WRAP FIDELITY
COMPARATIVE EFFECTS OF CAREGIVER, YOUTH PLAN AND TIME OF SERVICE ON ADHERANCE

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B.A., California State University, Sacramento, 2001

THESIS

Submitted in partial satisfaction of the requirements for the degree of

MASTER OF ARTS

in

PSYCHOLOGY
(Counseling Psychology)

at

CALIFORNIA STATE UNIVERSITY, SACRAMENTO

SPRING
2011
WRAP FIDELITY
COMPARATIVE EFFECTS OF CAREGIVER, YOUTH PLAN AND TIME OF SERVICE ON ADHERANCE

A Thesis

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Abstract

of

WRAP FIDELITY
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In this thesis, fidelity was assessed utilizing the Wrap Fidelity Index 3.0 at Stanford Home for Children to compare scores between four different groups: biological parents, foster parents, youth with a reunification plan, and youth without a reunification plan. Time frame was also considered a variable for analysis, with regard to Wraparound adherence. Results from raw data derived from the archival records of 313 subjects (122 parents, 191 youth) supported 1 out of 3 hypotheses. Wraparound adherence was provided differently to youth given time frame. There were no differences in Wraparound adherence between foster parents and biological parents nor were there differences given youth’s plan. How youth scored fidelity on each statistically significant Wraparound element given time frame is discussed.

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___________________________
Date
DEDICATION

This thesis is dedicated to the Stanford Home for Children’s Research Department. Their dedication and commitment to evaluating Wraparound fidelity provides Sacramento’s youth and families the opportunity… to dream, to overcome, to thrive.
ACKNOWLEDGEMENTS

Thank you to my committee chair, Dr. Marya Endriga for always meeting me right where I was, for providing encouragement while challenging me to work on the next steps, to think outside the box, to stay on top of deadlines and to make daily progress. I appreciate Dr. Endriga’s relaxed, yet sophisticated nature that places a person at ease while they struggle through the thesis process.

Thank you to Rikke Addis, Research Manager, at Stanford Home for Children, for always being available for me and keeping me grounded during the natural changes that occur within a non-profit agency. I thank Rikke for putting in countless hours of changing data sets, running additional statistical analyses, and assisting in discussion writing. Rikke’s honest, candid and passionate feedback has been a huge motivation during times of struggle.

Thank you to Belle Darsie and Anna Natify, Research Analysts, at Stanford Home for Children, for dropping everything to take the time out of their busy day to assist me with the statistical analysis. I thank Belle for being concise, knowledgeable, and creative throughout this process. Her enthusiasm has been a motivating factor to complete the mission. I thank Anna for being grounded, willing to try different avenues and always having a smile to warm me through the process.

Thank you to my family and friends who believed in me and pushed me towards success.
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Chapter 1
INTRODUCTION

Wraparound falls under the umbrella of Family Centered Practice, and encompasses a number of services that assist in the reunification and or permanent placement of children located in out of home care. Wraparound is a process involving broad but individualized treatment provided by a team of professionals and family members to help children within challenging social environments. The goal is to provide a stable, supportive and self-sustaining environment for the child and the family. It is the family that chooses the Wraparound team that is appropriate for helping them achieve their personal goals. Wraparound is comprised of close and extended family, social workers, and other professionals. During the process, each family establishes a desired outcome, whether it be for the child to live with family, or to remain in long-term foster care with family visitation. The purpose of this paper is to examine different aspects that would affect adherence to the Wraparound model in relation to services provided to children and their families in the hopes of providing a stable environment.

From the period of July 1999 and December 1999, Child Protective Services of Sacramento placed 3,867 children into protective custody. During this period of six months, 452 children were returned home and 436 children were adopted out (Child Abuse Prevention Council of Sacramento, Inc. 2011). Since 1997, the Adoption and Safe Families Act has changed the child welfare provisions that address the length of time children can stay in foster care, allowing for assessments of the biological family’s level
of well-being and the child’s safety in living with them, with the focus being on adoption as a permanent placement option. This has placed the emphasis on the safety of children and the permanency of their placement, encouraging states to expedite permanent placements and promote adoption. In concert with this, the Family Preservation and Family Support Services Program was given additional funding to allow for more time for children to be reunified with family. The goal is to prevent unnecessary separation of children from their biological family, improve the care for children and their biological family, and ensure permanency for children by reuniting them with their biological family (U.S. Department of Health and Human Services, 2010).

The treatment process known as Wraparound is designed to provide families who have children diagnosed with severe mental illness with services available through nonprofit providers. The Wraparound model represents a strength-based team planning process developed on an individualized basis for families with children whom are displaced from their biological family (Bruns, Burchard, Suter, Leverentz-Brady, & Force, 2004). Wraparound services focus on the functional needs within a home, whether it be a biological, foster or group home. The Wraparound model helps avoid ineffective expensive group home placements, such as the Sacramento Youth Detention Facility, while helping transition children back to biological or foster homes. One of the benefits of the Wraparound approach is that it individually tailors services for the specific needs of the children and their families (Myaard, Crawford, Jackson, & Alessi, 2000). Wraparound’s name comes from its goal of “wrapping” necessary services around the family unit (Malysiak, 1997). The integrity of Wraparound is evaluated through a tool
currently in its fourth revision, called the WRAP Fidelity Index or WFI 4.0 (Bruns, Suter, Rast, Walker, & Zabel, 2006). In Sacramento County, agencies are in the training and implementation stage to provide research to support for this latest revision of the Index, in which certain service descriptions for the interview format of the Index were redefined. Due to the transitional nature of this latest revision, for the purpose of this explorative research, archival data presented in this thesis will be reviewed and discussed within the context of the WRAP Fidelity Index 3.0 (WFI 3.0).

Burns, Suter, and Leverentz-Brady (2006) conducted a validation study using the Wrap Fidelity Index to examine the variables within the community mental health agency’s system level provision and the associations between the amount of supports in place. Their results indicated that the advanced number of organizational and system supports in place increased adherence to the Wraparound principles. The following study examined the Wraparound service used by foster parents and biological parents participating in a Sacramento County mental health service provider, Stanford Home for Children, and compared the degree of adherence between youth with a reunification plan and those youth without a reunification plan.

The study’s purpose was to look at differences in the WFI 3.0 measure between the total scores and the 11 subscale scores for foster parents and biological parents controlled by youth’s placement. Differences between the total scores and the 8 subscale scores for youth with a reunification plan and those without were also examined, followed by discussions regarding the possible reasons for why adherence was met or not met by the Wraparound team for all groups: foster and biological parents, youth with
reunification plan and those without. The length of time service was provided to the youth was also reviewed to see if adherence increased over time.

The findings were that adherence to the Wraparound model remained consistent between caregiver groups and youth’s reunification plan. There were differences in the degree of adherence to the Wraparound model depending on where youth lived and the time frame. The length of time for which Wraparound service was provided affected the degree of adherence to the model for caregiver type and youth’s plan regarding service for Community Based Services, Parent Voice and Choice, Cultural Competence, Strength Based Services, and Natural Supports.

**Family Centered Practice**

In the early 1990’s, the development of best practice recommendations for the model of “family centered practice” was directly influenced by the Individuals with Disabilities Education Act (IDEA) and efficacy research. The National Institute of Mental Health launched this model on a national scale through the creation of the Child and Adolescent Service System Program. Part C of the IDEA states that one goal of early intervention is to help families meet the special needs of infants and toddlers diagnosed with disabilities (Bailey, 2001). This initiative emphasized the importance of using family in all aspects of child mental health planning and implementation by empowering parents and collaborating with professionals (Johnson et al., 2003). Another term for this is service integration: the process by which two or more entities establish links for the purpose of improving outcomes (Park and Turnbull, 2003).

Part H of the same act provides guidelines for the way service providers supply
family-centered early intervention services to children and the families of children diagnosed with disabilities, treating the family as a unit, instead of focusing on one person within a family unit. Before the 1980’s, family centered practice consisted solely of providing parents mental health treatment along with their children. Now the concept of family centered practice has expanded to include professionals building partnerships with families to empower them and giving parents previously denied decision–making power, especially in the intervention phase (McWilliam, Tocci, & Harbin, 1998).

Family centered practice is now often times referred to as a cogent philosophy, not just a set of practices. Dunst (1997) describes family centered practice from both a conceptual and a philosophical perspective. Conceptually, this approach recognizes that the family has an important effect on the physical and emotional well–being of the individual family members. It also recognizes that when practitioners support the family, parents are in a better position to have time, energy, knowledge, and skills to benefit a developing child. Dunst (1997) defines family centered care in the following manner:

…the pivotal role of the family is recognized and respected. Families are supported in their care giving roles by building on their unique strengths as individuals and families. Opportunities are created for families to make informed choices for their children, and more importantly, these choices are respected. Family centered practices promote normalized patterns of living where family/professional partnerships are clearly evident. (Dunst, 1997, pg. 77, cited in Illback, et al., 1997)

Principles that make up the philosophy of family centered practice were adapted
by the early intervention field. During the 1960’s and 1970’s, “family centered care” was
used as a descriptor for service delivery and the concept of families becoming more
integrally involved in early intervention. In the 1980’s, family centered care was
formalized into a set of principles to guide service delivery (Bruder, 2000). These
principles are in the Public Law of 99 – 457 Education of the Handicapped Act
Amendments, 1986. Section 619 Part H created a new program for infants, toddlers, and
their families which required the development of an individualized family service plan
for each child and family served (University of North Carolina at Chapel Hill, 1998).

Family centered practice also recognizes the interrelatedness of family members
and the importance of acknowledging the needs of all family members, not just those
individuals with a disability. This philosophy is practiced in the parent–professional
relationship by sharing in decision making and planning around mutually agreed upon
goals while engaging each other with mutual respect, trust, and honesty (Dempsey &
Keen, 2008). The California Department of Social Services has a best practice guideline
that explains the difference between being professionally centered and family centered.
Professionally centered intervention provides services based on expert opinion of a
family’s deficits and needs, with a low level of family involvement in the decision-
making process. Services are then directed at correcting the family’s and the child’s
deficits, essentially molding the family. The professional is focused on identifying and
removing problems while maintaining a strict fixed role in the family’s life.

