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LOYOLA UNIVERSITY CHICAGO

CULTURAL COMPETENCE—DOES IT MATTER?:
LESSONS FROM A MIXED-METHODS STUDY
OF WRAPAROUND PRACTICE

A DISSERTATION SUBMITTED TO
THE FACULTY OF THE GRADUATE SCHOOL
IN CANDIDACY FOR THE DEGREE OF
DOCTOR OF PHILOSOPHY

PROGRAM IN SCHOOL PSYCHOLOGY

BY

JENNIFER J. ROSE

CHICAGO, ILLINOIS

AUGUST 2012

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It takes a village to raise a child, and a community of scholars and supporters to complete the doctoral process.

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ABSTRACT

This mixed methods study investigated whether caregivers' ratings of wraparound fidelity and satisfaction with the wraparound process differed based upon their facilitators' self-assessed cultural competence and caregivers' reported stress. An explanatory sequential design was used. The quantitative phase was completed first. Survey methodology was used to measure reported cultural competence, wraparound fidelity, satisfaction with the wraparound process, and parental stress. Facilitators ($n=58$) completed a self-assessment instrument, the Multicultural Counseling Knowledge and Awareness Scale (MCKAS; Ponterotto, 1997). The MCKAS survey yielded a 43% response rate. The MCKAS descriptive data found levels of reported cultural competence comparable to previously published studies. Telephone interviews were conducted with caregivers using two instruments: The Wraparound Fidelity Index, Version 4.0 (WFI-4; Wraparound Evaluation and Research Team, Bruns, & University of Washington, 2006) Caregiver Satisfaction Questionnaire (Rose, 2010) and The Caregiver Strain Questionnaire (CGSQ; Brannan, Heflinger, & Bickman, 1994). Relative to previously published studies, the caregivers ($n=6$) reported low levels of fidelity, slightly higher levels of Objective Strain, comparable levels of Subjective Internalizing strain and lower levels of Subjective Externalizing Strain. However, they also reported being satisfied with the wraparound process. It was not possible to determine whether caregiver ratings

of fidelity and satisfaction differed based upon their facilitator's self-assessed cultural competence due to the limited number of caregivers who participated in this study.

The goal of the second phase of the study was to explore the views of caregivers regarding culture and parental stress as factors during the wraparound process. The researcher employed a maximal variation sampling technique to compensate for the small number of caregivers in this study. The key findings are that caregiver stress may be reduced when parents feel supported by school personnel and they acquire strategies for managing their child's challenging behavior. The experiences of the caregivers in this study indicate that class and race were factors in developing home-school partnerships and implementation of interventions at schools. While the results of this study are not generalizable, the findings provide some evidence for the possible influence of class, race and culture in the wraparound process.

CHAPTER I

INTRODUCTION

Limited Access to Mental Health Care for Children

The issue of improving access to mental health care for children, sadly, has a lengthy history of unfulfilled need. The Joint Commission on the Mental Health of Children (1970) and the Project on the Classification of Exceptional Children (1975) documented that a significant number of children with emotional disturbance either received poor treatment or no treatment at all due to fragmented service delivery. These findings influenced the inclusion of school-based mental health services in the landmark Education for All Handicapped Children Act (P. L. 94-142) in 1975. However, seven years following the passage of P.L. 94-142, Knitzer's seminal publication, *Unclaimed Children* (1982), illustrated how disjointed services continued to impede access to mental health care. As a result, many children with emotional or behavioral disorders did not receive care, especially minorities.

As of school year 2007-08, 6.7% of students receiving special education services were supported in programs for emotional disturbance (ED) representing approximately 1% of total public school enrollment (U.S. Department of Education, USDOE, 2010). Providing in-school resources signifies the opportunity for more children with challenging behaviors to access emotional and behavioral supports. Unfortunately, opportunity does not always translate to timely and effective interventions contributing to

beneficial outcomes for these children and youth. Morrison and D’Incau (1997, 2000) found in their research on expulsions that students classified as ED may be (a) misdiagnosed; (b) not receive any supports until middle school, or until after expulsion and reassignment to an alternative school. Ineffective interventions and delayed identification contribute to challenging behaviors that are intractable with children experiencing a downward spiral of academic and social failure (Walker, Nishioka, Zeller, Severson, & Feil, 2000). Furthermore, there is a tendency for students receiving special education supports under the classification of ED to be placed in more restrictive settings than general education classes. For example in 2008, 23% of students with ED were educated less than 40% of the day in general education classrooms U.S. Department of Education, National Center for Education Statistics; USDOE, NCES, 2011). In comparison, only 9% of students with specific learning disabilities spent less than 40% of the school day in the general education setting during the same time frame (USDOE, NCES, 2011)

A number of children and youth who might benefit from behavioral or emotional supports delivered in school are considered ineligible because they are considered as “socially maladjusted” (SM). The Individuals with Disabilities Improvement Act (IDEA, 2004) does not define SM. However, some school personnel have interpreted SM as willful or intentional acts of misbehavior committed by students (Merrell & Walker, 2004, p. 902). Children and youth who meet the DSM-IV (American Psychiatric Association, 2000) criteria for impaired emotional functioning under the categories of conduct disorder (CD), or oppositional defiant disorder (ODD) may, in the absence of a

clear federal definition of SM, also meet the behavioral criteria established by local educational authorities (LEA) for identification of socially maladjusted students. Eligibility determination for special education under ED, in some instances, becomes a subjective interpretation of the degree of intent associated with inappropriate or disruptive behaviors. The exclusion of students considered as SM can result in students with CD or ODD being denied behavioral and emotional supports and protection from expulsions for behaviors related to their disorder (Merrell & Walker, 2004; Walker et al., 2000). Providing accessible and effective mental healthcare for the most vulnerable population children remains challenging, even with the purposeful inclusion of mental health services (i.e., P.L. 94-142) within schools.

Parental Stress and Treatment Choices

The *New York Times* (Warner, 2009, February 19) article, “Children in the Mental Health Void” described the impact of limited options for children’s mental health care on Nebraska’s public health system. The families of 36 youth (seven from out-of-state) relinquished their parental rights, under a law intended to prevent the abandonment of newborns, in order to secure treatment for their children. The *Times* article vividly documented the harrowing effects of extreme levels of parental stress, referred to in the literature as caregiver strain.

