

A QUALITATIVE EVALUATION OF WRAPAROUND SERVICES
FROM CAREGIVERS' PERSPECTIVE

by

MISTY R. ENGLAND

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Abstract

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Misty R. England, MSSW

The University of Texas at Arlington, 2013

Supervising Professor: Katherine Sanchez

Wraparound services are becoming a prominent form of service delivery for systems of care for mental health services for children. This study examined the benefits, limitations, obstacles and any other themes reported by caregivers with children aged 0-6 with a Serious Emotional Disturbance (SED) receiving wraparound service from a Community Based Mental Health agency. Responses of 24 caregivers to qualitative questionnaires were analyzed. Seven themes were identified: 1) program benefits; 2) wraparound facilitator characteristics; 3) wraparound team implementation; 4) implementation barriers; 5) program limitations; 6) juxtaposition of program appreciation despite lack of perceived effectiveness; and 7) other desired resources. Caregivers' responses provided an enriched understanding of the challenges they face and the success they have actualized after six to twelve months of program participation.

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Chapter 1 Literature Review

In 2002, President George W. Bush created the President's New Freedom Commission on Mental Health to analyze the status of mental health care in the United States, which had not been done in 25 years. Several of the commission's findings have shaped the transformation of mental health care over the past decade. The commission found that fragmentation of services was the most frequently identified problem by consumers and their families and the commission identified no fewer than 42 different federal programs offering services for mental illness. This fragmentation created a scattered distribution of resources and left consumers and families responsible for navigating and coordinating their care through a maze of agencies. The commission ultimately recommended a total transformation of how mental health services are delivered (Hogan, 2003).

One of the goals outlined by the commission was that mental health care should be consumer and family driven including an individualized plan of care for every child with serious emotional disturbance and more choices being offered. Wraparound programs for children were identified as an example of a method to reach this goal and to address the issue of fragmentation of service provision (Hogan, 2003).

In the United States from 2005-2006, approximately 15% of children (8.3 million), 4-17 years of age, had parents who spoke with either a health care professional or school staff about their child's emotional or behavioral difficulties (Simpson, Cohen, Pastor, and Reuben, 2008). Over 5% of children received medication as a form of treatment and over 5% received treatment other than medication or in addition to medication for emotional and behavioral difficulties (Simpson, Cohen, Pastor, and Reuben, 2008). Treatment was received from a variety of sources including, mental health private

practice, clinic or centers, the child's school, pediatric or general practitioners (Simpson, Cohen, Pastor, and Reuben, 2008).

Children who experience emotional and behavioral disturbances are more likely to be absent from school, have lower grade point averages, have lower graduation rates, lower reading and math scores, and are more likely to be involved with the criminal justice system (Kutash, Duchowski, Sumi, Rudo, & Harris, 2002; Mihalas, Morse, Allsopp, & McHatton, 2009). In 2006, \$8.9 billion was spent nationally for the treatment of children's mental disorders (Soni, 2009). Data from 2008 demonstrates that children who received treatment for emotional and behavioral difficulties had improved emotional and behavioral functioning, reduction in the use of inpatient facilities, a reduction in suicide attempts, increase in regular school attendance, and a reduction in suspension or expulsion from school (Blau, Huang, and Mallery, 2010). However, most of the children requiring treatment for mental health issues were still not receiving the services they require (Bruns et al., 2010).

In 2010, 10% of children in North Texas (Denton, Hood, Johnson, Parker, Tarrant and Wise counties) suffer from mental health problems and disorders (Jackson, Zhang, Tubb, Legrice, & Cardarelli, 2010). Of the parents with a child with a mental health issue, 20% reported that their child was unable to receive treatment for it. Similarly to the Simpson, Cohen, Pastor, and Reuben, 2008 national study, children in North Texas with mental health issues also had academic problems, behavioral problems at school, increased arrests or trouble with the police, increased suspensions, were more likely to bully and be bullied, attempted suicide at higher rates, struggled with self-esteem issues and exhibited eating disturbances (Jackson, Zhang, Tubb, Legrice, & Cardarelli, 2010).

Factors to Seeking Services

Research has found various factors that increase likelihood of mental health service usage. Boys are more likely to receive services for mental health issues than girls. Also, as a child ages service usage increases. Children with psychological disorders and functional impairments are more likely to receive services (Horwitz, Gary, Briggs-Gowan, & Carter, 2003). Externalizing problems are more likely to be treated than internalizing issues. The nature and severity of a child's issues impacts the stress on the family and in turn is a contributing factor for service use. If the condition is creating financial strain, disrupting family and social life and having other negative effects, mental health treatment is sought (Brannan, Heflinger, & Foster, 2003).

Factors are not limited to the profile of the child. Parents with higher education levels are more likely to seek treatment for their children. In addition, stressful life events such as divorce, relocation or death in the family can exacerbate the child's condition and at the same time interfere with consistent treatment being received (Brannan et al., 2003). A family's perception of the mental health system can affect help seeking behavior. If the family associates a stigma to seeking mental health treatment this would serve as a barrier. Other barriers include transportation, childcare provision, not having insurance or insurance not covering services, service availability and cultural considerations (Oilin et al., 2010; Rodriguez, et al., 2011).

Family constellation plays a role in seeking mental health services. Families with two parents sometimes feel they have necessary resources such as coping skills, dedication, patience and a partnership among the parents to deal with the issues in the home rather than seeking outside help. Whereas, single parent led families more readily recognize their limitations in dealing with the problem and will seek outside assistance (Brannan et al., 2003; Gaskin, Kouzis, & Richard, 2008).

Systems of Care

As part of the transformation of how mental health services are delivered to families of children with mental health issues including Serious Emotional Disturbance (SED) in an effort to eliminate fragmentation and inadequacy, the systems of care approach was adopted. The systems of care approach views the child within a family system and thus provides services to the family as a whole and allows involvement of caregivers in the planning, shaping and monitoring of the child and family treatment (Brannan, Heflinger, & Foster, 2003).

The systems of care philosophy requires collaboration across jurisdictions to provide necessary services to children with complex problems. It also dictates that services be community based and delivered in a culturally competent manner (Hodges, Ferreira, & Israel, 2012; Cook and Kilmer, 2012; Bruns et al., 2010).

There are four main guiding principles of systems of care (Cook and Kilmer, 2012). First, services should be individualized and strengths-based for each family. Next, in order to maximize choice a wide range of services needs to be offered to the family. Also, collaboration among agencies is vital in order to provide integrated and coordinated services. Finally, early identification and intervention is crucial to increase positive outcomes. Systems of care empowers families by recognizing them as the experts of their life and giving them “voice and choice.”

Wraparound Services

The most predominant method of systems of care service model utilized almost nationwide is wraparound (Bruns & Walker, 2011). A well-developed system of care provides a conducive context in which wraparound can be implemented (Walker & Sanders, 2011). Currently, wraparound is available in almost every state, 88%, and is

implemented state wide in over half of the states, servicing over 100,00 children and their families annually through 800 wraparound programs (Bruns & Walker, 2011, Walker & Sanders, 2010, Bertram, Suter, Bruns, & O'Rourke, 2011, Bruns, Sather, Pullman, & Stambaugh, 2011). In alignment with systems of care philosophy, wraparound tenets include individualization, cultural competence, strengths-based, outcome-oriented and requires a high level of collaboration (Walker, Bruns, Conlan, & LaForce, 2011, Walker & Sanders, 2011). Over the last ten years, research has expanded on wraparound and strides are being made to establish it as an evidence-based practice.

