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ORIGINAL PAPER

Theory Meets Practice: The Localization of Wraparound Services for Youth with Serious Emotional Disturbance

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Abstract This study identified statewide variation in implementation of wraparound for children on the severe emotional disturbance (SED) Waiver in Kansas. SED Waivers allow Community Mental Health Centers (CMHC) to offer an array of community-based services to high risk youth. Qualitative methods, including interviews, reviews of charts and billing records, and a survey, were employed. Stratified random sampling was used to select seven CMHCs, and random sampling was used to select individual cases for interviews. Although CMHCs shared similar wraparound philosophy and service initiation processes, each developed their own localized wraparound model within the confines of Medicaid eligibility and documentation rules. Eight models for wraparound team composition were identified. Findings demonstrate implementation of wraparound with fidelity to a central model is difficult on a large scale. The balance of standardized wraparound practices, localized innovations, and agency compliance with Medicaid is essential for optimizing children's mental health services.

Keywords Wraparound · Children's mental health · Serious emotional disturbance · Community mental health

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Introduction

Approximately 5 % of US children have serious mental illness, also called serious emotional disturbance (SED). However only about 50 % have contact with specialty mental health professionals (Federal Interagency Forum on Child and Family Statistics 2010). This gap suggests significant barriers or problems within the children's mental health system. The Comprehensive Community Mental Health Services for Children and their Families program was developed in 1993 as the most significant children's mental health project undertaken by the United States federal government to address these critical problems and barriers experienced by youth with SEDs. The Substance Abuse and Mental Health Services Administration (SAMHSA) provided more than 164 grants in 50 states, 2 territories and the District of Columbia, and has provided nearly $1.5 billion toward the development of local systems of care from 1993 to 2010, aimed at improving the lives of children (ICF Macro 2011; U.S. Department of Health and Human Services 1999). Many states embraced the opportunity to reform their mental health service system and encouraged the use of evidence-based practices to improve outcomes in children's mental health, but no single pathway to successful reform has been identified as evident by the varied models adopted across the United States (Bruns and Hoagwood 2008).

Wraparound Services

Many grantees incorporated wraparound into their service planning process because it has a family centered and strengths based philosophy similar to the systems of care philosophy. The use of wraparound as a service delivery model has steadily increased over the past twenty years

with a yearly estimate of 400,000 youth engaged in wraparound, and 88 % of states in the US offering some form of wraparound services for youth who have or are at risk for serious emotional and behavioral disturbance (Faw 1999; VanDenBerg 1993; Walter 2008). Wraparound is both a philosophy and service approach that integrates various formal services and informal supports for youth struggling with mental health difficulties affecting several areas of functioning and at risk for institutionalized care (Walker and Bruns 2007). Wraparound is a strengths-based philosophy of care that uses a team-based planning process to create an individualized network of professional community services and natural supports (supportive individuals from a family's interpersonal and community relationships rather than from the formal service systems). Typically, youth with SED have multiple needs across a number of domains and their families need support from agencies and the community in order to enable the youth to remain in their home and community settings, which makes wraparound an ideal approach for these youth.

The ten core values of wraparound are: (1) voice and choice for child and family; (2) team-driven process including youth and family; (3) community-based services; (4) cultural competence; (5) individualized and strength-based services; (6) inclusion of natural supports; (7) continuation of care; (8) collaboration; (9) flexibility in provision of services and funding; and (10) outcome-based services (VanDenBerg et al. 2003). Based on these values, the two main components of implementation are: (1) a family-centered decision-making process to identify the needed services and supports, and (2) a set of collaborative community services and natural supports that are implemented. These two components help define a measurable decision-making process that can be applied consistently across youth and their families (Burchard et al. 2002). However, these guidelines are still flexible enough to allow individualization based on the strengths and needs of each family and the resources of the specific community or state. This team-based process should be led by a wraparound facilitator and should include families, providers and members of the family's social support network (Walker and Bruns 2007).

Research studies of children involved in community wraparound models have shown improved school, social, emotional, and behavioral functioning for youth and improved quality of life and empowerment (Burns 2002; Mears et al. 2009; National Resource Network for Child and Family Mental Health Services 1999; VanDenBerg 1993). A meta analysis of the effects of the wraparound process found significant treatment effects for the following outcome areas: youth living situation, mental health outcomes, overall youth functioning, school functioning, and juvenile justice-related outcomes (Suter and Bruns 2009). In particular, studies focused on youth with mental illness have found improved behavioral and mood functioning (Evans et al. 1998), better school functioning, and decreased behavioral impairment (Anderson et al. 2003), and improved global functioning (Mears et al. 2009). As these are all areas in which youth with SED struggle, it seems that wraparound is a fitting approach for working with these youth and their families.