Caregiver strain is conceptualized as consisting of three dimensions: (a) Objective Strain, (b) Subjective Internalizing Strain, and (c) Subjective Externalizing Strain (Brannan & Heflinger, 1997). Objective Strain refers to events and situations associated with caring for a child with emotional and behavioral disabilities (e.g., expulsions,

encounters with juvenile justice, strained marital relationships; Brannan, Heflinger, & Foster, 2003, p. 83). Subjective Internalizing Strain is defined as internalized feelings linked with parenting a child with challenging behavior (e.g., concerns regarding the child's future; Brannan et al., 2003, p. 83). Subjective Externalizing Strain describes the caregiver's emotions associated with the effects of the child's behavior (e.g., shame, frustration; Brannan et al., 2003, p. 83). Caregiver strain differs from psychological distress. Psychological distress is best understood as a possible reaction of a caregiver based on their perception of life stressors (e.g., finances) and available resources for coping. Caregiver strain mediates the relationship between a child's problem behaviors and the caregiver's reaction (Brannan & Heflinger, 2001, p. 412). Multiple studies (Bickman, Foster, & Lambert, 1996; Brannan et al., 2003; Foster, Saunders, & Summerfelt, 1996; Lambert, Brannan, Breda, Heflinger, & Bickman, 1998) have documented the relationship between caregiver strain and a caregiver's decision to request mental health care for their child. The degree of perceived Objective Strain, however, has been found to be the strongest predictor of restrictive placement (Brannan & Heflinger, 1997; Brannan et al., 2003; Lambert et al., 1998).

Research has identified the following contributing factors to caregiver strain: (a) Child symptomatology and degree of impairment; (b) Caregiver satisfaction with family life; (c) Employment status and workplace challenges; (d) "Work-family fit," or the degree of supports and adaptations in place allowing caregivers to successfully parent a child with emotional challenges while also meeting employer expectations; (e) Caregiver perception of child; (f) "Provider/payer" issues (e.g., Lack of available slots in programs,

inability of caregiver to pay for service); (g) “Family perception” issues (e.g., Distrust of mental health care providers); and (h) Logistical obstacles to accessing mental health care (e.g., transportation issues and inconvenient appointment schedules; Brannan & Heflinger, 1997; Brannan & Heflinger, 2001; Brannan & Heflinger, 2006; Angold, Messer, Stangl, Costello, & Burns, 1998; George, Vickers, Wilkes, & Barton, 2008; McDonald, Poertner, & Pierpont, 1999; Rosenzweig, Brennan, Huffstutter, & Bradley, 2008).

Significant differences have been demonstrated in how African American caregivers of children affected by emotional, or behavioral problems rate their overall level of burden and degree of Objective Strain relative to other racial/ethnic groups (Brannan & Heflinger, 2006; McCabe, Yeh, Lau, Garland, & Hough, 2003; Taylor-Richardson, Heflinger, & Brown, 2006). This finding is consistent with results found within studies of caregivers of adults with mental illness (Stueve, Vine, & Struening, 1997), and elderly relatives (Pinquart & Sorensen, 2005). Researchers found that African American caregivers of children with behavioral challenges reported lower levels of caregiver burden and Objective Strain across different groups (e.g., insurance type-managed versus fee for care; parent versus relative caretaker; Medicaid recipients versus military; Brannan & Heflinger, 2006; Taylor-Richardson et al., 2006) and when controlling for symptoms severity, use of public sector services (e.g., child welfare) gender and household income (McCabe et al., 2003, p. 141). The double ABCX model developed by Brannan and Heflinger (2001) is a useful framework for understanding the difference in responses to stressors between African American and other caregivers. This

model examines the following factors: (a) Resources available to the family to cope with stressful events, (b) Perception of stressors, (c) Changes in stressors over time. African American caregivers may be protected from harmful stress levels by use of adaptive coping skills and holding a positive perception of the child in spite of his or her problem behaviors. Gerontology research has shown that African American caregivers possess “high levels of intrinsic motivation to provide care based upon the concept of familism (i.e., the needs of the family takes priority over individual needs) and the use of cognitive coping strategies (e.g., acceptance and reframing) help caregivers to find personal and spiritual meaning in the caregiving experience” (Pinquart & Sorenson, 2005, p. 96). In terms of parenting, Cartledge, Kea, and Simmons-Reed (2002) noted that minority families have a history of reliance upon informal supports such as extended family, pooling resources, strong relationships with non-related persons in the community, and faith-based religious resources (p. 121). The tradition of using informal supports that provide consistent opportunities for respite from caregiving may partially explain the difference in levels of caregiver strain across ethnic groups.

Research also supports the role of culture in the interpretation of behavior as problematic. For example, Cartledge and Milburn (1996) noted that aggressive response styles are often encouraged by families living in dangerous neighborhoods as a survival skill (p. 38). However, this behavior is viewed as dysfunctional within the classroom. This finding is supported by research noting that teachers tend to rate African American students higher than parents on measures of externalizing behaviors (Lau et al., 2004; Youngstrom, Loeber, & Stouthamer-Loeber, 2000), refer them more frequently than

parents on the basis of behavior for special education case studies (Gottlieb, Gottlieb, & Trongone, 1991).

Prevalence of Mental Illness/Emotional Disturbance Among Children

The next section reviews studies on the prevalence of childhood mental illness. This research is provided to help frame the incidence of disorders and document mental health service needs for children. The first two studies described in this section (The Methods for the Epidemiology of Child and Adolescent Mental Disorders [MECA] and The Great Smoky Mountains Study of Youth Study) used convenience samples. However, they have been widely cited (Garland et al., 2001; Hazen, Hough, Landsverk, & Wood, 2004; Hoagwood, Burns, Kiser, Ringeisen, & Schoenwald, 2001; Owens et al., 2002; Rones & Hoagwood, 2000; U.S. Department of Health and Human Services [USDHHS], 1999) in the absence of national epidemiology research to extrapolate national prevalence rates.