Unlike traditional methods of delivery in which families were often stigmatized, blamed and disrespected, wraparound recognizes the role of the family as the expert. Additionally, traditional systems of delivery included inpatient facilities and clinic-based outpatient therapy, whereas, wraparound focuses on a community-based approach (Farmer, Dorsey, & Mustillo, 2004). Wraparound has evolved the role of the child's family from consumer to decision maker increasing their self-determination (Bruns & Walker, 2011). The challenge in this model is to ensure that family members are properly educated and provided the resources necessary to make appropriate decision about care (Davis et al., 2011).

A major component of wraparound is the team that is created to assist the family. The team is often comprised of the caretakers, the child if age appropriate, extended family, friends and providers of services with a wraparound facilitator guiding the efforts (Walker, Bruns, Conlan, & LaForce, 2011, Walker & Sanders, 2011, Bruns et al, 2006). Teams consisting of four to seven members have been found to be the most effective. Because of the small size there are better attendance rates and they work as a cohesive group (Munsell, Cook, Kilmer, & Vishnevsky, 2011).

One of the roles of the team is to identify the strengths of the family, develop a plan based on these strengths and identify specific measurable goals to track progress throughout the process, so necessary adjustments can be made (Cook & Kilmer, 2012). Together they develop the wraparound plan identifying a unique set of services that can provide continuity of care addressing the complex needs of the child and family (Walker & Sanders, 2011).

Wraparound provision also provides training and support for team members to better respond to the needs of the child and family (Bruns et al., 2011). Support has been shown as a factor in reducing stress and improving health outcomes and the wraparound team offers this crucial element to the child and family (Davis, Gavazzi, Scheer, & Uppal, 2011). There are two types of support: perceived and enacted. Perceived support is when the child and family feel that adequate support is available should they need it and removes the sense of isolation. Enacted support is when others do something whether the support be emotional, instrumental or informational. Both types of support are necessary for positive outcomes (Davis et al., 2010; Davis et al., 2011).

By focusing on community based treatment options, the high expense of out of home placement is avoided (Bruns et al., 2011). Also, community agencies become better attuned and able to respond to the needs of their community creating a stronger connection between community members and agencies (Davis et al., 2011).

Service providers must collaborate together to offer the necessary spectrum of services needed by the child and families. Sometimes this requires organizations to implement system changes to accommodate wraparound and possibly offer training to staff. Key to successful coordination of services is communication and flexibility (Bruns et al., 2006). Service providers are beginning to recognize wraparound services as an

effective practice and the research is expanding and setting standards which programs must meet in order to be classified as wraparound giving it more credibility and legitimacy (Bruns et al., 2010.)

High levels of satisfaction have been found with the family and children served with wraparound and this satisfaction extends across diverse populations. However, wraparound was being implemented in various ways across the nation and there was some confusion as to whether wraparound was a philosophy, a model or a treatment. To eliminate some of this confusion, the National Wraparound Initiative (NWI) was formed in 2004 with 80 members including family members, advocates, youth consumers, service providers, administrators and policymakers (Walker, Bruns, Conlan, & LaForce, 2011). The NWI identified ten necessary elements for wraparound: family voice and choice, team based, natural supports, collaboration, community based, culturally competent, individualized, strengths based, persistence and outcomes based (Effland, Walton, & McIntyre, 2011).

Although the focus of wraparound is the family as a whole, often the mental health issues of the child become the sole focus of efforts and other needs within the family are overlooked. When this happens, a major opportunity is missed to address the needs of younger siblings and possibly provide prevention or early intervention services (Cook and Kilmer, 2012). In addition, one of the goals of wraparound is to assist families in building and maintaining connections to their community and their social support system, but many times these resources are excluded and dependence is placed on professional resources (Kilmer and Cook, 2012).

Proper implementation of wraparound requires organizational support, appropriate staff selection and training, effective coaching and system level partnerships resulting in wraparound fidelity (Effland, Walton, & McIntyre, 2011; Bruns et al., 2011).

Wraparound fidelity has been found to result in positive outcomes for children involved in wraparound services (Cook and Kilmer, 2012; Effland, Walton, and McIntyre, 2011; Bruns et al., 2006, Graves and Shelton, 2007).

Implementation of wraparound has not been found to be consistent across agencies (Munsell et al., 2011). Further research is needed to determine what core elements are not being implemented and to identify training and resource needs across agencies. Wraparound fidelity will also provide credence to wraparound outcomes studies. Crucial to the process of wraparound fidelity is the wraparound facilitator building rapport and trust with the family in order to gain a better understanding of the family dynamics, the shortcomings of previous interventions and to continuously monitor the changing needs of the child and family and respond accordingly (Munsell et al., 2011).

Another core element found in wraparound fidelity is team member consistent participation and the extent to which the tenets of wraparound are applied when the team develops a plan of care. Other areas interfering with wraparound fidelity could include systems issues at agency levels that may interfere with coordination of delivery of services (Munsell et al., 2011).

Wraparound services are supplied until formal wraparound is no longer deemed necessary and that determination is made by the team (Walker and Sanders, 2011). At the conclusion of wraparound service provision, the family should be infused with self-efficacy and have acquired necessary skills to navigate the systems and to cope with the stress brought about from their circumstances. They should feel more competent and capable to contend with future issues instead of being so heavily dependent on service providers (Graves and Shelton, 2007).

Community Based Mental Health Agency Program

A Community Based Mental Health (CBMH) agency program implemented wraparound services to institute system of care reform in six counties in Texas. The program serviced children aged 0-6 years with SED and their families. For fiscal year 2010 and 2011 a total of 67 children were enrolled in this CBMH agency program. The target goal was 50 per year.

Following the tenets of systems of care practice and the wraparound model, the program attempted to address fragmentation of services, provided early intervention in community based settings utilizing culturally competent, evidence based and family driven services while empowering the family. The program was federally funded through SAMHSA, US Department of Health and Human Services. The program was currently in their third year and the \$8.3 million will continue services until September of 2014 (Painter et al., 2011).

Chapter 2 Methodology

Wraparound services were provided in six counties in Texas by a Community Based Mental Health (CBMH) agency to families with children aged 0-6 years with Serious Emotional Disturbances (SED). Qualitative data was collected from caregivers participating in the program. Collection of qualitative data allows respondents to focus on their individual experience in their own words often answering open-ended questions. The responses collected provide rich and detailed descriptions that otherwise would not be captured with the use of quantitative data collection methods (Appleton, 1995). This data was provided for analysis to determine what benefits and deficits were reported in team participation, if any barriers to team building were identified by respondents and to identify any themes among the responses.

During this agency's previous System of Care program, caregiver participants expressed concern and frustration over the national instruments used for data collection, which were quantitative and did not allow them to aptly express themselves. Thus, a new qualitative measure was developed by a Community Evaluation Team (CET) consisting of caregivers and youth who previously received wraparound services. Participants in the CET were chosen by the agency's evaluators. Each family was assigned to an agency evaluator. After six months of program participation when the family had developed a good understanding of wraparound services and the purpose of evaluation, if the evaluator thought the family would like to participate in CET or if the family had expressed interest in participating in other meetings or events related to children and mental health, the evaluator told them about the CET and invited them to participate (Painter et al., 2011).

The CET conducted a Family Experience Study during a prior System of Care grant and themes identified from that study along with other areas of importance

identified by the CET were developed into qualitative questionnaires. Feedback and suggestions were made at several CET meetings and the questionnaire was specifically discussed during at least two CET meetings.

