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A Comparison of School-Based and Community-Based Adherence to Wraparound During Family Planning Meetings

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Abstract

Recently a number of studies have begun to examine how the wraparound approach is adhered to during family planning meetings in community-based settings. However, no studies have compared wraparound family planning meetings across community-based and school-based settings. The purpose of this study was to examine adherence to the wraparound approach during family planning meetings across school-based and community-based settings to determine if there is a difference in the participants, domains discussed, and key characteristics of wraparound. Over the course of 9 months, observations were conducted on community-based (N = 85) and school-based (N = 109) wraparound family planning meetings. Results indicate a number of similarities and a few differences between the settings. Implications, limitations, and suggestions for future research are discussed.

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Children and youth with emotional and behavioral disorders (EBD) evince a range of behaviors that adversely affect their educational performance and cannot be explained by intellectual, sensory, or other health factors (Individuals with Disabilities Education Act, 1997). These behaviors can include a number of internalizing and externalizing characteristics that inhibit their ability to build and maintain successful social relationships with peers, teachers, and adults. Historically, educational programs for these students have not been associated with positive outcomes (Kauffman, 2001). When compared to other disability groups, students with EBD have lower reading and math scores, lower rates of graduation, and are less likely to attend post-secondary school (Kauffman, 2001). As a result, youth with EBD traditionally experience problems in education and employment, and over half will be arrested at least once within 3 to 5 years of leaving high school (Wagner & Blackorby, 1996). A national study of school programs demonstrated that a lack of appropriate services, inadequate coordination and integration with service agencies, and limited support for families contributed to these poor outcomes (Knitzer, Steinber, & Fleisch, 1990).

Historically, therapeutic and support services for children with emotional disturbance (ED) and their families have been supplied by a variety of agencies including mental health, child welfare, and juvenile justice agencies (Knitzer, 1982). Over the last two decades there has been increasing recognition that these services have been inadequate, fragmented, and increasingly reliant on institutional care (Knitzer, 1982; U.S. Department of Health and Human Services, 1999). In response to the lack of

individualized and coordinated services for children with EBD and their families, the wraparound approach was developed to provide services within a system of care. A system of care is a framework for providing a comprehensive array of mental health and related services that are organized into a coordinated network to meet the needs of children and youth with EBD and their families (Stroul & Friedman, 1996). Within the system of care framework, wraparound has evolved as an approach for delivering individualized services to children with EBD and their families (Lourie, Katz-Leavy, and Stroul, 1996).

Wraparound has been defined as "a philosophy of care that includes a definable planning process involving the child and family that results in a unique set of community services and natural supports individualized for that child and family to achieve a positive set of outcomes" (Goldman, 1999, p. 29). There are 10 key characteristics of the wraparound approach: a) services and supports must be community-based; b) services and supports should be individualized, strength-based, and address the needs of children and families across multiple life domains; c) the approach must be culturally competent and focus on the unique values, strengths, and social and racial make-up of the families; d) families must be viewed as full and active partners in the approach; e) the approach must be a team-driven process that works together to develop, implement, and evaluate the plan of care; f) wraparound agencies must have access to flexible, non-categorized funding; g) wraparound plans must include a balance of formal and informal supports; h) communities, agencies, and teams must provide services on an unconditional basis; i) treatment plans should be developed and implemented on an interagency basis; and j) outcomes must be identified and measured for the child and family at every level of

service (Burns & Goldman, 1999). The results of a 1998 survey of state child mental health directors, estimated that as many as 200,000 children and families nationwide are being served through the wraparound approach (Faw, 1999).