On the other hand, family centered intervention provides services tailored to what
the family identifies as their unique needs and capabilities. Establishing the family as the
focus of service identifies all family members as eligible for services. The family, and not the professional, is the constant in the child’s life and is therefore in the best position to determine the needs of the child. Family centered practice supports and respects family decisions and provides intervention strategies designed to strengthen family functioning (Dempsey et al. 2008). This high level of family decision-making focuses on enhancing competencies while maintaining roles and service provisions in a flexible manner (California Department of Social Services (CDSS), 1998).

**Family Centered Practice Themes**

The characteristics of family centered practice and mental health models have been described throughout various types of research. The themes of family centered practice have been analyzed with great care to ensure that providers are consistent in providing service. McWilliam, Tocci, and Harbin (1998), interviewed six service providers whose philosophy of family centered practice highlighted family orientation, positiveness, sensitivity, friendliness, responsiveness, child skills and community skills as being key characteristics of application. The researchers interviewed these six service providers using descriptive, structural, and contrast questioning. The researchers then analyzed the information provided through the use of constant comparative coding in which codes were developed as themes emerged in the data. These researchers took the service providers’ information as well as how they practiced that service to formulate the aforementioned seven characteristics.

The researchers defined the characteristic of family orientation as services provided to the whole family, not just for the child. Positiveness is having unconditional
positive regard towards parents, without passing judgment on them. Sensitivity involves empathizing with the parents and understanding the families’ concerns, needs and priorities. Responsiveness relates to paying attention and attending to the parents’ concerns, and taking action when needs or complaints are expressed. Friendliness is related to treating parents as friends, listening to the parents’ own concerns and providing whatever support is necessary, even if it does not directly relate to the child’s need for services. The last two aspects, child skills and community skills, refer to understanding general knowledge about child development, child disabilities, and methods for teaching skills to children and interacting with them. McWilliam and colleagues (1998) explained that the results of this research convey that parents find it most helpful when the approaches are centered on parents’ concerns as well as the child’s.

Another research team examined a variety of articles that showed characteristics of family centered practice on an interpersonal level (between service provider and family) and on a structural level (agency) (Park & Turnbull, 2003). They also defined characteristics of how services are implemented to support the concept of family centeredness. The characteristics that promoted partnerships and supported family centeredness were openness, sharing information, showing empathy, solving problems together, being trustworthy, having reasonable expectations, displaying equal respect, sharing the same vision, and providing tolerance. The structural factors of family centered characteristics correlated with the community based treatment agency’s practices. The structural factors include flexible management, a central location, and continuity of care. Flexible management relates to the agency providing flexibility when
decisions are made regarding the needs of a family. Agencies and families need a central location where client information is gained and shared and where continuity of care for the family can take place. Park and Turnbull (2003) suggested that professionals receive training on interpersonal matters, positivity and proactiveness, skilled communication, being collaborative, tolerance, and keeping an open mind. The structural recommendations for professionals included understanding service systems, how to receive funding, knowledge of the development of children, and having a central location of information on the family. The effective application of the concept of family centeredness requires professionals to respect cultural and socioeconomic differences in families, seek family input at every level of the service provision, ensure that all needs expressed by the family are met, build on the family’s strengths, and have families evaluate the effectiveness of the service integration (Park & Turnbull, 2003).

Other research has supported specific characteristics of family centered practice by applying the empowerment approach with regard to parents’ concerns (Johnson, et. al, 2003). The empowerment approach sees parents as the target of change and the focus of services. Carpenter (1997) specifies that empowerment includes professionals coaching parents to utilize their own networking structures, sources of information, and support that they had prior to their need for services. Carpenter suggests that parents be integrated into the delivery of family centered service by being recognized for their contributions of obtaining resources for their family rather than their reliance on professionals. The third suggestion supports parents in researching, supporting, and sustaining services and supports for their child in an appropriate placement setting as well
as coordinating professional input as needed to achieve their particular goals.

Wraparound is but one approach under the family centered umbrella. There are other programs that promote similar concepts. The following programs have a different purpose and scope than Wraparound. However, their foundations are firmly rooted in family centered philosophy.

**Family Outreach Community Services**

A mental health service that embodies the characteristics of family centered practice is Family Outreach Community Support, or FOCUS, a new program in Sacramento County. FOCUS provides the family with individual, family and couples therapy as well as community connections and resources. The concerns of all family members are the basis for establishing interventions and specified outcomes. The strengths of all family members involved are viewed as resources for implementing the chosen intervention(s). Having the families involved in the decision making process allows family members and professionals to be intervention partners. Allowing the family members to be partners with professionals empowers families to make decisions, fostering their sense of control and simultaneously providing independent living skills after professional services are phased out. By using the family’s strengths, service is enhanced and promotes family capabilities and functioning (McBride, Brotherson, Joanning, Whiddon, & Demmitt, 1993). The difference between FOCUS and Wraparound lies within the main desired outcome of the family. FOCUS desires to keep children with their family to prevent out of home care while Wraparound desires to place children who reside in out of home care back with family (or as close to a family unit as
possible).

**Multisystemic Therapy**

Outcome studies have compared Wraparound with alternative treatment approaches and outcomes. One such study by Stambaugh and colleagues (2007) used the Child Behavior Checklist, Child and Adolescent Functional Assessment Scale (CAFAS), and the Multisector Service Contact Questionnaire (MSSC) to compare Wraparound treatment and Multisystemic Therapy. Multisystemic Therapy differs from Wraparound in that it intervenes on the individual level while Wraparound intervenes on the systemic level. Multisystemic therapy (MST) is heavily based on theory and research and desires favorable outcomes. MST is intensive, short term (3-5 months) therapy provided in the home and community for children that at imminent risk for out of home placement due to serious emotional concerns. The two are similar in that they both target the child’s ecology and aim to keep the child in their home community. The data from this study was taken from a Nebraska Center for Mental Health Services site that was funded between 1999 to 2003. This research compared outcomes on three different instruments (CBCL, CAFAS, MSSC) measuring the following groups: youth that received Wraparound only, youth that received MST only, and youth that received both Wraparound and MST. Those youth that received Wraparound and MST had higher scores on the instruments at intake, which indicated that the youth were displaying more severe emotional behaviors and a higher level of need. Results indicated that the Wraparound only group received 15 months of treatment, the MST only group received 5.5 months of treatment, and combined treatment groups received 10.2 months of
treatment. Youth that received MST only were more likely to participate in family preservation and family therapy as opposed to youth that received Wraparound only. This indicated that youth were more likely to participate in case management services. The Wraparound only group utilized more of the services measured by the MSSC than did the MST only group. The MSSC rates the types and frequencies of services received by youth, such as in patient therapy, outpatient therapy, case management, after-school services and transportation. CBCL results showed that 62% of the MST only group had scores that dropped below behavioral problems. Borderline range scores on the CBCL showed that application of only MST had a more favorable results in decreasing severe emotional behaviors than applying only Wraparound or Wraparound and MST. Results for the CAFAS showed percentages of youth that went from a severe impairment range to a minimal to moderate impairment for the following: 66% for MST only, 36% for Wraparound only, and 26% for Wraparound and MST. These results indicate that youth receiving only MST showed more improvement in clinical symptoms than did those who received only Wraparound when assessed at 18 months. Youth that received only MST were more likely than youth that received Wraparound to move out of the clinical range of impairment at the end of this research study. The scores on the CBCL showed that youth who received MST only improved at a faster rate and to a higher degree than youth that received Wraparound only. It is interesting to consider these results in the context of the differing purposes of MST and Wraparound. Wraparound only groups utilized a greater variety of services, as is the purpose of Wraparound, while MST only groups utilized fewer services. The instruments only assessed youth impairments in behaviors
and functioning in different environments. Progress in reunification plans or family connectedness (goals of Wraparound) was not assessed (Stambaugh et al., 2007).

In conclusion, over the last two decades, the Wraparound model has developed under the umbrella of family centered practice as an alternative to more traditional approaches that serve children with serious emotional disturbances and their families. Traditionally, service was provided to families using single mental health solutions that emphasized professionals in the expert role and limited family decision-making. Today, the Wraparound service relies on the family to provide more input on the services provided (Brown & Hill, 1996; Malysiak, 1997). Due to the emotional disturbances associated with Wraparound clientele, there are mental health challenges as well as social and educational challenges. The success lies in “wrapping” resources around a flexible and individualized support plan that creates a path to success for the entire family.

**History of Wraparound**

The formative work of Wraparound was begun in Canada by John Brown and his colleagues, who implemented many of the aspects of the Wraparound program (needs based, individualized, and non-conditional) through the Brownsdale programs. Following the Brownsdale programs, the concepts were utilized in the design of the Kaleidoscope program in Chicago. The Kaleidoscope program began implementing private agency based individualized services under Karl Dennis in 1975. In 1985, John VanDenBerg managed the Alaska Youth Initiative after seeking consultation from the Kaleidoscope program to provide social services to youth with complex needs who were placed in out of state institutions. These founders established the precedent of bringing
together state and county services to support individuals with complex needs. Systems of care is a concept that is readily accepted today. Children and their families have needs that span across the mental health, schools, and juvenile justice fields. Integrating these fields produces better results (VanDenBerg, n.d.).

Other foundational work that contributed to the Wraparound approach was highlighted by Malysiak (1997). The Wraparound approach began with professionals providing interventions to families. Over time, the approach was modified. The newer, modified approach wraps services around the family in a strength-based, family focused, ecological process that individualizes service in the least restrictive environment appropriate to the child’s needs. Services are provided to the family with both the parents and professionals collaborating around issues of diagnosis and treatment interventions.

The Wraparound model emerged from critical and constructivist thought that is rooted in the ecological systems theory. Wraparound serves families using individualized service plans at the systems level (Stambaugh et al., 2007). One of the ways the Wraparound model distinguishes itself from the professional model is that it does not use an expert model that sees the client or family as a deficit (Malysiak, 1997). Wraparound is committed to involving the family as the ultimate decision maker, enhancing the strengths of the family in order to meet their own needs, and coaching the family to form partnerships with others in the community. Without these commitments, Wraparound would be no different from programs that utilize the deficit model approach.