Three qualitative questionnaires were developed. For the purpose of this paper, responses to the follow-up questionnaire are being analyzed. The follow-up questionnaire consists of five multi-part questions. The first question pertains to improvement, which is the overall goal of the wraparound program. Rapport with the wraparound facilitator and progress of wraparound teams are addressed in the second question. Since the wraparound facilitator is such a crucial element to the entire process, having a good rapport is vital to the success of the program. Likewise, the wraparound team ideally should continue even after formal services are withdrawn so it is critical that these teams are established and properly implemented while participating in the program.

The CBMH agency partners with other agencies and organizations within the community to provide additional services (Painter et al., 2011). Participation in these other community mental health programs is discussed in the third question to ascertain if participants are availing themselves of these additional resources. One of the first resources provided to the family is The Family Guide, which is roadmap to the wraparound process and includes information, definitions of common terms, charts, and tables to help the family understand the program. Each guide is personalized with specific information deemed to be beneficial to that family. The Family Mentor is an additional resource that makes contact with the caregiver to provide support and information. Question four asks about the use of the Family Guide and Family Mentor. The final question asks about benefits of wraparound and is more open ended to allow respondents an opportunity to speak to anything not specifically addressed earlier in the questionnaire. See Appendix A for a list of the questions.

Data Collection

Questionnaires were administered verbally by the family's assigned evaluator either in the caregiver's home or another community location chosen by the caregiver such as a park or restaurant. The agency has an internal research division, which operates independently from service delivery. Evaluators were from the research division of the agency. New evaluators would review materials and then they would observe supervisors and experienced evaluators in the field. After multiple observations, an evaluator would be observed several times by a supervisor before conducting evaluations on their own. Questionnaires were administered in English and Spanish when necessary. Responses were recorded by the evaluator by hand and later entered into a database. Evaluators also included responses that did not directly correspond to questions asked as they often revealed significant information about caregiver experience.

All participant families were asked to complete the questionnaires. Once they indicated they wanted to participate in the evaluation process, consent was obtained in written form. See Appendix B. Most families opted to participate in the evaluation process. Confidentiality was maintained by assigning each family a code number as they entered the program. Responses to the questionnaires were coded with that number and no personal identifying information was included. All information was maintained in a locked file cabinet and a password protected database that was only accessible by the research division.

Between December 2010 and April 2011, the follow-up questionnaire was administered to 24 caregivers. Of the 24 caregivers interviewed during this time, 17 were at six-month follow-up and seven were at 12-month follow-up. No others had progressed further in the program at that time. Data provided for this paper was de-identified and

approval was obtained from both the University of Texas at Arlington's IRB and the agency's IRB.

Process of Analysis

An adapted form of Grounded Theory was utilized during the analysis process. Grounded Theory is an inductive research method that allows the data to guide the process (Coyne & Cowley, 2006). It is a process that is fluid during which the researcher analyzes the words, language and meanings of the data collected and is then coded repeatedly as to not miss any important themes, descriptions or theories, which are identified during the process (Walker & Myrick, 2006). This process allows the variables to emerge from the data instead of a researcher approaching the data with preconceptions on what the variables should be and attempting to make the data fit those preconceived notions.

The researcher did not create a coding sheet prior to analysis thus allowing the data to drive the process. First, the researcher read each interview three times. Then, the researcher went back through each interview line by line and began open coding. Inductive coding processes were used for analyzing this data. Indicators were identified which are words, phrases or sentences. The concept behind each indicator was coded. Coding allows for comparison, identification of categories and themes and organization of the data (LaRossa, 2005). Themes were extracted within each category. The themes were synthesized while still allowing the integrity of each response to be maintained (Aguirre & Bolton, 2013). Sub-themes within each theme were also identified. The researcher repeated this process with the data until all concepts were exhausted and themes were condensed.

Trustworthiness

In order to establish credibility, triangulation was utilized to ensure all categories and themes were identified and exhaustive and that data was categorized appropriately (Barusch, Gringeri, and George, 2011). Two members of the thesis committee analyzed the data in the same manner as the researcher to generate codes and themes.

The researcher and committee members met to review categories and themes generated. This allowed consistencies and differences in interpretation to surface, which led to reflexivity and eliminated threats to trustworthiness (Lietz, Langer, & Furman, 2006). A consensus was reached and the agreed upon categories and themes were utilized moving forward.

Chapter 3 Results

Analysis of the responses to the qualitative questionnaires resulted in the identification of seven themes. These themes included: 1) program benefits; 2) wraparound facilitator characteristics; 3) wraparound team implementation; 4) implementation barriers; 5) program limitations; 6) juxtaposition of program appreciation despite lack of perceived effectiveness; and 7) other desired resources. As part of this study, each theme identified a number of sub-themes. Each theme is discussed below in detail along with any sub-themes identified within each theme.

Program Benefits

“Things have been going wonderfully well...I've gained a lot from [the program] so far!” After six or twelve months of participation in the program, many of the caregivers stated that the program was beneficial and that it was progressing well. Five sub-themes were identified from the specific benefits identified by caregivers.

Improvement

“They've improved a great deal!” was the response of one caregiver when asked if there had been any improvement at home and school. Improvement in the behavior of the child was the primary goal of the program. “Yes, things have improved. There are less fights with his brothers,” stated one caregiver about progress in the home.

Some respondents perceived significant improvement at school. One caregiver reported that things have, “improved greatly and school is great.” “Things have been going well and have improved at school. My child's behavior has been improving,” responded another.

One caregiver discussed how being around the other children had helped her son, “Yes, can definitely tell he’s learning and being around other kids taught him to go to the bathroom more, more independence and more social skills.”

Two parents specifically mentioned an improvement to their children’s communication skills. “My kids have learned to communicate so much better and they have mellowed out a lot,” answered one caregiver. The other stated, “Yes, [my child] has absolutely improved a great deal. He is even speaking some and learning signs. He has finally moved up to his age group, the twos in his Child Development Center class.”

A few respondents disclosed that their children had seen improvement in behavior in either school or at home, but not both. Some of the caregivers reported that this early in the program no improvement in behavior had yet to be realized.

Skills

“I’ve learned a lot, how to cope with [my child], how to get services for [my child], how to help him,” are some of the skills one caregiver identified obtaining through participation in the program. Several of the caregivers had acquired skills to assist in dealing with their children who had been identified as having SED. The acquisition of these skills was another program benefit they identified.

“I’ve learned to have patience and be a little easier,” stated a caregiver. Several caregivers reported learning to be more patient when dealing with their child. Another caregiver also responded, “I have learned patience and how to try different activities to calm him down.” “Teaching me how to be a little more patient, be more open, not as closed as I was. I’m open to more suggestions now as a family than I was,” are some of the skills one caregiver described gaining.

Two caregivers discussed having a better understanding of their children and how to help them. For example, one caregiver stated, "I understand what issues need to be taken care of." And another responded, "A better way of understanding my child and dealing with him."

Other types of skills obtained by participating caregivers are more practical. "Better routines to make things run smoother," answered one caregiver. Another stated, "They've helped me with strategies, counseling, ways of trying more things with my daughter."

The holistic approach of wraparound provided both the child whose behavior brought the family to the program and the caregiver of the child with a set of skills that could potentially help the family to function more harmoniously.

Wraparound Team

One of the tasks a caregiver was charged with during the program was to organize their wraparound team. The wraparound team was to meet periodically to discuss the child's progress, the family's needs, and strategies on how to meet those needs. The hope was that even after completion in the program, the wraparound team would remain a resource of which the family could continue to avail themselves.

One caregiver expressed her initial skepticism and surprise at the benefit that came from her team, "I never thought the way to fix problems was to bring in extra people for a team, but it seems to be working well for us."

The program assisted the family in putting together the team and provided direction for what the role of the team should be. This was found to be beneficial as expressed by a caregiver, "Overall team concept is what we were doing before, but without wraparound, we would've wasted time figuring stuff out."