Originally, wraparound was initiated in community-based settings with mental health and child welfare agencies serving as the entry point for services (Burns & Goldman, 1999). Recently, however, education has begun to assume a lead role in initiating the delivery of services based on the wraparound approach (Burns & Goldman, 1999). Although it has been suggested that wraparound in community-based and school-based settings adhere to the same elements and requirements of wraparound, these different types of organizational approaches may vary in the degree and nature in which they adhere to the principles of wraparound (Burns & Goldman, 1999). For instance, in separate studies that examined the implementation of wraparound in community-based and school-based settings, it appears that when schools served as the entry point for services, meetings were more likely to focus on educational domains, include parents and teachers in the planning process, and provide an agenda which resulted in a more organized meeting (Epstein et. al., 2003; Epstein, Nordness, Gallagher, Nelson, Lewis, & Schrepf, in press). However, when community-based services serve as the entry point for services, meetings where more likely to include a family advocate, focus on cultural domains, and include informal supports, such as friends, neighbors, and extended family members (Epstein et. al., 2003; Epstein et. al., in press).

Given these different organizational approaches to planning wraparound, research is needed to determine if there is a difference in how wraparound is adhered to during family planning meetings across community- and school-based settings. Given the

increasing popularity of the wraparound approach for children with EBD and their families, understanding how the approach in school-based settings compares to community-based settings is essential for determining which approach may serve a child and family's needs the best.

One method for assessing the wraparound approach is to observe the planning of formal and informal services during family planning meetings. Family planning meetings are organized by a care coordinator trained in the wraparound approach and are held monthly, or as needed, to design, revise, and evaluate a plan of care for the family in the presence of formal and informal supports. The purpose of this study was to assess adherence to the wraparound approach during family planning meetings across school-based and community-based settings to determine if there is a difference in the participants, domains discussed, and key characteristics of wraparound.

Method

Setting

Team meeting observations were conducted on families participating in an evaluation designed to examine the impact of a system of care for children with ED and their families in Lancaster County, Nebraska. Lancaster County includes the Lincoln metropolitan area and surrounding communities with a population of approximately 275,000. The system of care that facilitated the wraparound approach was Families, First, and Foremost (F3), a project funded by the Center for Mental Health Services, Department of Health and Human Services to establish a comprehensive system of care in Lancaster County. The intent of F3 was to organize a coordinated network of supports using the wraparound approach to meet the complex and changing needs of children with

EBD and their families. F3 provided wraparound services at 6 school-based locations and 8 community-based cultural centers.

Participants

In this study, 46 families served through school-based and 37 families served through community-based wraparound delivery models were observed during family planning meetings over the course of nine months. The average number of observations conducted on each family was 2.33 (range 1 to 4) and the average number of times a care coordinator was observed was 13.85 (range 4 to 18). Six care coordinators from 6 schools in the Lincoln Public School system and 8 care coordinators from the community-based agencies were observed during the family planning meetings. The average family case-load for the school-based care coordinator was 8. The community-based care coordinators maintained an average of 4. The smaller case load average for the community-based care coordinators was due to half of the care coordinators being employed part-time.

F3 served 119 families of children with EBD in Lancaster County. Families were eligible for inclusion if their child was between 5 and 18 years of age, identified by a child-serving system as having EBD, and had experienced substantial limitations in particular life domains (e.g., family, school, relationships) due to emotional or behavioral problems. Families in the school-based approach were referred from the participating schools and families in the community-based approach were referred from the cultural community centers. Participation in the evaluation and observation was optional for families.

Informed consent for the observations was obtained through verbal and written consent. When care coordinators scheduled a family planning meeting, the family was asked if it would be acceptable for an observer to attend the meeting. Once verbal permission had been granted, an observer attended the meeting with an Observer Confidentiality Statement and Permission Form. Before the start of the meeting the Observer Confidentiality Statement and Permission Form were signed by the observer, care coordinator, and caregiver.

