reduce the length and complexity of service involvement needed.

The Education Review Office (2023) recommended that services for children and youth in Aotearoa should focus on preventing exclusion from mainstream, and increasing early identification and responsivity, funding and resourcing, flexibility and choice, consistency and clarity of eligibility criteria, partnership with whānau, inter-agency co-ordination and support, accountability of providers, and availability of Kaupapa Māori approaches. The Wraparound Process as provided by TKT IWS demonstrated adherence to many of these recommendations. Considering the results of the current project, future endeavours within TKT IWS (and in collaboration with other relevant providers) should prioritise: preventing exclusion and retaining children and youth in mainstream; intervening earlier and preventing harm; improving the efficiency and clarity of the services eligibility, admission, and flexible funding processes; and incorporating, collaborating with, or offering Kaupapa Māori services and approaches.

Future research should also investigate the lack of change in caregiver resources according to the CAFAS, and the reasons for increases in and use of residential placements. This would require a bigger sample size which would permit robust analysis of the equity of outcomes across gender and cultural identities, and the significance of the change or lack of in caregiver resources and residential placement. Collecting follow-up outcomes a year or more after discharge would also be helpful in acquiring data about the stability of outcomes.

General recommendations

In light of the results of the current research project, increased investment and provision of the Wraparound Process is recommended; for children, youth and whānau with HCN in Aotearoa and more broadly across diverse contexts and populations. It is important that these interventions are designed and delivered in a way that is attuned and responsive to the contexts and needs of the specific population being served. The development and implementation of holistic, integrated, equitable systems of care for children, youth and families is critical given the magnitude and chronicity of inequitable service experiences, outcomes, and unmet emotional behavioural needs in youth. Partnership should permeate all levels and aspects of service design and delivery, including bureaucratic processes such as those determining eligibility, access, and flexible funding. A strong focus on whakawhanaungatanga, relational safety, trust, and goodwill is critical to effective service delivery and partnership with Māori whānau.

Malla et al. (2018) provided a useful set of guidelines for the reform, development, and implementation of adequate and appropriate services for children and youth with unmet needs based on international evidence. These guidelines asserted that services should be: specifically designed for target populations and their intersecting needs; sensitive to cultural, historical, and local context; utilise evidence-based approaches while also centring service user preferences; easily accessed by youth and families; and well-connected vertically and horizontally to other relevant services, authorities, and institutions. The Wraparound Process is a framework that aligns with these principles and TKT IWS's delivery met many of these criteria, although difficulty accessing their services was an area of concern.

However, it is important to acknowledge that increased development and implementation of holistic systems of care is a recommendation situated within a societal system that is not especially conducive to its actualisation. The very factors that inspired the conception of systems of care and the Wraparound Process are the same factors that ultimately continue to inhibit them. The Wraparound Process identifies, mobilises, and coordinates relevant services and resources. As outlined by Burchard et al. (2003) one of the necessary conditions of Wraparound is system and community support. Wraparound interventions require that adequate, relevant, and functional services and resources exist and are accessible within the local community. This simply is not the reality for many communities within a modern capitalist society.

Obviously, this is a monolithic problem which is intimidating to confront. However, the problems we face as a society will only continue to worsen until we take to the roots. Conceptualisations and solutions to problems that only focus on individual factors and neglect to consider and address systemic factors are inevitably inadequate (Macleod & Munn, 2004) and public health initiatives that selectively focus on individual and cultural risk factors to explain disparities are condescending, paternalistic, reductivist, and ultimately pathogenic (Nkansah-Amankra et al. 2013).

I certainly do not claim or hope to have all the answers, but I do exist within a vast relational global network made up of wise and skilful people and communities, all of whom I am sure hold parts of the solution. Structural aspects of Western society and systems clearly perpetuate inequity and limit available resources for systems of care and families (particularly those of marginalised identities) to draw from. By upholding Eurocentric belief systems as objective and superior, the dominant Western paradigm subversively sanctions power hierarchies that subjugate non-dominant groups. It is not a societal context that fosters the necessary conditions for holistic, effective service provision.

Despite the emphasis on personal gain in modern capitalist society, research has demonstrated inequity harms us all, regardless of our social standing. Humans are, after all, social animals who have evolved to live in co-operative, harmonious social contexts. Communities characterised by chronic competition, scarcity, social fragmentation, and individualism harm us all (Pickett & Wilkinson, 2007, 2015). Therefore, inequity is a problem that belongs to everyone. Acknowledging and addressing its causes is a duty that belongs to everyone too and is especially relevant when considering the design and implementation of services for children, youth and whānau with HCN.

A system reform is required, driven by decolonisation, and requiring ongoing societal engagement. Such an immense paradigmatic shift requires persistent commitment and action within and between all levels in society; government, academia, practice sectors, service providers, community networks, families, and individuals. Ongoing prioritisation of equitable policies and allocation of resources is crucial. Choice, empowerment, and autonomy, which are critical components of recovery and wellbeing (Chirkov et al., 2011) can only exist within an environment where actual choices are available.

System reform is a task beyond the remit of TKT IWS or any one service provider and/or practice sector. However, researchers, service providers, and practitioners must reflect on what part they can play in challenging inequity and contributing to positive system reform. Development and normalisation of personal and professional reflexivity processes in research and practice that increase awareness of positionality, biases, and epistemological leanings is foundational to decolonisation of academia and service delivery. Engaging in personal decolonisation processes as researchers and practitioners can then permeate and shape the contexts in which we relate and have influence, normalising reflexivity and divestment from the dominant paradigm.

Personal decolonisation and reflexivity practices are not prescriptive processes, nor something that can be captured or ticked off by a checklist or a short training module. Resources such as those on allyship by Jen Margaret, a te Tiriti educator and researcher (Margaret, 2010c, 2010b, 2010a), and Diana Amundsen's piece on decolonisation through the role of Pākehā identity (Amundsen, 2018) are useful places to start for Pākehā and Tāngata Tiriti in Aotearoa. More generally, engaging with Indigenous, cross-cultural, and decolonising paradigms, frameworks, and approaches is crucial to expand one's own worldview and become more aware of one's own positionality (e.g. Braun et al., 2014; Thambinathan & Kinsella, 2021; Tuhiwai Smith, 2021c; Wilson, 2008b).

Research and service provision are potent contexts for decolonisation and social justice to incite positive social change. For example, caregivers in the current project described instances where TKT IWS staff used their professional positioning and privileges to advocate for whānau, help them navigate complex systems and hold other providers accountable. Providing navigation and advocacy within systems that can be discriminatory is a powerfully beneficial action that service providers can and should take. Supporting this notion, legislation and codes of conduct/ethics often mandate the demonstration of social justice, responsibility, and advocacy in professional roles (Came et al., 2020; Code of Ethics Review Group, 2012; Pitama et al., 2017; Ramsden et al., n.d.).

Decolonisation and the pursuit of social justice and equity is a professional responsibility of academics and practitioners in the social and health sectors. We should therefore acknowledge and use our power and privilege to decentre the Eurocentric paradigm and pursue epistemological equity in research and practice (Dei, 2008; Thambinathan & Kinsella, 2021). Epistemological equity refers to the treatment of diverse cultural knowledge systems as equal in value, importance, and legitimacy. To achieve epistemological equity, we need to critically examine and change the ways that society and power structures perpetuate inequity, and how we may be complicit in these processes. Diverse epistemologies and frameworks need to be brought into mainstream discourse, with conscious awareness and curiosity about how Eurocentrism permeates academia and scientific theory and practice, shaping what we consider to be legitimate in terms of evidence, practice, and knowledge. Increasing diverse cultural representation within academia and service provision is critical to privilege diverse perspectives and approaches. The results of this can be overwhelmingly positive; culture-based Wraparound initiatives are best practice for children and youth of colour with HCN, demonstrating higher ratings of cultural sensitivity and service satisfaction compared to usual system of care interventions, while retaining high fidelity to the Wraparound practice model (Palmer et al. 2011). Culture-based interventions also uphold Tiriti obligations by centring tino rangatiraranga/self-determination.

Critical analysis of the conceptualisations and measurement of wellbeing, pathology, social-emotional behavioural difficulties, and success needs to be prioritised in research and practice. Typically, conceptualisations and measurement of outcomes tend to be reductivist, impersonal, and emphasise conformity to Eurocentric ideals. The outcomes and problems targeted by interventions are often determined and defined by professional bodies and funding authorities and are therefore reflective of their needs, perspectives, and interests, rather than those of service users, children, youth and whānau. They are rarely cross-culturally relevant and tend to underprivilege the voices and perspectives of children, youth, service users, and marginalised groups. As stated by Palmer et al. (2011) while accountability to relevant agencies and funding authorities is important, primary accountability should be to the community served.

Definitions and measurement of problems, wellbeing, and target outcomes should therefore be informed by service users as well as practitioners, researchers, and service providers. Outcome evaluation should utilise various methods and types of data collection and evaluation that privilege service user perspectives. Upholding the voices and perspectives of children and youth is especially important given their underrepresentation in health research (Giodarno et al., 2023b).

Critical analysis of existing measurement strategies and tools needs to occur alongside the development and implementation of culturally relevant, collaborative measurement tools. A prerequisite to this is the development and adoption of culturally and personally relevant definitions of wellbeing and success which are informed by the perspectives of those whose wellbeing is being evaluated. Academic and professional conceptualisations of wellbeing and success inform the definition and measurement of desired outcomes and shape societal attitudes, beliefs, systems, and services. Currently, conceptualisations and measurements of wellbeing and outcomes are largely bound within the dominant Western paradigm and contingent on conformity to prescribed norms, therefore perpetuating inequity. As demonstrated in the qualitative study, caregivers described not only a reduction of symptoms and increased functioning captured in a manner captured by psychometrics, but also various positive familial, systemic, cultural, and spiritual phenomena that need to be acknowledged as valid and important indicators of increased wellbeing and quality of life.

To mitigate biases and increase the utility of data collected, outcome evaluation should utilise different types of data and involve input from children, youth and whānau as well as practitioners and service providers. Kaupapa Māori measurement and case management strategies are valuable tools in the pursuit of a partnered/*braided rivers* approach to Wraparound which weaves together wisdom from Western and Indigenous knowledge systems.

Culture-based measurement and case management strategies should be adopted wherever possible (Duckworth et al., 2021; Macfarlane, 2009, 2012). In a conversation about cultural competence within the Wraparound Process and in alignment with publications about culture-based Wraparound (Palmer et al., 2011a), John VanDenBerg explained that in order to be culturally competent, a Wraparound approach should be designed by the people, for the people, to fit the people. It is not an approach that should be designed and then adapted afterwards to be culturally competent. Furthermore, he stated that outcomes should also be defined by service users (personal communication, April 4, 2023). It is critical that Kaupapa Māori methods, led by Māori researchers and practitioners are adopted in both research and practice when evaluating and delivering interventions and services that serve Māori populations. Kaupapa Māori approaches are essential in the pursuit of equitable systems of care in Aotearoa. Although some Kaupapa research exists about the Wraparound process (Kirkwood, 2014; Tamihere, 2015), this is an area where continued Kaupapa research would be of great value, particularly in terms of the potential to deliver high quality Wraparound in a culture-based manner within Te ao Māori.

As outlined by Chorpita et al. (2011) the disproportionate emphasis on knowledge proliferation and scientific legitimisation of therapeutic interventions for children and youth (as defined by rigid Eurocentric standards of efficacy and replicability) has been impressive in terms of innovation and effort but ultimately has not been helpful in an applied sense. We possess an inordinate amount of knowledge, but we are limited by our inability to effectively synthesise and apply it. It is neglectful to continue designing and delivering manualised, impersonal interventions that produce desired results in perfectly controlled conditions but have limited utility and flexibility in the real world, with real people. Social, emotional, and behavioural problems (especially those referred to by the HCN label) are complex, systemic, relational phenomena. Therefore, effective interventions and solutions must also be systemic and relational, targeting multiple contributory mechanisms. Applied effectiveness is almost undeniably more important than efficacy derived from strictly controlled randomised control trials that typically target a singular problem. The scoping review in this thesis demonstrated how variable and complex the needs, contexts, resources, and target problems are across contexts where the Wraparound Process is delivered. In the qualitative study, Māori whānau revealed the complex, intersectional nature of their difficulties and unmet needs. The results of studies in this thesis therefore align with Silva et al.'s (2020) recommendation that the Wraparound Process is evaluated through a systems lens that does not centre efficacy, but rather, examines interventions' responsivity and effectiveness in relation to relevant communities, organisations, and systems.