**Qualifications for Wraparound**

Children who qualify for Wraparound in Sacramento County have similar
fundamental needs and concerns. To enroll in Sacramento County Wraparound services, youth must be under 21 years of age, have serious emotional or behavioral problems, and need intensive treatment services, and as a result are considered to be at risk of restrictive placement. Examples of youth at risk would be individuals who have been removed from their family environment through Child Protective Services, have dropped out of school, or are in the juvenile justice system. Eligible Sacramento County youth can also be living in a county funded group home, but must display two or more symptoms based on a diagnosis from the DSM-IV-TR (Diagnostic and Statistical Manual of Mental Disorders Fourth Edition text revision). These youth are included because Sacramento County’s goal for Wraparound also includes moving a youth from a highly restrictive environment to a lower level of care. Youth may also be eligible while living at the home due to the need to stabilize their home environment and prevent them from transitioning to a higher level of care.

**WRAP Fidelity Index**

The WRAP Fidelity index assesses specific areas that professionals adhere to when providing training and support to youths and their respective families. Bruns, Ermold, Burchard, and Dakan (2000) developed the first WRAP Fidelity Index in March 2000. The index was developed as a pilot study in four states: Pennsylvania, Kansas, Vermont, and Nebraska. It assessed parents, youth, and resource facilitators (staff providing Wraparound services) across nine elements. The nine elements were “Individualized Services and Supports”, “Strength Based Natural Supports”, “Child and Family Team”, “Community Based Services”, “Collaboration”, “Flexible Services and
Funding”, “Outcome Based Services and Supports”, “Parent/Youth Voice and Choice”,
and “Cultural Competence”. The initial index had four questions per element. Each
group of people (parent, youth and resource facilitator) was asked specific questions
pertaining to the nine elements.

When the WRAP Fidelity Index 2.0 was developed and tested, its purpose was to
assess the extent to which professionals adhered to the Wraparound elements. The
assessment was developed through interviews with multiple participants in the
Wraparound program. The pilot studies for the first index showed some items that had
low variability, resulting in respondents assigning the highest rating possible on a three-
point scale. The index was revised to better describe specific provider behaviors and
show how the provider’s behaviors adhered to the philosophical elements of Wraparound.
The WRAP Fidelity 2.0 also had reverse-scored items, split one element into two, added
items to all elements, and created a manual with scoring guidelines (Bruns et al., 2004).

The WRAP Fidelity Index 3.0 has eleven elements where each of the three groups
are asked the same questions regarding each element. The index is administered via brief
confidential telephone calls or in person interviews with three respondents: caregivers,
youth age eleven and above, and resource facilitators (Suter, Force, Bruns, Leverenz-
Brady, & Blanchard, 2002). The WRAP Fidelity Index 3.0 measures how the provider
implemented services by assessing the opinions expressed by the caregiver, youth, and
facilitator about the provider’s service, measured across eleven domains. The domains
are “Voice and Choice”, “Youth and Family Team”, “Community Based Services and
Support”, “Cultural Competence”, “Individualized Services”, “Strengths Based
Services”, “Natural Support”, “Continuation of Care”, “Collaboration”, “Flexible Funding and Resources”, and “Outcome based Services” (Bruns et al., 2004). Each domain has a specified number of questions, and scores are assigned to the items, ranked on a scale from 0 (low fidelity) to 2 (high fidelity) (Suter et al., 2002). The WRAP Fidelity Index 3.0 measures the empowerment of parents by asking such questions as: “Do you feel comfortable expressing your opinions even if they are different from the rest of the team?”, “Are important discussions or decisions about your child or family made when you are not there?”, “Do team members ‘overrule’ your wishes regarding your child?”, and “As the primary caregiver, are you given highest priority when making major decisions?”

Bruns and the Wraparound Evaluation and Research Team (n.d.) have developed and tested the reliability and validity of the Wraparound Fidelity Index 4.0 (WFI-4). The development of this new tool occurred during the time that data was being selected for this thesis and as a result, data was analyzed from the Wrap Fidelity Index 3.0. The WFI 4.0 includes an interview with team members as well as with caregivers, youth, and Wraparound facilitators. The WFI 4.0 has also included four phases of the process (Engagement and Team Preparation, Initial Planning, Implementation, and Transition) and within these four phases, different questions are keyed to 10 Wraparound Elements or Principles. The WFI 4.0 has added Persistence as an element and has deleted Flexible Funding as an element (Bruns, et al. & National Wraparound Initiative Advisory Group; 2004).
Outcomes and Effectiveness of Wraparound

How well have family centered services and Wraparound helped families achieve their desired outcome? According to research by McBride and colleagues (1993), families could be strengthened by utilizing family as the focus of services and defining family roles. The McBride and colleagues (1993) study was part of a larger study that evaluated the implementation of Individualized Family Service Plans (IFSP) (McBride, Brotherson, Joanning, Whiddon, & Demmitt, 1992). The researchers evaluated data from family and professional interviews on how well family centered practice had been implemented. Fifteen families and fourteen professionals participated in this study. The researchers taped interviews with the families and professionals about their experiences developing the IFSP using open-ended questioning. The taped interviews were then used as the basis for data analysis. The information was categorized into three different themes, with examples of how the theme was implemented. The three themes that emerged were: the family is considered the focus of services, family is involved in decision-making, and family functioning is strengthened by interventions. Examples of the ‘family is considered the focus of services’ theme are: how attention is provided to the family beyond the specific needs of the child, professionals respect the family values and routines, and fathers, siblings and other family members are always involved in the treatment process. Examples under the ‘decision-making’ theme are: how the parent’s role determined decision making in the IFSP process, family deferred to professional advice on the development of goals for the IFSP, parents were observer and informant, parents had the final say on decisions, and choices about services are provided to
families. An example of ‘intervention strengthens family functioning’ is that parental involvement in the process increased their confidence and skills as well as their emotional well-being.

Based on the interview data, the study helped create a structure for analyzing services that are provided to families with an IFSP. It has also helped professionals provide family centered practice, as defined from a family’s perspective.

**Family and Professional Perceptions of Family Centered Practice**

Within Family Centered Practices, professionals attempt to implement their ideal practice with an eye towards sensitivity, adopting a family systems view, and enhancing parental confidence. Sensitivity to the family’s strife in life requires professionals to understand what the family is going through, utilize active listening when assessing for needs, and allow the family to determine what interventions are necessary in order to meet their goals. A family systems approach brings together everyone that the family considers to be helpful in meeting their goals. Enhancing parental confidence is comprised of reinforcing the parents’ strengths, empowering the parents to work through their difficulties, and providing assistance through collaboration between team members.

A study conducted by McWilliam, Snyder, Harbin, Porter, and Munn (2000) examined how professionals adhered to the practice they provided to families and how families viewed their services. The families and professionals involved were to describe the services they received or provided. They were also asked to describe an ideal practice and what characteristics would indicate a closer adherence to a family centered practice. The participants consisted of 198 professionals and 118 family members recruited from
100 North Carolina counties. The professionals worked for in-home based early childhood intervention programs funded by Mental Health/Developmental Disabilities/Substance Abuse Services (35%), the Developmental Evaluation Center (33%), and health departments (32%). The family member sample was obtained from a statewide call-in program operated by the Family Support Network and North Carolina’s database of early intervention recipients.

Comparisons of aspects of family centered practice were obtained through instrumentation of the Family Orientation of Community and Agency Services (FOCAS) (Bailey, 1991) and the Brass Tacks-Evaluation Version (P.J. McWilliam and R.A. McWilliam, 1993). The FOCAS measures how therapists focus their early intervention and practices along two opposing points: professionally centered or family centered. The Brass Tacks addresses dimensions of family centeredness such as: sensitivity, adopting a family systems view, and behaviors that enhance parental confidence.

Results showed that professionals considered their applied practice to be more highly family centered, while families did not share that view. Families felt that they could have received better service that would have better adhered to the side of the FOCAS measure that represented family centered practice. Characteristics that professionals felt they provided to the family were: giving them choices in regards to getting the youth into inclusive programs, helping them with their needs, and their adherence to the model improved due to the families’ input. The sole characteristic that families reported as being close to adhering to the family centered practice as represented by the FOCAS measure was that they were getting their needs met. Families wanted the
flow of services to be improved, so as to adhere to the family centered practice outlined in the FOCAS measurement.

In conclusion, the study indicates that professionals believe that their practice adheres to a family centered practice model, while families believe otherwise. This suggests that professionals may demand more participation from the family than the family desires to give due to the professionals’ desire for the family to work through their difficulties. Families felt that the service the professionals were giving was just enough for them to feel successful. The prevailing belief is that when families do not know what to anticipate from services, they are more likely to be satisfied with less than ideal practices. McWilliam and colleagues (2000) were not alone in their findings. Another study by Ziolko (1991) implies similar characteristics of what constitutes a family centered practice. Adherence to the model involves professionals being aware of and sensitive to the stages of grief and of family adjustment. Application is seen as the professional counseling the family, providing modeling behaviors for parents, providing parent support groups, and consulting with the multidisciplinary team.

**Biological and Foster Parent Involvement**

Parental involvement is very important in Wraparound. Research shows that a valid indicator of quality outcomes and satisfaction with the child’s treatment process lies within parental involvement (Soodak and Erwin, 2000). Allowing the biological parents to reconnect with their children through the Wraparound process can have significant effects on the entire family. Involvement in the Wraparound process is seen in the efforts to regain custody of their child and/or have as much of a connection with them as
possible, if reunification at home is not possible. Reconnection and reunification have many definitions that have changed over time. Family reunification was once viewed only as the physical return of the child to the care of the biological parents. Now reunification can be seen on a continuum, ranging from the child’s physical return home with the biological family to the child’s reconnection with family and family continuity, regardless of whether the child actually returns home (Robinson, Kruzich, Friesen, Jivanjee, & Pullmann, 2005). For this project, reunification is defined as the youth’s physical return home to his or her biological parents.

There are many scenarios that result in children having to live outside of their biological homes. Some children are removed from their homes by their respective county’s Child Protective Services due to parental abuse, neglect, and/or drug use. In other instances, biological parents voluntarily place their child in the county’s care due to their inability to ensure the child’s safety. On occasion, children are placed under the care of family members when biological parents are not able to care for them due to the recommendation of Child Protective Services. In all of the above examples, a child is considered to be under the care of a different entity than their parents: a group home, foster home, kinship or alternative treatment facility.