The Methods for the Epidemiology of Child and Adolescent Mental Disorders (MECA) Study was an epidemiology methodology study (Shaffer et al., 1996). The purpose of this research was to measure the effectiveness of the National Institute of Mental Health (NIMH) Diagnostic Interview Schedule for Children (DISC) in the MECA study. Researchers used a diverse sample (51% White; 15% African American; 28% Hispanic and 6% other) of 1,285 randomly selected youths between the ages of 9-17 years old from Georgia, New Haven, CT, New York, and Puerto Rico.

The study found that 21% of the sample met the *DSM-III-R* diagnostic criteria and experienced mild levels of impairment. Moderate (12%) to severe (5%) levels of

impairment were found within the sample. The most common diagnoses within the study cohort were as follows: (a) anxiety disorders (13%), (b) disruptive disorders (10%), (c) mood disorders (6%), and **(d)** oppositional defiant disorder (6%).

The Great Smoky Mountains Study of Youth, a longitudinal study of children aged 9, 11, and 13 at baseline (Burns et al., 1995; Costello et al., 1996; Farmer, Burns, Phillips, Angold, & Costello, 2003) is discussed at length in the next section. The sample (N=1,015) was drawn from the southern Appalachia region of North Carolina and was disproportionately White (92%) with a small representation of African Americans. However, this is one of the few studies to research mental health needs among Native Americans (n=323).

The initial study (Burns et al., 1995) investigated prevalence rates for mental health service needs and access to treatment. The researchers found that 20% of the children met the criteria for a *DSM-III-R* diagnosis, however only 40% of youth with impaired functioning received any care. The most common diagnoses found among the sample were as follows: (a) anxiety disorders (5.7%), (b) tic disorders (4.2%), (c) conduct disorder (3.3%), (d) oppositional defiant disorder (2.8%), and (e) ADHD (1.9%; Costello et al., 1996). The most recent research from Great Smoky Mountains Study of Youth (Farmer et al., 2003) extended the research by examining lifetime usage rates for mental health services three years after the initial data collection for children ages 12, 14 and 16. This research found that within a one-year period, an average of 18%-19% of youth accessed mental health services. Lifetime (e.g., birth through ages 12-16 based upon age

of entry to the study) use of mental health services was reported by 54% of the study cohort.

Data collected from the National Health and Nutrition Examination Survey (NHANES) represent the first nationally representative research on prevalence and treatment of childhood and adolescent mental disorders (Merikangas et al., 2010). The weighted sample consisted of 3,024 children ages 8-15. The DISC-IV was used to evaluate the presence of a disorder based upon DSM-IV diagnostic criteria. The DISC-IV was administered to youth for the following conditions: (a) generalized anxiety disorder (GAD), (b) eating disorders, and (c) major depressive disorder/dysthymic disorder (MDD/DD). Parents/caretakers were contacted and administered the DISC-IV for MDD/DD, eating disorders, ADHD and conduct disorders. Levels of impairment ranging from “disorder without impairment” (e.g., intermediate or severe rating on one or more questions) to “disorder with severe impairment” (e.g., intermediate or severe rating on two or more questions; one or more questions with a severe rating) were identified. Impairment was defined based on the impact of the disorder on (a) relationships with family, peers and teachers; (b) self; (c) academic progress (p. 76). The results of the survey showed that 13.1% of children 8 to 15 years old exhibited a disorder without impairment, while 11.3% of children and youth surveyed met the criteria for severe impairment. The most commonly occurring disorders with severe impairment were: (a) ADHD (7.8%); (b) mood disorders, inclusive of MDD and DD (2.9%); (c) and conduct disorder (1.7%). Approximately one out of two subjects had sought treatment within the previous year. However, the proportion of children and youth who sought treatment

varied by condition: (a) anxiety disorders, 33.9%; (b) mood disorders, 50.7%; (c) ADHD, 48.5%; (d) conduct disorders, 44.2%. These results probably reflect lower tolerance for externalizing behaviors associated with ADHD and CD and the severity of symptoms (e.g., suicidality) related with mood disorders.

It is important to note that the variance in findings is influenced by difference in methodologies utilized (e.g., sampling procedure, selected diagnostic tools and process) across the three studies. Furthermore none of the studies sampled children under the age of eight, despite evidence that onset for mental disorders can occur in early childhood. Regardless, it is evident from the epidemiology research that the prevalence of mental disorders among U.S. children and youth indicates the need for a systematic approach to ensure adequate identification and support of those who may benefit from intervention.

Characteristics of Children with Serious Emotional Disturbance

The term serious emotional disturbance (SED) has been referenced within education (e.g., Individuals with Disabilities Act [IDEA], 1990) and in mental health (e.g., the Public Health Service Act of 1993). In the field of education, the term SED was revised to emotional disturbance (ED) within the 1997 amendment to IDEA. As outlined in Individuals with Disabilities Improvement Act, 2004 (IDEIA), to meet the criteria for special education under the classification of ED, the child, or youth must exhibit behaviors that impact academic progress and cannot demonstrate SM behaviors:

Emotional disturbance means a condition exhibiting one or more of the following characteristics over a long period of time and to a marked degree that adversely affects a child's educational performance: (a) An inability to learn that cannot be explained by intellectual, sensory, or health factors, (b) An inability to build or maintain satisfactory

interpersonal relationships with peers and teachers, (c) Inappropriate types of behavior or feelings under normal circumstances, (d) A general pervasive mood of unhappiness or depression, (e) A tendency to develop physical symptoms or fears associated with personal or school problems. Emotional disturbance includes schizophrenia. The term does not apply to children who are socially maladjusted, unless it is determined that they have an emotional disturbance under paragraph (c)(4)(i) of this section.

The term serious emotional disturbance, as defined in the Public Health Service Act refers to, “persons (1) from birth up to age 18; and (2) who currently have, or at any time during the last year, had a diagnosable mental, behavioral, or emotional disorder of sufficient duration to meet diagnostic criteria specified within DSM-III-R.” When the term SED is included in this document, unless noted, it will refer to conditions as defined within the Public Health Service Act. The term ED will be used in reference to students meeting criteria for special education within the classification of emotional disturbance.

Data from the Great Smoky Mountains Study of Youth (Costello et al., 1996) found that 11% of children within the study cohort met the criteria for SED on one or more measures (e.g., Children’s Global Assessment Scale, Child and Adolescent Functioning Assessment Scales, Child and Adolescent Psychiatric Assessment).