The relative neglect of systemic, relationally centred knowledge and practice in academia, science, and service delivery is reflective of the ubiquity of Eurocentrism. It is true that when a problem is systemic and relational, it is more complex to understand, communicate, and address. Similarly, when solutions and interventions are systemic and relational, they are more complex to design, evaluate, implement, and generalise. However, the problems that individuals, families, communities, and societies face are inherently and unavoidably complex. Interacting, difficult to observe dynamics generate overlapping problems such as HCN, SEBD, high rates of unmet mental health needs, dysfunctional overburdened healthcare and social sectors, and inequity. In order to be successful in addressing these problems, research and service delivery needs to identify and target interacting factors and generative systemic mechanisms (Bronfenbrenner, 1977; Macleod & Munn, 2004; Nkansah-Amankra et al., 2013).

The Western paradigm tends to underprivilege relationality. Relationality is an extraordinarily powerful and legitimate force in service delivery and science. Recognition of the importance of relationality does exist within mainstream research, particularly within the social sciences. Rogerian practice or person-centred therapy provides a framework with which therapists engage in relationally centred work to foster client recovery and healing. Rogerian therapy identifies the therapeutic alliance (the relationship between client and therapist) as the core ingredient for positive change. Rogerian principles such as unconditional positive regard, authenticity, empathic understanding, and being client-led have been identified as crucial ingredients for therapeutic alliance (Yao, 2023).

The therapeutic alliance continues to emerge as the most robust, consistent factor associated with positive outcomes in therapy; far outweighing factors such as clinical experience, techniques and treatments used, supervision, and continued education (Miller et al., 2020; Muran & Barber, 2010). Despite extensive evidence supporting and examining the importance of the therapeutic alliance, research has struggled to quantify core factors that reliably foster alliance (Baldwin et al., 2007; Miller et al., 2020). As Baldwin et al. (2007) stated, each therapist brings their personality, life, and professional experience to every therapeutic relationship. The interaction between therapist factors and client factors shapes the nature and magnitude of the therapeutic alliance between service providers and service users. In short – positive relationships are what most reliably produces positive therapeutic outcomes. For those in fields of research and practice who are trained to distil extraordinarily complex social phenomena down to checklists and operationalised manuals, or focus on very small aspects of complex phenomena, it is frustrating to know that time and time again the difficult-to-define relational alliance between service providers and users is what most reliably produces and facilitates healing. I am reminded of the whakataukī: ‘He aha te mea nui o te ao? He Tāngata! He Tāngata! He Tāngata!’[92] which speaks to the importance of humanity, connection, and relationships. In this context it reminds us that it is not professional qualifications, the latest training or therapeutic model, or the specific techniques that matter most; but rather, the simple yet extraordinary power of meaningful, intentional relationships.

Future research, service delivery initiatives, and system reform should therefore centre relationality. While this is a recommendation that is difficult to define in a generalisable manner, Miller et al. (2020) provide useful guidelines on how to improve therapeutic outcomes as service

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[92] What is the most important thing in the world? It is people! It is people! It is people!

providers through deliberate practice, which prioritises fostering therapeutic alliance, person-centred care, eliciting meaningful outcomes and feedback from service users, and adjusting one's own practice in response. Indigenous and diverse cultural paradigms centre relationality in frameworks of knowledge and practice and need to be recognised as sources of abundant strength, innovation, and wisdom. Through decentring the dominant paradigm and pursuing epistemological equity, we can increase collective wisdom and wellbeing, and ultimately pursue a better, more equitable future for all.

Concluding comments

The current thesis demonstrates that the Wraparound Process, both generally and as delivered by TKT IWS in Aotearoa, is an effective service delivery framework which can meet the needs of culturally diverse children, youth and whānau with HCN. However, it is important to recognise and address the significant systemic barriers to optimal, equitable implementation of the Wraparound Process, through reflexive decolonisation. Systems of care can only operate sustainably and optimally within caring systems. This research project therefore adds to the growing body of evidence strongly calling for systemic societal reform.

I would like to conclude this thesis with an excerpt of an article *Young people get sick from the outside in* by Glenn Colquhoun, a General Practitioner working with young people in Horowhenua who has published work about the role of adverse childhood events (ACEs) in the lives of young people he works with (Colquhoun, 2023):

"I do love us, though. Especially our kids. And I wish you could see how brave they are. How much they want to be loved. I wish I could show you how the ones you might be most afraid of are funny and wise and doing what they are doing because they are somehow fighting back. They'd help you believe. I'm sure of it.

It'd be nice to chew the fat one day. We need help. Our families. Our country. Our histories. Sometimes they make our kids sick. It doesn't have to be that way. It would be good to talk about it a bit more than we do. So many of you have found a way through. I know there is love in you. In all of us. And I know you'd know what to do. I've never met anyone who doesn't". (Colquhoun, 2023)

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Appendix A

Interview guide

1. What did you like the most about the Wraparound Process and why?
2. What was the most important part of the Wraparound Process for you/your whanau?
3. Did you feel that the Wraparound process took into account your family's culture, values, beliefs and perspectives?
    - How so?
4. What could have been better? How would you change it?
5. What was the hardest part/why?
6. How has your life changed?
7. What are the main differences you noticed from other services you have engaged with?
8. How would you describe your overall experience of the Wraparound process?
9. Rate your experience of Intensive Wraparound Services from 1 - 10.
10. That is the end of my questions – is there anything else you would like me to know about you and your whānau?
11. END
12. Transcript form
13. Do you have any questions?
14. How did you find the interview?
15. Thank them, give voucher.

Appendix B

Letter of Support from Cultural Supervisor, Dr. Simon Bennett

MASSEY UNIVERSITY
SCHOOL OF PSYCHOLOGY

11th October 2018

Health and Disability Ethics Committee
Ministry of Health
PO Box 5013
Wellington 6140

Tēnā koutou,

Re: Cultural Consultation – Ms Lucy Lightfoot
Wraparound in Aotearoa: An evaluation of outcomes, validation of a new measure, and an exploration of Maori experiences of Intensive Wraparound Services.

I am writing to confirm that Lucy Lightfoot has sought my cultural advice in preparing her ethics application and developing her research project. I have reviewed a summary of her research, a schedule of interview questions as well as an email outlining her specific cultural considerations in relation to her proposed study. In addition I plan to meet with Lucy in person as part of her cultural consultation process.

Lucy's study will aim to validate the outcome measure used by Ministry of Education's (MoE's) Intensive Wraparound Service (IWS), explore outcomes, and investigate Māori families' experience of IWS. The fact that Lucy is a Pakeha researcher who is undertaking a project involving a specific focus on outcomes for Māori is unusual but by no means unprecedented in the NZ context. In this regard I was very impressed with Lucy's reflections on this aspect of the proposed study. Lucy demonstrated a keen awareness of the power dynamics inherent in the researcher-participant relationship, acknowledgement of her own position of privilege and recognition that having not had a lived experience of *being Māori* could limit the lens through which she views her data. Suffice to say I am comfortable that Lucy has given thorough consideration to the key cultural issues that arise from her proposed study.

It is also pertinent that the project itself comes from a strengths based position. Early indications suggest that Māori youth/families benefit from IWS to a greater extent than non-Māori. The question I would therefore pose is, what is it about IWS that has resulted in this apparent trend? It is likely that Lucy's study will shed some light on the answers to this questions.

I have a close working relationship with Lucy's first supervisor Dr Ruth Gammon and have indicated to both my availability and willingness to have an ongoing consultative role in this project should significant issues arise pertaining to her participants. I have encouraged Lucy to contact me should issues arise during the course of her fieldwork. If you have any questions please do not hesistate to contact me.

Noho ora mai rā,

Simon Bennett, PhD
Ngāti Whakaue, Patu Harakeke, Kati Waewae
Kaimatai Hinengaro Matua: Māori Clinical Psychologist, Senior Lecturer
School of Psychology, Massey University Wellington
DDI: +64 4 979 3609

Appendix C

Information Sheet

Wraparound in Aotearoa: An evaluation of outcomes, validation of a new measure, and an exploration of Māori experiences of Intensive Wraparound Services.

INFORMATION SHEET

Researchers Introductions

Primary Researcher

Kia ora, my name is Lucy Lightfoot and I am a Doctoral Student in the School of Psychology at Massey University in Wellington. I have been studying Psychology for seven years, and I have worked in behavioural therapy and mental health support. I am currently completing my Doctorate of Clinical Psychology in order to become a Registered Clinical Psychologist. I was born in Auckland but grew up in Wellington. I have a strong passion for the wellbeing of New Zealand youth and their families, and I greatly enjoy working with young people. I am supervised by Dr. Ruth Gammon, a Senior Lecturer, and the Director of the Psychology Clinic at Massey University in Wellington. She is a Registered Clinical Psychologist (with the New Zealand Board of Psychology) and has a PhD in Clinical Psychology and a Master's Degree in Social Work (MSW). She has worked in the mental health, education and social services sectors as a practicing clinician for over 30 years, with a primary focus on high and complex needs youth and families and wraparound programs.

Research Supervisor

Dr. Ruth Gammon is from the United States and practiced there until 2010, when she accepted her current role at Massey University. She has worked with various organizations in New Zealand, providing training, consultation, supervision and client treatment. She also conducts research through the

University with a focus on improving services for young people and their families. Most of her research projects involve evaluating or reviewing wraparound programs like the Ministry of Education’s Intensive Wraparound Services (IWS). The Ministry of Education wants to ensure that their services are meeting the needs of those they serve, continually improving their services and following best practice. Therefore, they have contracted with Massey University to review their program, and explore outcomes and experiences so that they can continue to improve and provide the best services possible.

Project Description and Invitation

The current research project aims to explore outcomes of the Ministry of Education's (MoE's) Te Kahu Tōī, Intensive Wraparound Service (IWS), explore Māori experiences of the service, and validate the measures used by the service to measure progress and outcomes. Three main questions will be addressed by two studies.:

1. How do Māori families engage with and experience the Wraparound process and what are their outcomes like?
2. According to an objective, standardised measure (as well as IWS’ measures), what are the outcomes for youth and families who participate in IWS for 1 year?
3. Does the measure that IWS uses to assess progress and outcomes compare well to widely used outcome measures? Is it reliable and valid with New Zealand youth and families?

The first study will address the first question. Families and youth who identify as Māori will be asked to engage with the primary researcher in a semi-structured interview. These interviews will take place at a location convenient for you, and will be voice-recorded and transcribed. All interviews will be confidential, and no identifying information will be given to the Ministry or put in publications that would identify you or your family.

To address the second and third questions, a second study will be done involving data that will be collected at your usual meetings. Your IWS psychologist will complete some extra measures as well as the usual ones that they fill out in order to provide you with progress and outcome results. You will not need to do anything in order to take part in the second study, but the additional data that is collected will help us to evaluate the measures the Ministry is using and determine the outcomes of youth and families engaged with IWS.

I would like to invite you to participate in this research. Your participation would be greatly appreciated, and will help the Ministry to best support youth and families like yourself.

Participant Identification and Recruitment

- For the first study, involving the interviews, we are interested in talking to Māori youth and families that have been engaged with IWS for a minimum of six months
    - Once a family agrees to participate, an interview with Lucy Lightfoot will be organised
    - Youth are welcome to participate in the interview, as we are interested in their perspectives too. To participate, they must be able to understand the project and consent to being involved. Youth participation is also dependent on the caregiver's consent to allow them to participate.
- For the second study, involving the collection of extra data, we are interested in the participation of families who are currently engaged with IWS and have had their first meeting with IWS within the last six months.
    - If you agree to your data being used, your IWS psychologist will fill out extra measures at two separate time points, one year apart. Your data will be anonymised.

Koha

Participants who take part in the interview will be thanked for their time and involvement with a $30 supermarket voucher at the end of the interview.

Project Procedures

- If you and your family choose to take part in the interview study, you will meet with the primary researcher, Lucy Lightfoot, at a location of your choice. You will be asked general, neutral, open questions related to your experiences with the Ministry of Education's IWS.
- Each interview is expected to take between 15 minutes and an hour, depending on your experience with the programme and what you want to share. You are not expected or required to share any personal information that may be distressing.
- In the unlikely event that participants experience any discomfort in recalling their experiences they may discontinue the interview at any time and a de-briefing will occur. Participants will be able to access support through Dr. Ruth Gammon, a clinical psychologist, or their IWS psychologist. Appropriate referrals can be made if necessary.