Inclusive practice and concurrent planning are aspects of treatment that when applied properly result in successful reunification. “Inclusive practice” is a term used in research that is defined as the attempt(s) to integrate the biological parent into the foster child’s life. Allowing biological parents to have as much contact with their child as possible while they are living in out of home care—for instance, encouraging biological
parents to participate in the direct care of the child whenever possible by allowing access to the child through visits and other forms of contact—assists in successful reunification. (Leathers, 2002). Frequency of parental visits is a stronger predictor of reunification than parental characteristics, child characteristics and the reason for child placement (Leathers, 2003). Allowing the biological parent to visit the child in the foster home without a formally scheduled appointment is a highly inclusive visiting practice, as opposed to formally scheduled appointments. Understanding and clarifying biological and foster parents roles and how tasks are allocated or shared helps both sides stay equally involved during the reunification process. When roles are not clearly defined, there is a greater risk that biological parents will be excluded from the process (Poirier and Simard, 2006). Allowing visits within the foster home gives foster parents a temporary respite and allows the biological parents the opportunity to witness and model the behavior of the foster parents. Positive results of inclusive visiting practice results in increased parental visits, less disruption in the child’s life, fewer attachment conflicts, and fewer placement disruptions (Leathers, 2002).

Similar to inclusive practice, concurrent planning allows social workers to simultaneously plan for more than one possible outcome. For example, social workers can implement practices for youth who live in foster care that support the reunification process or a long-term permanency plan. For the purposes of concurrent planning, social workers seek out foster families that are trained and supported in working with and mentoring biological parents. The benefits of concurrent planning include: a decrease in the amount of time that the youth are in out of home care, enhanced communication
between foster parents and biological parents, foster parents staying in touch with the youth after they move back home, and the option of having the children stay with foster parents for the long term (Edelstein, Burge & Waterman, 2002).

Another way to help parents reconnect with their children is by implementing empowerment. Carpenter (1997) states that a way for service providers to empower parents is for the providers to “let go”. By allowing the parents to make the decisions and engage in conflict resolution, the service providers give the parents the opportunity to practice skills which will help them lead full and meaningful lives. The parents are not relying on professional services to help them be proficient, law-abiding members of society. If the service providers are constantly making decisions and resolving conflicts, then parents feel inadequate and will only problem solve with the support of professionals. This research concluded that parents felt empowered by the treatment team when parents had a role in which they gained information, investigated interventions, planned and developed their own interventions, and monitored the treatment of their family.

Parent education can have a positive impact on family centered practice. Greene (1999), shares that a comprehensive partnership between parents and professionals must include education for the parent. Parent education, as described by Greene (1999), includes components involving the parent being an advocate for their child and developing strategies for the parent to help their child fulfill their potential. For parent education to be effective, professionals need to be sensitive to the activities already happening in the family’s home, such as additional services being provided, being
sensitive to how much homework is assigned, and how many hours are spent on collaboration between system partners. The concept of collaboration needs to be taught to the parents. The professionals should not assume that the parents understand the construct. Instead, they should explain the importance of equality, trust, and mutual respect in an effort to avoid parents acting as if that the professionals are the experts or teachers. Family centered practice tries to stay away from the “professionals as expert” model. Greene (1997) shares that family members are teachers of professionals because they are the providers of knowledge about their child’s disability, can recognize interventions that are successful, and identify resources that are available.

Difficulties with concurrent planning relate to the biological and foster parents’ feelings surrounding the process. Foster parents may feel shock, disappointment, and anger when they strive to adopt a youth who subsequently returns home when the biological family completes their reunification plan. Foster parents may feel that Wraparound services should be tailored towards adoption instead of reunification. Foster parents may also feel competitive with, undermined by and resentful of the biological family, especially when the youth talk about how hard the biological family is striving to get them home.

On the other hand, biological parents may feel that the system is not supporting them and that they do not have a voice or have any power in the situation. Specifically, biological parents may believe that social workers favor foster care or adoption and do not work hard enough to return the youth back home. When feelings and concerns such as these occur, inclusive practice and concurrent planning are difficult to implement due
to the hurt feelings of both the biological and foster parents (Edelstein et. al., 2002).

Difficulties that parents have with the Wraparound process can result from misconceptions about the goal of child protective services. In a situation in which Child Protective Services has taken a child out of the biological parents’ home, parents are likely going to be distrustful of them. Many parents feel that these entities and professionals are not actively listening to them and are challenging their role as parents. Many biological parents feel they are being evicted from their role as parents, due to how the professionals taking on some of the responsibilities that the parents regarded as being theirs (Harden, 2005). Professionals may make decisions regarding interventions they feel are in the best interest of the child without consulting the biological parents, have meetings with the youth without the parents being present, or decide on how flexible funding is utilized without consulting the parents. When parents seek out professionals to assist them with their child, many believe that the changes taking place go beyond their parenting expertise. Through the process of seeking professional help from such sources as child protective services or county wide mental health services, parents may feel isolated or not listened to (Harden, 2005). For service delivery to be successful, parents desire particular characteristics that would assist them through the Wraparound process. They want funding to remain community based, flexible, and short term. Parents want to be able to identify and evaluate their own goals and be active participants in the planning and delivery of Wraparound services, especially in decision-making and funding allocation. The treatment goals should be reviewed regularly to make sure that the changing needs of the youth and their families are addressed by the service providers
(Brown & Hill, 1996).

Foster parents need to be educated about the child that they are taking in, as limited experience with this child’s mental health needs can affect their ability to receive appropriate service and maintain placement stability (Pasztor, Hollinger, Inkelas, & Halfon, 2006). Since foster parents are expected to take in a child, they are no longer perceived as substitute parents, but instead are considered to be active members of the service delivery team. Foster parents may be expected by professionals to act as role models for the biological parents, serve as biological parent advocates, and involve biological parents in decision-making.

Recent research has indicated that family centered services are being provided to children in foster care who have been diagnosed with a mental health problem. The research has focused on the foster parents’ satisfaction with services, differences between foster parent satisfaction and professionals providing family centered practice, and interventions deemed successful in helping foster parents with the reunification process. Due to the mental health needs of these children, familial precursors, and foster parent instability, there is a need to provide family centered practice for children living with foster families. A child’s placement can be unstable when foster parents caring for a child with a mental health disorder feel that their needs are not being met by service providers or foster family agencies. When foster parents need additional assistance with family centered services and believe they are not receiving it, the child’s placement can be jeopardized or lost entirely, causing the child to make moves through multiple foster placements. Lengthened transition time back to the biological family is the result of
numerous moves through the foster care system (Holland & Gorey, 2004). Additional intervention strategies include telephone contact and foster parent assistance. Telephone contact was reported by parents to be the most-used form of contact with their child (Robinson, et al. 2005). The foster parents can also help support and facilitate the reunification process by teaching the children ways in which to form healthy attachments in their new homes, and allowing the child to mourn the loss of their birth family and to take treasured items from the family of origin (Landsman, Thompson, & Barber, 2003).

Research shows that training and support for foster parents motivates them to be more involved in reunification efforts. In a study, foster parents who received training and support participated in most activities. Those foster parents that received only training or only support participated in the next highest amount of reunification activities. Reunification activities defined in research by Sanchirico and Jablonka (2000) were: taking child to visits with family, encouraging phone calls with parents and other family members, providing supervised visitation, involving family in celebrating birthdays and holidays, inviting family to visit in the foster home, involving family in shared decision making, and other activities to help the child stay connected with family. Training has slightly more influence on visitation activities (taking child for visits, providing supervised visitation), while support has slightly more influence on non-visititation activities (encouraging phone calls, involving family in celebrating holidays and birthdays). Foster parents participated in all activities equally when foster parents received training and support (Sanchirico & Jablonka, 2000).

Areas of need identified by foster parents included time constraints,
communication between system partners, information about the foster child, and the role of foster parents during the reunification process. Foster parents found that acquiring services for their foster child was more difficult and time consuming than they originally believed. Though foster parents felt that gaining access to services was feasible, they had difficulty with lengthy waits and time delays. In addition, foster parents felt that the application process for services took too long. Effective and efficient communication with the service providers is another area of need identified by foster parents when seeking out mental health treatment for their foster child (Pasztor et al., 2006).

In order for foster parents to provide effective intervention in the home, details of the content and quality of information about the child should be shared by the service providers. Foster parents tend to seek out service providers who provide that information in a collaborative style. Foster parents were especially frustrated when the records of the child’s mental health treatment were lost during transitions between placements. Another challenging situation is when professionals withhold information about a child’s diagnosis for fear that the foster parents would not accept the child for placement. When asked, perspective foster parents stated, “If we can be trusted with the care and 24-hour protection of a child why can’t we be trusted with physical and mental health information about that child?” (Pasztor et al., 2006 pg. 45).

An interesting finding was that foster parent’s experienced difficulty gaining information from the child’s biological parents and that the biological parents were resistant to learning about the needs of their children. This was especially true if the biological parents experienced guilt due to their child’s difficulties. Transporting the
children to treatment also was an area of difficulty reported by the foster parents. There was also confusion about the role of the foster parents in the child’s life. The foster parent’s perception was that service providers viewed them as glorified babysitters with no rights to the child’s information (Pasztor et al., 2006).

The foster parent’s perception of the roles filled by members of the treatment team can affect how well the overall process adheres to the Wraparound model. Frisen (2001) reviewed a change in Kansas where all foster families were contracted and told to meet permanency deadlines and participate in community-based treatment teams. When compared to foster parent satisfaction with community-based treatment teams, 89% felt that the agency was responsive to their needs as a foster parent, 75% felt that they were an important member of the case planning team, and 76% felt that their opinions were an important part of case planning team decisions. An interesting finding was that foster parents wanted the community treatment team to focus on more responsiveness to the foster children. The foster parents wanted their foster children’s needs to be seen as important and unique. This could be interpreted as a desire for client-centered services rather than family-focused services, which would include the biological parents. Therefore, biological parents and foster parents may have opposing views as to where focus should be applied in the family unit. Foster parents may consider an ideal service to be one that assists the child with their mental health needs while not attending to the biological parents’ mental health needs and desired services.

The family-centered approach has benefited the child welfare system by showing a reduction in maltreatment and family separations, increased reunifications, and reduced
child behavior problems while simultaneously improving family cohesion and adaptability (Huebner, Jones, Miller, Custer, & Critchfield, 2006). This research used customer satisfaction as a measure of the outcome and viewed parents as the customers because they were the ones receiving family centered services. The parents received protection and permanency services such as investigations, in home service, and out of home service for placed children. The research also took satisfaction surveys from foster care providers and foster parents. It is interesting to note that more foster than biological parents responded to the survey: 32% of biological parents vs. 68% of foster parents. The survey showed that the biological parents who received the comprehensive family services were more satisfied than the parents that did not receive family centered services. Some administrative-level satisfactory elements listed were phone calls returned in a timely manner, simplicity in appointment making, and the ability to meet with staff personnel. Examples of satisfaction on a personal level included feeling respected, feeling safer and more secure, and feeling that their family members were better able to care for themselves. The survey also showed satisfaction with the professionalism and politeness of staff, and a willingness by parents to seek out the agency if another family crisis occurred.