Wraparound Fidelity

Despite the identification of the core values by the developers of wraparound, adoption of wraparound significantly varies across the country. Agency and other organizational values are related to some of the variation in implementation (Bruns et al. 2006; Grosz et al. 2001; VanDenBerg et al. 2003; Walker and Koroloff 2007; Walker and Schutte 2005). Wide variation can be found in the supports for implementation of wraparound offered by host organizations and broader systems of care, and evidence confirms an association between these supports and the ability to conform to the standards of high-quality wraparound (Bruns et al. 2006; McGinty et al. 2001). The collateral systems and natural supports that are involved and to what extent may vary among localized wraparound models. Overall, this variation raises the issue of fidelity between states and even within states and is a concern as professionals and agencies interpret wraparound within the context of their specific communities. Without a sufficient degree of treatment fidelity, accurately attributing outcomes to the overall treatment effort or isolating effective components of the overall service delivery becomes very difficult (Salend 1984).

Studies demonstrate that establishing treatment fidelity while maintaining the flexibility to individualized services can be a key challenge. Many of the states implementing widespread wraparound believe it works best at the local level because communities know their own needs and what services they are able to provide (Faw 1999). When wraparound implementation is localized, standardized statewide training and ongoing assessment of the commitment to the values of the model can help maintain the fidelity of the wraparound model. A comprehensive literature review concludes "those who promote and implement wraparound face the dual challenge of further identifying, defining, and streamlining key components and processes while simultaneously maintaining wraparound's key feature of flexibility for individualized planning" (Walter 2008, p. 25).

Wraparound in Kansas

The core values of collaborative, strength-based wraparound and the positive experiences of those who have

been involved in wraparound have resulted in widespread acceptance and adoption of wraparound for serving youth with SED in many states including Kansas (Walter 2008). Kansas utilizes statewide wraparound services as an integral part of the children's Medicaid Home and Community Based Waiver for Seriously Emotionally Disturbed (SED) Children and Youth, also called the SED Waiver. Kansas is among at least ten other states which provide the waiver as a Medicaid funding source, and the provision of wraparound services is part of the federal regulations for those states providing waiver services. Kansas was at the forefront of children's community-based mental health treatment by gaining federal approval to offer the SED Waiver with wraparound services which is now offered statewide to 26 Community Mental Health Centers (CMHC), with an estimated total of 3,446 children receiving waiver services. The waiver is available to individuals 4–22 years of age who have been deemed eligible by a qualified mental health professional as having a SED and being at imminent risk of state hospitalization. The waiver provides Medicaid funding for an expanded array of specialized community-based services provided in a child-centered and family-oriented system of care. SED Waiver services include wraparound facilitation, parent support and training, independent living skills building, attendant care, professional resource family care (crisis stabilization) and short term respite care. Wraparound service can be critical to maintaining youth who suffer from SED in their home and community. Key components of wraparound in Kansas include identification of a wraparound facilitator for each youth, strengths assessment and development of a Plan of Care, development of an individualized team of professionals and natural supports for each youth, and regular wraparound meetings. A fully-functioning wraparound process is intended to form a safety net comprised of family and community support. Wraparound working in tandem with intense community services is theoretically the best combination to maintain the child who is experiencing SED in the community.

This paper discusses a qualitative exploration into how statewide wraparound is being implemented in various local communities in support of youths who meet criteria for the SED Waiver across Kansas. The overall research question was: how does interpretation and implementation vary in a statewide wraparound program for youth on the SED Waiver?

Methods

Research Design

The research design was a qualitative method that suited the exploratory nature of the research. The research method integrated multiple data sources including: (1) an online survey with Community Based Services (CBS) Directors; (2) in-depth interviews with youth on the SED Waiver, parents, natural supports, and mental health center staff; and (3) medical chart reviews. As a university based research team, the researchers were invited to conduct this study by the Department of Social and Rehabilitation Services, Division of Disability and Behavioral Health Services.

Sampling Procedures

An online survey was sent to all 26 CBS Directors in the state of Kansas. A stratified random sample was used to select an unbiased sample of CMHCs for inclusion in the in-depth interviews. For stratification, the researchers tallied the number of youth receiving SED Waiver services by counties within each CMHC catchment area and overlaid that onto the five state population categories (Frontier, Rural, Densely-settled Rural, Semi-urban, Urban) based on the Kansas Department of Health and Environment's Frontier through Urban Continuum. The researchers collapsed the original five population density categories into three categories (Densely-settled Rural, Semi-urban, and Urban) to increase the number of CMHCs in the least populated categories to ensure anonymity of the selected CMHCs. This method ensured equal representation between the least and most populated areas of the state. Each CMHC was assigned a population type based on the most densely populated county within the center's catchment area. The percentage of youth receiving SED Waiver services in each of the three population types served as a guide for how many CMHCs to select from each category.