Data Management

- All data from measures will be anonymized, and the researcher will not know which families the data belongs to.
- Voice recordings will be transcribed into text, and the voice recordings will then be deleted. Any identifying information will be removed from the transcripts, and pseudonyms will be used to preserve participant's identities.
- Data will be held at Massey University in a secure, locked location that only the primary researcher and supervisor will have access to. After ten years, the data will be securely destroyed.

- A summary of the project findings will be provided to Ministry's IWS program managers and staff for dissemination to participants.

Participant's Rights

You are under no obligation to accept this invitation. Your choice to participate or not to will not affect the provision of services from the Ministry.

If you do decide to participate, you have the right to:

- decline to answer any particular question;
- withdraw from the study at any time;
- 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 findings when it is concluded.
- ask for the recorder to be turned off at any time during the interview.
- Ask for the interview to stop at any point.

Project Contacts

Please feel free to contact the Primary Researcher or her Supervisor (contact details below) at any time if you have any questions or concerns regarding the project.

Lucy Lightfoot

Doctoral Student and Primary Researcher

School of Psychology – Massey University, Wellington Campus

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Email: Lucy.Lightfoot.2@uni.massey.ac.nz

Dr Ruth Gammon

Sr Lecturer / Clinic Director / Project Supervisor

School of Psychology – Massey University, Wellington Campus

PO Box 756 | Wellington | 6140

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Email: R.Gammon@massey.ac.nz

(include statement about being reviewed by ethics committee once that has been done)

Appendix D

Consent Form

Wraparound in Aotearoa: An evaluation of outcomes, validation of a new measure, and an exploration of Māori experiences of Intensive Wraparound Services.

PARTICIPANT CONSENT FORM

I have read, or have had read to me, and understand the Information Sheet. I have had the details of the study explained to me, any questions I had have been answered to my satisfaction, and I understand that I may ask further questions at any time. I have been given sufficient time to consider whether to participate in this study and I understand participation is voluntary and that I may withdraw from the study at any time.

- I agree/do not agree to participate in this study under the conditions set out in the Information Sheet.
- I agree/do not agree to my IWS data being used for the purposes of the current research project.

If you and your family identify as Māori:

- I agree/do not agree to participating in an interview about mine and my family's experience with IWS
- I agree/do not agree to the interview being sound recorded

- I wish/do not wish to have the transcript of my recordings returned to me for review and approval.

Declaration by Caregiver:

I ___________ [print full name]__________ hereby consent to take part in this study.

Appendix E

Authority for the Release of Transcripts

Wraparound in Aotearoa: An evaluation of outcomes, validation of a new measure, and an exploration of Māori experiences of Intensive Wraparound Services.

AUTHORITY FOR THE RELEASE OF TRANSCRIPTS

I confirm that I have had the opportunity to read and amend the transcript of the interview(s) conducted with me.

I agree that the edited transcript and extracts from this may be used in reports and publications arising from the research.

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

Full Name - printed ....

Appendix F

Table of Sources included in Scoping Review

Author & Country	Population	Intervention	Research Design	Cultural Considerations & Adaptations	Fidelity	Outcomes Measured	What were the outcomes?	Equity of outcomes measured or reported
1. Anderson et al., (2003) USA	467 youth between 5-17, with a DSM-IV diagnosis or special education designation, multiservice involvement and at risk or already in an out of home placement. (*n* = 467). Demographics: Average age ~13yo. 65% male. Of the males; 56% African American/biracial/another underrepresented racial ethnic group, 44% Caucasian. 35% female. Of the females, 59% African American/biracial/another underrepresented racial ethnic group, and 41% Caucasian.	The Dawn Project: a coordinated services network.	Quantitative: quasi-experimental single-group pre-test post-test design. Measures taken at enrolment, 6 months, and 12 months.	Not evident in theory, not evident in description of service delivery, evident in research design.	Fidelity mentioned but not measured.	Functioning and impairment. Residential restrictiveness. Recidivism rates determined. (Clinician rated measures and administrative data)	Clinically and statistically significant reduction in impairment/improvement in functioning. Increased percentage of young people living in less restrictive environments. 83% of those who completed the programme were successful in staying out of justice system. Of those who didn't complete only 9% stayed out of justice system.	Impact of demographic factors/ ethnicity on functioning not mentioned – unclear if analysed. In terms of restrictiveness of placement, African American females and Caucasian males more likely to be in a restrictive placement at 6 month measurement. Minority males significantly less likely to complete programme.

2. Anderson, (2011) USA	Young people with multisystem emotional and behavioural challenges and their families. (*n* = 365) Demographics: mean age 12.55. 72% male, 28% female. 55% from a underrepresented ethnic group, 45% Caucasian.	The Dawn Project System of Care: provides Wraparound services for young people with multisystem challenges and their families. Typically referrals occur because of severity of challenges and involvement with multiple child-serving systems.	Quantitative: quasi-experimental single-group pre-test post-test design. Measures taken at enrollment, 12 months, 24 months.	Evident in theory, minimally evident in research design, not evident in description of service delivery.	Fidelity mentioned and measured.	Emotional behavioural problems and functioning (caregiver and clinician rated).	School functioning significantly improved between enrolment and up to 36 months post enrolment. Improvements in school functioning significantly associated with improvements in clinical functioning even after controlling for influence of time.	Yes. Ethnic identity was not associated with change over time.
3. Behnke et al., (2020) USA	Latinx students (*n* = 241). Demographics: 51% female 49% male. 32% students in eighth grade, 21% in ninth grade and 27% in tenth. Remainder age/grade unknown/not mentioned.	Juntos 4-H intervention: wraparound program supporting Latinx youth to stay in school, achieve high school graduation, and attend higher education.	Mixed-methods: quasi-experimental pre-test post-test single-group study	Evident in theory, research design, and service delivery.	Fidelity not mentioned or measured.	Purpose made survey 'assessing grit, academic success, belonging, social support, parent engagement, college going attitudes'. (student-rated).	Improvement in academic attitudes and behaviour All participants graduated from high school on time. Improvement in measurements of 'college readiness'. Improvement in ratings of family engagement. Improvement in ratings related to sense of belonging.	N/A, population entirely Latinx.
4. Bernard et al., (2015) USA	Families with a youth younger than 18 who had a current or historical diagnosis of a mental/emotional/behavioural disorder resulting in substantial functional impairment (total *n* = 284). Demographic data for total *n*: 62.8% male, 36.8% female,	PARK project – school based wraparound system of care in Connecticut, delivered across 9 schools.	Quantitative: quasi-experimental single-group pre-test post-test design. Measures taken at baseline and then every 6mos up until 36mos.	Not evident in theory or description of service delivery. Minimally evident in research project.	Fidelity not mentioned or measured	Mental health outcomes and engagement/ accessibility of father. (Both caregiver report)	Ratings of mental health difficulties decreased from entry to 12 months for all three indicators. Access to father had a moderating effect on mental health scores for internalising behaviours and total problems but was not statistically significant.	Yes. No reported effect of race on outcomes.

	65% Latino, 33.5% African American, 14.6% Caucasian, 2.4% other.							
5. Blizzard et al., (2017) USA	Youth 5-21yo not receiving other intervention and assessed to have residential treatment level of need (*n* = 231). Demographics: 39.8% female, 60.2% male. 41.6% White, 52% Black, 6.5% other. Comparison group 6-18yo, 1+ outpatient mental health visit and a valid MH diagnosis (*n* = 2079) Demographics: 46.7% female, 53.3% male, 66.9% White, 31.4% black 1.7% other.	Medicaid Wraparound program for youth diverted or transitioned from residential care.	Quantitative – quasi-experimental design comparing engagement and residential outcomes of Wraparound group (in 90 day period after discharge) versus TAU group (in 90 day period after a mental health visit).	Not evident.	Fidelity mentioned and measured (WFI-4). Average scores 76 (caregiver) and 78 (youth and team members) indicating adequate fidelity.	Engagement with outpatient services. Residential treatment. (clinician observation of administrative data)	Wraparound/intervention group more likely to engage in outpatient care, and higher dosage of engagement. No difference in outpatient clinic follow up after inpatient discharge. Rates of residential treatment for Wraparound group were 75% lower than pre-intervention in the 90 day period following service exit. Residential treatment remained 60% lower for the last three 90-day periods. Data on residential treatment not available for control group.	No
6. Bruns et al., (2014) USA	Youth 6-17yo diagnosed with a mental, behavioural or emotional disorder in the last 12mos that required clinical care. (*n* = 93) Demographics: 57% male. Mean age 11.9. 61% racial or ethnic	Statewide, cross-agency wraparound initiative for youth with SED.	Quantitative: Randomised controlled experimental pre-test post-test design. Control group traditional intensive case management. Measures taken at	Not evident.	Fidelity mentioned and measured. fidelity found to be poor across all measures employed despite WFI scores being far	Behavioural and emotional symptoms and youth functioning. Satisfaction with services. Residential placement and restrictiveness. (clinician and caregiver response measures).	No significant between-group differences in outcome trajectories for symptoms, functioning, or residential restrictiveness over the 12month period. No differential findings in line with the wraparound theory of change such as alliance, empowerment	No.

	minoritised groups (41% African American, 12% mixed race, 1% Native American, 8% Other, 16% Hispanic).		baseline, 6 months, and 12 months.		above national means during pilot.		and caregiver satisfaction.	
7. Carney & Buttell, (2003) USA	Youth 17 and under, referred to juvenile court or with charges filed for unruly or delinquent offences. (total *n* = 141 youth) Intervention group (*n*=73): Demographics: 39.7% female, 60.3 male. 45.2% Caucasian, 53.4% African American, 1.4% biracial. Mean age 14.8. Control group/TAU (*n* = 68): 36.8% female, 63.2% male. 55.9% Caucasian, 42.6% African American, 1.5% biracial. Mean age 14.9.	Juvenile Delinquency Task Force Implementation on Committee (JDIC): Wraparound service engaging youth and their family to address problems which may reduce further involvement of juvenile justice system. Control group received services as usual provided by juvenile court system.	Quantitative: experimental pre-test post-test design where youth entering juvenile justice system randomly assigned to either wraparound condition or TAU with follow up at 6-, 12- and 18-months.	Not evident.	Fidelity not mentioned or measured.	Recidivism and at-risk behaviour assessed (Running away, truancy, school suspension, assaultive behaviour, police contact, arrests, incarcerations, employment). (caregiver rated and administrative data)	Wraparound youth missed school less, were suspended less, did not run away as frequently, were less assaultive and less likely to be picked up by police. Conventional services youth more likely to be employed. No significant differences between two groups in number of subsequent offenses. Significantly less at-risk behaviour, no difference in actual offenses.	No
8. Champine et al., (2019) USA	Caregivers of children with severe psychological health needs (*n* = 122). Demographics: mean age 38.9, range 20-72. 19.7% Black/African	Partnership for Kids (PARK) project – school-based SOC for youth 5-19yo and their families.	Quantitative: quasi-experimental single-group pre-test post-test design. Measures taken at intake and	Evident in theory and research design, not evident in description of service delivery.	Fidelity not mentioned or measured.	Discrimination, parent stress, service access, general satisfaction, and perceived cultural competence (caregiver rated).	No significant decrease in parental stress, distress, or dysfunctional interactions. Caregivers in frequent discrimination group scored higher on total parental stress, parental distress, and	No.

	American, 7.4% White, 61.5% Latino/a, 1.6% Asian, data missing for 8 caregivers. 86.9% female.		every 6mos up to 36mos post-intake.				dysfunctional interactions. They also had higher service use. Service satisfaction and cultural competence rated favourably.	
9. Champine et al., (2020) USA	Youth with severe emotional and behavioural challenges (*n* = 77). Demographics: mean age 13.5, range 8-18. 66.2% male. 68.8% Latinx, 46.8% Black/African American, 28.6% Other, 7.8% as White/European American and 1.3% as Native American.	Partnership for Kids (PARK) project: school-based SOC. Provides access to school-based care coordination services and an array of other services and activities.	Mixed-methods: quasi-experimental single-group pre-test post-test design. Interviews and data collected at intake and every six months.	Evident in theory, service delivery and research design.	Fidelity not mentioned or measured.	Satisfaction with services (caregiver and youth response measures)	Youth and caregivers rated service favourably across all domains (cultural sensitivity, general satisfaction, active participation and youth outcomes). For youth, improvements in psychological and behavioural functioning was most helpful. For caregivers, provision of specific youth and family services was most helpful.	No.
10. Cox et al., (2009) USA	Children in residential care (n = 176). Demographics: 7 – 18yo (mean 14.6yo). 56.7% male. 55.6% Caucasian. 32.6% African American. The rest were Hispanic, Asian, or other.	Wraparound Process implemented with children in residential care in an effort to expedite transition to a home and community-based setting.	Quantitative: Quasi-experimental single-group pre-test post-test design.	Not evident in research design or description of service delivery. Minimally evident in research design.	Fidelity measured with WFI-3. Administered to facilitators and parents. However, very few caregiver scores collected so facilitator scores only analysed. Results indicated reasonable fidelity;	Standard measure of emotional behavioural problems and functioning (clinician rated). Attainment of goals. Success in transitioning to a home setting and / or maintaining placement.	62% of youth moved from severe to marked impairment range on measure of emotional behavioural problems and functioning to minimal to moderate range by termination. At closure 59% met service goals and 59% were living in a home setting. 51% met both of these objectives, 16% met one, and 33% met neither. 57% were discharged to a home setting. Youth who met treatment goals had significantly	Yes. Participants who met treatment goals did not differ significantly based on gender, ethnicity or diagnosis from those who did not.