Mark and Buck (2006) described the characteristics of children with SED utilizing data from the 2001 National Health Interview Survey. The large sample (N=13,579) represents an 81% response rate from interviews conducted concurrently with collection of the U.S. Census and provides national estimates of characteristics of children with SED. Children were identified based upon receiving scores at, or above the 90th percentile on the Strengths and Difficulties Questionnaire (SDQ). The findings showed that African Americans, Hispanics, children living in households below the

poverty line, and households with Medicaid or other public insurance plans were disproportionately represented among children with SED.

The U.S. Department of Education funded National Longitudinal Transitional Study (NLTS-2) documented the poor outcomes for students receiving special education services as children/adolescents with ED. Compared to other students with disabilities, students with ED have the lowest high school graduation rate (56%), the highest arrest rate (47%) and the greatest likelihood of being on probation or parole (35%; Wagner, Newman, Cameto, Garza, & Levine, 2005). Students with ED are also more likely to be suspended, or expelled than other students with disabilities. The National Transition Longitudinal Study-2 (Institute of Education Sciences; 2006) reported that 73% of students with ED had been suspended, or expelled at least once. To put this finding in perspective, students with ED are more than two times as likely as students with cognitive impairments and almost three times as likely as students with learning disabilities to be excluded from school for disciplinary reasons. These statistics are in sharp contrast to expectations voiced by high school students with ED who overwhelmingly believe that they will graduate from high school (84%) and have a paid job (93%; Wagner, Newman, Cameto, Levine, & Marder, 2007).

Characteristics of School-Based Mental Health Programs

It is well-documented that schools are the primary source of mental health care for U.S. children, and the majority (85%) of children with a mental illness diagnosis and seventy-two percent of youth with SED (e.g., diagnosis and impairment per the Public Health Service Act, 1993) from the Great Smoky Mountains Study of Youth received

mental health services in schools (Burns et al., 1995). For most of the youth with a formal diagnosis (67%), school was the only source of mental health care. Furthermore, school was the entry point for most youth, including those receiving services from mental health specialists (e.g., psychiatric hospitals, community mental health centers, psychologists; Farmer et al., 2003).

In a national survey utilizing a representative sample of U.S. schools (N=2,125) most schools (87%) reported that all students had access to mental health supports (Foster et al., 2005, p.15). However, students of color attending schools with large minority enrollment had fewer opportunities to access care than youth attending schools enrolling fewer minorities. Having on-site mental health services was identified as a critical element for addressing student need because it was not perceived as stigmatizing (p. 73).

The majority of respondents indicated that students could access individual (76%) or group (68%) counseling at school. School counselors, nurses, and psychologists were most frequently identified as staff providing mental health services. While access to care is important, arguably, the quality of treatment is critical given the potential deleterious effects of poorly implemented interventions (Hoagwood et al., 2001). Additionally, Rones and Hoagwood (2000) found that selection of developmentally appropriate interventions and treatment fidelity significantly influenced treatment outcomes for school-based mental health interventions. Effective school-based interventions are available (Rones & Hoagwood, 2000); however knowledge regarding usage rates of evidence-based interventions and quality of implementation in schools continues to be limited.

Minority Children are Underserved by Current Systems

While mental health service delivery, in general, does not meet the demand for care, children of color continue to fare poorly relative to their peers (Cooper et al., 2008). African American and Hispanic children are less likely than White children to receive specialty treatment and medication (USDHHS, 2001, p. 23). Disparities in care result in higher levels of impairment for African American and Hispanic children relative to White children upon entry to treatment (p. 27). Child welfare and juvenile justice have become the mental health care providers of record for African American and Hispanic children (p. 32). Most of these children demonstrate the results of unmet need. For example, a randomly selected, stratified sample of 1,829 males and females held in Cook County, Illinois juvenile detention facilities found that 59% of African American and 65% of Hispanic males met the DSM-III criteria (excluding conduct disorder) for a psychiatric disorder (Teplin, Abram, McClelland, Dulcan, & Mericle, 2002). A study measuring mental health needs among Northern Plains Native American adolescents found that 21% of the sample met the criteria for mental health or substance abuse disorder (Novins, Beals, Sack, & Manson, 2000). However, only four in ten of these youths had actually received mental health care over the course of their lifetime (Novins et al., 2000). Previous research has found that Native American children either receive no treatment, or are removed from their homes and placed in restrictive settings (Isaacs-Shockley, Cross, Bazron, Dennis, & Benjamin, 1996, p. 24). There is limited research on the mental health care needs of Asian American children (USDHHS, 2001). However, in a study of California systems of care, Mak and Rosenblatt (2002) found that usage patterns for

Asian American children mirrored the data for adults. Asian Americans are less likely to access mental health treatment than other racial/ethnic groups, however, those who do eventually seek care display severe levels of impairment. An ecological approach to research that considers the effects of context and culture upon the mental health and access to services for children of color appears appropriate given the disparities in mental health service delivery (Isaacs-Shockley et al., 1996; McLoyd, 1990). However, number of studies examining the role of culture within the helping relationship of children and families serviced by staff in public sectors of care is limited.

Barriers to Treatment and the Role of Culture

In a seminal report on race, ethnicity and mental health, the U.S. Surgeon General found that the primary barriers to treatment for minority clients were: (a) cost, (b) stigma, (c) fragmentation of services, (d) absence of culturally competent providers, (e) clinician bias, (f) lack of bilingual providers, (g) client mistrust and fears due to historical discrimination or experiences of political abuse (USDHHS, 2001, p. 4). Limited financial resources are perhaps the greatest obstacles for minority families' access to mental health care. Minority families are three times as likely as White families to be poor (Children's Defense Fund, 2008). In 2007, 20% of Hispanic and American Indian, 13% of African American and 11% of Asian American were uninsured (Children's Defense Fund, 2008). Minorities represented approximately 5-6 million of the 11 million uninsured children in America (Federal Interagency Forum on Child and Family Statistics, 2009). Admittedly, health care coverage is an issue for Americans regardless of race. However, poverty and lack of insurance combined with culturally related barriers (e.g., limited number of