A total of eight out of 26 CMHCs were randomly chosen, and of the eight selected, seven CMHCs agreed to participate in the in-depth interviews, and one declined. Four CMHCs were categorized as Urban, three were Semi-urban, and one was Densely Settled Rural. Researchers worked with each of the seven CMHCs to select three current clients that would serve as the focus of the in-depth interviews and the corresponding data collection. The CMHCs provided researchers with a de-identified list of 1,709 client cases identified by a code that carried no identifiable information. Following receipt of the list of cases, researchers provided the seven CMHCs with a list of 120 randomly chosen cases from which to recruit a maximum of three participants for in-depth interviews. Of those 120 randomly chosen participants, 15 clients participated in interviews. Four CMHCs provided three youth/parent and staff interviews, while three other CMHCs only provided one youth/parent and staff interview per center.

Data Collection

The researchers were interested in the many different individual, family, and service level factors that influence the wraparound process, and so in-depth, face-to-face interviews were conducted with youth on the SED Waiver, their parent/natural guardian, natural supports, and treating CMHC staff. In addition to the in-depth interviews, the researchers conducted chart reviews and administered a CBS Directors' survey.

CBS Directors' Survey

A comprehensive online survey was developed for CBS Directors across the state to describe wraparound practices at their CMHCs. In two cases, the survey was administered by phone due to complications with the online survey. On average, the survey took 1 h to complete. The online survey provided a statewide look at the delivery of wraparound and focused on the individual center's wraparound philosophy, purpose, and core values, wraparound staff training, wraparound facilitation, billing and documentation related to wraparound, wraparound team development, and barriers to implementing wraparound (see Table 1 for an excerpt of survey questions). The first screen of the survey contained an information statement that informed participants of their rights, ensured confidentiality, and explained that completion of the survey indicated their willingness to participate in the study. An oral informed consent process was conducted as part of the two surveys completed by phone.

Interviews

Semi-structured, in-depth interviews were the primary form of data collection. Each identified client participant participated in a group interview which could include the parents, child, and any parent-invited natural supports. Additionally, a group interview was held separately for all CMHC staff who worked with that client. In CMHCs where three client participants were not identified, CMHC staff interviews still occurred but were not linked to any specific client's wraparound process but were instead about the general wraparound process at their center. The length of each interview was approximately 1 h. All interviews were conducted by two social work researchers, both had a master's in social work and one was working on a doctorate in social work. At the beginning of each interview, interviewers explained the study, informed participants of their rights, ensured confidentiality, and obtained signed

Table 1 Example questions from survey and interviews

Survey questions
Describe your center's wraparound philosophy as it relates to the SED Waiver process
How would you describe the fit between your wraparound philosophy and the way your staff implement it?
What is your perception of the quality of wraparound facilitation training your staff received?
Do you offer formal internal wraparound training?
Which of the following best describes the role of wraparound facilitators?
What job positions could bill using the wraparound facilitation code at your center?
Describe your overall sense of how effective the wraparound phase of the SED Waiver has been for your center
What are the biggest challenges your center faces with the wraparound process?
Interview questions for CMHC staff
What is the purpose of the wraparound component of the SED Waiver process?
What are the typical roles of each person on the wraparound team?
Describe the benefits to your clients and parents when the wraparound process works the way you believe it should
Have you taken any type of wraparound training? If so, what was it? How helpful was?
How was it determined that this client was to begin the SED Waiver eligibility process?
Who is on the client's wraparound team?
How did the wraparound process start and develop for this client and parent?
As you are implementing the wraparound process for this client, are there any barriers you identified?
From your perspective of how you do wraparound here, what are the downsides?
Interview questions for parents and youth
Who is on your child's Wraparound Team?
What were your wraparound meetings like?
How is wraparound going for you so far?

informed consent for the study. With consent, all interviews with digitally recorded, and later transcribed. For the youth/parent and natural support interviews, the focus was on their experience with the wraparound process. For the CMHC staff interviews, the focus was on how wraparound was implemented at their particular center and the benefits/barriers associated with wraparound. Table 1 includes an excerpt of the interview questions for families and staff.

Chart Reviews

Chart reviews were conducted for the 15 clients that participated in an interview. A Medical Chart Review Checklist was developed to collect data in the key fields of interest, including demographics; diagnoses; SED Clinical Waiver Eligibility date; SED Waiver services billed, other services billed; and purpose, dates, attendees and progress notes at wraparound meetings. With assistance provided by key staff at the CMHCs, the same two social work researchers who did the interviews also performed the chart reviews. Interrater reliability was conducted on three of the chart reviews and agreement was high at a 98 % average.