					6.6 out of maximum of 8. Element adherence scores ranged from fairly low (3.8) for natural supports to quite high (7.8) for individual services and supports.		more collateral supports. Children who lived in a home setting at discharge had significantly more natural supports. Level of impairment at service entry did not predict goal attainment. Number of collateral supports and adherence to the principle of community involvement were found to be significant predictors of goal attainment. Youth impairment at intake predicted living situation at closure as did collateral supports and community involvement. With baseline impairment controlled for, collateral supports predicted goal attainment but did not reach significance as a predictor of successful discharge to a home setting. Community involvement still predicted goal attainment and living situation at closure.	
11. Crusto et al., (2008) USA	Children 5yo or under exposed to family violence (*n* = 82). 56% male, 44% female. 55% Latino/Hispanic, 27% Black/non-	Child and Family Interagency Resource, Support, and Training Program (Child FIRST): wraparound program for children exposed to violence experiencing	Quantitative research: quasi-experimental single-group pre-test post-test study. Measures taken at baseline	Not evident in theory, minimally evident in research design, not evident in description of	Fidelity not mentioned or measured.	Trauma symptomatology, traumatic events, parental stress, and satisfaction with services. Service utilisation and experiences of violence	Decreased exposure to traumatic events Decreased family and non-family violent events Decreased posttraumatic intrusive thoughts and avoidance	Yes, all feasible covariates (gender, age, race/ethnicity) tested as part of analyses, none found to

	Hispanic, 9% White, 1% other, 9% unknown. Mean age 3.3yo.	or at high risk for developmental delays and/or social, emotional, or behavioural difficulties.	and discharge.	service delivery.		(caregiver report via structured interview).	Decreased parental stress Decreased parent-child dysfunctional interactions Decreased perception of 'difficult child' Significant effect of hours and length of service: those with more hours and service length improved more. Parental ratings of services favourable.	be significant.
12. D. Evans et al., (2017) USA	Justice-involved youth in Orange County Florida served by youth advocate programmes (YAP) (*n* = 249). Demographics: 66% male, 34% female. 57% Black, 23% White, 20% Hispanic, 1% other. 22% under 16, 78% 16 or older.	Youth Advocate Programmes: Wraparound programs across the US to youth in foster care, juvenile justice and the mental health system. Incorporate a focus on advocacy and mentoring.	Quantitative: Quasi-experimental research design with control group. Target population propensity score matched to probation cases.	No.	Fidelity not mentioned or measured	Justice contacts (arrests, adjudications, risk scores, commitments)	At intake intervention group had higher rates of mental health dx, suicidal ideation and histories of abuse. Slight differences in contact with justice system: intervention youth arrested significantly more oftenin the two-year follow up period. Higher percentage of intervention group arrested at least once. Those in intervention group more likely to be arrested for misdemeanours. No significant group differences in felony arrests. Most significant difference: Probation youth significantly more likely to be committed to the state juvenile justice agency in two year follow up period.	No
13. Eadie et al., (2022)	259 Australian youth (at least 5yo)	Evolve Therapeutic Services: trauma-	Quantitative: quasi-experime	Evident in theory, research design	Fidelity not mentioned or	Functioning and emotional behavioural	80% consumers demonstrated improved functioning	Yes: Indigenous consum

AUS	in care enrolled in evolve therapeutic services (ETS) Demographics: median age 10yo (range 5-17), 38.2% Indigenous. 66.7% male, 33.3% female)	informed collaborative wraparound model	ntal single-group pre-test post-test design.	and service delivery.	measured.	problems (clinician report measures).	(11.2% deteriorated, 8.5% stayed stable). Significant improvement in 7/13 HoNOSCA items across entire population.	ers had significantly greater improvement in 3 domains: antisocial behaviour, emotional symptoms, and peer relationships. Non-Indigenous consumers had greater difficulties with self-care and independence at baseline.
14. Feely et al., (2022) USA	Families engaged with child welfare after a maltreatment report (n = 6249.) 39% of families White, 22% Black, 38% Latino, 1% other ethnicity.	Community Support for Families (CSF): a voluntary community child maltreatment prevention program families are referred to as a differential response to traditional investigative approaches after a child welfare allegations.	Quantitative: quasi-experimental single-group pre-test post-test design. Interviews done at baseline and 6 month intervals up to 36 months.	Evident in theory and research design. Not evident in description of service delivery.	Fidelity not mentioned or measured	Subsequent reports and substantiated reports of child maltreatment within 18 months of the index report that triggered referral to services.	Treatment participation not associated with a subsequent report. Treatment completion associated with a lower rate of substantiated reports.	No significant difference in subsequent report being made. No significant differences in treatment.
15. Fletcher & Tan, (2021) USA	Intervention Group: Economically disadvantaged African American students at specialist wraparound school (*n* = 177). Control Group: African American students at a	Specialist trauma-informed STEM school providing education and wraparound support onsite.	Mixed-methods: Qualitative analysis of stakeholders perspectives, quantitative analyses of surveys administered to both groups.	Evident in theory and service delivery. Not evident in research design.	Fidelity not mentioned or measured.	Graduation rate. Level of engagement with education (behavioural, cognitive, emotional) (self-report survey).	Graduation rate: 95% from 2017-2018 Engagement with education: significantly higher in behavioural and cognitive domains for intervention group. No difference in emotional domain.	N/A (intervention served solely African American population).

	comprehensive high school (*n* = 179). All students 9th – 12th grade.							
16. Fowles et al., (2018) USA	Families of children with emotional behavioural difficulties (total *n* = 314). Intervention group (*n* = 133): 59.3% White, 38.4% African American, 20% Latinx origin, 2.3% other. 67.2% male. Control group (*n* = 181): 55.6% White, 24.3% African American, 20.1% other, 13.8% Latinx origin	Intensive home-based adaptation of Parent-Child Interaction Therapy paired with Wraparound case management services.	Quantitative: quasi-experimental design comparing intensive home-based PCIT to traditional clinic-based PCIT.	Evident in theory and research design. Not evident and description of service delivery.	Fidelity mentioned not measured.	Disruptive behaviour andparent-child interactions (both clinician-rated). Attrition derived from administrative data.	Statistically significant change in both groups across all outcomes with medium – large effects. ECBI scores moved on average from clinical range to normative range in both groups. No significant difference between groups. Home based participants with wraparound intervention significantly more likely to complete (64.66%) than clinic-based participants (33.15%)	Yes. Non-Latino White participants less likely to having missing archival data compared to participants of racial ethnic minoritised identities No differences otherwise (in attrition, completion, duration, and outcomes).
17. Hyde et al., (1996) USA	Youth at risk of residential placement or being returned/diverted from out of state residential placement (total *n* = 106). Two intervention and two control/TAU.	Individualised Wraparound model provided by the Family Preservation Initiative as part of system reform movement to increase community-based intervention and reduce residential placements.	Quantitative: descriptive cross-sectional multiple cohort study. Groups non-random. Unequal attrition and high variation in demographics between groups.	Evident in theory and service delivery, not evident in research design.	Fidelity not mentioned or measured.	Restrictiveness of living environment, school attendance, vocational attendance, harmful behaviour, community engagement, usefulness of services, and overall adjustment. (youth, parent, case manager report measures)	Adjustment to community ratings: Wraparound Diversion: 48% good, 28% fair, 24% poor. Wraparound Return: 46% Good, 29% fair, 25% poor. Pre-Wraparound: 14% Good, 64% Fair, 22% Poor No-Wraparound 0% good, 40% fair, 60% poor. 10 days or more community involvement 68% for WD, 56% for WR, 42% for PW and 0% for NW. Parent ratings more favourable: 61% for WD, 90% for WR, 50% for	No

							PW and 20% for NW. Wraparound groups appeared to be more involved in community. Services judged to be helpful. Both youth and caregivers felt providers listened to needs and concerns. Parental ratings tended to be more positive.	
18. Shailer et al., (2018) AOT/ NZL	Youth with emotional-behavioural needs (*n* = 8) Demographics: 5 female, 3 male. 13 – 16yo. Caregivers (*n* = 16) Facilitators (*n* = 6) Wraparound team members (*n* = 16) Total sample represented 16 Wraparound teams (total *n* = 46). Demographics of families participating: NZ European (Pākehā) (37.5%), Māori (18.8%), NZ European (Pākehā)/Māori (21%), Middle Eastern (12.5%), other European (12.5%), South African (6.3%).	Wraparound service delivered by District Health Board mental health service.	Qualitative: thematic analysis of semi structured interviews with youth, families and members of wraparound teams.	Somewhat evident in theory, evident in service delivery, not evident in research design.	Fidelity mentioned and measured using WFI-4. Above average fidelity achieved (81.83 %).	Experience of intervention. (service user, provider, caregiver, and team member report via interview)	Seven themes 1: Overall experience positive 2: Relationship with facilitator positive and impactful 3: characteristic Wraparound philosophies and principles and their importance 4: Supportive nature of process – emotionally, safe service, practically, professional 5: Outcomes – empowerment and hope, family relationships/dynamics, individual change, parent, young person 6: Challenges: both personal and systemic 7: feedback re: continuity of care, transition, role clarity for team members and accessibility of services for youth	No.

19. K. M. Ward & Bosek, (2002) AK	Individuals with developmental/intellectual disabilities and history of sexually problematic behaviour (*n* = 26). Demographics: 100% male. 50% Caucasian, 34.5% Alaska Native, 11.5% African American, 3.8% Hispanic Age range (13-18) to (37+).	Behavioural Risk Management: community-based wraparound provision of individualised support and supervision to reduce probability of re-offending.	Mixed-methods: (Case series, descriptive, observational data).	Not evident.	Fidelity not mentioned or measured.	Repeat sexual offenses, instances of inappropriate /high risk sexual behaviour, observed quality of life/freedom in community (clinician-report/observation).	No repeat offenses. 11 have had incidents of inappropriate/high risk behaviour. QoL: Several participants have reduced supervision/increased independence in living. Decreased need for alarms and staff monitoring. Increased access to community	No.
20. Kendziora et al., (2001) USA	Case study: Eric, 17yo male of Arikara, Crow, and Hidatsa descent.	The Sacred Child Project: an inter-tribal Wraparound project that serves seven distinct tribal groups on four reservations.	Qualitative: interview with Eric and his family presented in narrative form	Evident in theory, research design, and service delivery.	Fidelity mentioned but not measured.	Interview with Eric and his wraparound team	Eric living at home, family safe, rejecting antisocial activities, practicing multiple prosocial activities. Employed and working toward GED. Planning college and career. Strongly connected to mother, family and community. Less withdrawn, more outgoing, more emotionally expressive. Less anger, more participation in home, more able to share problems. Increased confidence and hope for future.	NA
21. Klag et al., (2016) AUS	Youth under 18 with severe and/or complex psychological/behavioural problems in out of home care and under child protection	Evolve Interagency Services (EIS): Collaborative 'wrap-around' coordinated mulit-agency approach for youth and their system.	Quantitative: quasi-experimental single-group pre-test post-test design.	Not evident in theory or research design, minimally evident in description of service delivery.	Fidelity not mentioned or measured.	Youth emotional and behavioural functioning. (clinician-rated measures).	Statistically significant improvement in ratings of general adjustment, mental health, wellbeing, and functioning by end of treatment. 17.7% moved from clinical to non-clinical range on CGAS.	Yes. No significant interaction of time and Indigenous status.