Observation Measure

The Wraparound Observation Form-Second Version (WOF-2) was used to assess adherence to the key characteristics of wraparound during family planning across both settings. The 48-items of the WOF-2 gathers information on 8 key characteristics of the wraparound approach including: (a) community-based services (e.g., information about resources/interventions in the area is offered to the team); (b) individualized services for the family (e.g., all services needed by the family are included in the plan); (c) family driven (e.g., the family is asked what goals they would like to work on); (d) interagency collaboration (e.g., staff from other agencies have an opportunity to provide input); (e) unconditional care (e.g., for severe behavior challenges, discussion focuses on safety plans rather than termination); (f) outcomes that are measurable (e.g., the plan of care goals are discussed in objective, measurable terms); (g) management of team meeting (e.g., key participants are invited to the meeting); and (h) care coordinator (e.g., care coordinator makes the agenda of the meeting clear to participants). Each of the 48 items are operationally defined in the WOF-2 observation manual and require the observer to select one of the following three responses: Yes, No, or Non-Applicable. The WOF-2 is

scored by totaling the applicable responses for the items under each of the eight key characteristics. The total score indicates how much an essential element to the wraparound process is adhered to during family planning meetings. Seventeen of the 48 items relate to specific care coordinator behaviors, including the six items under the care coordinator characteristic. The remaining 31 items refer to team related behaviors, which may include the family as well as the formal and informal supports at the meeting. In addition to the 8 key characteristics, the observer records the participants at the meeting and their relationship to the child, life domains discussed in the plan of care, and the length of the team-planning meeting . Previous research has established the WOF-2 to be a reliable instrument for assessing adherence to the key characteristics of wraparound during family planning meetings (Nordness & Epstein, 2003).

Training procedure. Four graduate research assistants and an individual hired from the community were trained to use the WOF-2 through a series of steps. First, the observers were instructed on the philosophy of the wraparound approach and the need for instruments that can reliably measure wraparound. Second, the purpose of the WOF-2 and how it is used to assess the implementation of the wraparound process during family planning meetings was explained to the observers. Third, observers were given the WOF-2 manual that operationalizes each item on the form. Observers then read the manual thoroughly. Fourth, the observers met with the primary investigator to discuss any questions or concerns they had regarding the manual. Fifth, each observer observed a wraparound family planning meeting without filling out the WOF-2. The purpose of this was to familiarize the observer with the wraparound meeting process without having

to worry about completing the form. Finally, the observer in training went to three meetings with an already trained observer to demonstrate inter-observer agreement.

Inter-observer agreement was assessed on an item-by-item basis at each of the three family planning meetings. If the observer in training disagreed with the trained observer on a particular item, they would discuss the item to ensure future agreement. If they disagreed on an item more than once, the observer in training and the trained observer discussed the item further, and attended a fourth meeting to ensure agreement on the item.

Data Collection Procedure

Data were collected over the course of 9 months, during 109 school-based family planning meetings and 85 community-based family planning meetings. The observations were conducted in the following manner. First, prior to each team meeting, the care coordinator obtained the family's permission for an observer to attend the meeting. Second, before the meeting began, the observer presented the parent and the care coordinator with an observer confidentiality statement to verify family permission for the observation and to assure the confidentiality of the observation. Third, the observer sat in a location away from the participants so as to not distract from the meeting. Fourth, the observer noted the participants and their role at the meeting, as well as the meeting time and location. Fifth, during the course of meeting the observer marked a Yes, No, or N/A (not applicable) to each of the 48 WOF-2 items. Sixth, at the conclusion of the meeting any questions that needed further explanation (e.g., convenience of the arrangements for the family) were asked of the family or care

coordinator. Finally, the data were entered into a database and a photocopy of the WOF-2 was sent back to the care coordinators for their own use.

Interobserver agreement checks were conducted on 20% (N = 39) of the observations by having two observers independently observe a family planning meeting using the WOF-2. Observations were distributed among care coordinators and observers. The average percent inter-observer agreement across each WOF-2 item was 97.7% with a range of 85% to 100%. An agreement of 100% was obtained on 32 items. Additionally, an average Kappa statistic of .91 with a range of .44 to 1.0 was obtained across the same observations. Thiry-six of the 48 items exceeded .80, which is considered "perfect" in the benchmarks described by Landis and Koch (1977). Only two items were below the .61 level, which is the cut-off for demonstrating substantial strength of agreement.