Participants

The researchers completed 43 total interviews, predominantly group interviews, with a total of 86 participants (see Table 2 for participant roles). The interviews reflected the opinions of CMHC direct service staff, CBS Directors, current clients receiving SED Waiver and wraparound services, parents, and natural support persons. The 15 youth participants ranged in age from 5 to 17 with a majority being male (66.7 %). The majority of the youth were Caucasian (73.3 %), followed by Latino (13.3 %), African American (6.7 %), and other (6.7 %). Education level of the youth ranged from pre-school to beyond 12th grade, with the majority being in first through fifth grade (46.7 %). For the statewide CBS Directors' survey, there was a response rate of 62 %, with 16 of the 26 CBS Directors completing the survey. The majority of the directors were female (69 %).

Table 2 Interview participants by type

Participant	Frequency N = 86
Community mental health center staff	
Wraparound facilitator	17
Case manager	4
Targeted case manager	8
Parent support specialist	3
Community psychiatric support and treatment worker	1
Psychosocial group worker	1
Attendant care worker	1
Qualified mental health professional	4
Team leader	2
Alternative school program coordinator	1
CBS directors	7
Youth	15
Youth's parents	19
Natural supports	3

Data Analysis

Miles and Huberman's (1994) qualitative methods descriptions, data reduction, data display, and conclusion drawing and verification techniques were used to distill the prominent thematic patterns from the data. The various data sources were organized into bundles which included a youth wraparound summary that detailed each youth's case, transcriptions of the youth, parent, and staff interviews, chart reviews, and the results of the CBS Directors' Survey. Each member of the research team reviewed a bundle for specific themes, and an analysis was conducted on the common themes across the individual bundles within the specific CMHCs. The common themes across each CMHC were compiled into CMHC profiles which included themes that were established based on the research literature. The themes across the CMHCs were summarized in matrices by the research team and became the organization of the findings. None of the specific data elements were intended to stand alone, therefore, there was no extensive analysis of a specific item or a statistical analysis of the online survey.

In all stages of research, additional methods to enhance the rigor of analysis were used (Miles and Huberman 1994). These methods included: triangulation of viewpoints by purposefully interviewing people in various roles within the CMHC, peer debriefing and support meetings among the research team members, member checking with participants and incorporating their feedback to refine the analysis, and providing a detailed audit trail during analysis.

Human Subject Review and Conflict of Interest Statement

Participant protections for this study were reviewed and approved by the Institutional Review Board at the University of Kansas and the participating CMHCs. There were no known conflicts of interests in this study.

Results

Data collected from the various sources provided a broad overview of how wraparound is being interpreted and

implemented in support of youth on the Kansas SED waiver. Across the CMHCs included in the study, results revealed similarities reflecting the central state guidelines and trainings, in addition to differences in the localized implementation. The most prominent similarities and differences in wraparound delivery across the CMHCs are described in this section.

Wraparound Similarities Across the State

Across the CMHCs, the most prominent similarities were in the understanding and initiation of the statewide wraparound program. These similarities are likely a reflection of required state trainings on the philosophy of wraparound and the standardized state eligibility criteria for the SED waiver.

The surveys and interviews revealed that all of the participating CMHCs shared a common understanding of what was the purpose of the statewide wraparound program for youth on the SED Waiver. This overarching purpose of wraparound is to help high need clients and their families achieve an acceptable level of mental health functioning for a sustained period of time. One CBS Director described how wraparound works in tandem with the Kansas SED Waiver, "The wraparound component is an integral part of the SED Waiver process in that it assists in identifying strengths, needs, areas for work, and various supports and strategies to attain the treatment goals." Wraparound Teams exist to provide ongoing assessment and service coordination for the short-term provision of intensive services to help the client remain at home and avoid inpatient psychiatric hospitalization. Wraparound Teams assess the client's presenting problems, what the client's needs are, how support can be provided, what services are appropriate, and how they are going to be provided to help the client reach her or his goals. Teams evaluate client strengths, natural and collateral supports, and level of need across settings, at initiation and throughout treatment. Several parents and even some of the children verbalized the relief and comfort they felt in being supported by a team of people. One youth explained, "The people who come talk to me, they're like my people, you know…–They're like the engine, creating electricity, and the light bulb is me. Ding!" According to staff members, the provision of these supports through wraparound will "help the kids and the families more independently deal with their behaviors related to their mental illness," so that they "function to a level where they wouldn't need us anymore." These findings are all reflective of the current consensus description of wraparound as a structured, individualized family-driven team planning process that creates a plan that is more effective and relevant to the child and family and achieves positive outcomes (Bruns et al. 2010).