“My team is great. They help me out. They genuinely care about us,” expressed a caregiver. Once the wraparound team was established, a major benefit of the wraparound team identified by caregivers was support. Another caregiver explained, “The team gives me support. I remember at the beginning, I didn’t think I needed a team! Man, I am glad I have their support now!”

Resources

The program provided families with various types of resources, both tangible and intangible. Most of the caregivers found some of the resources helpful. One of the first tangible resources given to a caregiver was the Family Guide, which included information about the program, contact information for various resources in the community and was customized to their situation.

Caregivers were asked if they received the Family Guide and if it was useful. Some of the caregivers found this resource helpful. “Yes, I have the guide. It’s been a big help,” replied one caregiver. Another caregiver stated, “I read it before, the whole thing. Yes, it was helpful.” Some of the caregivers revealed that they had not read it, but found it assuring to know they had it just in case they needed to look up something like this caregiver, “I received the guide and I haven’t read it too much, but it is helpful if I need something.”

A few caregivers found the Family Guide to be informative. One caregiver learned about resources that were available to the family, “It has helped me understand services and support that is out there for us.” Another used it to assist in organizing the wraparound team, “The guide helped me get my team together. Yes, it’s great.”

A caregiver stated, “Yes, it has helped out so much, so has my mentor.” Each family was assigned a Family Mentor who made contact early on in the program to serve as an additional resource to the family. Many caregivers did not utilize this resource extensively, but a few who did found it beneficial. For example, one caregiver said, “I speak with her weekly. Has provided an excellent service.”

All participant families were given information about other community programs pertaining to mental health and children. The families were encouraged to attend these activities. “Yes, we attend...meetings once a month and it is very helpful,” reported one caregiver.

Several families attended playgroups and found them to be useful. “Yes, the...playgroups. We like it. I’ve learned a lot,” replied one caregiver.

Some caregivers were invited to participate in the Community Evaluation Team (CET) and found it to be educational. According to one caregiver, “Yes, I’ve been a member of your CET and I like what I’m learning there.”

The wraparound facilitator also often assisted families with accessing services in the community. Sometimes the wraparound facilitator assisted families with access to medical care. “Wraparound has helped me a lot and to get some things that we couldn’t get on our own in the form of services. [Wraparound Facilitator] helped me get an appointment with Dr. [Name],” replied a caregiver whose child met with a psychiatrist.

Some of the families experienced financial hardships and the program was able to assist them with transportation or fuel reimbursement to attend meetings. During the holidays, a party was held for the families during which the children received gifts. Appreciation was expressed by a caregiver, “[Wraparound Facilitator] offered to reimburse our gas for the holiday party and we’re going too because it is the only thing I know my kids might get for Christmas.”

The following statement came from a caregiver who was assisted with community resources for her children and for herself:

[Facilitator] helped us find a camp for the girls to go to this past summer. They also went to the YMCA until school started. [My child] was in Head Start for the summer and [Facilitator] helped me. I didn't pay anything. [My child] goes to a counselor once a week. [Facilitator] got me in an anger management class.

Intangible resources were also vital assets obtained by caregivers. Many caregivers expressed having recently gained a sense of hope about their child's future. As explained by a caregiver, "Yes, hope and confidence that I am handling this problem correctly. They have provided me continuous support."

Several caregivers felt more confident in their abilities to care for their children. For example, "Yes, I feel Wrap has really helped us all get confidence in dealing with [the child's] behavior," replied one caregiver.

By providing support, some caregivers felt empowered such as the caregiver who stated, "Yes, they have supported me and they have shown me that I can be dependent on myself."

Wraparound Facilitator

"My wrap facilitator is a lot of support and keeps me centered," stated one caregiver. The wraparound facilitator was the primary contact for the program with the families. The wraparound facilitator assisted families in a myriad of ways including providing resources, assisting with putting the wraparound team together and was often a member of the wraparound team. Because of the substantial role the wraparound facilitator played with the family, the wraparound facilitator was often seen as a benefit of the program.

The wraparound facilitator often provided information to caregivers whenever questions would arise. “[Wraparound Facilitator] just usually is who I ask about things and she always has the answers,” replied one caregiver.

An additional source of support was another way many caregivers viewed the wraparound facilitator as demonstrated by the caregiver who stated, “I’m just glad I have [Wraparound Facilitator] to talk to.” The following statement from a caregiver illustrated the various ways the wraparound facilitator often helped families:

Now, I ask the wrap facilitator things and she helps me to understand...My wrap facilitator has covered all our bases and then some. She even cooked me a turkey for Christmas...I’ve gotten some valuable support and friendship from the wrap facilitator and I never expected to get so much from her. It is good to know I have that kind of support!

Wraparound Facilitator Characteristics

Some of the questions asked of the caregivers were intended to judge the rapport between the families and their wraparound facilitator. An outcome of the analysis of the responses resulted in the identification of five sub-themes: 1) available; 2) effective communicator; 3) has best interest of family in mind; 4) competent; and 5) negatives/barriers.

Available

“My wrap facilitator is always available and easy to talk to. She always calls me right back,” reported a caregiver. Most of the caregivers commented that their wraparound facilitator was readily available to them, usually by phone. Another caregiver stated, “She is always available when I need her and returns calls quickly.”

The caregivers were able to contact their wraparound facilitator for information, “Usually call the wrap facilitator if need something.” Caregivers were also able to call the

wraparound facilitator for support as stated by a caregiver, “Things have improved because I have [Wraparound Facilitator] to call now.”

Effective Communicator

“Wrap facilitator is very easy to talk to. That’s what’s been so wonderful,” expressed a caregiver. Respondents were asked directly if their wraparound facilitator was easy to talk to and most responded in the affirmative. One caregiver elaborated by saying, “Yes, wrap facilitator is great and wonderful to talk to.” Another stated that the facilitator is, “Very easy to talk to.” Similarly, “Our wrap facilitator is definitely easy to talk to and understand,” reports another. This sentiment was repeated by many caregivers such as, “Our wrap facilitator is so easy to talk to!”

Caregivers often translated the effective communication skills of the wraparound facilitator as positive character traits. For example, one caregiver stated, “[Wraparound Facilitator] is great to talk to and cares a lot.” Another said, “Yes, she is very easy to talk to and very kind.”

One caregiver expressed how she felt her wraparound facilitator was one of the few people with whom she could be truly honest.

I feel my wrap facilitator is wonderful. I can be honest about everything with her. You know how you get asked by well-meaning folks all the time how you are doing? Well, I always say, “Fine, fine.” And I’m not. With [Wraparound Facilitator] I can answer honestly and that is such a big stress reducer to have someone to whom you can respond honestly with the truth.

Language barriers could have been an obstacle to communication between wraparound facilitators and caregivers. One caregiver described how the wraparound facilitator overcame this obstacle, “Yes, a little bit because she speaks a little Spanish

and I speak a little English, but [Wraparound Facilitator] brings someone with her who speaks Spanish when we don't understand each other. "

For the majority of caregivers, the wraparound facilitator was seen as an effective communicator and this was important to the progress of the program and assisted in building rapport.

Best Interest

"She seems like she cares about my kids' well being," expressed a caregiver when asked if the caregiver felt the wraparound facilitator had their best interest in mind. Another responded, "Wrap facilitator, I really like her. I didn't like the first one, but this one does have our best interest at heart." "Yes, she is very easy to talk to and she is interested and invested in our family," said another caregiver. Many caregivers responded with a simple, "Yes."