Youth and Placement Plans

Youth with a Reunification Plan

An outcome highly valued by the biological family and youth is reunification. Since the passage of the Adoption and Safe Families Act of 1997, achieving permanency for children is of paramount importance. This act also mandated that permanency
decisions and the facilitation of adoptions must occur within a smaller timeframe (Mapp & Steinberg, 2007). This has resulted in child welfare setting a goal to define outcome measures for permanency of children and to make federal funding for permanency contingent on the state’s progress towards these outcomes. One of the ways in which county mental health providers can assist in the reunification process is by allowing biological parents to visit their child while they are in alternative home placements. The level of participation by biological parents who were allowed parental visiting is a strong predictor of reunification. Not only are parental visits important, but the frequency of visits is important as well.

Parental visiting is defined as scheduled face-to-face contact between parent and child (Haight, Black, Workman, & Tata, 2001). Leathers (2002) examined whether there were certain patterns in practice that correlated with more frequent parent-child visits, which in turn would predict an increased likelihood of reunification. Leathers found that 50% of children were visited by their mothers during administrative case reviews. However, only 5% of children received informal visits. Leathers found that the more frequently that mothers visited their children, the greater the caseworker’s prediction of reunification. A more significant predictor of caseworkers’ expectations for reunification was if the child visited the mother at her home. Allowing the parents to have unsupervised visits in their home was considered to be highly predictive of both frequency of visits and the likelihood of reunification. Other features that contributed to the likelihood of reunification were mothers who attended administrative care reviews, attendance at school conferences, doctor’s appointments, and other types of structured
events and appointments (Leathers, 2002).

Haight and colleagues (2001) recognized that immediacy of visitation contributes to successful reunifications. The establishment of regular visits between parents and children immediately upon placement in foster care was a positive predictor of the child returning home. Research has identified other interactions between parent and child during visits that assist with the reunification process. Examples include having parent and child in a room equipped with developmentally appropriate toys, having unobtrusive supervisors observing visits through a one-way mirror, and allowing the parent and child the freedom to engage in mutual involvement. All contribute to successful interactions and, thus increasing the likelihood of reunification.

Haight and colleagues (2001) conducted intense interviews with the biological mothers and asked them what factors facilitated or impeded their visits. Interviewees stated that their feelings surrounding the visit were a factor that contributed to successful interactions with their child. Some mothers were overjoyed to be visiting with their child, while others were saddened by the nature of the visit. The joyful mothers immediately interacted with their child, while those that felt sad were hesitant to do so. Another helpful factor was being able to visit with children while engaging in normal daily activities within their community.

Haight and colleagues (2001) recommends that social workers and service providers individualize each visit plan in an effort to promote successful interactions. Haight and colleagues (2005) provides the example of “leave taking,” in which the mothers and their children negotiate separation at the end of the visit, which influences
how stressful or traumatic the separation is for the two parties. Haight and colleagues note in his article that parents’ feelings affect the leave taking process, and describes interventions in which a professional gives parents emotional support by listening to their stories, affirming their situations, and noting positive aspects of their actions. The professional suggests strategies for leave taking used by other mothers, and ask the mothers which strategies they believe their children will respond to in a positive fashion. The professional coaches the mothers in role-playing sessions on how to apply the strategies successfully before the visits occur.

There are other predictors for a safe reunification, as evidenced by research done by Karol and Poertner (2003). Depending upon different indicators of safe reunification, judges, substance abuse counselors, and private child welfare caseworkers differed in their reunification decision-making. The six areas of functioning that the authors found to be significant when the three groups decided on the indicators of safe reunification were motivation, recovery, competency and reliability, social support, parenting, and legal. The authors showed how certain aspects and areas of functioning seen by biological parents in recovery indicate whether or not they feel that reunification will be established. This article showed that it is important for team members meet together to discuss the biological parents progress towards reunification goals. Discussion on what constitutes progress on the biological parents’ part assists all parties (judges, counselors and social workers) in making reunification decisions. Determining the specific behavioral indicators of higher functioning can assist in discussion of what constitutes reunification planning and success.
Youth need services to be tailored to their individual needs in order to obtain successful reunification with their parents. Difficulties in achieving this goal can relate to the youth’s feelings about living in foster care and having visitation with biological family. Edelstein, Burge and Waterman (2002) provide recommendations for social service and mental health professionals when providing service to youth. Youth may feel that they have to keep biological family secrets private and separate from their foster family. The emotional costs of keeping information private include wariness and a decrease in spontaneity, constricted emotional expression, and withdrawal. Alternatively, youth with a reunification plan may become increasingly close to foster parents over time and not want to return to their biological family due to the biological parents’ inconsistency. Over time, youth may also have become “parentified” and feel responsible for the biological parent’s emotional well-being (Edelstein et al., 2002). In order to provide for the child’s needs and support the reunification process, foster parents who choose to take an older child should be adequately prepared and supported by professionals. Professionals should be trained to give assistance and provide foster-adoptive parents with resources for support groups to help develop the relationship between the foster parent and the youth. Within such groups, discussion, treatment, and processing of feelings between the foster-adoptive and biological parents can take place. Foster-adoptive parents and biological parents need professional mental health treatment to process the potential of losing the youth to the biological family. Youth need their own individual therapist to deal with the conflicting emotions that result from living with foster parents while remaining in contact with their biological parents.
Youth without Reunification Plans

Research by Edelstein and colleagues (2002) discusses the needs of youth, biological family, and foster parents when a youth’s reunification plan has failed but parental rights have not been terminated, and the youth lives with foster parents who would accept adoption as a long-term permanency plan. Even when reunification is not the ultimate outcome, an improved relationship between child and parent can be a desirable outcome. When a child is placed in a long-term foster care home, the caseworker may have to disregard reunification plans when it is in the child’s best interest that the child and their family of origin not reunify. Loss of the ability to reunify is considered appropriate if the parent has abused the child and has not fulfilled rehabilitation tasks mandated by the Child Protective Services social worker. In this case, the caseworker can ask the court to change the child’s placement plan to long-term placement. The purpose of long-term placement is to find a home for the child to reside in for more than a few months, with the possibility of adoption.

However, preservation of biological ties and attachments can be in the best interest of the child. The Replacement with Birthfamilies Project (Replacement) strived to define reunification as a continuum, with reconnection to a biological family being considered just as valuable as adoption (Mapp & Steinberg, 2007). The Family Reunification Continuum begins to build relationships by having the biological parents and their child write letters to one another. This is succeeded by phone calls, visits, and finally reunification, if appropriate. The results of Mapp and Steinberg’s (2007) research shows the importance of using some form of attachment to provide family centered
practice for families that would result in meeting a family or youth’s goals. Mapp and Steinberg (2007) show that letters to the child from their biological parents can be used in therapy to successfully process feelings. Biological parents calling to speak to their child can help the child develop their identity based on family history. Assessments of how children feel after returning from a visit are used to determine whether to place the child back in the biological home or to allow the child to reassess their desire to return home. The authors state that any form of reconnection is of value to the child.

Barriers to reconnection can occur if biological parents feel that their child’s foster care placement is not legitimate or appropriate. Parents may try to sabotage the relationship between their child and the foster parents, stop working towards reconnection, and/or try to force reunification, even if goals leading up to reunification are not yet satisfied. Another situation that may hinder positive feelings is if the biological parents do not know their child’s foster parents. Compounding the problem, there is a lack of support groups for biological parents who have children in foster care (Haight et al. 2005).

A solution to resolving difficulties for youth not returning home is to have the biological parents involved in their child’s adjustment and growth in the foster home. Tiddy (1986) describes the process of renegotiating the client’s ties to their biological family. Youth need closure, to finish unfinished business and maintain some form of contact in order to work through the disappointment of not achieving reunification. Tiddy (1986) recommends therapy sessions that include the biological and foster families. The goal in having blended therapy sessions is to allow the child to express
his/her feelings to both families. All parties must be able to trust the therapist, and child needs to know that the therapist or practitioner is willing to help form ties between the child and both families. Preparatory work with the biological parents is necessary to teach them to be compassionate and non-judgmental as they come to terms with the fact that their child will not return to their home. The practitioner must also work collaterally with the foster family to ensure that they have proper training in dealing with the child’s displaced anger. The foster family needs the practitioner to assist them in understanding the child’s feelings, which could lead to regressive inappropriate behavior.

Ultimately, integrating biological and foster families as much as possible gives the yields the best chance of successful long-term placement for a foster child.

**Impact Over Time**

Stambaugh and colleagues (2007) examined the effectiveness of Wraparound for 213 youth. Developing outcomes and measures that describe growth towards a long-term goal, but allowing for individually determined objectives over time, can assess parents’ attainment of the goals (McConnell, 2001). Based on past WRAP Fidelity Index outcomes for the site that these authors took research from, within Year 1 WFI scores were 80.3%, Year 2 were 82.7%, and Year 3 were 83.2%. The percentages are the Total Score on the WFI. A score of 80% or higher indicated that the services had high fidelity and adhered to Wraparound principles. The results show that over time, Wraparound was adhered to more closely. A higher score on the WRAP Fidelity Index indicates that the family, professional, or child agrees that they are gaining services tailored to a family centered perspective or that are tailored to meet their ultimate family goal. The outcomes
stated above show that this study is consistent in providing a family centered practice to family and children who are gaining Wraparound services. According to this study, scores on the Child Behavior Checklist and the Child and Adolescent Functional Assessment Scale demonstrated that the youth improved over time (baseline to 6 months, 12 months, and 18 months). Improvement was depicted by decreasing scores on the two assessment tools, which correlated to fewer symptomatic presentations by youth. However, this study did see at the 18-month assessment that youth receiving Wraparound remained in the borderline to clinical range on the Child Behavior Checklist, which indicates a high level of mental health need.