Results

Given that the data was not independent, the findings can only suggest that there may be a significant relationship between the variables. To determine if there was a difference in the implementation of the wraparound process in community-based and school-based settings, a two-way contingency table analysis using crosstabs was used. A two-way contingency analysis is a chi-square test used to evaluate whether a relationship exists between two variables. The chi square test is an appropriate test to use when analyzing differences in response totals between two categorical variables (Green, Akey, Salkind, & Akey, 1999). The two variables examined were center (i.e., school-based, community-based) and the response variable (i.e., yes, no) for participants, domains, and the eight key characteristics of wraparound measured by the 48-items of the WOF-2.

Participants present. A summary of the comparison between community-based and school-based settings for meeting participants are presented in Table 1. The most frequent professional support to attend the family planning meetings across both settings were mental health therapists. The most frequent informal supports for the school-based settings was extended family members, whereas, friends and neighbors were the most frequent informal supports for the community-based settings. The results suggest that there may be a statistically significant difference in the attendance of three participants during family planning meetings. Teachers and other professionals such as a job coach or parole officer, were more likely to attend school-based family planning meetings, whereas a family advocate was more likely to attend community-based family planning meetings.

Domains discussed. A summary of the comparison between community-based and school-based settings for domains discussed are presented in Table 2. The most frequently discussed domains for the community-based and school-based settings were education and home. The least discussed domains included safety, culture, and substance abuse. While the education domain was frequently discussed across both settings, it was discussed more in school-based settings than in community-based settings.

Comparison of School-Based and Community-Based Adherence to Wraparound. A summary of the comparison between school-based and community-based settings in their adherence to key characteristics of wraparound is presented in Table 3. To determine if there was a difference in the adherence to key characteristics of wraparound, the number of applicable Yes/No response scores under each characteristic was summed and a chi square analysis was conducted. For the purpose of analysis, N represents the

number of applicable responses under each key characteristic of the WOF-2. The Yes column reports the number times the key characteristic was observed during family planning meetings, and No shows that elements of the key characteristic were not observed during family planning meetings. The numbers in parenthesis represent percent occurrence.

The results suggest that there may be a statistically significant difference between the community-based and school-based settings for two of the eight characteristics at the .01 level: Interagency Collaboration and Care Coordination. The school-based settings adhered to the Interagency Collaboration characteristic 99% of the time, whereas the community-based settings adhered to the characteristic 90% of the time. For Care Coordination, the school-based settings adhered 95% of the time, whereas the community-based settings adhered 85% of the time.

Discussion

The purpose of this study was to compare adherence to the wraparound approach during family planning meetings across community-based and school-based settings. Based on the results from the 194 observations across school-based and community-based settings there were very few differences in the procedures that were adhered to during wraparound meetings. Across participants the increased participation of teachers and other professionals in the school-based settings was not surprising, as we would expect the increased access, or immediate availability of such supports to increase their participation in wraparound. The increased participation of family advocates in the community-based settings is most likely due to the collaborative nature of the community centers working in conjunction with family advocacy groups to support the families

Consistent with previous research (Epstein et al., 2003; Malysiak-Bertram, Bertram-Malysiak, & Duchnowski, 1999), there was limited participation by informal supports across settings. Informal supports, such as family friends are an essential component of the process as they can serve as social supports for the family that can exist beyond public funding. Across domains, discussion related to the education was [significantly] higher in the school-based settings as one might expect with the increased participation of school personnel in the family planning meetings.

In adherence to the essential elements of wraparound, there was a difference across two of the eight of the characteristics measured by the WOF-2. The Interagency/Collaboration and Care Coordinator characteristics were more likely to be adhered to in the school-based settings than in the community-based. The Interagency/Collaboration characteristic measures the amount of formal and informal collaboration evidenced during family planning meetings and includes items that observe the attendance of formal/professional supports during family planning meetings and the chance for formal and informal supports to provide input during meetings. This difference may be explained by the advantage of school-based wraparound programs having access to trained professional staff, access to supportive services, and mandated service delivery mechanisms (Eber, Nelson, & Miles, 1997) readily available for the child and family. The second difference was for the Care Coordinator characteristic. This characteristic specifically targets care coordinator behavior during family planning meetings. Therefore, explanations for the discrepancy in adherence may be related to management, supervision, hiring practices, and training of care coordinators across the settings. Describe any specific differences in these areas you know of.