Additionally, results showed the CMHCs in Kansas shared a common view of what the philosophy behind wraparound implementation should be, and this common philosophy aligns with the ten core values of wraparound (VanDenBerg et al. 2003). Many participants in the study indicated that wraparound is client- and family-centered and goal directed with individualized treatment planning and interventions. Families not only participate, but impact the development of team goals according to some participants. Parent and youth interviews revealed that at least three of the older clients were active participants in their wraparound teams with activities such as participating at meetings, giving input to their treatment plan and supporting communication between team members. Additionally, most of the study's parents reported participation including input into building the wraparound team, developing the treatment plan, advocacy and communication. Wraparound is strengths based according to many participants. There is strong consideration of how to address clients' needs, but wraparound also focuses on increasing opportunities provided by existing client skills and abilities. Services included in wraparound are community based and culturally competent, because as one staff person explained, "all things are best addressed within the context of the system in which a person finds themselves." In Kansas, wraparound empowers parents with education and resources that are naturally around them or available in the community. Services are provided in the least restrictive environment of home and community, "in a manner that respects the family's culture, value and life choices." Participants stressed the importance of collaboration in wraparound, and one interviewee explained, "The more elements of the system you have in play, the more likely it is that you can find the element that increases the chances of success."

Overall, the centers followed similar steps when initiating the wraparound process though who initiated the process did vary. It is likely that the similarity of this process across the state is driven by the state program parameters. When either an internal or external referral is received, an intake is completed to determine eligibility. Following the intake, the families are introduced to services, a wraparound team is developed, and an initial wraparound meeting is scheduled. This local process is reflective of the engagement and team preparation phase identified in national literature in which the groundwork for trust and shared vision among family and team members is established (Walker et al. 2004). The main focus of the initial meeting is to educate and prepare the youth and their family for services and the wraparound process. In addition, a strengths and needs assessment and a wraparound treatment plan, also called Plan of Care, are developed during the initial meeting. The staff members, youth, and

parents confirmed that input is solicited from all the team members, and the main focus is on the youth's needs, strengths, potential services, and goals.

Wraparound Differences Across the State

Despite similarities in the overall purpose and initiation of the program, several differences in how CMHCs in Kansas are implementing the statewide wraparound program for youth on the SED Waiver were revealed. These differences suggest that localized models of implementation are occurring.

Variance in the Wraparound Process

Across CMHCs, respondents described differences in the logistics of the local wraparound process. At most centers, the review of the treatment plan required for all youth receiving wraparound through the SED Waiver, also called Plan of Care, occurs every 90 days and there is one annual meeting. These meetings, in particular the annual review, are necessary for providing justification for keeping children on the SED waiver. The annual meeting is typically more formal and attended by more team members than the 90 day reviews. A meeting can also be called in a crisis or transition situation. There were differences in how the Plan of Care Review was handled across CMHCs. Various staff members, including the targeted case manager (responsible for billing for services), licensed mental health professional, wraparound facilitator, or case manager (responsible for providing direct services), were responsible for writing the Plan of Care at the different CMHCs. Additionally, the frequency of Plan of Care Review meetings and who attended seemed to vary. One CMHC reported that a Plan of Care Review occurs every 10 weeks. Another center scheduled meetings at a little less than every 90 days in case there are scheduling difficulties, whereas other centers scheduled right at 90 days. There also seemed to be a range of practices about the frequency and purpose of annual wraparound meetings and how those were distinct from Plan of Care Reviews at several CMHCs. Though these are all components that are included in descriptions of wraparound implementation, it has been acknowledged that these essential activities can be accomplished "in ways that are appropriate for individual communities or even individual teams" (Walker and Bruns 2008, p.4).

Localized Wraparound Team Structures

According to the survey and interviews, Kansas wraparound teams are responsible for a common set of duties that include: facilitating/scheduling the wraparound meetings, managing the Plan of Care, keeping track of the youth's progress, billing for services, and providing direct service for the youth. However among the CMHCs, there was distinct variation reported in interviews and noted in chart reviews in regards to the structure of the wraparound team and how staff was organized around these signature tasks which is reflective of national recognition that wraparound "teams may use a variety of processes or procedures for eliciting needs or goals." (Walker and Bruns 2008, p. 4). Each center has developed a customized approach for delivering these services based on their history and philosophy and the needs of clients and staff. One aspect of these models is the degree to which generalized versus specialized roles are employed. This is best described on a continuum, with one center having highly generalized staff members who perform all key duties to another center where each of the duties are completed by a different specialized, single individual. The generalist versus specialized roles within CMHCs affected the composition of the wraparound team. Table 3 provides details about wraparound team composition by CMHCs.