One of the caregivers viewed the assistance received in accessing resources as an indication of the wraparound facilitator having her entire family's best interest in mind, "Yes, she helps with many things: my health, things that come up, helps us find other professionals for us to see."

One caregiver talked about how the wraparound facilitator went above and beyond and succeeded in making Christmas special for the family.

Ever since my mom died, I've never been able to celebrate Christmas without feeling horrible because she used to decorate a lot and had activities for us every day before Christmas. Because of you all with [the program] and my wrap facilitator, I can be happy about it again. My wrap facilitator did so much for me with a huge bag of toys and stuff for my son and then a bag of stuff for me! I was so surprised because I didn't expect anything. Then, she gave me all the goods for the Christmas meal and cooked a turkey!

Competent

“She’s very good. She does her job well...when [Wraparound Facilitator] gets involved, she’s involved, but I haven’t needed her as much as other families,” stated a caregiver. Most of the caregivers expressed that they could rely on their wraparound facilitator to effectively assist in many ways, which is an indicator of competence. Another caregiver said, “Wrap facilitator was so great for everything.”

Additionally, most caregivers stated that their wraparound facilitator had explained the program including graduation to them, which gave them an understanding of what to expect from the program and how it should progress.

Negatives/Barriers

A few of the caregivers had some negative experiences with their wraparound facilitator or had difficulty reaching their wraparound facilitator. However, none of the respondents gave purely negative feedback. Negative comments were usually mixed with positive throughout the interview.

One caregiver seemed disillusioned when the wraparound facilitator appeared to not be as available to the family as before, “Things changed a lot since January. We have a lot less contact with our wrap facilitator and I have been feeling like something was up, like she was told not to spend as much time with us as she has been.”

Another caregiver’s child was exhibiting increasingly negative behaviors and the caregiver experienced frustration in accessing appropriate resources to address these behaviors. The caregiver was dissatisfied with the perceived minimal or inadequate assistance received from the wraparound facilitator.

Lately she won’t call or text back when I call her, so no, she’s not easy to talk to. I feel she sometimes has my best interest, but lately...since I told her about my son’s violent episode and she said to wait and see what [Evaluation] said, whenever

we finally get in, she seems hard to reach....[I] met some of the other client's of hers and we all exchanged numbers and they tell me that she's really bad about returning their calls too.

Wraparound Team Implementation

An additional third theme that emerged from the data was implementation of the wraparound teams. Three sub-themes were identified. One sub-theme was the size of the wraparound teams. Wraparound teams ranged in size from three to ten members.

The second sub-theme was the composition of the wraparound teams. Most wraparound teams consisted of family, friends and the wraparound facilitator. Several wraparound teams also included representatives from other agencies. One caregiver described their wraparound team as including, "family, therapists (speech and occupational), friends, school." Another caregiver said, "It includes the office manager of Head Start, his teacher, grandmother, me and [Wraparound Facilitator]."

The final sub-theme identified was meeting consistency. Only about half of the respondents were having wraparound team meetings on a regular basis. There were several barriers identified by the caregiver as to why team meetings were not being held consistently or at all. These obstacles are addressed in the theme below of Implementation Barriers.

Implementation Barriers

Caregivers identified many barriers obstructing full participation in the program and/or having wraparound team meetings on a consistent basis. Some were unable to put the team together or had not yet held a wraparound team meeting at this stage of the program. Two sub-themes of obstacles were identified, client specific and program structure.

Client Specific

Caregivers identified several barriers to properly implementing wraparound teams. A few of the families had not yet been able to put their wraparound team together. They were unable to identify people willing to commit to being on the wraparound team. "I'm still trying to find people to be on the team. Most of the people I thought could be on the team became unreliable," explained a caregiver. Another caregiver stated, "I have a feeling we need to re-pick those on our team. It seems that they aren't as willing as they first appeared to be."

Despite being unable to put together a full wraparound team, one family continued to persevere with the meetings, "Our team is [Wraparound Facilitator] and us two. We just don't have other people, but we have meetings."

"I feel that it is hard to get everyone together for a meeting," explained a caregiver. Once team members were determined, scheduling conflicts often became an obstacle in planning the meetings. Another caregiver stated, "No, we haven't really ever got one [team]. We were supposed to, but we didn't. Everyone's busy. We have a list of people, but can't get them all to meet at the same time." Another caregiver seems hopeful despite the encountered difficulty in getting everyone together, "We haven't met yet because of different things such as schedules, but we will meet soon."

A few families were also experiencing marital problems which made program participation and wraparound team meetings difficult to coordinate. This difficulty was explained by a caregiver, "Things have been slow because we haven't been able to get the team together. There have been some emotional issues in my marriage, which slowed us down and crises."

Another caregiver's primary focus had to change from program participation to handling her divorce, "My goal is divorce and who gets the kids because it's not closed yet." One caregiver was currently residing at a shelter and explained that the situation had hampered program progress, "Things have not improved under the situation, the separation and situation with the family."

In one family, the illness of a child's sibling impeded regularly meetings at times and was adversely affecting the child's behavior.

With the health problems of my older daughter who is terminal with Lupus and has had recent serious strokes and was in the hospital ICU last month, this makes [my child] act out worse. She says she will die when [older sister] dies. Lots of crying jags...My team does meet regularly when my older daughter is not in the hospital or ICU. She in ICU last month and it was so scary. She's home now.

Program Structure

One caregiver commented that the structure of the program did not conform to the resources they had available for putting together a wraparound team.

It's more the program itself. There's this assumption that people have all these supports and don't know it and you just have to pull out the wheel and put names there. Not everybody has that. We have supports in care of emergency, but everyday people work and at first the team sounded good, but it just doesn't work for us.

Because of financial difficulties, one caregiver expressed frustration at having to go to the office of the wraparound facilitator to have meetings and seemed disheartened by one experience that did not go well when she went to the wraparound facilitator's office.

I always have to go to her office for meetings and sometimes I have no gas... But she's never offered to reimburse me for gas when I go to meetings at her office. She only came to my house once or twice at the very beginning. ...No, we aren't having regular meetings because we've only had two so far. Once, we all went and she was late and everyone else had to leave! We drove to her office for nothing!

Program Limitations

Four areas of program limitations were identified and grouped as sub-themes: 1) Family Guide; 2) Family Mentor; 3) participation in other meetings; and 4) frustration with resources.

Family Guide

“I have the guide, but I’ve never even touched it,” stated a caregiver. A few caregivers stated that they never received a Family Guide. Several stated that they never read it or did not use it often like the caregiver who said, “I have glanced at it, but not really used it.” Another stated, “Yes, we received the guide and have rarely used it at this point.” A few read it and did not find it useful. “A lot of info provided in there we already knew, so it wasn’t that helpful,” reported one caregiver.

Family Mentor

Only a few of caregivers said that they had not been assigned a Family Mentor or had never spoken to one. Several other caregivers said that they had limited contact with the Family Mentor and contact usually took place early in the program. “I have only spoken with her once in the beginning of the process,” stated one caregiver. Another said, “I spoke to the mentor on the phone once at beginning of services, but I don’t remember much about it.”

Because of the minimal contact with the Family Mentor, the Family Mentor was not viewed as a benefit of the program by a caregiver who stated, “I think I spoke to a Family Mentor one time, but that was way at the beginning so I haven’t really gotten

much out of the...Family Mentor yet.” Another caregiver stated that they “haven’t had the need to call the Family Mentor much.”

Other Meetings

Caregivers are encouraged to attend meetings such as support groups and other agency community meetings about children and mental health. Of those who stated they had not attended, only one said they had no interest in attending, “No, honestly I don’t think we need to go.” There was no perceived benefit in attending by this caregiver.