culturally competent providers) drive the underserving of minority children. The four largest racial/ethnic minority groups (e.g., African Americans, Hispanics, Asians, and Native Americans/Pacific Islanders) currently represent 30% of the U.S. population (U.S. Census, 2010). By 2020, minorities are projected to account for 40% of the population (U.S. Census, 2004). Presently, the majority of mental health care providers are White, a situation that is not projected to change (APA, 2003). The President's Commission on Mental Health (1978) described the experience of minorities treated by White service providers as "demeaning" and "disrespectful." Unfortunately, over twenty years later, Hispanics and African Americans, continued to report having unpleasant experiences with their providers due to cultural issues such as racism (USDHHS, 2001, p. 29). In a recent survey measuring the status of U.S. mental health service delivery for children, "Poor provider cultural competence" was selected as one of the top three barriers to effective service delivery across the four major racial/ethnic minority groups (Cooper et al., 2008, p. 49). The U.S. Surgeon General found that racial/cultural insensitivity was a critical factor in African American and Hispanic families' termination of treatment at higher rates than Whites (USDHHS, 1999, p.181). Published research has documented the concerns of African American parents that treatment would be ineffective because the providers would lack the cultural knowledge necessary to assist their children (Copeland, 2006; McKay et al., 2004).

Culture influences values, beliefs and coping styles. Individuals also have "cultural identities" (USDHHS, 2001), or "personal identities" (Arredondo et al., 1996). Unique experiences, contexts, and stages of human and personality development

contribute to individual differences within racial/ethnic groups. Culture is an element that can influence rapport and the development of a trusting relationship deemed essential to client self-disclosure. Sue and Sue (2008) noted that unresolved cultural issues on the part of the therapist might be contributing factors to high termination rates among minority clients. Examples include: (a) cultural biases transferred from parents to their children; (b) conscious and subconscious acts of microaggression (i.e., verbal, non-verbal and environmental cues that occur during the therapeutic session that “send denigrating messages [from majority culture therapist] to a target group such as people of color,” p. 107); (c) insufficient pre-service training in cultural competence; and (d) lack of information regarding the significance of societal factors such as institutional racism upon the behaviors of minority clients.

In a rare study of client perception of multicultural competence within the therapeutic relationship, Pope-Davis et al. (2002) developed the “client strategic interaction model” (p. 365) to illustrate the dynamic interaction between client needs and other elements (i.e., “client characteristics,” “client processes,” “client appraisals,” and “client-counselor relationship”) that described the clients’ assessment of therapists’ cultural competence. The findings of this study supported the importance of the therapist’s ability to meet their client’s needs (e.g., support with managing depression) as the salient factor in the client’s satisfaction with the client-therapist relationship. However, the study authors noted that issues related to race/ethnicity are perceived by the client to be intertwined with the presenting problem. Clients, who are frustrated with their therapist’s lack of cultural competence, may terminate therapy as a result.

There is evidence suggesting that cultural factors and racial stereotypes influence the relationship between school staff and parents of color. Davies (as cited in Sheridan, 2000) found that “educators believed parents who were less educated, poor, and non-White were deficient in their abilities to help their children with schoolwork and uninterested in their child’s education” (p. 347). Lott and Rogers (2005) noted that teachers had pessimistic beliefs regarding children of color and considered African American students as engaging in high rates of disruptive behavior. The teachers’ negative attitudes frequently translated into treating students of color differently than their peers.

Ingraham (2003) in a multiple case study of pre-service school psychologists found that attitudes toward the student and the consultant’s skill in addressing cultural factors might influence problem formation and intervention outcomes. Rogers (1998) studied the impact of race on perceptions of consultant multicultural sensitivity and competence including communication style (e.g., “race-sensitive” or “race-blind”) during consultation. The findings suggested that consultants who engaged in race-sensitive forms of communication were perceived by both White and African American observers as being more multiculturally sensitive than those who ignored racial issues that arose during the consultation process.

Ideally, culturally competent services should “incorporate respect for and understanding of ethnic and racial groups, as well as their histories, traditions, beliefs, and value systems” (Substance Abuse and Mental Health Services Administration [SAMHSA], 1998). Sue (2001) identified several roadblocks to widespread acceptance

of the need for practitioners to develop cultural competence (a) an etic, or universal approach to etiology and treatment of emotional problems, (b) discomfort with discussing issues regarding prejudice, discrimination, and oppression, (c) Eurocentric theoretical orientation of psychology, (d) viewpoint that the client has the primary responsibility for treatment success, (e) inability to acknowledge personal biases, and “ethnocentric monoculturalism” (e.g., the perspective that the values and customs of the dominant culture are superior and the power exists to impose this belief system on others).

School Psychology and Multicultural Competence

Content analysis of research publications provides perspective regarding the salience of a given topic. For example, the percentage of total articles published in school psychology journals between 1975-2003 that addressed diversity issues ranged between 8.9%-16.9% (Brown, Shriberg, & Wang, 2007; Miranda & Gutter, 2002; Rogers Wiese, 1992). It is interesting to note that Rogers Wiese specifically focused on articles with racially, ethnically, linguistically diverse persons. However, two recent publications, defined articles with a diversity focus as those that addressed *all* students who differed from the White, middle-class, heterosexual norm group (Brown et al., 2007; Miranda & Gutter, 2002). Articles concentrating on issues involving school achievement or consultation represented 15.5% and 8.7% respectively of articles published between 2000 and 2003. These analyses did not include two significant contributions to multicultural school psychology research: the recent NASP publication, *The Psychology of Multiculturalism in the Schools: A Primer for Practice, Training and Research* (Jones,

2009) or the *Multicultural Handbook of School Psychology: An Interdisciplinary Perspective* (Esquivel, Lopez, & Nahari, 2007).

In contrast, Sue et al. (1982) are credited for first addressing the need for cultural competence and generating a practice model (multicultural counseling competencies, or MCC) utilized initially in counseling psychology. This is significant because of the emphasis upon developing practitioner skills to work effectively with persons from one of the four major racial/ethnic minority groups. MCC have inspired research within the counseling psychology field. Seventy-five articles have been published in 17 different journals and one book chapter on the subject of multicultural counseling competence between 1986 and 2005. The field of counseling psychology also has two journals, *Journal of Multicultural Counseling and Development* and *Cultural Diversity and Ethnic Minority Psychology*, featuring research on race, ethnicity, and culture.