A study by Bruns, Suter, Force and Burchard (2005) assessed the relationship between adherence to Wraparound elements and outcomes for participating families. The Wrap Fidelity Index (2.0) was administered when outcomes were assessed, over a period of 6 months. This was done in order to determine if the administration of the Index predicted future outcomes. The Restrictiveness of Living Environment Scale (ROLES) which quantifies the restrictiveness of a youth’s living placement along a continuum from (0) being independently living to (10) incarceration, was used alongside the Wrap Fidelity Index. The research found that after 6 months of Wraparound service, there was an increased negative correlation between the Wrap Fidelity Index and the ROLES scale. At intake, the correlation was -.06 and at 6 months the correlation was -.21. This indicated that as families gained Wraparound services, youth transitioned to less restrictive environments (Bruns, Suter, Force, & Burchard, 2005).

In summary, the present study analyzed archival data on the Wraparound Fidelity
Index 3.0 from Stanford Home for Children. It was hypothesized that 1) biological parents would adhere more closely to Wraparound principles than foster parents; 2) youth with a reunification plan would adhere more closely to Wraparound principles than youth without a reunification plan; and 3) that Wraparound adherence would be greater for youth who received services for longer than a year than youth that had received services for less than a year.
Chapter 2

METHOD

Participants

For the purpose of this study, data were generated from raw archival data of the WRAP Fidelity Index 3.0 from Stanford Home for Children, beginning in August 2008. Raw data were entered into SPSS by researchers at Stanford Home for Children between the 2002 and 2007. Generated data was gathered by selecting caregiver characteristics (foster and biological family) youth characteristics (with a reunification plan and those with no plan) and whether or not caregiver and youth had supplied answers to the measure. Generated data were organized into a different SPSS data file from the original data set. Differences between and within groups will be identified through analysis of variance (ANOVA) in order to determine whether characteristics would affect adherence to the Wraparound model.

Participants selected were parents (biological and foster) and youth (with a reunification plan and those without a reunification plan) of children diagnosed with an emotional and/or mental health disorder that were receiving Wraparound services from Stanford Home for Children between the years of 2002 and 2007. The participant groups included in the analysis were selected based on particular characteristics for the analysis. The caregiver group consisted of biological parents and foster parents indicated by the caregiver report. For the first hypothesis, the caregiver form scores of the Wrap Fidelity Index were utilized. The youth group consisted of youth with a reunification plan and
youth that did not have a plan to reunify with biological family. For the second and third hypothesis, the youth form scores of the Wrap Fidelity Index were utilized. Parents were divided into biological parents, $N = 91$, and foster parents, $N = 31$. Youth were divided into those living in four different types of homes (biological parents, foster home, kinship, and group homes) and having a reunification plan, $N = 46$, and those who did not have a plan, $N = 145$. Age, gender, and ethnicity are summarized in Table 1 for all groups.

**Design**

To analyze differences between groups on the Total WFI scores, independent $t$ tests were computed in SPSS for caregiver form and youth form. Significant differences were followed by a series of one-way analyses of variance to determine which Element scores were significant.
Table 1

*Descriptive Statistics on Participants*

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<td>Male</td>
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<tr>
<td>Maximum</td>
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<td>Other</td>
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**Initial Data Gathering Procedures**

The research department at Stanford Home for Children recruited a random sample of youth enrolled in the Wraparound program at the time of the Wrap Fidelity’s assessment. The participants interviewed for the Wraparound Fidelity Index included resource facilitators (Wraparound Facilitator), caregivers (foster parents, biological parents, social workers, group home staff, grandparents, and kin) and youth (child). For the purpose of this research, only the caregiver’s interview and the youth’s interview along with the corresponding outcome scores were used to test the hypotheses. All parents and youth included in the study were receiving Wraparound services when a researcher (staff from the Stanford Home for Children Research Department) called to ask for an interview in order to collect data for the Wrap Fidelity Index 3.0. The participants were approached after receiving approximately 6 months of Wraparound services from Stanford Home. The parents and youth who stayed in Wraparound longer than one year were interviewed at least twice. Stanford Home for Children collected data for the WFI 3.0 twice a year, in November and May. A research assistant contacted Wrap Facilitators, parents, and youth to ask if they would like to participate in the WFI 3.0 interview. Upon agreement, the research assistant met with the youth, parent, and Wrap Facilitator individually to conduct the interview. The measure was administered interview-style with open-ended questioning facilitated by the research assistant, whom was not part of the Wraparound team. The time needed to administer the interview ranged from 45 minutes to one hour, depending on the amount of information the
interviewees provided. All raw data was collected on three WFI 3.0 forms: Resource Facilitator Form, Caregiver Form, and Youth Form. Once interviews were completed and all raw data collected from the forms, the research assistant entered the data into SPSS. Parents and youth were asked to provide information for the WFI 3.0 multiple times while receiving Wraparound services from Stanford Home for Children. Intervals for the administration of the measure were three months, six months, one year, and over one year of receiving service. After five years of research, the total amount of clients surveyed equaled \( N = 337 \). The total number of research staff who interviewed the parents was ten. The parents and youth were asked to consent to participate in research upon admission into the Stanford Home Wraparound program, and were asked to consent to a confidentiality agreement as well. Parents and youth of legal age signed a general consent form allowing the Research Department to contact the parents and team members for the purposes of the study. The generation of data from archival data was approved by Gordon Richardson, Director of the Research Department of Stanford Home for Children, for the sole purpose of facilitating this study.

**Selection of Sample from Archival Data**

The intent of this thesis was to analyze archival data collected from parents and youth on the WFI 3.0 over a five-year period, December 2002 to August 2007. Raw data on the specific groups for this study were organized by categorizing specific characteristics (caregiver type and youth plan) and placed into a different SPSS file. The particular groups were selected based on the hypothesis, biological parents, foster
parents, youth with a reunification plan and those youth with no plan.

**Measure**

**Wraparound Fidelity Index**

The Wraparound Fidelity Index (WFI 3.0) measures the level of adherence to particular core elements (11 for parents, 8 for youth) of the Wraparound treatment model. Scores above 80% on the WFI 3.0 for the Total Index score and each Element scores indicate high fidelity to the Wraparound service model. In December 2002, Stanford Home started using the 3.0 version, and in 2008 began training Wrap Facilitators to utilize the 4.0 version of the WFI. Due to this research falling in the middle of the transition between versions, the data gathered will be from the WFI 3.0 version. The index takes interview data from three different sources: the Wraparound Facilitator, defined as the case manager of the client’s Wraparound team; the Caregiver, defined as the parent of the youth; and the youth, the clients contracted by the county to receive Wraparound services. Data gathered for the purposes of descriptive statistics were obtained from all forms. Data gathered for analysis were obtained from caregiver and youth form. Each form generates demographic information, such as age of client, gender, race, relationship to the client, legal custody of client, whether there is a plan to reunite the client with biological parent, whether the client is a ward of the state, and how many months the client has been receiving Wraparound.

The WFI 3.0 has a main index score as well as 11 subsection scores. There are 11 core Wraparound elements to the Index. Descriptions of the 11 core elements are
provided in Table A. Caregivers are asked questions on all 11 elements; however, youth are only asked questions on the first 8 elements. The researcher asks open-ended questions and the responses are circled on the form into numbered categories corresponding to “yes”, “sometimes”, “no’ or “missing” descriptors. Each form is given to a research assistant in order to place the raw numbered scores into SPSS. To give an example of the style of interview, the interviewer may ask the caregiver, “Describe to me how a typical team meeting goes for you,” to answer a closed-ended question under the Parent Voice and Choice Element: “Do you feel comfortable expressing your opinions even if they are different from the rest of the team?” The interview style is not intended to ask each question as they are displayed on the form. Instead, the open-ended style is meant to generate a conversation, and the interviewer asks leading questions that match the closed question on the form as much as possible. Occasionally, a question is not applicable to the client or the client’s team, in which case the N/A category is available. Examples of questions from Youth and Family Team Element are: “Do your child and one of her or his biological parents actively participate on the team?” “Is there a friend or advocate of your family who actively participates on the team?” “Does your team consist of people you want on the team?” Internal consistency on the each question that made up each Element were calculated utilizing Cronbach’s alpha to find the strength of the variables.

Bruns (n. d.) states that the Wraparound Fidelity Index 3.0 have demonstrated adequate test retest reliability, internal consistency, and inter-rater reliability. The
Wraparound Fidelity Index 3.0 has been assessed on test – retest reliability and results show that within two weeks significant correlations for the caregiver forms ($r=.88$), youth forms ($r=.64$) and facilitator forms ($r=.84$) were significant. The correlations between the caregiver forms and the facilitator forms were significant at the $p<.05$ and the youth form was significant at the $p<.10$ level. Inter-respondent agreement was assessed for the national WFI 3.0 sample of 667 families in 10 different sites by calculating the Intraclass Correlation Coefficient (ICC) for agreement between sets of respondents. Results found moderate ICCs of .58 for all three respondents, .44 for facilitator and caregiver agreement, .49 for caregiver and youth agreement, and .45 for facilitator and youth agreement. These ICCs indicated good inter-respondent agreement for a scale of this nature.

In regards to validity, Bruns (n. d.), reported that the WFI correlates with ratings of an external Wraparound expert, better child and family outcomes, and higher levels of community and system supports for Wraparound. In regards to construct validity, confirmatory factor analyses (CFA) was done to confirm that there is good “fit” between scale items and a proposed set of factors (i.e., wraparound principles) they are intended to measure. Using WLSMV estimation, a CFA of the caregiver form of the WFI 3.0 found a Root Mean Square Error of Approximation (RMSEA) of 0.059 for a 44-item solution. A result of under 0.060 indicates a good “fit” of items to a proposed factor structure (Wraparound Evaluation and Research Team, 2010). Bruns, Suter, & Leverentz-Brady (2008) found a pattern of results that supports the hypothesis that the WFI 3.0 can
discriminate between wraparound and non-wraparound interventions for youth with complex needs. They also found that programs with greater support in implementing the process such as training, coaching, quality assurance, and interagency collaboration achieved higher fidelity scores.