	orders (*n* = 664). Demographics: mean age 10.6yo at admission (range 1-17). 61.6% male and 38.4% female. 26.9% Aboriginal and/or Torres Strait Islander background.						Significant proportion of young people moved to non-clinical range on 11/13 HONOSCA items.	
22. Klayman & Crawford, (2007) USA	SED youth (*n* = 104). Demographics: 74.2% male. 58.2% African American, 35% White, 6.7% Asian/Caribbean/Native American/native Alaskan or Hawaaiian. Age data not provided.	Community Kids: wraparound mental health program providing care coordination, family support and access to a multitude of appropriate services.	Quantitative: quasi-experimental single-group pre-test post-test design. Measurements collected at baseline, 6 mos, 12mos, 18mos, 24mos.	Evident in theory. Minimally evident in description of service delivery.	Fidelity not mentioned or measured.	Behavioural and emotional symptoms, functioning. (clinician, youth, and caregiver response measures).	significant decreases after 18months in anxiety, depression, delinquency, aggression, and withdrawal. Significant improvements in social and educational functioning Reduction of youth placed in out of home care at 18 months (24% to 7%). Reduction of youth sent to detention facilities (21% to 11%) Reduction in self-harm in past 6 months (20% to 3%). Absenteeism reduced by 20%.	No.
23. Lawton et al., (2021) AOT/ NZL	Pregnant Māori (Indigenous) women. Study in progress at time of write up, target population size had not been reached. Goal is minimum: *n* = 432; 216 in intervention group, and 216 in	He Korowai Manaaki – a kaupapa (by Māori for Māori) wraparound maternity care pathway.	Quantitative: quasi-experimental clinical trial with intervention group and control group (TAU).	Evident in theory, service delivery, and research design.	Fidelity not mentioned or measured.	Primary outcome timely vaccination (all age-appropriate vaccinations complete by 6mos of age) Secondary outcomes infant hospitalisations, length of hospital stays, obstetric, delivery, and infant outcomes	Study still in progress	N/A, population entirely Māori

	control group. At date of publication 251 recruited for intervention group).					and service engagement outcomes. (Clinician observation/administrative data)		
24. Lyall et al., (2021) AUS	Pregnant women who were Aboriginal/ Torres Strait Islander or whose partner was (*n* = 7) Significant Others (*n* = 6) Health Professionals (*n* = 4) Case Managers (*n* = 3) Total (*n* = 13)	Empowering Strong Families: holistic smoking cessation program.	Qualitative analysis: narrative inquiry of interviews.	Evident in theory, research design and service delivery.	Fidelity not mentioned or measured.	Valued features of intervention, smoking cessation/reduction, satisfaction with intervention (service user-report via interview).	Features of value identified: relationship-based care, holistic, flexible, individualised Indigenous based caree. Smoking cessation: 36% quit at 3-months, 18% smoke free 1-month post-partum, nearly half reported a quit attempt during treatment, nearly all reported reduction in number of cigarettes. High levels of satisfaction with intervention.	N/A (intervention served solely Indigenous population)
25. Madden et al., (2012) USA	Youth (5 – 17yo with complex mental health and behavioural needs) and caregivers who had been recently reunified, and CPS caseworkers (total *n* = 23). Demographics: Youth (*n* = 6): 4 male, 2 female. Mean age 13.5 (10-17). 1 African American, 2 Biracial (African American/Latino), 1	Pilot Wraparound program designed to reunify youth in out of home placements with their families.	Qualitative: case series and interview analysis.	Evident in theory, not evident in description of service delivery or research design.	Fidelity not mentioned or measured.	Barriers to reunification and outcomes drawn from case series and interviews (caregiver report and clinician observation)	Barriers identified: System Level: difficulties collaborating with residential treatment centres (incompatible philosophies and practices), finding well qualified suitable service providers, facilitating preparatory pre-unification contact Program level: Difficulty collaborating with CPS, limited cultural competence. Case level : Youth behaviour severity and caregiver	No.

	Latino, 1 White. Caregivers (*n* = 6): All female. Mean age 50.1 range 33-67. 3 African American, 2 Latino, 1 White. Staff (*n* = 11): 2 male, 9 female. Mean age 28.3, range 22-49. 1 African American, 1 Asian, 1 Native American, 8 White.						ambivalence, difficulty determining readiness for reunification, inadequate preparation for reunification, logistical difficulties, financial insecurity. Case outcomes: 5 of 6 youth successfully reunified with caregivers in community. Ongoing tracking at time of publication found 50% had successfully sustained placement.	
26. McCarter, (2016) USA	First time offenders, age 11-16, assigned to agency attorney (total *n* = 29). Intervention group (*n* = 22): Mean age 14.59 (range 13-16). 68.2% African American, 22.8% Caucasian, 4.5% other, 4.5% didn't answer. 81.8% male, 18.1% female. Control group (*n* = 7) mean age 14.22 (range 13-15). 71.4% African American, 14.3% Caucasian, 14.3% no answer. 85.7% male, 14.3% female.	Wraparound modelled forensic social work services in addition to traditional court-appointed legal defense services for juvenile offenders.	Quantitative: experimental pre-test post-test design. Participants randomised to intervention group or TAU (legal defense services).	Evident in theory, somewhat evident in research design, somewhat evident in service delivery.	Fidelity not mentioned or measured.	Strengths, functioning, behavioural/emotional and social problems (self-report measure). Recidivism as indicated number of days between first petition filed and any subsequent during 12month study period. (administrative date_	Treatment group showed statistically significant improvements compared to control group on 6/8 scales. No significant results in terms of recidivism.	No.
27. Méndez &	Case study of a Mexican family: a	Tree of Life activity: a therapeutic activity	Qualitative: Descriptive article	Evident in theory, research design	Fidelity not mentioned or	Various outcomes explored in case study	Supported development of dialogue and solutions that	N/A.

Cole, (2014) USA	mother (25), daughter/identified client (13), and brothers (11 and 9).	undertaken as part of wraparound approach with Latino families to increase cultural relevance of intervention.	with case study.	and service delivery.	measured.	(clinician-report).	all members of the family contributed to. Increased engagement of family members in treatment.	
28. Milwaukee County Behavioral Health Division, (2002) USA	Children with complex needs and their families (*n* = 874). Demographics: 70% male 30% female. Average age 13.2, range 4-17. 67% African American, 6% Hispanic, 25% Caucasian, 1% Native American, 1% Asian.	Wraparound Milwaukee: provides cost effective, comprehensive, individualised care to children with complex needs and their families.	Quantitative: quasi-experimental single-group pre-test post-test design. Measures taken at intake, 6mos and 12mos.	Not evident.	No mention of fidelity or measurement.	Emotional behavioural problems and functioning at intake, 6mos, 12mos: Rate of offenses, felonies, and misdemeanors also examined. (caregiver, self, clinician report and admin)	Significant reduction in emotional behavioural symptoms and improvement in functioning across all measures. Significant reduction from three years prior to intervention to three years post intervention in percentage of clients referred for felonies and misdemeanours Significant reductions from one year prior enrolment, during enrolment, and after enrolment in multitude of specific offences.	No
29. National Crime Prevention Centre, (2012a) CAN	Intervention group: Gang-involved young adults (*n* = 99) Demographics: mean age 23.9yo, range 16-30. 66 males and 33 females. Participants 'primarily Aboriginal' but specific proportion not provided. Comparison group (*n* = 29) gang-involved, Aboriginal high-risk youth and adult offenders. Minimally	Regina Anti-Gang Services Project: integrates elements of Wraparound, Multisystemic Therapy (MST), harm reduction, and cultural/faith-based support.	Mixed-methods: Quasi-experimental pre-test post-test design with non-random control group. Data collected at baseline, during intervention, discharge and followup over 24 months.	Evident in theory, research design, and service delivery.	Fidelity not mentioned or measured.	Gang membership, substance use, risk and prevention, identity, attitudes about conflict/violence/guns/aggression) (clinician and service user rated measures, administrative data, focus groups, and observations).	Positive change in gang-related attitudes and beliefs (no between group difference) Decrease in overall risk index (significant compared to control group) Significant reduction in depression ratings at 6 months and overall downwards trend (no between group difference) Steady decline in gang affiliation over all time points. (Significantly less gang affiliation in treatment group).	No

	involved in the intervention, receiving five or fewer hours of contact a month and only participating in recreational activities.						Reduction in nonviolent crime across all time points (significantly less in intervention group). Reduction in violent crime (no significant difference between groups) Insignificant change in employment rates. No significant difference between groups. Insignificant change in substance use overall and no significant differences between groups.	
30. National Crime Prevention Centre, (2012b) CAN	Youth at risk of gang involvement, youth displaying gang-associated behaviours, and youth currently in gangs (n = 132). Demographics: mean age 14yo. 84% male, 16% female. 60% 'visible minority', 13% Aboriginal, 27% Caucasian/ other.	The Surrey Wrap: youth driven wraparound approach for gang-related crime prevention.	Quantitative: quasi-experimental pre-test post-test design with matched control group.	Evident in research design. Minimally evident in theory and description of service delivery.	Fidelity mentioned but not measured.	Risk/responsitivity /recidivism, gang involvement (clinician-rated measures)	Statistically significant decrease in negative police contacts for those in programme. Comparison group showed an increase. Limited impact on absenteeism and tardiness. Limited evidence of any reduction in gang activity.	No.
31. National Indian Child Welfare Association, (2015b) USA	Youth from tribal communities in San Felipe and North Dakota. Demographic data and details of populations served not provided.	Tribal Wraparound	Qualitative: Descriptive review of applications of culture-based wraparound.	Evident in the theory, research design, and service delivery.	Fidelity mentioned and reportedly measured but data not provided in article.	Not detailed in summary paper. Reference to positive outcomes of a case study included in current review.	Not detailed in current paper	N/A – populations served all of underrepresented identity and outcomes not reported.
32. Painter	40 caregivers	Collaborative system of	Qualitative:	Not evident	Fidelity mentio	Experiences during	Referral:	No.

et al., (2011) USA	of children with SED. Demographics: 85% of children male, between ages of 8 and 18. Remaining between 4 and 7. 38% African American, 33% Latino/Hispanic 25% Spanish speaking.	care for families of children with SED.	structured interviews, a priori content analysis.	in theory or description of service delivery. Somewhat evident in research design.	ned but not measured.	referral, engagement, experience, and transition out of service (caregiver report via interview)	High proportion reported recurring problems at school. Moderate proportion reported financial issues, family violence and lack of social support. Engagement High proportion emphasised importance of quality relationship with facilitator and positive connection with caregiver. Moderate proportion reported value of home visits. Experience: High proportion reported feeling empowered, moderate-high proportion reported learning new skills (e.g. parenting skills). Moderate proportion reported better familial relationships less, less isolation, whole family support. 59% said caregiver needs addressed, 41% felt they weren't. transitioning out: low-moderate proportion reported meeting most/all goals by discharge, moderate proportion felt they were not ready, moderate-high proportion knew about discharge ahead of time. Moderate proportion lacked informal supports (no	

							support once facilitator/other professionals gone). Almost half reported staff turnover (38% reported experiencing change in facilitator. 60% of those families reported it had negative effects.	
33. Painter (2012) AUS	Youth 5-17yo who were diagnosed with a SED based on DSM-IV criteria and at risk of removal from home/school or had multiple agencies involved (*n* = 160) Demographics: mean age 11yo. 76% male, 24% female. 41% White, 33% African American, 24% Hispanic/Latino and 3% Native American.	Wraparound Service Delivery in a systems of care community	Quantitative: quasi-experimental single-group pre-test post-test design. Measures taken at baseline and every 6 months up to 24 months.	Minimally evident in theory, research design, and service delivery.	Fidelity mentioned and measured. Overall score 86% indicating high fidelity (WFI-4 and WOF-2).	Behavioural-emotional problems, functioning,, caregiver strain, and satisfaction with services. (caregiver and youth report measures).	Caregiver rated: statistical and clinical levels of improvement (in behavioural and emotional problems, functioning, and caregiver stress) by 6 months, sustained to 24 months. Youth rated: Rated selves lower than caregivers on problems - in non-clinical range on behavioural and emotional rating scale across all data points. Some significant improvements on ratings at 12 – 18months. Depression showed significant improvement by 18 months, sustained to 24 months, and overall downward trend across data points. Statistically and clinically significant level of change found from intake – 12 months and sustained at 24 months.	No
34. Palmer et al., (2011b) USA	African American, Native American, Latino-American and Hmong-	Connecting Circles of Care (CCOC): a culture-based wraparound initiative developed in	Mixed-methods: descriptive outline of approach , how it is applied	Evident in theory, research design and service delivery.	Fidelity mentioned and measured. WFI-4 used to	Cultural competence, service provision, emotional behavioural problems and service	High scores in cultural sensitivity (significantly higher than other SOC sites) Significant reduction in	N/A – all recipients underrepresented identity

	American youth with emotional behavioural needs and their families. Demographic data not provided.	response to race-based disparities in out of home placements. Serves underrepresented communities, targets barriers to and discrimination in care identified for these groups.	for different communities while maintaining model fidelity, and preliminary outcomes.		assess Wraparound across four racial/cultural groups. Overall scores above national means.	satisfaction (caregiver and youth report).	problem behaviours. Caregivers report higher satisfaction with services compared to average satisfaction scores at other SoC sites.	
35. Raffaele Mendez & Randle, (2021) USA	Unaccompanied homeless youth (*n* = 9): Demographics: Ages ranged from 17-20. 4 female, 5 male. 1 Hispanic, 2 Caribbean, 2 African American, 4 European-American	'Starting Right, Now' – grassroots community-based residential initiative for unaccompanied homeless youth who have remained in highschool.	Qualitative: thematic analysis of interviews with service users.	Not evident.	Fidelity not mentioned or measured.	Impact of intervention (service user report via interview)	Three overarching themes with subthemes: 1: Construction of new models of relationships (functional support system, fostering trust with adults, more prosocial friendships) 2: Learning adaptive strategies for living (identifying maladaptive strategies, learning adaptive strategies, enduring frequent obstacles and setbacks with ongoing support) 3: Increasing hope, direction, and purpose (less worry about basic needs, increased capacity for self-development and planning, increased hope and goal setting, increased motivation to help others in difficult circumstances). Every participant accepted to a college or trade school and received a scholarship.	No.