Each CMHC had a core group of individuals who addressed the core wraparound duties and usually attended meetings, and a secondary group of team members who offered supportive services for specific client needs and may or may not attend meetings. However, the actual job titles or roles of the individuals who filled these responsibilities on the wraparound team varied significantly by CMHC. For most centers, the core group included the wraparound facilitator, targeted case manager, and case manager, and the secondary group included the medical staff, parent support specialist, attendant care worker, in home therapist, and school staff. However at some centers, the outpatient therapist or the parent support specialist was included as a key member of the core wraparound group.

There was significant variation between CMHCs as to who was responsible for providing wraparound facilitation. Several of the CMHCs included individuals with a dedicated wraparound facilitator, who was responsible for running the team meetings and facilitating the cases. Other core group members were responsible for the case manager duties and delivering services directly to the youth. In contrast, at two other CMHCs, the wraparound facilitator duties were completed by a targeted case manager or case manager in addition to their own duties. At another CMHC, two case managers were assigned to each team, one to complete wraparound duties and another to complete targeted case manager duties.

Data from respondents seemed to suggest that these differences were partially a result of the availability (or lack) of resources at CMHCs. For example in the centers where wraparound facilitation was conducted by staff who also filled other roles for the client such as case manager, CBS directors mentioned the lack of funds as a challenge to

Table 3 Wraparound team composition by community mental health center

Community mental health center	Core team members	Supporting team members	Staff members who performs wraparound facilitation
1	Wraparound facilitator	Medical staff	Dedicated wraparound facilitator
	Parent support specialist	Outpatient therapist	
	Field intake specialist	School staff	
	Case manager		
2	Case manager	Medical staff	Case manager
	Team leader	Parent support specialist	
		In home family therapist	
		Attendant care worker	
		School staff	
3	Targeted case manager	Medical staff	Targeted case manager
	Case manager	Parent support specialist	
	SED Waiver Coordinator	School staff	
	Outpatient therapist		
4	Wraparound facilitator	Medical staff	Wraparound facilitator
	SED Waiver coordinator	Parent support specialist	
	Targeted case manager	School staff	
	Case manager (can only attend when youth is present)		
	Outpatient therapist		
5	Targeted case manager	Medical staff	Case manager
	Case manager	Attendant care worker	
		Parent support specialist	
		Team leader	
		Outpatient therapist	
		School staff	
6	Wraparound facilitator	Medical staff	Wraparound facilitator
	SED Waiver coordinator	Alternative school coordinator	
	Recovery specialist (case manager)	Parent support specialist	
		Outpatient therapist	
		Attendant care worker	
		School staff	
7a[a]	Targeted case manager (acting as wraparound facilitator)	Medical staff	Targeted case manager
	Case manager	Parent support specialist	
	Targeted case manager	Outpatient therapist	
	Supervisor	School staff	
7b	Targeted case manager	Medical staff	Targeted case manager
	Case manager	Parent support specialist	
	Outpatient therapist	School staff	

[a] At CMHC #7, two different models were used for wraparound team composition and are, therefore, listed as 7a and 7b

having a full-time, dedicated wraparound facilitator as some of the other centers had. The interpretation of billing guidelines and restrictions by CMHCs also seemed to have an impact on implementation variation. According to some centers, individuals in certain roles (e.g. case managers) are unable to bill for activities such as wraparound meeting attendance, yet other centers did not seem to be burdened by these same constraints despite being in the same state system.

Multi-Level Wraparound Training

Wraparound training for direct service staff seems to be an essential component to promoting quality wraparound

services as discussed by staff participants and CBS Directors across centers. In fact, professionals serving on wraparound teams require significant training and supports in order to provide high-quality wraparound (Walker et al. 2003). There are three state-wide trainings that provide varying amounts of wraparound information and are required for mental health staff in specific roles or who provide certain services. These trainings are: (1) separate online trainings that case managers and targeted case managers must complete before providing services or billing for Medicaid reimbursement; (2) the Interactive Community Event (ICE) training, a two-day live training for all staff who bill case manager and targeted case manager Medicaid codes; and (3) online Wraparound Facilitator Training for those who facilitate wraparound meetings. Any additional wraparound training requirements are customized by each CMHC. CMHCs differed regarding who completed wraparound trainings, amount and type of local training, and beliefs about the quality and usefulness of trainings.