Many of the findings from this study were similar to previous research. For instance, both settings demonstrated high adherence to providing individualized services, a family driven approach, unconditional care, and appropriate management of the team meetings. However, both settings had difficulty involving informal supports in the process and discussion related to substance abuse and culture remains low. In addition, both settings had difficulty adhering to the Community-Based Services and Measurable Outcomes characteristic. The Measurable Outcomes characteristic includes items that review of short and long-term goals within the plan of care. While many care coordinators review short-term goals on a monthly basis, they may neglect to review long-term goals that should include a plan for exiting wraparound.

Limitations

There are several limitations in the present study that should be recognized. First, the data for the present investigation came from a single system of care that was managed in a mid-size, Midwestern city. Therefore the findings from this study may not generalize to other communities. Future research should replicate this study in other communities to determine how well the findings generalize to other systems of care around the country. Second, it is often easier to measure adherence than it is to measure competence in treatment research (Chambless & Hollon, 1998). The WOF-2 was designed to measure the occurrence or nonoccurrence of behaviors that adhere to the wraparound approach. It does not assess the competence with which those behaviors were demonstrated. For instance, goals and objectives may be identified as being discussed in a family planning meeting, but those goals and objectives may be inappropriate or not designed to address the family's specific needs. Research is

emerging to recognize the importance of measuring competence as well as adherence in outcome research (Chambless & Hollon, 1998). However, there is a limited sense of how to best measure the quality of implementation in treatment research (Chambless & Hollon, 1998). Nonetheless, future research on the WOF-2 needs to consider the quality and competence of the behaviors as they are carried out. Third, the WOF-2 does not measure the cultural competence element of wraparound. Several items to assess cultural competence were included in the initial WOF, but because of the difficulty in reliably observing these behaviors during family planning meetings, they were deleted from the scale. Fourth, the presence of observers at family planning meetings may have some effect upon the behavior of the participants. Future research might examine observer effect by using alternative observation strategies such as audio or videotapes. Fifth, the influence of care coordinator background factors such as educational background, ethnicity, and training on planning meetings were not examined in this study. These factors may influence care coordinator performance and impact how wraparound is implemented during family planning meetings. Similarly, child and family demographic factors such as age, gender, and income were not examined in this study. Future research should consider the impact of these factors on adherence to the wraparound approach. Sixth, the subscales of the WOF-2 were not examined to determine if they are independent of each other or not. Future research should conduct additional analysis to determine the relationship among the items within the scale. Finally, the WOF-2 was designed to measure the wraparound process during family planning meetings. It does not measure how well the planned for services were actually implemented. In the future,

researchers will need to extend the research beyond planning meetings into community and school settings.

Future Research

There are several areas in need of further study including those that have already been mentioned (i.e., measuring competence, the implementation of wraparound beyond meetings). First, previous research on community-based mental health interventions has found that consistent adherence to treatment improves outcomes that pertain to adolescent behavior (Henggeler, Melton, Brondino, Scherer, & Hanely, 1997). Future research should determine the relationship between adherence to the wraparound approach and child and family outcomes. Second, future research should examine the relationship between the participants, domains, and key characteristics to determine if a correlational relationship exists between the variables. For instance, it may be that discussion on the mental health domain is related to the attendance of therapist at the family planning meeting. Understanding such relationships would increase our understanding of how these variables interact and influence family service delivery. Finally, to improve the implementation of wraparound, future research should examine factors that relate to adherence or none adherence to the wraparound approach. For example, it could be that specific formal (e.g., teachers, therapist) and informal (e.g., grandparents, boyfriend/girlfriend) supports impact adherence to the elements of wraparound during family planning meetings by helping the family attend the meeting and advocate for the welfare of the family.