36. Raghavan et al., (2013) USA	Multinational refugees who survived torture (*n* = 172). Demographics: 66.9% men, 33.1% women. Originally from: 54.7% Africa, 25.6% Asia, 12.8% Europe, 7% the Americas. 27.2% Muslim, 24.4% Buddhist, 33.1% Christian. Mean age 36.9. Range 20.8-75.5.	Program for Survivors of Torture (PSOT): Comprehensive torture treatment program	Quantitative: quasi-experimental single-group pre-test post-test design.	Evident in theory and research design, minimally evident in description of service delivery.	Fidelity not mentioned or measured.	Distress and trauma symptoms. (self-report measures) nonclinical variables: immigration status, employment, income.	45% of treated clients displayed clinically significant improvements over 6 months following intake. Secure immigration status strongest correlate of clinical improvement. 21.5% secured asylum during time, 68.6% remained insecure. 9.9 already secure. Psychotherapy and attendance at educational sessions predicted improvement in symptoms.	No (but all underrepresented identities).
37. Rutman et al., (2020) CAN	Pregnant or parenting women with substance use and complex issues (*n* = 125 clients) across 8 provider sites. Demographics: 100% female, 54% 30yo or older, 53% Indigenous, 27% European/ White and 15% mixed race. Varied across sites though (97% Indigenous at an Indigenous focussed group in Winnipeg, 0% in program in rural Nova Scotia).	Eight multi-service Wraparound programs offering holistic support to vulnerable parenting or pregnant women. Programs are heterogeneous and specific services and supports arise from local context. 7/8 programs have substance use as primary eligibility criterion.	Qualitative: Interview analysis	Evident in theory, research design and service delivery.	Fidelity not mentioned or measured.	Circumstances at initial engagement, hopes about intervention, utilization of services, satisfaction, what had changed (service user report via guided conversation).	Programs' focus on the social determinants of health is paramount. Increasing access to and accessibility of healthcare helpful. On-site substance use and trauma/violence counselling highly impactful. Deep appreciation for support related to navigating child welfare issues. Importance of developmental lense and approach. Importance of cultural programming promoting (re)connection to culture (knowledge, community, healing, practices).	No.
38. Siennick et al., (2020)	Youth with prior police contact	School-based intervention with specialised	Quantitative: experimental	Not evident.	Fidelity mentioned but not	Measured school suspension (time	Null finding - no difference between groups in terms of	No

USA	(total *n* = 869) Intervention group (*n* = 440). 65% male, 8% White, 70% Black, 18% Hispanic, 4% other. Grade 9-12, mean 10.23. Control group (*n* = 429). 63% male, 8% White, 69% Black 20% Hispanic, 3% other. Grade 9-12, mean 10.28.	onsite staff members (case manager, social worker and juvenile probation officer. Control condition was TAU – received traditional services provided by school, community, or court sanctioned.	randomised control trial.		in relation to Wraparound practice model – in relation to own intervention which was 'loosely based on the RNR and wraparound models'. Fidelity not measured.	between enrolment and first suspension) as well as types of suspension and juvenile justice system contact (time between enrolment and first contact with system). (administrative data).	suspension or juvenile justice contact and subtypes of these outcomes.	
39. Simmons et al., (2008) USA	Youth aged 10-17 with substance use disorder or at-risk of developing one (*n* = 190). Demographics: 74.6% male. 62% Hispanic/Latino, 33% African American/Black, 5% White/Asian/Native American. Mean age 14.7.	Hartford Youth Project (HYP): outreach and engagement service for youth with substance abuse issues. Coordinated multi-service approach.	Mixed-methods: Quantitative descriptive (cross-sectional data) and qualitative case studies.	Evident in theory and service delivery. Not evident in research design.	Wraparound fidelity not mentioned or measured.	Treatment completion rates and various outcomes presented in case studies (clinician report/observations).	48% completed treatment. Prior to intervention, completion rate for this population was 30%. Positive outcomes of two case studies presented: decreased substance use, increased positive relationships and community engagement.	No.
40. Smelson et al., (2013) USA	Homeless veterans with a substance use disorder and a co-occurring mental health disorder (*n* = 333). Demographics: 96.1% male. 61.9% African American,	MISSION-VET: wraparound intervention to augment TAU and engage/retain homeless veterans with Substance use and COD.	Quantitative:Quasi-experimental pre-test post-test design with non-randomised control group (TAU). Measures taken at baseline, 6mos,	Minimally evident in research design – addiction measure used validated across diverse racial identities. Not evident in theory or descripti	Fidelity mentioned and MISSION-VET fidelity measure used. Developed specifically for intervention though. Unclea	Inpatient hospitalization events, outpatient treatment engagement, addiction severity index (clinician administered interview) and related variables (employment, psychiatric data).	Outpatient treatment engagement: higher in wraparound + TAU group at 12 month post-test. Inpatient Hospitalisations: No difference between groups at 12 month post-test. At intake wraparound + TAU group had	No.

	26.6% White, 11.5% other. Mean age 46.5		and 12mos). .	on of service delivery.	r to what extent it maps onto wraparound model, no evidence of it being cross-validated with wraparound fidelity measures.		significantly higher hospitalisation rates. Addiction severity: Wraparound + TAU group less likely to drink to intoxication and experience serious tension or anxiety.	
41. Stenersen et al., (2021) USA	Youth with emotional behavioural difficulties (*n* = 1138) and their caregivers. Demographics: Age range 3 – 19yo (mean 11.53). 64% male. 21% non-Latinx Black, 31% non-Latinx White, 48% Latinx of various ethnicities. Youth of other ethnic identity (Asian, Native Hawaiian, American Indian, multiracial) excluded due to small sample size.	Statewide system of care providing Wraparound. Little information provided about the service (history, location, procedures etc).	Quantitative: Quasi-experimental single-group pre-test post-test design. Measures taken at intake, during service, and at six month follow up.	Evident in theory and research design. Not evident in description of service delivery.	Fidelity mentioned but not measured.	Caregiver strain, frequency of team meetings, mental health outcomes/response to treatment, perceptions of care. (administrative data, caregiver report measures)	At intake: Caregivers of Non-Latinx White youth reported significantly more problem behaviours and lower functioning than other groups. Caregivers of non-Latinx White youth reported higher levels of global strain. No difference in number of lifetime traumatic events or trauma symptomatology across race/ethnicity. Non-Latinx White youth had a significantly higher likelihood for a history of trauma. During service provision: Non-Latinx White youths had significantly more meetings. Follow-up and discharge: No racial-ethnic disparities in outcomes at follow up or amount of change from intake to follow	Yes.

							up when controlling for baseline measures except for one outcome: non-Latinx White youths displayed higher levels of trauma symptoms and increased likelihood trauma symptoms fell above the clinically significant range. No racial-ethnic disparities in terms of mutual discharge or number of days enrolled Impact on Level of Disparities: No significant differences in rate of change on any outcome across race-ethnicity. Satisfaction with Services and Mutual Discharge: Caregivers of non-Latinx Black youths reported significantly less satisfaction with respect from staff and respect of their religious beliefs than caregivers of non-Latinx White and Latinx youth. No significant difference in rate of non-mutual discharge on basis of race-ethnicity. Caregivers feeling they had ability to choose service only predictor of mutual discharge from services.	
42. Syvertsen et	Youth 14 – 24yo in foster care/the	Opportunity reboot model: a program	Quantitative: quasi-experime	Evident in theory, research design	Fidelity not mentioned or	Quality of relationship with case manager/me	Relationship with case manager significantly	No differences by racial/et

al., (2021) USA	juvenile justice system/homeless/ disconnected from school and/or work (*n* =291). Demographics: mean age 19.5. 48.3% female, 29.3% male, 2.3% missing/didn't want to answer, 4% transgender. 83% youth of colour: 25.8% Asian/pacific islander, 21.8% Black, 17.1% White, 11.7% Spanish or Hispanic, 11.1% mixed, 6.4% Native American or Alaskan, 3.4% other, 2.7% missing.	enhancement model integrated into existing wraparound programs to leverage social capital and create pathways to education and career opportunities.	ntal single-group pre-test post-test design. Multiple measures taken at baseline and service exit.	and service delivery.	measured.	ntor, learning opportunities, goal support, work readiness, responsible decision making, relationships skills, communication skills, self awareness (self report)	associated with stronger learning opportunities and goal support. Learning opportunities significantly associated with increased work readiness skills at T2. Goal support not significantly associated with work readiness skills at T2. Developmental relationships not significantly associated with increased work readiness skills at T2. Significant indirect effect from developmental relationships to work readiness through learning opportunities.	hnic group explored due to small sample size – noted as a study limitation.
43. Totten & Dunn, (2011) CAN	Street and gang-involved youth with problems including: substance use, delinquent behaviour, violence, gang involvement, mood difficulties, and difficulties with interpersonal, educational and familial domains. Eligibility determined by purpose made risk tool.	Youth Alliance Against Gang Violence Project (YAAGV) / the Warrior Spirit Walking Project (WSW): an innovative, evidence-based initiative for Aboriginal youth who are gang-involved or at high risk of gang involvement.	Quantitative: quasi-experimental pre-test post-test design with non-randomised matched control group. Measures taken at baseline and every 6 months following.	Evident in theory, research design and service delivery.	Fidelity not mentioned or measured.	Vocational/educational engagement and skills, healthy relationships and role models, protective and risk factors related to gangs, crime, access to and dosage of services, gang exit and resistance and substance use (service user rated, observational, focus groups, administrative data). .	Positive change in overall risk identified in favour of intervention group, but inconsistent and limited to discrete time periods. Limited evidence of positive change that was sporadic and unpredictable (limited to discrete time periods) Participants spoke favourably about: the cultural school and its impact, program staff and cultural programming.	No, but population 98% first nations.