The list of required participants for the state-wide wraparound facilitator training has evolved over time. All case managers and targeted case managers for all CMHCs are required to take the online training for their area of service provision plus the ICE training so they get an explanation of the wraparound process when they learn about the SED Waiver. CMHC policy determines who takes the state online wraparound facilitator trainings to learn facilitation. This could include dedicated wraparound facilitators who only do wraparound facilitation, case managers and targeted case manager who have dual roles which include facilitation, and team leaders or other managerial staff who supervise staff involved in wraparound.

In addition to the state-wide trainings, all but one of the seven CMHCs in this study provides some internal wraparound training. These in-house trainings are based on their local needs. All but one center mentioned the importance of "shadowing" training techniques which permitted new wraparound facilitators to observe wraparound meetings prior to facilitating. Also at all centers, new trainees have one-on-one mentoring and/or supervision related to wraparound service delivery. Staff at one center reported that the most valuable training piece was actually attending meetings, observing, and later asking questions of the meeting facilitators. Some CMHCs have developed resources, such as a wraparound checklist or a SED Waiver Guidebook, and held special trainings for staff to review wraparound requirements and introduce new state developments and compliance issues.

The notions of the quality of the provided state and local trainings also varied among staff. Staff at some of the CMHCs reported the online state trainings were helpful in providing a background of the wraparound process and how it fit within the continuum of services. In contrast, staff at other centers described the online state trainings as only providing surface information and failing to explain how wraparound is actually done. According to one CBS director, the online training was "a good statement of wraparound values, but misses the part about how you actually do that," and another characterized it as "watered down." They were frustrated that they did not have a person to ask questions during online trainings and that staff in differing roles completed different parts of the training rather than everyone completing the same trainings. Staff also differed in their views about the effectiveness of the localized trainings on wraparound provided specifically at their centers. Some staff felt these trainings had a depth that the online trainings did not, providing clarification on how wraparound is actually done and in person consultation. However even these localized trainings had challenges. Even though interviewees described these various internal resources and trainings, knowledge and utilization of these supports was often low among staff according to respondents. About the trainings in general, one staff member said, "I think the barrier is that most trainings talk about the perfect scenario of how this should look and what you should do and how you should bring all these people together and how important it is," but few cases ever follow this perfect scenario.

Discussion

This study describes how the wraparound process is delivered as part of the SED Waiver across Kansas. To understand the structure of wraparound, the overall purpose and philosophy of wraparound must be understood in conjunction with the localized models of delivery utilized by each CMHC. Across locales in Kansas, there was considerable agreement among interviewees about purpose and philosophy of wraparound which is reflective of the conceptualization within the literature base (Bruns et al. 2010). Additionally, the eligibility and initiation process for wraparound varied little across CMHCs. These similarities are important as they indicate statewide consensus in the program and its goal regardless of the details of implementation. These similarities in the reported purpose of wraparound and the initiation process for new clients are likely due to the required state trainings which provide a broad overview of wraparound and the standard state parameters for the existence of the program.

However, despite these similarities, the researchers found that when it came to actual implementation there was significant variation. Though initiation of wraparound was similar at CMHCs, the local processes surrounding

meetings, team structures and roles, and training varied. The frequency and purpose of various types of meetings associated with wraparound were inconsistent (i.e., wraparound meetings, Plan of Care meetings), as reported by staff and family participants from various CMHCs. Also the involvement of staff in wraparound differed by CMHC. For example, the Plan of Care was not developed by the same team member in each CMHC, and the composition and roles of the wraparound team significantly varied by CMHC as well. Wraparound teams at all of the CMHCs seemed to be composed of a group of core members and supporting members; however the respective roles varied by center. Some CMHCs defined more generalized staff roles to include a wide range of responsibilities whereas others had more specialized staff who focused on one set of responsibilities. While some of this variation may be solely due to resource availability, it seems that some of the variation is due to differing interpretation across the state of the guidelines associated with program.

While there are statewide Kansas training modules, individual CMHCs generously supplement them with internal training, both formal and informal. There is a broad range in the format of the local, internal trainings as well as significant variation in the satisfaction staff have with all forms of training. Similar to the findings in Kansas, research has found that wraparound providers are often trained through agency-sponsored inservices (Bruns et al. 2007) which helps develop a more locally appropriate approach but may result in underdeveloped plans, inadequately trained staff, and poor implementation and outcomes (Bruns et al. 2010). Providing further complication is the fact that training and supporting professionals from various backgrounds involved in wraparound, including wraparound facilitators, parent professional partners, psychologists, social workers, and school staff, is difficult because of the range of education, knowledge, and skills that are needed to properly implement the process (Walker and Schutte 2005). Based on past and current findings, it is curious to consider the rationale for these training differences, and the following questions: (1) Do some centers require less training?; (2) Are there fewer resources available for training at certain centers?; and (3) Are some centers less focused on the specific guidelines and parameters of the centralized state view of wraparound?