Throughout the five years of administration of Wraparound with status reports occurring every six months, the Stanford Home Wrap Fidelity Index has maintained an average fidelity at 79.5% for facilitators, 78% for caregivers, and 76% for youth (Stanford Home Research, 2003 – 2007).
Chapter 3

RESULTS

Fidelity Differences in Groups

Effects of Caregiver Type

To test the first hypothesis that biological parents would have higher fidelity than foster parents, an independent-samples \( t \) test was conducted to compare biological parent Total WFI 3.0 score and foster parent Total WFI 3.0 score. A significant difference would show support for hypothesis one stating that there is a significant difference between Wraparound service fidelity provided to foster parents as opposed to biological parents. Reliability coefficients were analyzed to find the level of internal consistency for caregiver scores. Cronbach’s alpha revealed overall that the internal consistency on the scale given caregiver scores were high at an alpha level of \( \alpha = .83 \). Using the Explore procedure in SPSS, extreme scores and deviations from normality were noted, but the deviations were taken to meaningfully represent the target population so the data were not altered. Levene’s test showed no violation of the homogeneity of variance assumption, \( (F < 1, p > .05) \). An independent samples \( t \) test was conducted to examine whether or not there were differences between adherence to the model based on caregiver. The result of the \( t \) test failed to reveal a statistically significant difference in the scores for biological parents Total WFI 3.0 score \( (M = 6.38, SD = 1.02) \) and foster parents Total WFI 3.0 score \( (M = 6.33, SD = 1.16) \), \( t (120) = .23, p > .05 \). These results suggest that contrary to the first hypothesis, there is no evidence that Wraparound
adherence is greater for biological parents compared to foster parents.

**Effects of Youth’s Plan**

To test the second hypothesis, an independent-samples \( t \) test was conducted to compare youth with a reunification plan and those youth without a reunification plan on youth Total WFI 3.0 scores. A significant difference would show support for hypothesis two stating that there is a difference between Wraparound service fidelity provided to youth with a plan and those youth without a plan. Cronbach’s alpha revealed overall that the internal consistency on the scale given youth scores were moderate at an alpha level of \( \alpha = .73 \). Using the Explore procedure in SPSS, extreme scores and deviations from normality were noted, but the deviations were taken to meaningfully represent the target population so the data were not altered. Levene’s test showed no violation of the homogeneity of variance assumption, \( (F < 1, p > .05) \). An independent samples \( t \) test was conducted to examine whether or not there were differences between adherence to the model based on youth’s reunification plan. The results of the \( t \) test failed to reveal a statistically significant difference in the scores for youth with a reunification plan on youth Total WFI 3.0 score \( (M = 6.01, SD = 1.30) \) and youth without a reunification plan on youth Total WFI 3.0 score \( (M = 6.09, SD = 1.17) \), \( t (189) = .364, p > .05 \). These results suggest that contrary to the second hypothesis, there is no evidence that Wraparound adherence is greater for youth with a reunification plan compared to youth without a plan.
Effects of Time in the Program

To test the third hypotheses, an independent samples *t* test was conducted to compare adherence given youth in the program less than 12 months and youth in the program more than 12 months on youth Total WFI 3.0 scores. A significant difference would show support for hypothesis three stating that there is a difference between Wraparound service fidelity provided to youth in the program more than 12 months as opposed to those youth in the program less than 12 months. Using the Explore procedure in SPSS, extreme scores and deviations from normality were noted, but the deviations were taken to meaningfully represent the target population so the data were not altered. Levene’s test showed that the two variances are not significantly different, thus the two variances are approximately equal, (*F* = 1.49, *p* = .223). Descriptive statistics, including group sizes, are provided in Table 4. The results of the *t* test reveals a statistically significant difference in the scores for youth in the program longer than 12 months (*M* = 6.43, *SD* = 1.06) than youth in the program less than 12 months (*M* = 5.96, *SD* = 1.18), *t*(229) = -3.01, *p* < .01. Comparison of means reveals that youth in the program longer than 12 months have a higher fidelity adherence than youth in the program less than 12 months, thus supporting hypothesis three.

In order to locate differences between the youth Element scores given time in the program, a series of one-way analyses of variance (ANOVAs) were conducted on each youth element score to find where the significant difference was. Using the Explore procedure in SPSS, some extreme scores and deviations from normality were noted, but
the deviations were taken to meaningfully represent the target population so the data were not altered. Descriptive statistics are included in Table 2. Scale descriptive statistics, reliability coefficients (α), and correlations among the eight youth element scores are presented in Table 3. Most of the variables were weakly to moderately intercorrelated and the scales lacked internal consistency.
Table 2

*Group Sizes, Mean Scores, and Standard Deviations, for Wraparound 3.0 Youth Element*

<table>
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<tr>
<th>Youth Element</th>
<th>&lt;12 months</th>
<th>12+ months</th>
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</thead>
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<tr>
<td>1. Voice and Choice</td>
<td>6.84</td>
<td>7.18</td>
</tr>
<tr>
<td></td>
<td>(1.50)</td>
<td>(1.14)</td>
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<tr>
<td></td>
<td>139</td>
<td>84</td>
</tr>
<tr>
<td></td>
<td>4.23</td>
<td>4.39</td>
</tr>
<tr>
<td>2. Youth and Family Team</td>
<td>4.23</td>
<td>4.39</td>
</tr>
<tr>
<td></td>
<td>(1.60)</td>
<td>(1.64)</td>
</tr>
<tr>
<td></td>
<td>143</td>
<td>85</td>
</tr>
<tr>
<td></td>
<td>4.67</td>
<td>5.21</td>
</tr>
<tr>
<td>3. Community Based Services</td>
<td>4.67</td>
<td>5.21</td>
</tr>
<tr>
<td></td>
<td>(1.86)</td>
<td>(1.77)</td>
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<td>86</td>
</tr>
<tr>
<td></td>
<td>7.30</td>
<td>7.62</td>
</tr>
<tr>
<td>4. Cultural Competence</td>
<td>7.30</td>
<td>7.62</td>
</tr>
<tr>
<td></td>
<td>(1.33)</td>
<td>(.98)</td>
</tr>
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<td>86</td>
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<tr>
<td></td>
<td>6.91</td>
<td>7.43</td>
</tr>
<tr>
<td>5. Individualized Services</td>
<td>6.91</td>
<td>7.43</td>
</tr>
<tr>
<td></td>
<td>(1.49)</td>
<td>(1.31)</td>
</tr>
<tr>
<td></td>
<td>143</td>
<td>86</td>
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<td>7.11</td>
</tr>
<tr>
<td>6. Strength Based Services</td>
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<td>7.11</td>
</tr>
<tr>
<td></td>
<td>(1.69)</td>
<td>(1.49)</td>
</tr>
<tr>
<td></td>
<td>144</td>
<td>86</td>
</tr>
<tr>
<td></td>
<td>5.34</td>
<td>6.41</td>
</tr>
<tr>
<td>7. Natural Supports</td>
<td>5.34</td>
<td>6.41</td>
</tr>
<tr>
<td></td>
<td>(2.50)</td>
<td>(2.40)</td>
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<td></td>
<td>129</td>
<td>80</td>
</tr>
<tr>
<td></td>
<td>6.38</td>
<td>6.68</td>
</tr>
<tr>
<td>8. Continuation of Care</td>
<td>6.38</td>
<td>6.68</td>
</tr>
<tr>
<td></td>
<td>(1.83)</td>
<td>(1.84)</td>
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<td></td>
<td>126</td>
<td>80</td>
</tr>
</tbody>
</table>

*Note.* Numbers in italics reflect group size (*n*). Numbers in parentheses are standard deviations. <12 months = in the program less than 12 months; 12+ months = in the program for 12 months or longer.
Table 3

**Correlations, Means, Standard Deviations, and Coefficient Alphas for Wraparound 3.0**

<table>
<thead>
<tr>
<th>Youth Element Scores</th>
<th>YE 1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
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<tbody>
<tr>
<td>1</td>
<td>–</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>0.07</td>
<td>–</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>3</td>
<td>0.18*</td>
<td>0.07</td>
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<tr>
<td>4</td>
<td>0.49*</td>
<td>0.09</td>
<td>0.24*</td>
<td>–</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>0.37*</td>
<td>0.24*</td>
<td>0.06</td>
<td>0.48*</td>
<td>–</td>
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<tr>
<td>6</td>
<td>0.29*</td>
<td>0.18*</td>
<td>0.23*</td>
<td>0.50*</td>
<td>0.53*</td>
<td>–</td>
<td></td>
<td></td>
</tr>
<tr>
<td>7</td>
<td>0.33*</td>
<td>0.25*</td>
<td>0.18*</td>
<td>0.41*</td>
<td>0.37*</td>
<td>0.40*</td>
<td>–</td>
<td></td>
</tr>
<tr>
<td>8</td>
<td>0.22*</td>
<td>0.19*</td>
<td>0.07</td>
<td>0.36*</td>
<td>0.37*</td>
<td>0.45*</td>
<td>0.34*</td>
<td>–</td>
</tr>
<tr>
<td>M</td>
<td>7.06</td>
<td>4.46</td>
<td>4.84</td>
<td>7.46</td>
<td>7.41</td>
<td>7.22</td>
<td>6.25</td>
<td>6.77</td>
</tr>
<tr>
<td>SD</td>
<td>1.20</td>
<td>1.66</td>
<td>1.97</td>
<td>1.17</td>
<td>1.11</td>
<td>1.28</td>
<td>2.14</td>
<td>1.59</td>
</tr>
<tr>
<td>α</td>
<td>0.43</td>
<td>0.27</td>
<td>–</td>
<td>0.43</td>
<td>0.66</td>
<td>0.65</td>
<td>0.76</td>
<td>0.53</td>
</tr>
</tbody>
</table>

*Note. N = 146. YE = youth element; 1 = Parent Voice and Choice; 2 = Youth and Family Team; 3 = Community Based Services; 4 = Cultural Competence; 5 = Individualized Services; 6 = Strength Based Services; 7 = Natural Supports; 8 = Continuation of Care; 9 = Collaboration; 10 = Flexible Resources; 11 = Outcome Based Services. Cronbach’s alpha could not be calculated for Youth Element 1 due to insufficient sample size. *p < .05.*

Using a Bonferroni correction to protect against Type I error, only one way analysis of variance on results with a significant at p < .01 were interpreted. An inspection of the group means indicated that youth who had been in the program for 12 months or more (M = 7.34, SD = 1.31) were significantly higher in Individualized Services (Element 5) than those who had been in the program less than 12 months (M = 6.91, SD = 1.49), F(1, 211) = 6.80, p = .01. Youth who had been in the program for 12
months or more ($M = 6.41, SD = 2.40$) were significantly higher in Natural Supports (Element 7) than those who had been in the program less than 12 months ($M = 5.34, SD = 2.50$), $F(1, 207) = 9.22, p = .003$. Presentation of the series of one way analyses of variance for Element 5 and Element 7 are displayed in Table 4. Caution should be exercised in interpreting these results due to low scale internal consistency.
Table 4