Others discussed why they had not been able to attend a meeting. A busy schedule was a common obstacle to attendance like the caregiver who explained, “No, we have not participated in other meetings due to family obligations and work.”

Another caregiver identified transportation and scheduling as a barrier to attending, “No, because of timing. I need transportation with lots of seats to haul the kids and myself and husband around all at once.”

Frustration with Resources

Caregivers are also provided with resources to address specific issues with their child or family. Although, the wraparound facilitator assisted families with access to services, the agency had no control over the quality of services provided by the outside resources.

Some of the caregivers expressed the frustrations they experienced when attempting to avail themselves of community resources. Two caregivers encountered wait lists. One caregiver stated, “I’ve been frustrated that there’s not enough services that you trust with services and wait lists and then you find they are not interested in helping you.”

Another caregiver facing a wait list wanted the program to fill the hole in service provision and stated,

I'm very worried right now because my son is showing violent behaviors and the wrap facilitator said to just wait for the [Agency] assessment, but they will take six to twelve months. I cannot wait that long. My son pulled a butter knife and held it to my daughter's throat. He's four. I think he needs more help and the services have helped with some things, me for instance, but I need them to help with my son's behavior and they aren't yet.

One caregiver was disqualified from receiving legal services from a community agency because of past criminal history and the blame for being unable to use the resource was transferred to the wraparound facilitator who had tried to help.

I do think that the wrap facilitator should know enough about resources not to send you on a chase when they send you somewhere they know cannot help you. See, specifically [Agency] refused to help with legal aid for divorce because I have some convictions of misdemeanors.

A wraparound facilitator assisted one caregiver in scheduling a doctor's appointment for her child for which the caregiver was appreciative. However, the caregiver then expressed her dissatisfaction with the provider, "...the meds do NOT work and I was surprised at how quickly Dr. [Name] met with us and then let us go. How can he know in such a short time that [my child] has to have meds? Why would he prescribe something so strong it made him scream?"

If the child was old enough to attend school, the child's school often became an additional resource for families and the school system had programs in place to address the needs of these children. However, the school was a source of discontent for one caregiver who stated, "I've been frustrated with the school not being willing to give him mere Behavior Plan for an IEP. I still am frustrated with the school."

Juxtaposition – Appreciation/Effectiveness

“Things [with wraparound] have been going well. Things [child’s behavior] have not improved under the situation,” responded a caregiver. While analyzing the data, a juxtaposition emerged of caregivers expressing that things were going well with wraparound and/or that they had gained benefits from participation in the program and despite that there was no perceived improvement in the child’s behavior which was the primary goal of the program. This contradiction was seen in the following response, “Everything is going pretty well right now with wrap....My child’s behavior is still pretty unpredictable at school...She recently bit a girl who told on her and pointed her finger in her face, so she bit her wagging finger.”

“It’s been going good...Not really gained anything from wrap that has helped overall, but I’m just glad I have [Wraparound Facilitator] to talk to,” stated one caregiver. Caregivers perceive the support they are receiving as beneficial and a sign that the program is going well even though there may not be perceived improvement in their child’s behavior.

No, haven’t gained anything really. I wish. I’m really frustrated though. It has helped me, but not with [child’s] behavior. I need help with my son’s violence and I don’t see why we have to wait six to twelve months when he’s violent. Wrap facilitator did help us, but she hasn’t helped my son yet.

Since respondents are only six to twelve months along in the program, they are seeing a more immediate effect in the support they are receiving even though it has not yet translated into improvements in behavior as expressed by a caregiver, “Things have improved because I have [Wraparound Facilitator] to call now. Things haven’t had a chance to improve yet....Wraparound has helped me a lot and to get some things that we couldn’t get on our own in the form of services.”

Other Desired Resources

The final theme that emerged from the data was the desire for additional resources. A caregiver living in a rural area stated, "I wish this town would get a Big Brothers program started." Another family was obviously experiencing serious financial difficulties with which assistance was required as demonstrated by this statement, "We never have food and we need more help than we're getting."

A few of caregivers expressed a need for education on specific issues. One caregiver stated, "I need more information on how to handle Bipolar and ADHD and integrating them together with the behavior issues." Another caregiver expressed interest in additional education by saying, "I'd go to a meeting or a training that had someone discussing behavior or meds."

Chapter 4 Discussion

Through the analysis of qualitative responses of caregivers participating in a wraparound program administered by a Community Based Mental Health agency, the purpose of this study was to identify the benefits received, program limitations, obstacles to participation and any themes in responses. Seven themes, each with sub-themes, were identified: 1) program benefits; 2) wraparound facilitator characteristics; 3) wraparound team implementation; 4) implementation barriers; 5) program limitations; 6) juxtaposition of program appreciation despite lack of perceived effectiveness; and 7) other desired resources.

Program Benefits

Participation in the program yielded several benefits for families. Caregivers were asked specifically about improvement in their child's behavior, which is the program's stated primary goal. However, what is actually being measured is the caregiver's perception of any improvement in their child's behavior. If each caregiver were given goals that are measurable, a better measure of improvement over time may be able to be captured (Bruns et al., 2010). Caregivers could speak to the success or lack of success in reaching these goals and respond to the question with more concrete examples instead of using broad sweeping statements or simple yes/no responses as many of the caregivers gave.

The wraparound program was able to assist the target children indirectly by empowering caregivers with new skill sets. Several of the caregivers discussed acquiring patience and a better understanding of their child's needs which allowed them to better implement the strategies they learned in dealing with their child. These coping skills benefitted both the children and caregivers.

The wraparound team served as a source of caregiver support, which allowed the caregiver to not feel so isolated. A few caregivers expressed initial skepticism about the wraparound team concept, which was overcome when they found their wraparound team to be beneficial.

Wraparound treats the entire family and not just the child with SED. In line with this, caregivers participating in this agency's program stated that resources were provided for needs of the family and not just the target child. Families were often referred to outside resources to help with various needs that arose within the family. Occasionally, the Wraparound Facilitator would intervene with another agency on behalf of the family to ensure that services were provided. In addition, some families received assistance in the form of gas cards or transportation to facilitate access to these resources.

Several caregivers discussed the bond that had formed between them and their assigned Wraparound Facilitator. This relationship was often viewed as a benefit of the program. The Wraparound Facilitator was a strong source of caregiver support and someone the caregiver could rely on to assist with a myriad of needs.

Wraparound Facilitator Characteristics

A key component to the wraparound process is the Wraparound Facilitator. Therefore, caregivers were asked about their perception of their Wraparound Facilitator. Their responses offered insight into the rapport established. The responses provided identified characteristics that were important in building the caregiver/Wraparound Facilitator relationship. These included the Wraparound Facilitator's availability, effective communication, competency and having the family's best interest in mind. When caregivers felt their Wraparound Facilitator exhibited these character traits, a greater

satisfaction with the program was expressed. However, the few who found these traits lacking in their Wraparound Facilitator expressed frustration.

Wraparound Team Implementation/Implementation Barriers

Several of the respondents reported that their wraparound team was not meeting on a consistent basis and others reported that after six or twelve months of program participation, a wraparound team had not yet been organized. This is significant because research has shown that the ability of a team to accomplish their goals is impacted negatively by team member turnover and inconsistent team participation as there is a disruption in cohesion and functioning which interferes with implementing the plan of care (Munsell et al., 2011).

The primary obstacle to proper wraparound team implementation cited was scheduling conflicts. One factor that may help overcome this barrier is to keep the team size relatively small. Research has shown that fidelity to implementation is more easily maintained with a wraparound team consisting of four to five members and that the team is more effective at this size (Munsell et al., 2011; Wright, Anderson, Kooreman, and Wright, 2006).