Rogers and Conoley (1992) conducted a survey of masters'/EdS and doctoral level school psychology programs on approaches to preparing students to work with culturally diverse populations. The majority (69%) of program directors stated that practicum students spent less than 25% of their time with minority clients. One-third of respondents replied that less than 5% of the practicum involved working with culturally diverse clients. Ochoa, Rivera, and Ford (1997) found that although 80% of the school psychologists responding to their survey had taken a bilingual assessment course, most (87%) did not feel competent in this domain. This phenomenon was echoed by multiple studies cited in Lopez and Rogers (2007) indicating that most pre-service and practicing

school psychologists did not believe they had the skills to work with culturally diverse children and their families.

These findings are astonishing considering the number of issues, currently affecting U.S. schools, that are linked with factors related to race and ethnicity: (a) increasing diversity of racial and ethnic groups in U.S. schools; (b) the achievement gap between minority and White students; and (c) disproportionality in discipline and special education (especially for African American males). Currently, most teachers and persons within the mental health field are White. Hence, the potential for misunderstandings stemming from cultural differences between school staff students and families is substantial.

Systems of Care

It has been suggested that to increase acceptability of accessing mental health services among minorities, providers must engage families and build relationships with key organizations (e.g., religious institutions, community organizations). Systems of care (SOC) is a philosophy of addressing mental health needs of children with SED that was developed to reduce the fragmentation of mental health services and empower families via the use of natural supports to keep their children at home. The core values of SOC are summarized as the provision of individualized supports delivered within the family's community in a culturally competent manner (Stroul, 2002; Stroul & Friedman, 1986). The Child and Adolescent Service System (CASSP) under the umbrella of National Institute of Mental Health (NIMH) was established in 1984 to help support the concept of system of care. Passage of the Comprehensive Community Mental Health Services for

Children and their Families Act in 1992 provided funding to support expansion of locally based systems of care in states. During a ten-year period (1993-2003) the Children's Mental Health Initiative (CMHI) provided almost three-quarters of a billion dollars in funding to 92 awardees supporting over 62,000 children and adolescents. The eligibility criteria for children to be supported within a SOC are (a) child is 21 years-old or younger; (b) have a DSM-IV diagnosis that has lasted at least one year, or has the potential of lasting up to a year; (c) has impaired functioning in home, school and the community; (d) has involvement with at least one publicly funded service agency (e.g., child-welfare; USDHHS, 2003, p. 7). Minorities (African American, 26%; Hispanic, 11%; Native American, 10%; Biracial, 8%) from poor households (56%) headed by single women (44%) reflect a substantial proportion of children and families supported via SOC (USDHHS, 2003, p.12)

Research Base for Wraparound

The wraparound approach is the leading practice approach within SOC because of compatibility with the values base and principles of SOC. Early research on wraparound was focused on outcomes and measured access to coordinated care and supports, restrictiveness of placement in addition to changes in emotional functioning and adjustment across home and the community. Therefore, most of the early studies utilized pre-experimental case study or pre-post research designs. Studies of early programs include the landmark Kaleidoscope Program in Chicago (Cumblad, 1996, as cited in Burns & Goldman, 1998); the Alaska Youth Initiative, or AYI (Burchard, Burchard, Sewell, & VanDenBerg, 1993, as cited in Burns & Goldman, 1998); and Project

Wraparound in Vermont (Clarke, Schaefer, Burchard, & Welkowitz, 1992). A case study design was used to document outcomes for the Kaleidoscope and AYI programs. The case studies illustrated, in perhaps a way that a more empirical research design could not, how children and families with the highest needs (e.g., out-of-state placements, extensive histories of physical abuse, neglect, criminal behavior) could return to their communities, and in many cases their homes, and be successful in school, hold jobs and have more harmonious family relationships. The Project Wraparound study is notable for the early use of a repeated measures research design using validated instruments to assess outcomes. The Child Behavior Checklist (CBCL), Connor's Hyperkenesis Scale and Child Well-Being instruments were used to measure clinical outcomes for 19 children whose families were part of the larger demonstration project, Project Wraparound.

As use of wraparound increased, more rigorous research designs were utilized to measure efficacy. Burns, Goldman, Faw, and Burchard (1998) identified 16 studies on the efficacy of wraparound. The majority of the studies ($n=12$) were pre-post studies. One early study (Hyde, Burchard, & Woodworth, 1996) used a quasi-experimental design while the following studies used an experimental design: (a) Clark, Lee, Prange, and McDonald (1996); (b) Clark et al. (1998); and (c) Evans, Armstrong, and Kuppinger (1996). A follow-up study, Evans, Armstrong, Kuppinger, Huz, and McNulty (1998) was not included in this summary of wraparound research. Since 2000, the majority of research investigating the efficacy of wraparound has used case study and quasi-experimental designs (Anderson, Wright, Kooreman, Mohr, & Russell, 2003; Anderson, Wright, Kelley, & Kooreman, 2008; Bickman, Smith, Lambert, & Andrade, 2003; Bruns,

Rast, Peterson, Walker, & Bosworth, 2006; Mears, Yaffe, & Harris, 2009; Myaard, Crawford, Jackson, & Alessi, 2000; Pullman et al., 2006). A major advantage of case study and quasi-experimental research designs, from a clinical perspective, is that the researcher can select a comparison group (albeit not always totally comparable to the treatment group) without being forced to randomly select candidates for treatment among a group of children who are all at-risk of being removed from their homes and communities. An experimental study (Carney & Buttell, 2003) investigated the efficacy of wraparound in comparison to standard treatment provided by the juvenile court system for adjudicated youth. A matched group of 141 youth (73 to wraparound and 68 to treatment as usual) were randomly assigned to treatment conditions. Youth receiving wraparound supports were more likely than youth in the control group to engage in pro-social behaviors (i.e., attend school, avoid suspension, and refrain from assaulting others). However, there was no significant difference in the recidivism rate for youth supported via wraparound and those receiving treatment as usual.