Implementation of wraparound with a strong fidelity to a central model is difficult on a large scale such as in the statewide SED Waiver program in Kansas. Illustrating the vital importance of context-sensitivity, one of the major findings in this study is the ability of each of the CMHCs to develop their own localized model of SED Waiver wraparound within the confines of a clear set of eligibility and documentation guidelines. These local adaptations need to be further explored to determine if they present potentially useful practices for all. The range of localized models also raises some interesting questions about the implementation of wraparound. Each localized model has its own history, unspoken rules, and procedures. Initially, this seems less than remarkable, but when you begin to make comparisons across the localized models, the assumptions of the respective models are suspect. Each localized model implies the critical personnel, roles and duties for their approach to best conduct wraparound. However, there are information gaps as certain practices, relating to allowable staff billing and wraparound team membership, are viewed as acceptable under state or federal rules in one place, and unacceptable in others. This seems to stress the importance of a more comprehensive statewide training that not only imparts information about the wraparound philosophy but also clarifies the specific guidelines and restrictions set by the larger administrative body. Additionally, the variation in the resources available to the CMHCs delivering wraparound across such a widespread area definitely contributes to the localization of models. The differential accessibility of resources suggests that some centers may need additional support or require creative solutions for implementation. Regardless, there seems to be a wealth of localized practical information relating to wraparound that could be valuable to all centers indicating that centers could benefit from sharing best local practices, reviewing them, and providing them in a format to each other that could be easily accessed, utilized and supported. Statewide newsletters, meetings, and/or trainings could be utilized to showcase these local practices and provide support in cases where a wraparound program is being implemented in a wide area. Neither statewide nor localized levels of expertise are currently being fully utilized. The comparative analysis of these models, driven by local convention, has the potential for informing the development of best practices.

The results also broach an interesting question about the implementation of quality assurance and fidelity. Wraparound is clearly a model that has been tested and proven to be effective when standards of fidelity are honored (see Bruns 2008 for summary). The local variations highlighted the challenges of implementing such a model on a large-scale basis. If the "innovations" are driven by localized conditions, where do the standardized practices of a rigorously tested model fit and how do you support its implementation? Overall, more consistent guidance about the ''nonnegotiables'' of the wraparound model are needed in order to assure quality and fidelity (Bruns et al. 2010), especially in cases of widespread implementation such as in the state of Kansas.

Limitations

Several limitations must be noted in the interpretation of these findings. Recruitment was difficult as the research

was completed on an extremely tight timeline. In addition, it's always difficult to infringe on the critical daily time demands of mental health practitioners in CMHCs. These normally significant tensions were escalated by fiscal restraints that had recently increased the workloads in the CMHCs. Due to these circumstances, limited interviews were secured with families and natural supports, and none were conducted with collateral supports. The views of the CMHC staff, for whom wraparound is a part of their job, are more heavily represented in these findings. Additional feedback from families and supports may have revealed further differences in how the state wraparound process was viewed. However, the family interviews that did occur seemed to suggest that across CMHCs, the families had only basic understanding of the details of wraparound implementation but were understandably more focused on child outcomes, and so more family interviews may not have revealed additional information about the localized models.

In this study, the researchers took a very concentrated look at the delivery of wraparound service, and in some cases, the questions may have seemed obvious and the description of these practices may have seemed tedious. Practitioners may have not given us the "textbook" version of their wraparound routines, but rather a "Cliff Notes" version that highlighted the critical dimensions. Additionally, some of the localized variations in implementation were not revealed until after interviews were completed and data analysis was conducted. As such, the researchers were unable to illicit further information about the reasons behind these variations by CMHCs. Also the limited amount of client data and the explorative nature of this study prevent us from being able to draw causal conclusions about the effectiveness of the various localized models for client outcomes. Future research could avoid the limitations of this study by allowing a more extended study timeline, over recruiting and sampling families, and starting with a specific study focus on the varying local models.

Conclusion

Wraparound is a team-based, family-centered service delivery approach that has been widely described in the literature and implemented across the country. Though a common understanding of the approach exists among service providers, this study found that localized variation in implementation emerges in large scale programs despite the presence of centralized training and guidelines. This suggests further examination of the localized best practices that emerge, their universal appeal to all agencies, and their fit with the standards or ideals of wraparound theory and application as provided in the overall literature is necessary in order to understand and optimize children's mental health services across all agencies. To further study these localized models, future research should take the next step to quantitatively compare factors such as wraparound fidelity, staff productivity, and child and family outcomes between the models.

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