Team composition was found to consist primarily of family, friends and the wraparound facilitator. A few teams did have representatives from other agencies. Professionals, other than the wraparound facilitator, may be hesitant to commit to team participation because they have daily schedules that must be maintained and meetings at off hours cut into their personal time. Some programs are attempting to encourage more professionals to become involved in wraparound teams by creating a reimbursement code that professionals could use when attending such a meeting (Munsell et al., 2011).

Program Limitations

The Family Guide is one the first tangible resources provided to participant families upon entry into the program. The Family Guide provides information about the program and additional resources relevant to each specific family. Most caregivers reported having received the Family Guide, but many did not actually utilize it regularly and some never read it. Several of the responses suggest that the guide was often bypassed when information was needed and instead a call was placed to the Wraparound Facilitator. Possibly, the caregivers felt that it was easier to call the Wraparound Facilitator. However, this creates reliance upon the Wraparound Facilitator for information that they already have at their disposal. Perhaps, someone should sit down with the family early in the program and review the Family Guide so that a better understanding of its usefulness may be gained and the caregiver can be more self-reliant. After all, once program participation concludes, the Wraparound Facilitator will not be an available resource. Also, this would free up the Wraparound Facilitator's time to deal with more pressing matters.

Initially, the program had intended to have several Family Mentors and for each Family Mentor to be assigned a set of participant families (Painter et al., 2011). However, this was not actualized and there was only one Family Mentor for all of the families. While a few caregivers found the Family Mentor to be a continued source of support, most reported having minimal contact with the Family Mentor, which occurred at the beginning of program participation. In order for the Family Mentor to be a more viable resource to families, perhaps a second contact should be made by the Family Mentor further along in the Wraparound process after the family has become adjusted to the program. Entering a new program can at times seem overwhelming and participants may feel as though they are receiving a deluge of information all at once. This second contact

could prevent this resource from being lost in the initial barrage of information. Also, additional Family Mentors could be recruited from successful program graduates as the program progresses.

Some families stated that they were attending regularly in community meetings pertaining to children's mental health with other agencies or participating in support groups. Several of the caregivers who had not yet attended any such events expressed interest in participation. The data set was collected at six and twelve month participation time frames. Perhaps with further time in the program, their situations may stabilize more and allow them to be more available to attend additional events.

Since one agency is unable to provide services for every need that may arise within a family, Wraparound Facilitators often refer families to outside community resources for assistance. During the wraparound process, families come to depend upon and trust their Wraparound Facilitator and it is important to maintain that trust. For this reason, it is vital for the facilitator to keep up to date on different types of services, such as financial, legal, transportation, and medical, provided by agencies in the community and also be aware of any restrictions on service provision. This will help establish further credibility with the family for the facilitator. If a facilitator does refer a family to an agency with whom they have limited knowledge, it is important to convey that limitation of knowledge to the family. This could prevent backlash against the facilitator should the agency be unable to provide requested services.

Juxtaposition – Appreciation/Effectiveness

Many families did perceive improvement in their child's behavior. However, several of those who did not perceive improvement in the child's behavior, still found the program to be beneficial. This created a seemingly lack of consistency in responses.

This inconsistency may be explained because the caregiver was receiving additional sources of support that they were not previously receiving and it may have made the situation seem more manageable despite a lack of improvement. When discussing the benefits received from the program, many of the caregivers talked about the support they received from the Wraparound Facilitator and their Wraparound Team and how helpful it was to them. This support may have created a new environment for caregivers where they no longer felt isolated in coping with stress.

Some caregivers also reported having received a new skill set to assist in dealing with their children such as patience and practical skills. The combination of these two factors, support and skills, which directly affect the caregiver, may be responsible for the perception that the program is working despite the lack of improvement in the child's behavior. This can be seen as a positive outcome of the program since research has shown that over time caregiver support will result in the child's treatment needs being met (Davis et al., 2011).

Other Desired Resources

Consistent with other research, transportation was a common barrier to accessing other resources. Obstacles such as financial, transportation and child care are even more prevalent for families living in rural areas (Brannan, Heflinger, and Foster, 2003) and many of the participant families resided in rural counties. These families often have limited access to local professional service providers and would benefit from collaborations formed between the program agency and clinicians who are sensitive to the needs of this population and can respond accordingly (Bruns et al. 2010).

Program implementation was in some cases adversely affected by a lack of resources for basic needs of the family. One caregiver expressed not even having

enough food for the family. If a caregiver is unable to provide for the most basic needs of the family, it is difficult for any focus to be placed on emotional issues being experienced by one the children. Over half of the participant families reported a household income of less than \$20,000 annually placing them below poverty level (Painter et al., 2011). Perhaps one of the first steps of program participation is to ensure the family has access to sufficient resources to provide for the basic needs of the family possibly ensuring more full participation in the wraparound process.

Study Limitations

The data analyzed in this study was collected previously by the Community Based Mental Health agency implementing wraparound services. Therefore, the researcher was unable to return to respondents to validate the statements as coded as recommended by Grounded Theory. Also, during the collection process responses were hand written and then transcribed. Recordings of responses lend more credibility that responses are accurately documented.

For the purpose of this study, only the second of the three questionnaires was analyzed, which represents caregivers participation at the six or twelve month mark in the program. To determine if there is continued improvement and if any of the changes are long lasting further study of the final questionnaires would be needed.

Implications for Research

Since the Wraparound Facilitator fills such a key role in the wraparound process, further research is needed on the best practices of effective Wraparound Facilitators. Focus should be placed on how they effectively utilize their time to meet the needs of

their clients while also empowering the caregivers to be more and more self-reliant as the wraparound process progresses.

Proper wraparound team implementation appears to be a major obstacle for many participant families. Further research could focus on specific steps and timelines for organizing an effective wraparound team. This could include key characteristics to seek out when choosing people to participate in the wraparound team.

The final recommendation for future research would be in the area of collaboration among agencies. Collaboration is one of the ten identified elements necessary to successful wraparound (Efland, Walton & McIntyre, 2011). Collaboration should include a wide range of agencies that can respond to various needs families may have such as, financial, transportation, health, employment, food, and housing. Further research should look at if collaboration is being actualized and if so how is this facilitated so that it may be replicated with agencies who may not be experiencing similar success.

Chapter 5 Conclusion

Many of the caregivers identified benefits they received while participating in the wraparound program which included support from the wraparound facilitator and their wraparound team, a new skill set that helped them while dealing with their child and access to resources both tangible and intangible.

However, fidelity in implementing wraparound teams was not being met by many of the participating families. Obstacles to effectively implementing the wraparound teams were found to be finding the right people to commit to being on the team and scheduling conflicts preventing all members to attend consistently.

Finally, a need for additional services emerged from the data. These deficits in resources such as financial, transportation and child care often interfered with families being able to fully participate in the program or prohibited access to other agencies to receive additional services.

Appendix A
Follow-Up Questionnaire

Question 1: How are things going with wraparound? Has there been any improvement at the home, school, daycare, etc. If so, how have things improved? If not, why do you think things have not improved?

Question 2: Is your wraparound facilitator easy to talk to? Do you feel she/he has your best interest in mind? Has she explained the graduation process to you? Has your wraparound team been meeting regularly? Please describe the makeup of your wrap team.

Question 3: Have you had the opportunity to participate in any other meetings (online or in person) such as support groups, advocacy groups or other meetings focusing on children's emotional, behavioral and mental health? If yes, was the information helpful? If not, how could Hand in Hand help enable you to attend and encourage you to participate in such a meeting?