	Treatment/ Intervention group (*n* = 160): Demographics: 53% male 42% female. 98% First Nations (60% Cree, 25% Metis, 5% Dene, 2% Dakota, 1% Saulteaux, 1% Sioux, 1% Mohawk, 2% mixed First Nations) and 2% Caucasian. Average age 18 years. Age range 11 – 21. Control Group (*n* = 57) not taking part in intervention: 37% male, 63% female. 93% First Nations. Average Age: 17.5 years.						Participants expressed concern about: Wanting more of a vocational focus, problematic staff members, not having flexible enough, difficulty being around other gang involved youth, and finding cultural activities difficult due to abuse that had happened in that context.	
44. Werrbach et al., (2013) USA	Passamaquoddy (Native American tribe) children with emotional or behavioural needs (*n* = 204). Demographics (age, gender) not provided.	Kmihqitahasultipon Wraparound Project: culture-based system of care initiative.	Qualitative: descriptive and case series	Evident in theory, research design and service delivery.	Fidelity not mentioned or measured.	Various outcomes explored in case studies (clinician report/observations).	Case studies presented with following outcomes: Engagement of family labelled ‘resistant’ previously, avoided out of home placement, pregnant teen successfully transitioned to adulthood and became service provider, family supported to remediate complex unsafe home situation and getting child back, 1:1 support provision helped child previously unable to	N/A (intervention served solely Passamaquoddy population)

							attend community daycare to transition.	
45. Wu et al., (2018) USA	Intervention group: Youth with SEBD, 16 or younger, in a home-community based setting. (*n* = 496). Demogrpahics: 63% male, 37% female. 30% White, 64% Black, 6% other. Control group: youth receiving TAU for severe mental illness (*n* = 993). 59% male, 41% female, 27% White, 67% Black, 6% other.	Statewide oordinated care services (CCS)	Quantitative: Quasi-experimental pre-test post-test design with control group. Compared psychotropic polypharmacy one year before and one year after discharge.	Not evident	Fidelity not mentioned or measured.	Psychotropic polypharmacy defined as fifteen or more days of overlap of psychiatric medications from three or more therapeutic classes.	No significant difference in reduction of polypharmacy between groups. Propensity scoring excluded CCS youths with highest use of mental health inpatient/residential services and psychotropic treatment from analysis – compared to CCS group included in study this group had a greater reduction.	No
46. Yohannan et al., (2017) USA	Low-income youth (6-18years) with serious emotional disturbances (*n* = 1006). Demographics: 61% male, 39% female. 55% Caucasian, 45% African American.	State provided Wraparound services in Michigan.	Quantitative: quasi-experimental single-group pre-test post-test design. Measures taken at intake and exit.	Evident in theory and research design. Not evident in description of service delivery.	Fidelity measure used. Mean fidelity scores ranged from 58/100 – 72/100 indicating a generally moderate level of fidelity.	Youth functioning, attrition (clinician-rated and administrative data).	Over half did not complete services. Within low SES group, African American youth had significantly higher rates of attrition. No difference in higher SES group. For those who completed, fidelity scores did not vary based on racial-ethnic identity. Completion resulted in improvements in emotional behavioural functioning. African American youth had significantly lower impairment at both baseline and exit. Youth who discontinued early experienced less of a	Yes

							reduction in impairment.	

Appendix G

Massey Research Case Study

Research Case Study

Nau i whatu te kākahu, he tāniko taku

An exploration of how my Doctoral Research has influenced my personal and professional growth and identity.

A research case study presented in partial fulfilment of the degree of Doctor of Clinical Psychology.

This case study represents the work of Lucy Lightfoot during their doctoral project and internship at Child Health, Wellington Hospital, in 2021.

Abstract

The current case study outlines my doctoral research project and the impact it has had on my professional development and work as a clinician, and my personal growth and identity. It opens with my pepeha, which I have continued to work on throughout my time in the Massey Clinical Program. A pepeha is a way of introducing oneself that describes your ancestry and connections to the land. My pepeha represents who I am, and where I have come from. To me, it is a symbol of the journey of self-exploration and strengthening of my identity that has occurred during my clinical training. This journey has been partly inspired by the evolution of my research project and myself as a clinician. I then provide a summary of my doctoral research project, and reflections. Reflections focus on how my doctoral research has influenced my personal and professional identity, focussing especially on the influence of learning about te ao Māori, exploring my own whakapapa, and integrating my values of activism and social justice into my personal and professional life.

Tēnā koutou katoa

Nō Ingarangi, me kotarani, me Tarara, me taungerong ōku tīpuna

Ko Wayne Lightfoot toku Matua
Ko Debra Blackett toku Whaea
No Tamaki Makaurau raua

I whanau ahau kei Tamaki Makaurau
I tipu ake ahau kei Te Whanganui-a-Tara

Ko Lucy Lightfoot toku ingoa
He kaimatai Hinengaro ahau

No reira,
Tena koutou, tena koutou, tena koutou katoa.

As stated in my pepeha, I was born in Tāmaki Makaurau and grew up here in Te Whanganui-a-Tara. My whakapapa connects me to Scotland, England, Dalmatia and the Taungurung people – an Aboriginal mob in Australia. My father was the first person in his whānau to acquire tertiary education, and my mother got her law degree during my infancy as part of an adult 'restart' programme designed to make interventions in underprivileged people's lives. I am proud to come from a lineage of resilient, resourceful people who have overcome adversity to make meaningful contributions to their communities and better lives for those who come after them. Many people in my whānau, including myself, are neurodivergent, and/or have lived experience of emotional behavioural difficulties. In terms of my personal and professional identity, this has conferred both pronounced strengths and vulnerabilities. I have wrestled with these vulnerabilities throughout my training, and at times felt pressured to compartmentalise or deny these experiences to conform to what I felt was expected of me as a clinician. Over time, and with input and support from many wise people (such as my research supervisors, my current internship supervisor, my therapist, my friends, and my peers) I have learnt to integrate these parts of my identity and accept them as being part of what makes me an effective, authentic clinician, in a way that only I can be.

Nau i whatu te kākahu, he tāniko taku is a whakataukī I chose to guide my research kaupapa. It means 'you weave the cloak, and I the border'. It is often used in the context of parenting. It can relate to the nature/nurture concept, wherein the genetics of the child is the cloak, and the border is the nurturance that child receives. It also relates to the concept of 'it takes a village to raise a child' –

how the input of many people is central to a child's development, and while the parents' role is important, the work of many is required. It felt pertinent to my research in a number of ways. To me, it aligned with the philosophy of Wraparound as an intervention, which emphasises the need for parents and their children to be embedded in a supportive, connected community. It also reflected my own conceptualisation of my research, and the importance of humility. While I may be the one who is recording the stories whānau have told me, and reporting outcomes (weaving the border), it is the participants stories and experiences that are the true taonga (or the cloak). My research is as much theirs as it is mine, and I am enormously privileged to have been invited into their lives and experiences. Finally, the whakataukī also relates to my own continued development as a clinician, and a person I want to be. One of my favourite sayings is 'I am an amalgamation of all the people I have ever loved'. I would not be where I am today or who I am today, in both a professional sense or a personal sense, without the efforts, input, love, support, guidance, and learnings that people in my community have offered me.

Many aspects of completing this doctorate and clinical training I expected. It is difficult to describe how hard it has been. It has constantly challenged me beyond anything else I have ever experienced. It has brought to me to question and analyse my identity and my place in the world; my way of thinking, my academic abilities, my values, my assumptions and biases, my understanding of myself and others, my political views, and my coping skills. I have come to believe that to work as a psychologist safely and effectively, one must be radically self-aware, humble, accepting of one's own human fallibility, and committed to continual growth. In this way, my doctoral project and clinical training has guided, influenced, and inspired my own growth and identity formation. This informs the way that I move in the world and make sense of things, including the way that I interact with and understand my clients.

Doctoral Research Overview

My doctoral research focusses on assessing the value of using Wraparound as an intervention for high and complex needs youth in Aotearoa. It takes a particular focus, in alignment with responsibilities conferred by the treaty, on the experience of Māori whanau who have received the intervention. I partnered with the Ministry of Education to conduct my research project. The Ministry of Education established New Zealand's first formal Wraparound service (Te Kahu Tōi Intensive Wraparound Services) demonstrating above average fidelity to the practice model several years ago. The research project aims to establish the outcomes the intervention produces, a well as reflect on the applicability and acceptability of the approach for Māori rangatahi. Hopefully the project will produce important knowledge, applicable both locally and globally, in terms of interventions for under-served youth (especially Indigenous youth) that are culturally sensitive, holistic, system-focussed, community-based, and effective. The focus on experience of Māori communities was an integral consideration, and should be in the establishment of any therapeutic service in Aotearoa for the following reasons: the obligating of the crown and psychologists in Aotearoa to provide care that upholds the principles of the Treaty of Waitangi, the hardships Māori face as a result of colonisation, reflected in the unique yet related experiences of Indigenous peoples worldwide (e.g. high rates of indigenous youth being uplifted from whānau and becoming isolated from their whakapapa, whenua, and culture); high rates of suicide, distress and harm, and disproportionate incarceration and contact with the justice system, robustly predicted by time spent in state care. Furthermore, there is increasing awareness of the severe shortcomings, and harm caused by imposing Western frameworks of wellbeing and recovery (and interventions based on these frameworks) on Indigenous peoples. In particular, these frameworks tend to neglect taking into account cultural beliefs, values, and practices, sorely limiting the potential benefits of any intervention.

Methods

My project is three-pronged and mixed-methods. It comprises: a scoping review of the use of Wraparound in indigenous and minority communities to establish the research base so far, an interpretative phenomenological analysis of conversations with Māori whānau who have received support from the Ministry of Education's to explore Māori perspectives on Wraparound as an intervention, a quantitative analysis of outcomes will be performed. A group of youth have been recruited and scored on both the Child and Adolescent Functional Assessment Scale (CAFAS) and a purpose-made measure by the Ministry of Education.

Participants

Participants for the study were recruited through IWS and their employees. IWS provided consent forms and information sheets (developed by the principal researcher) to families currently engaged with IWS who meet criteria for either the qualitative or quantitative sub-studies. The primary researcher was only given access to the data of families who consent to the study. To recruit participants for validation of the IWS measure, and for the interviews, IWS asked at their monthly meetings with families whether they are interested in participating in research, and then provided them with the appropriate consent forms and information sheets describing the studies and providing researchers details should they want any more information. All families who were engaged with IWS and had been for six months or less were offered consent and information forms pertaining to the quantitative study regarding outcomes and measures. All families who self-identified as Māori and were engaged with IWS for at least six months were offered consent and information forms pertaining to the qualitative study involving interviews regarding Māori experiences of IWS. All families who agree to participate in the quantitative study will be included in the study. Five families were randomly selected from the pool of those families who met the criteria for interviews and expressed a desire to participate on the consent form.

Procedure

Information regarding the study was provided and consent acquired by IWS prior to any access of data or contact with participants by the primary researcher. Youth and family participants in the quantitative sub-study had to do nothing for the study other than engage with IWS as per normal, as the IWS staff completed the measures needed for the research. Thus, their consent is provided to allow IWS staff to share the information they collect (and collect extra information via the CAFAS) regarding their young person and family with the researcher to be used in this study and possible publications. If a family expressed interest in taking part in the interviews, IWS provided the lead researcher with their contact details in order to organise a meeting. Interviews were conducted at a time and location convenient for the families involved, whether that may be the family home or a room at the family's local Ministry of Education Office or school. Parents/carers were invited to bring family or support people to the interview, and the young people engaged with IWS were also invited to take part, depending on their age and parent/carer's desire to have them participate. The interviews varied in length from half an hour to two hours, and were semi-structured, allowing for prompts and clarifications of answers

Data Analysis

Quantitative analyses will be used to explore data from the IWS measure and the CAFAS. A paired t-test will be used to evaluate change achieved between the baseline measure and the measure taken one year on. In terms of the interviews, all conversations were recorded using a dictaphone and transcribed verbatim. Transcripts were reviewed with participants for accuracy if they desired. Transcriptions will be uploaded onto QSR NVivo software for analysis and the analysis will follow the guidelines of interpretative phenomenological analysis (Smith & Shinebourne, 2012). In order to ensure the analysis is valid, codes will be checked to ensure the same process of coding was undertaken across interviews. Organisation and grouping of data will also be reviewed to ensure data were appropriately and accurately categorised.

Ethics

Participant and Researcher Safety

The risk of harm to participants was deemed minimal. However, all of the interviews were conducted in whānau homes by the principal researcher. In order to ensure the safety of both the researcher and the whānau being interviewed, a number of protocol were put in place. Supervision from qualified and experienced clinical psychologists was used. Practice interviews took place with clinical supervisors prior to actual interviews to ensure procedures are appropriate and carried out responsibly, sensitively, and ethically. Participants were reminded (it was also outlined on the consent sheet) that they were welcome to stop the interview at any point, ask to have the dictaphone turned off, or refuse to answer any question. It was also be made clear that choosing to do so would not affect the provision of services from IWS.

To ensure the primary researcher's own safety when visiting family homes, when a family consented to being interviewed, the IWS psychologist did not pass on the family's contact details if they felt there were any significant safety risks posed by the primary researcher meeting privately with the family at their home. Regardless of whether families contact details were passed on, and whether they are selected for an interview, they were be thanked for offering to take part. They were told that families were randomly selected to take part in the interviews from the pool of families who volunteer. Additionally, the primary researcher informed their supervisor/s when they were going to an interview, and what the projected finish time was. The primary researcher contacted their supervisor/s when the interview was complete or if it was going to run over time.

Although unlikely (as the interview targets information regarding the experience of the Wraparound intervention, rather than sensitive information about the family's and youth's experience) there was an acknowledged possibility that individuals could become distressed during the interview. In this scenario, the researcher had a plan to cease the interview, turn off the dictaphone, and offer support. If further support was required, it could be accessed through the family's IWS psychologist or the primary researcher's clinical supervisor. Once the immediate distress had been resolved, the participant could be reminded of their rights to cease the interview if they wanted to, or proceed at another time. Fortunately, this did not occur.