Suter and Bruns (2009) completed the first meta-analysis of wraparound research conducted since 1986 to examine the evidence base for this approach. Research using quasi-experimental as well as experimental designs was included given the emphasis upon this design in wraparound efficacy research. Additional selection criteria included evidence of control group and clear identification of the wraparound philosophy as guiding the intervention process. Seven studies met the inclusion criteria (Bickman et al., 2003; Carney & Buttell, 2003; Clark et al., 1998; Evans et al., 1998, Hyde et al., 1996; Pullman et al., 2006; Rast, Bruns, Brown, Peterson, & Mears, 2008). Suter and Bruns

(2009) calculated effect size for each study in addition to these short and long-term outcomes related to stability and location of living arrangement and functioning across home, school and in the community. Overall effect size was .33 indicating a small-medium effect across all seven studies. It was necessary to impute data to calculate effect sizes for two studies (Bickman et al., 2003; Evans et al., 1998); hence, an overall effect size of .40 was calculated excluding these studies. Effect sizes for individual outcomes (i.e., place of residency) ranged from .21 for juvenile justice to .44 for living situation. These findings are comparable to the Carney and Buttell study (2003) indicating that additional interventions beyond the current wraparound approach are needed to reduce recidivism rates.

Treatment integrity (also referred to as treatment fidelity; Gresham, 2005) instruments were developed beginning in the late 1990s partially in response to research documenting that SOC increased access to services but did not necessarily result in better outcomes than traditional treatment approaches (Bickman et al., 1996; 2000; 2003). The research focus shifted from measuring the relationship between participation in the wraparound process and access to supports, to investigating the relationship between treatment integrity and child outcomes. There are currently seven measures of wraparound treatment fidelity that examine team, agency, and system implementation fidelity (Bruns et al., 2008). Research evaluating treatment integrity has typically utilized the Wraparound Fidelity Index (WFI) or the Wraparound Observation Form (WOF). Eight studies employed a treatment integrity measure in an attempt to determine a link between fidelity to wraparound principles and outcomes (Bruns, Burchard, Suter,

Leverentz-Brady, & Force, 2004; Bruns, Suter, Force, & Burchard, 2005; Bruns, Suter, & Leverentz-Brady, 2006; Bruns, Suter, & Leverentz-Brady, 2008; Epstein et al., 1998; Epstein et al., 2003; Nordess, 2005; Ogles, Carlston, Hatfield, Melendez, Dowell, & Fields, 2005). Use of treatment integrity measures demonstrated the link between adherence to wraparound principles and outcomes for children and families (Bruns et al., 2005). This research also revealed the connection between systemwide adherence to wraparound principles and the degree of treatment integrity exhibited by wraparound teams (Bruns et al., 2006). Students on teams implementing wraparound with fidelity experienced better outcomes than youth on teams exhibiting lower levels of treatment integrity. This finding is supported by additional research indicating that treatment fidelity was instrumental to success of school-based mental health interventions (Rones & Hoagwood, 2000).

Currently, there are a limited number of peer-reviewed publications that have examined outcomes for school-based wraparound (Eber, Hyde, & Suter, 2011; Eber & Nelson, 1997; Eber, Osuch, & Redditt, 1996; Eber, Sugai, Smith, & Scott, 2002; Eber et al., 2009). To date, one study (Walker, 2001) has examined the role of culture in the wraparound process from the family's perspective.

Theoretical Framework

Ecological systems theory examines human development through the framework of context and inter-relationships. The model is represented as relationships nested within a series of concentric circles beginning with primary relationships within the home, peer group, or classroom (e.g., the microsystem; Bronfenbrenner, 1979). The next level,

mesosystem, describes connections between a child's primary relationships (e.g., home and school). Another layer, exosystem, illustrates the influence of structures such as the school system, parents' workplace, and community resources on relationships at the two previous levels. The outermost level of this model, macrosystem, addresses the impact of broader cultural factors (e.g., racism, political climate) on all levels of the child's life. The child is shaped and in turn shapes his environment based upon responses to the child from elements in his surroundings. Wraparound directly addresses factors at the mesosystem level, the context characterized as the connection between two or more microsystems. Wraparound principles, in particular, the element of natural strengths, focuses on building strong networks (e.g., mesosystems) between the child, their families and persons with direct impact on daily life. The wraparound principle of natural supports framed within the context of ecological systems theory relates to the concept that increasing the number of protective factors (e.g., connections at the mesosystem level) will enhance the child's development (Garbarino, 1982, p. 23).

Social Reproduction theory (Bourdieu, Passeron, & Nice, 1990) provides a framework for examining the role of culture within the helping relationship. The crux of this theory is that schools "reproduce" or perpetuate class structure based upon the assessment of various forms of capital (e.g., symbolic, economic, social and cultural) or resources held by children and their parents. The capital enables individuals to access items of value (e.g., educational opportunities that will lead to a successful career). Parents, who come from a different background than the dominant group, will often face difficulty obtaining resources because those in power devalue their communication style,

or cultural capital. The “habitus” or process of socialization is a key concept as it relates to the process of developing the values, norms and behaviors that are consistent with a person’s background. Habitus also describes the process of assimilation that persons from outside the dominant culture often engage in to acquire resources held by the ruling class (Harker, 1984). Social Reproduction theory provides the framework for examining the quality of the connection between home and school (e.g., the mesosystem). The concept of cultural capital, in particular, has been widely used by scholars within the sociology of education field (Harry, Klingner, & Hart, 2005; Lareau, 1987; Lareau & Horvat, 1999; Lewis, 2005; Reay, 1998; Reay, 2004; Weininger & Lareau, 2003) to explain inequities in academic outcomes across class and racial lines as identified in qualitative research. Cultural capital provides a lens through which researchers may view how the degree to which a parent is able to positively engage school staff, contributes to the educational experience of their children. For example, parents who are educated professionals are likely to be comfortable with challenging the educational system to leverage more resources for their children. Furthermore, school personnel view these parents as equals because their approach to engagement and values system are compatible with their own (Lareau, 1987). In comparison, low-income parents frequently either relinquish control to educators, or they are rebuffed because their communication style is inconsistent with the educators’ values (Lareau & Horvat, 1999). Symbolic violence is another concept within the framework of Social Reproduction theory that is central to the study of interaction between school staff, parents and children. Symbolic violence is defined as the actions through which those who are in power devalue those whose cultural capital does not

match the normative standard of the ruling class. It is a means of keeping the power and class structure intact by negating, or diminishing any behaviors that are not valued by the dominant group. This means that the perpetrator of symbolic violence may engage in behaviors that enforce the notion that the victim is a member of the subordinate group. Symbolic violence is characterized by behaviors that occur at the subconscious level. Therefore, enactment of symbolic violence frequently occurs without forethought on the part of the perpetrator since these behaviors are integral to the normative standards and are accepted as 'business as usual' (Herr & Anderson, 2003). Examples of symbolic violence within the school setting include: (a) labeling students, (b) dismissing student opinions as inaccurate, or disrespectful, (c) ignoring students, (d) curriculum that focuses on the accomplishments of the dominant group.