Question 4: Have you received the Family Guide to Hand in Hand and Wraparound from your Family Mentor? Have you used it often? If yes, how has it helped you? If not, did you not find it helpful? How often have you spoken with your Family Mentor? Has the Family Mentor provided an additional, helpful resource for you to use?

Question 5: Have you gained anything from wraparound that has helped you while working with your child and family?

Appendix B
Consent Form

Hand in Hand: Planting Seeds for Healthy Families

(Consent to Participate) Parent/Guardian/Legally Authorized Representative and their Minor Child

You and your child are invited to participate in a study of infants and pre-school children who have been identified with an emotional disturbance. This study will try to learn how best to help your child and serve your family. A federal Center for Mental Health Services (CMHS) grant was awarded to MHMR of Tarrant County in order to evaluate a community-based mental health service system for infants and pre-school children and their families.

This project involves interviewing you up to 5 times: when you and your child begin wraparound services and then every 6 months for 2 years. You will be asked to continue participation in the study even if you and your child stop receiving services from this project. The interview will take about two to three hours to complete. You will receive a \$20 gift card from a discount or department store (Wal-Mart, Target) at the end of each interview for your time and effort.

To the extent allowed by the Privacy Act of 1974 and the Health Portability and Accountability Act (HIPAA) of 1996, everything that you talk about will be kept confidential. The information from other agencies, databases, people you identify to help us stay in contact with you, interviews, contents of locator forms, and questionnaires will be confidential. This confidentiality, however, does not cover everything. For example, it does not apply to disclosure of medical information in cases of medical emergency, reporting if you are likely to harm yourself or others, or when reporting suspected child abuse and neglect.

The Evaluation & Outcomes Division of MHMR of Tarrant County received a Certificate of Confidentiality on 11/30/2009 from the federal government to protect the people who interview you from being forced, even under a court order or subpoena, to identify you or provide certain other information about you. This certificate offers a special protection for your information. It does not imply that the government has approved or disapproved of this project. An exception occurs if the interviewers learn about child abuse or neglect or they are told that you or your child plans to harm yourselves or someone else. In these cases, the interviewer will notify the appropriate authorities. Also, the US Dept of Health and Human Services may review records that identify you as part of an audit.

In addition to your consent to participate, the Division is asking for permission to collect, use, and disclose protected health information about you and your child. Under federal law, researchers cannot collect, use, or disclose health information without your permission. The following types of information will be collected and used: what's been going on with your family and what types of services that you and your child received, including mental health and substance abuse treatment. This information is needed to develop and evaluate the project. If you deny permission, you cannot participate in the study but you can receive wraparound services. Your child's participation in treatment will not be affected no matter what you decide.

A code number will be assigned to your family so that your name will not be connected with the information transmitted electronically to the national researchers. Files with identifying information will be kept in locked files behind secure office doors in the local offices of the researchers at MHMRTC. Computer records that will be created for data storage and analysis will be kept confidential for research purposes only and will remain without names. Researchers will summarize this information with that of other caregivers. The reports issued will not include your name or social security number. All forms will be shredded two years after

the project has ended (10/1/2016). This includes information that would identify you, such as your name and social security number. Giving your social security number is voluntary.

The Evaluation & Outcomes Division would like your okay to contact some persons and agencies whose names are listed on the last two pages of this consent (pages 4-6). Researchers want to see what help your family gets during the time of this study. In addition, those listed may help us locate you for follow-up interviews you agree to by participating in the study. These agencies usually require your written okay before they will release any information. As explained before, this information will be kept confidential.

The risks associated with participating in this study are as follows:

- Having confidential information collected;
- Being asked personal questions about your family and your child's problems;
- Being inconvenienced by the time spent in interviews;
- Experiencing stigma for having used mental health services;
- Feeling threatened by something new and different;
- The confidentiality does not cover everything. It does not apply to disclosure of medical information in cases of medical emergency, reporting if you are likely to harm yourself or others, or reporting suspected child abuse and neglect.

As a participant in this project, you understand that:

- Your participation in the evaluation is voluntary. You may choose to quit at any time without consequences.
- Whether or not you participate in the evaluation will not negatively affect your child's treatment or legal status.
- Your answers to the interview questions will not affect your child's treatment in any way.
- You do not have to answer any questions that you do not want to answer.
- You can stop the interview at any time without any negative consequences. However if you do not intend to continue at a later, at a more convenient time, we ask that you provide the evaluator with the reason for leaving the study.
- Your identity will not be revealed in any report written about this study or to anyone outside of it without your okay in writing except for circumstances listed above.
- Your answers will be kept in a locked file in a locked room by the research staff.
- Responses to questions asked of the family will be shared with the national research contractor without identifying information.

The Institutional Review Board of Mental Health Mental Retardation of Tarrant County reviews research studies to ensure that safeguards have been provided for privacy and confidentiality. It has approved this research study. The Director of Client Rights for MHMR of Tarrant County and Chairperson of the MHMR Institutional Review Board is Paul Duncan. Please contact him at (817) 569-4429 if you have questions about your rights as a participant. Dr. Kirstin Painter is the research coordinator for this study. Please contact her at (817) 569-4443 for concerns about the study.

Authorization for Participation and To Collect, Use, or Disclose Health Information for Research Purposes: Your signature below indicates that you have read or had read to you the above and have decided that you will participate in this study and will give permission for the

protected health information, of you and your child named below, to be collected, used, and disclosed for the purposes noted previously. Its general purpose, the details of involvement, and possible risks and benefits has been explained to your satisfaction. You give permission to the agencies, providers, and individuals listed on pages 4-6 to release protected health information for these purposes.

This release is for information on services provided and data collected on you and your child during the term of this grant and six months after (until 3/1/2015). The information may also be used to locate you so that you can participate in the follow-up interviews for research purposes only. Therefore, you give permission for research staff of this project to be given information about the whereabouts of you and your child.

You still have the right to stop at any time and discontinue without consequences after signing this form. However, any information that has already been collected may still be used if the evaluators need it to assist in the completion of the research study.

This authorization shall end six months after the term of this study (until 3/1/2015). Your signature indicates that you understand the voluntary nature of this research project and are willing to participate. By signing, you still have the right to stop your and your child's participation at any time without consequences. **Your signature also indicates that you have a copy of this form.**

Child's Name (Print)

Legally Authorized Representative's Name (print)
Date

Legally Authorized Representative's Signature Date

Evaluator Certification:

My signature indicates that I have read and explained the details of this consent to the participant whose signature is affixed above. I gave the opportunity for questions to be asked and answered. It is my opinion, that the participant understands the form

Evaluator's Name (Print)
Date

Evaluator's Signature (Person obtaining authorization) Date

Permission to be Photographed: I give permission to have a photograph taken of my child and family. This photograph is for follow-up purposes only. The only persons to have access to this photograph are staff on the evaluation team.

Legally Authorized Representative's Initial here: _____

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Biographical Information

Misty R. England received a Bachelor of Arts in Communication from the University of Texas at Arlington in 1997. After several years of success with a career in the corporate realm, Misty decided to return to school to pursue a Masters degree in Social Work and expects to graduate in the Summer of 2013.

Misty had the opportunity to work with veterans during an internship at the Department of Veteran Affairs in Fort Worth. During her other internship, Misty worked at Mental Health Mental Retardation of Tarrant County. During her time at this agency, Misty worked with adolescents at an inpatient rehabilitation facility and facilitated smoking cessation groups with the Mental Health Division of the agency.

After graduation, Misty will obtain her LMSW and seek employment with an agency where she hopes to work with adolescents with mental health issues. After two years, Misty hopes to obtain her LCSW and may pursue a PhD in the future.