The possibility was also acknowledged that sensitive information could be disclosed during interviews. At the beginning of each interview, a confidentiality statement was provided outlining the nature and limits of confidentiality. The primary researcher ascertained that at least one registered clinical psychologist is available for supervision during interviews if required**.**

Informed Consent

Youth, especially those receiving treatment for mental health issues, are regarded as a vulnerable population. Hence, special consideration needed to be taken in terms of how consent is obtained (Drotar, 2008; Hoagwood, Jensen & Fisher, 2014). Informed consent can only be achieved if the participant has the capacity to provide consent, has been provided with and understands information about the research, and chooses to participate voluntarily without coercion and manipulation. Where research involves children (under the age of 18), consent has to be obtained from parents. If the child is above seven years of age then 'child assent' is considered mandatory also (Nijhawan et al., 2013). It is ethically responsible to recognise that children are capable of being partners in research, and should be provided the right to receive information, be listened to, have their opinions and feelings taken into account, and give or withhold their consent if competent to do so. Involving youth in decision-making fosters trust, engagement and a better relationship between the client and practitioner, and also sits in alignment with the ethos of Wraparound (Nijhawan et al., 2013).

Hence, in the current study, both caregiver consent and youth assent were sought for both the quantitative and qualitative components of the research. Information sheets clearly outlined the purposes of the current study, the possible implications, and what to expect if families chose to participate. Additionally, it made clear that families are able to withdraw their consent at any stage of participation. Consideration was given to the inherent power dynamic between the IWS employees who provide families with services, and who also asked families to participate. A requirement of informed consent is that it is free from coercion and manipulation, and if consent is withheld, no negative consequences will arise (Nijhawan et al., 2013). Hence, it was made very clear that participation in the research was optional and choosing not to take part would not affect provision of services.

Confidentiality

Confidentiality and anonymity is especially important in research that involves youth. Important considerations include protection of identity via anonymity, confidentiality of collected data, and a safe and private location to conduct the interviews (Powell, Fitzgerald, Taylor & Graham, 2012). Participants were asked to choose a location for the interview that is most convenient and comfortable for them. All data (including interview transcripts, consent forms, audio recordings, and outcome data) was stored and transported securely. Electronic data was sent from MoE via secure email with protective firewalls. It will be stored under password protection. Physical documents will be kept in a locked file cabinet in a locked office at the Massey University Psychology Clinic in Wellington, accessible only by the principal researcher's supervisor. In order to protect the identity of participants, identifying information was removed from transcripts and participants were assigned a number. Once audio recordings are transcribed, they were deleted or destroyed. Once the research is completed, all data will be securely held for the minimum ten year period before being destroyed in accordance with Massey University Policies. In order to avoid biases in responses regarding IWS, participants were assured that their responses will be anonymised and will not affect provision of services.

Cultural Considerations

The current study focused on Māori experiences, involved Māori participants, and has implications for Māori. Hence, deep and thorough consideration of the principles of the Treaty of Waitangi and their application to the current research was extremely important. In order to engage in the process of thinking about ethics in a culturally safe manner, Te Ara Tika - Guidelines for Māori Research Ethics (Hudson & The Putaiora Writing Group, 2010), was used as a framework upon which to build the kaupapa of the current study, and shape and formulate my thinking in regards to culturally safe conduct and research. Te Ara Tika outlines four tikanga based principles to consider during the conception and implementation of research: whakapapa, which refers to the purpose of the project, tika, which refers to the design of the project, manaakitanga, which refers to cultural and social responsibility, and mana, which refers to justice and equity. While conceptualising the current study and using Te Ara Tika as a guide, the primary researcher identified the following ethical concerns. The primary researcher engaged with a number of resources and sought cultural supervision from Dr. Simon Bennett in order to formulate the following solutions.

First, the weighted issue of comparing ethnicities and reporting results was considered. MoE employees stated that data appears to show Māori youth and families are benefitting from IWS to a greater extent than non-Māori. However, it was unclear at this stage whether Māori had better outcomes overall or improved to a greater extent due to having lower baseline measures on some factors than non-Māori. If the latter is true, it is important to think about how to report this in a culturally sensitive manner. Historically, Māori have been depicted in research in a way that emphasises disparity, and deficits, rather than distinction and difference, and puts the onus on Māori for addressing the inequity reflected by statistics regarding the health status of Māori. More recently, the status of Māori health and wellbeing is recognised as the result of negative experiences resulting from colonisation processes (New Zealand Psychologists Board, 2009). Hence, it was important to ensure results were framed in a strengths-based way, and negative generalisations are avoided. Results needed to be reported with explicit reference to the societal and institutional factors that produce inequity. The primary researcher adhered and referred to Te Ara Tika throughout the research process, including while working with statistics and writing up results. Additionally, reporting emphasised the idea that with a culturally competent and tailored intervention, Māori whānau thrive and experience positive outcomes - a testament to moving away from traditional, manualised Western models of health and treatment and towards philosophies and practices such as Wraparound that emphasise, utilise, and acknowledge culturally relevant strengths, values, beliefs, and practices.

The second ethical consideration concerned the primary researcher's position as a Pākehā researcher/clinical psychology trainee, the associated dangers of making assumptions, and the importance of conducting oneself and the research project in a culturally safe manner. Because I am not Māori, I am naive to the experiences of Māori and approach these experiences with an outsiders lense. This is an important factor that was considered throughout the entire duration of the research project, but especially during the interviews. Because of my own cultural background, I acknowledged the risk of making incorrect assumptions, coming across as tokenistic, or causing offence. Additionally, as a non-Māori trainee clinician and researcher, there is an intrinsic, inherent power dynamic. Many whānau in IWS are likely to have had experiences with Pākehā clinicians that has shaped their feelings towards them. Hence, consideration of the whakawhanaungatanga process, cultural humility and openness, and thoughtfulness about how to ensure whānau felt respected and comfortable is centrally important. In order to address this, I used the Hui Process as a framework with which to engage with families (Lacey et al., 2011). Questions in the interview were kept general and open, to avoid implying any assumptions about culture, perspectives, and values, and how that might affect their lived experience. Interviews were conducted in a manner that aimed to be comfortable and flexible for whānau - multiple whānau members were welcomed, interviews were conducted whānau homes, karakia were offered, and sharing of kai or a hot drink often took place.

Reflections: how my doctoral research has influenced my personal and professional identity, and clinical practice.

I have grown up cognizant of the importance of acknowledging Māori as tangata whenua and kaitiaki of Aotearoa and have always regarded Māori culture as a unique taonga to be treasured. I studied te reo at highschool and university and have always treasured being invited into te ao Māori. My doctoral project opened up increased opportunities to learn about te ao Māori and reflect deeply on my own responsibilities under the treaty, as a citizen of Aotearoa, a healthcare provider, and a person who values social justice and equality. This led to many (ongoing) realisations, self-directed research, kōrero, professional development and grassroots action, all of which would be difficult to detail in this document. However, I will try to outline some of the more poignant learnings and moments that have shaped who I am today.

The first formative moment in my training was when I went to write my pepeha, as part of a class activity. I knew that being able to share my pepeha central to engaging in the hui process with Māori tangata whai ora and establish whakawhanaungatanga, in my research, in my clinical work, and in my personal life. However, I found that I couldn't even begin writing my pepeha at first. Due to disconnection within my own whānau, I had very little knowledge about my ancestors, who they were, where they were from, and what they had been through. On reflection, it is not surprising that I am drawn to systemic child and family work, or that my research focusses on addressing the needs of youth with complex issues and histories – after all, as I once read quoted in 'The Body Keeps the Score' – 'most research is me-search'.

Exploring my whakapapa became an interest and an ongoing side project during my doctoral research. I felt it was important for me to gain an understanding of my whakapapa in order to be able to practice authentically and openly, particularly with Māori whānau. It was also a tangible way that I could demonstrate the values I hold such as social justice, equality, and autonomy in service provision. This is particularly important to me as a person with lived experience. Marsha Linehan, in her description of coming up with Dialectical Behavioural Therapy, speaks about the power imbalance inherent to traditional Western psychologist/client relationships. Specifically, she points out how unnatural and unreasonable it is to expect a client to be so vulnerable and open, when traditional practice dictates that psychologists typically share very little about themselves in exchange. This goes against everything we know about how mutual trust is established in relationships, and yet we know that the therapeutic relationship is the cornerstone of any effective intervention. I have always struggled with this concept, and the idea that self-disclosure is taboo. I understand of course that it can at times be inappropriate, and that boundaries are necessary to preserve the therapeutic nature of the relationship and the safety of both parties. I also think it self-disclosure can be one of the most powerful therapeutic tools in our repertoire. Whakawhanaungatanga, as well as the hui process, appealed to me hugely as it outlined an established way that self-disclosure occurred, and trust was established in te ao Māori. Studying these practices and using them in my work helped me to see how important these processes are, and how I could generalise these learnings to all my clients. Importantly, following tikanga (especially as a non-Māori clinician) also demonstrates cultural awareness, respect, humility and acknowledges that the clinician and the client are equals, who are both experts and students in their own areas. Given that my research involved conducting interviews with Māori whānau in their homes, the importance of demonstrating cultural humility was especially pronounced.

Exploring my own whakapapa led to a wealth of discoveries. I got in contact with my cousin, who was doing her own research on our ancestry and was focussing primarily on our Indigenous Australian heritage, which none of us knew much about at all. I also began recording interviews with my grandfather about his life and had conversations with my parents about their upbringings and their own parents. As I already knew, there was a lot of mamae/trauma weaved into my lineage. My whānau has historically avoided these painful stories and experiences. However, when I began to ask questions and hear the stories of my whānau, themes of extraordinary resilience, social conscience, intelligence, passion, cheekiness, charisma and an indomitable commitment to survival and overcoming adversity emerged. Although this didn't detract from the very real pain and adversity that had been experienced, it allowed me to view these experiences in a very different way. In reflecting on this, I am reminded of a whakataukī: Ka mua, ka muri: walking backwards into the future. This whakataukī refers to the idea that we should look to the past to inform our future. Armed with my new knowledge, I was able to look back upon the mamae in my whānau with not only sadness (and perhaps an indignance/sense of unfairness), but also awe, inspiration and an understanding of the continued, magnificent efforts of my whānau to overcome adversities and heal.

Learning about my indigenous heritage has also been an emotional and rewarding experience spurred by this project. I learnt that on my father's side we whakapapa to the Taungurung people, a mob within the Kulin Nation. At first, I felt conflicted about claiming this identity, given my alienation from the culture, and my experience growing up Pākehā, and benefitting from all the associated privileges. However, as I did more research I realised that it was important to claim this identity. Very few familial lines exist today as a result of brutal colonisaton and the stolen generation. Most Taungurung people are white-passing as a result of intentional assimilation and racial 'dilution'. I realised that my uncertainty in exploring Taungurung culture was largely driven by internalised colonial concepts such as blood quantum – that you must be a certain 'percentage' of an ethnicity to identify with it. In the Indigenous Australian community, there is a saying 'No matter how much milk you add, it's still tea'. I realised that our clan had its own distinctive language, art forms, and practices, and it is important to do the most I can to learn about these and keep them alive. I am excited to continue learning about Taungurung culture and am grateful that my research inspired this journey. My own process of realising the effects of colonisation on my whānau and trying to reconnect with my whakapapa made me much more aware and attuned to the experiences of Indigenous people.

My clinical training, doctoral research, and own personal journey has resulted in me prioritising decolonisation as a framework that guides my work and my way of life. Academia often outlines and describes the problems and limitations of Western/colonial-centric systems, institutions, and knowledge but being a Western/colonially based system itself, it doesn't necessarily challenge them in a meaningful way that makes a substantial difference. It has become vitally important to me to engage with and demonstrate decolonisation theory and practice in my everyday life. It is important to me to not be complicit in systems and practices that cause harm and contribute to inequality. In practice, this means engaging with up-to-date discourse from diverse sources, remaining humble and open to criticism, and practicing regular self-reflection to recognize and challenge my biases and limitations. I acknowledge both the strengths and limitations of academic expertise and qualifications, as well as the expertise of clients in their own experiences. I also recognize the value of Indigenous and non-Western conceptualizations of wellbeing and healing practices and commit to educating myself on them. Additionally, I endeavour to use my privilege as a psychologist to advocate for and participate in activism. Most importantly, I strive to embody these values not only in my professional life but also in my personal life.

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