Implications

The implications from this study suggest that there are few differences in the implementation of wraparound across community-based and school-based settings. From an organizational perspective, these findings support the use of school-based and community-based programs as a vehicle for implementing the wraparound approach. Both settings were able to focus discussion across a variety of domains and adhere to a family driven process. However, the school-based setting did seem to benefit from access to additional supports as demonstrated by a greater adherence to the interagency collaboration characteristic. The implications from this finding may suggest that families in need of additional professional supports may benefit from the access a school-based approach provides. From an agency perspective, the findings highlight some of the strengths and weaknesses associated with both approaches to service delivery. Finding ways to increase the participation of informal supports and effectively measure outcomes are areas in need of additional attention across both settings. Furthermore, participants in the community-based setting may need additional training to improve interagency collaboration and care coordinator performance. From a research perspective the findings from this study suggest that different settings for implementing wraparound may lead to differential adherence to the wraparound approach in some areas. As different methods of implementing wraparound continue to emerge, further investigations will be useful in determining which approach may best address the needs of children and families.

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Table 1

Comparison between Participants in Community-Based and School-Based Family Planning Meetings

Variable	School (n = 109) N (%)	Community (n = 85) N (%)	X^2
Family Participants at Meetings			
Mother only	75 (69)	67 (79)	3.55
Child	66 (61)	55 (65)	.35
Siblings	18 (17)	20 (24)	1.49
Both parents	26 (24)	10 (12)	4.62
Extended Family (Grandparents)	21 (19)	12 (14)	.90
Non Family Participants at Meetings			
Therapist	53 (49)	33 (39)	1.86
Mentor	10 (9)	11 (13)	.70
Family Advocate	12 (11)	22 (26)	7.31*
Health & Human Services Rep.	23 (21)	8 (9)	4.86
Teacher	38 (35)	13 (15)	9.44*
Family Friends (neighbors)	14 (13)	15 (18)	.87
Other Professionals	27 (25)	8 (9)	7.62*
School Counselor	12 (11)	4 (5)	2.51

*$p < .01$

Table 2

Comparison between Domains Discussed in Community-Based and School-Based Family Planning Meetings

Variable	School (n = 109) N (%)	Community (n = 85) N (%)	X^2
Domains Discussed at Meetings			
Education	105 (95)	69 (81)	8.43*
Family	102 (94)	82 (97)	.82
Social/Recreational	79 (73)	54 (64)	1.77
Legal	52 (48)	42 (49)	.06
Mental Health	49 (45)	46 (54)	1.61
Medical/Self Care	50 (46)	40 (47)	.03
Residential	49 (45)	43 (51)	.61
Safety	37 (34)	24 (28)	.72
Vocational	32 (29)	20 (24)	.83
Substance Abuse	19 (17)	15 (18)	.002
Cultural	8 (7)	7 (8)	.05

*$p < .01$

Table 3

Comparison of Adherence to the Key Characteristics of the Wraparound Across School-Based and Community-Based Settings

Characteristic and Adherence	N	Yes (%)	No (%)	X^2
1. Community- Based Services				
School	452	346 (77)	106 (23)	
Community	298	228 (77)	70 (23)	.0001
2. Individualized Services				
School	784	758 (97)	26 (3)	
Community	523	497 (95)	26 (5)	2.25
3. Family Driven Process				
School	1074	1069 (99)	5 (1)	
Community	700	690 (98)	10 (2)	4.69
4. Interagency/Collaboration				
School	582	557 (99)	25 (1)	
Community	339	304 (90)	35 (10)	12.79*
5. Unconditional Care				
School	82	80 (98)	2 (2)	
Community	59	56 (95)	3 (5)	.70
6. Measurable Outcomes				
School	276	220 (80)	56 (20)	
Community	189	140 (74)	49 (26)	2.04
7. Management of Team Meetings				
School	513	502 (98)	11 (2)	

Community	344	326 (95)	18 (5)	6.01
8. Care Coordinator				
School	635	601 (95)	34 (5)	
Community	416	355 (85)	61 (15)	26.49*

* $p < .01$