ANOVA  F Ratios for Time in the Program of Youth Wraparound 3.0 Element Scores

<table>
<thead>
<tr>
<th>Element</th>
<th>Source</th>
<th>SS</th>
<th>df</th>
<th>MS</th>
<th>F</th>
<th>p</th>
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<tr>
<td>5. Individualized</td>
<td>Between</td>
<td>13.73</td>
<td>1</td>
<td>13.73</td>
<td>6.80</td>
<td>.010</td>
</tr>
<tr>
<td>Services</td>
<td>Groups</td>
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<td></td>
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</tr>
<tr>
<td></td>
<td>Within</td>
<td>426.34</td>
<td>211</td>
<td>2.02</td>
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<td></td>
</tr>
<tr>
<td></td>
<td>Groups</td>
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<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Total</td>
<td>440.07</td>
<td>212</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. Natural Supports</td>
<td>Between</td>
<td>55.97</td>
<td>1</td>
<td>55.97</td>
<td>9.22</td>
<td>.003</td>
</tr>
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<tr>
<td></td>
<td>Within</td>
<td>1257.31</td>
<td>207</td>
<td>6.07</td>
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<td></td>
</tr>
<tr>
<td></td>
<td>Groups</td>
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</tr>
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<td></td>
<td>Total</td>
<td>1313.28</td>
<td>208</td>
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Chapter 4
DISCUSSION

The purpose of the study was to evaluate whether or not specific participant characteristics would affect Wraparound adherence for a sample population from Stanford Home for Children. Participant characteristics and their effect on adherence to a treatment model is important for future training of professionals and sensitivity to the needs of particular families. Analysis of Wraparound adherence examined biological and foster parents and whether or not the youth had a reunification plan or long-term permanency plan. Wraparound adherence was also investigated to determine if length of service affected levels of adherence.

**Biological and Foster Parent Total Fidelity Scores**

Results did not support the hypothesis that Wraparound adherence would be greater for biological parents than foster parents. Results showed that there were no significant differences between the two groups, meaning that Wraparound provided the same treatment process for both biological parents and foster parents. The lack of difference may be due to Wraparound providing the family with the same types of services regardless of family characteristics. Wraparound makes every effort to explore the family’s needs before applying treatment, allow the family to develop their own interventions, and connect the family to their natural supports. Showing no differences
between groups is a positive thing for the process since it supports the notion of the service being valid between groups. Another reason there was no difference seen could be due to foster and biological parents needing the same types of services from Wraparound. For example, both foster and biological parents may need assistance getting involved in church and transportation to outside resources and/or job interviews.

Research has shown the importance of parental involvement, parent education, frequency of visiting towards reunification, clarifying biological and foster parent roles, and empowerment. Results support the notion that both biological and foster parents were supported through these concepts in order to assist in the youth and family’s goals. Biological and foster parents reported that the Wraparound process they experienced were similar in what the model was intended to provide thus suggesting that caregiver characteristics did not change the treatment provision provided by Stanford Home for Children’s Wraparound program.

**Youth’s Plan**

Results did not support the hypothesis that Wraparound adherence would be different for youth with a reunification plan compared to youth without a reunification plan. This lack of difference could be due to the same factors that resulted in the lack of difference in adherence between the two caregiver groups. Wraparound serves youth for the goal of permanent placement. When youth have a reunification plan, Wraparound strives to bring youth back home. The same service would be provided to youth with no reunification plan, as Wraparound would be seeking out long-term permanent placement.
This is consistent to the literature regarding concurrent planning where social workers can plan for two different types of permanency plan, one where youth return to biological family and those youth that stay in long term foster care (Edelstein et al., 2002). Services provided similar not dependent on youth’s plan shows how efforts were made to stabilize youth in their foster home while connecting youth with their biological family (Mapp & Steinberg, 2007).

**Impact of Time Frame**

Wraparound adherence was found to be different given the youth’s length of time with Wraparound provision. Those youth that were in the program longer than 12 months had adherence scores that were higher than those youth in the program less than 12 months. As the process of Wraparound continues through time, the family’s goals change, youth move placements, and connection with biological family may be more frequent.

The Individualized Services (Element 5) of the WFI 3.0 showed youth in the program longer than a year showed higher adherence to the model. Differences in time frame for this element could relate to the youth feeling that they are gaining services more tailored to their individual needs over time. The team is able to understand the family and youth and make plan effectively since they become more acquainted over time. The team’s development of the plan over time meets the youth’s needs at home, school, and the community. As the team implements interventions over time, youth are able to stabilize in the environment and reduce maladaptive behaviors (Bruns, et al.,
Difference in adherence to the model was shown for Natural Supports (Element 7) on the WFI 3.0 across time. Youth in the program longer than a year had higher adherence to the model indicating that youth are able to gain more support from family and friends as opposed to the professionals. Literature supports this result since youth are able to rely on family and friends, they are able to decrease their dependence on restrictive environments (Bruns et al., 2005).

**Limitations**

There are many limitations to this present study that warrant discussion. First, utilizing data from one non-profit community program does not necessarily allow for generalization of the results to other service providers that provide Wraparound service. Second, choosing to use preexisting data from a community sample that is at risk did not allow for random assignment and use of a control group for ethical as well as practical reasons. A third limitation is that the comparison between four groups (foster and biological parents, youth with and without a reunification plan) does not shed light on Wrap Fidelity issues affecting other subgroups, such as grandparents, facilitators, social workers, and youth already reunified with family. Comparison between the four groups and other groups served by Wraparound could bring up interesting data indicating how fidelity was met.

In regards to sample characteristic and statistical analysis; scales lacked internal consistency, thus items within element categories were not correlated together and lacked
Future Research and Clinical Application

This research indicates the need for further understanding of the different Wraparound services provided to foster and biological parents and their children, and how those services are impacted by where youth reside and the time frame of treatment. The results of this study only show whether or not there were differences in Wrap Fidelity between groups. It did not assess the foster parents’, biological parents’, and youth’s satisfaction with Wraparound services, nor did it assess why particular services (Element scores) had low fidelity. Further research can assess whether or not parents and youth are satisfied with the services provided to them. Assessing satisfaction can provide insight into which aspects of Wraparound service the family considers helpful in meeting their needs. Asking families for the reasons behind low element scores can provide a clearer perspective of why or why not a service was provided. More information as to why service did not meet the criteria for which it was intended can indicate whether more flexibility needs to be incorporated into future revisions of Wraparound.

Once barriers to providing service have been identified by families served, Stanford Home for Children can change the way training is provided to their employees. Barriers effecting Wraparound service could be due to non-compliance to treatment recommendations. For example, non-compliance could be accidental failure to follow through on treatment (Della Toffalo, 2000). Other examples are parents agreeing with treatment because the team recommends it so, but not following through on the
recommendation because they fear retaliation. Future research could determine specific factors that may support noncompliance.

Now that Wraparound Fidelity Index 4.0 has been developed, it will assist in assessing the conformance to the Wraparound practice model as well as the adherence to the principles of Wraparound in service delivery. The 4.0 version allows providers to see whether or not they were providing the typical activities of a high quality Wraparound service team. Another form, the Team Member form, allows an external evaluator to assess how well the service is being provided. An outsider can evaluate the barriers to the service being provided within any stage of service and as a result changes in service can be provided for better outcomes (Bruns, no date). Analyze utilizing the Wraparound 4.0 on the different caregiver’s and youth’s plan is highly recommended for high fidelity and successful evidence based practice for Stanford Home for Children.

Families and youth needing professional assistance in stabilizing the home and being self-sustaining come with different needs and capabilities. Seeking to understand our different families and youth’s needs through research such as this thesis attempted to accomplish can strengthen treatment and its approach in a timely and effective manner. Training curriculum can be developed in order to more effectively serve particular characteristics of youth and families. Since length in time in the program and caregiver type affected adherence, training on these factors can assist in providing treatment necessary to adhere more closely to the Wraparound model.
## APPENDIX

### Table A

**Definitions of the Eleven Core Wraparound Elements**

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<thead>
<tr>
<th>Essential Elements of Wraparound</th>
<th>Definition</th>
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<tr>
<td>1. Voice and Choice</td>
<td>Families must be full and active partners at every level of the Wraparound process. If the team cannot reach consensus, the final decision should be up to the caregiver.</td>
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<td>2. Youth and Family Team</td>
<td>Wraparound is a team – driven process involving caregivers, youth, natural supports, and community services working together to develop, implement, and evaluate the individualized plan.</td>
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<td>3. Community – Based Services and Supports</td>
<td>Services and supports that the youth and family receive should be based in their community. The family should not have to leave their community if more restrictive services are necessary.</td>
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<td>4. Cultural Competence</td>
<td>The team should not only be respectful of the family’s beliefs and traditions, but also actively seek to understand the family’s unique perspectives and convey them to others.</td>
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<td>5. Individualized Services</td>
<td>Services and supports are tailored to the unique situation, strengths, and needs of each individual,</td>
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and may involve existing categorical services and informal supports; modifying existing services and supports; and/or creating new services and supports. Further, the team should create a specific plan to meet the family’s goals and a crisis/safety plan to manage potential emergencies.

6. Strengths – Based Services

The focus of the team should be on what is working and going well for the family. While goals may be drawn up based on the family’s needs, the plan should capitalize on the family’s positive abilities and characteristics.

7. Natural Supports

Services and supports should reflect a balance of formal and informal community and family supports rather than a reliance on formal professional services.

8. Continuation of Care

Services and supports must be provided unconditionally. In a crisis, services and supports should be added rather than placing the youth with a new provider.

9. Collaboration

The team should coordinate services and supports so they seem seamless to the family rather than disjoined.

10. Flexible Funding and Resources

Successful Wraparound teams are creative in their
approach to service delivery and have access to flexible funds and resources to implement their ideas.

11. Outcome – Based Services

Specific, measurable outcomes should be monitored to assess the youth and family’s progress towards goals.

*Note.* Caregivers are asked questions from the Wrap Fidelity Index on all 11 elements. Youth are asked questions from the Wrap Fidelity Index on the first 8 elements.
REFERENCES