Importance of this Study

The majority of research on wraparound has focused on demonstrating increased access and improved coordination of care for children and families and outcomes (e.g., reduction in residential placements). The paucity of research regarding cultural competence and wraparound is remarkable given the emphasis within the field of psychology on forging a therapeutic alliance between providers and clients combined with findings from client-matching literature illustrating the salience of race/ethnicity regarding the therapeutic relationship (Pope-Davis et al., 2002). Most wraparound studies, to date, mention race only in reference to youth outcomes. Exploration of the dynamics between predominately White, middle-class female wrap facilitators and minority families has been limited. Furthermore, the relative absence of literature

documenting families' perspective on cultural competence as an element of the wraparound process is surprising given the core values of this practice stress family voice and cultural competence. There is a clear need to recognize the voices of both practitioners and families regarding the role of culture in the wraparound process to gain perspective on this issue.

Projected minority population growth coupled with the shortages in mental health services call for accessible supports delivered in a culturally competent manner.

Wraparound is one of the few evidence-based practices for supporting children with SED that also empowers their families by having them select treatment priorities while also emphasizing the use of natural supports within the family and community. Therefore, it has been recommended that school psychologists become knowledgeable regarding the principles and skills related to wraparound (Quinn & Lee, 2007). School psychologists are frequently utilized to deliver mental health services within the school setting (Foster et al., 2005). However, most of the literature regarding wraparound focuses on implementation by community mental health agencies. Little is known regarding application of this practice by school-based wraparound facilitators.

There has been extensive research regarding treatment fidelity in relation to outcomes for youth supported with wraparound (Bruns et al., 2004; Bruns et al., 2005; Bruns et al., 2006; Bruns et al., 2008; Epstein et al., 1998; Epstein et al., 2003; Nordess, 2005; Ogles et al., 2005). This line of research is an important contribution to the wraparound field as it has documented the link between adherence to wraparound principles (e.g., family voice and choice, community-based treatment and culturally

competent service) and outcomes for youth and families. However, including the perspectives of families regarding the aspects of treatment fidelity contributing to successes and failures could enhance this line of research.

Finally, it has been well documented that perceived caregiver burden (stress) influences the type of treatment (e.g., community versus residential) selected by the family. However, the elements of perceived parental stress and cultural competence relative to caregivers' assessment of wraparound integrity and satisfaction with the process have not been explored.

To summarize, incorporating the voices of families and facilitators regarding cultural competency, parental stress and wraparound practice would add to the existing research base. Specifically, a research design incorporating quantitative and qualitative methods would provide the opportunity to better understand the complexities of the cultural competence construct as an element of treatment integrity. Quantitative methods provide an opportunity to measure quantifiable elements (e.g., the prevalence of school-based wrap facilitators who rate themselves as culturally competent, assessment of adherence to the principles of wraparound degree of satisfaction with wraparound and caregiver stress. Blending quantitative methods with qualitative methods provides an opportunity to acquire a deeper understanding of the relationships between cultural competence, caregiver stress, adherence to wraparound principles, and satisfaction with wraparound than quantitative or qualitative approaches used alone.

Purpose of this Study

This study aimed to examine the perspectives of wrap facilitators and caregivers regarding the role of cultural competence in the wraparound process. An explanatory mixed methods sequential design was used. Quantitative data using survey methodology were collected during the first phase of this study. Self-perceived levels of cultural competence, as endorsed by wrap facilitators recruited from consultees of a nationally recognized wraparound trainer, were measured using a cultural competence survey, The Multicultural Counseling Knowledge and Awareness Scale (MCKAS; Ponterotto, 1997). Caregivers assessed adherence to wraparound principles using the Wraparound Fidelity Index (WFI-4; Wraparound Evaluation and Research Team, Bruns, University of Washington, 2006). Four questions were included to query caregivers regarding their level of satisfaction with the wraparound process. Perceived caregiver stress levels were measured using the Caregiver Strain Questionnaire (CGSQ; Brannan, Heflinger, & Bickman, 1994). In the second phase, it was planned to use results from the quantitative data to purposively select caregivers meeting the following criteria: (a) Caregivers matched with wrap facilitators who endorsed either high, or low levels of cultural competence based on their MCKAS scores, (b) Caregivers who endorsed very high or very low levels of satisfaction with the wraparound process, and (c) Caregivers who endorsed either high or low levels of caregiver stress. Follow-up semi-structured interviews were conducted with these caregivers to build upon quantitative results, thus providing additional information for outlier data obtained during the quantitative phase of the study.

Research Questions: Quantitative

1. To what extent, if any, do wrap facilitators perceive themselves to be culturally competent?
2. What is the primary caregiver's assessment of the adherence to wraparound principles and level of satisfaction based on their experience with the process?
3. What is the primary caregiver's perceived level of stress?
4. Is there a difference in caregivers' assessments of adherence to wraparound principles and degree of satisfaction with wraparound between those working with facilitators in the group reporting high versus the group reporting low levels of cultural competence relative to the reported mean scores for the MCKAS?
5. When controlling for caregiver stress, is there a difference in caregivers' assessments of adherence to wraparound principles and level of satisfaction between those working with facilitators in the group reporting high versus the group reporting low levels of cultural competence relative to the reported mean scores for the MCKAS?

Research Questions: Qualitative

How do primary caregivers describe their facilitator's cultural competence, the stress associated with parenting a child with challenging behaviors, and/or emotional problems and their overall impression of the wraparound process?

Research Questions: Mixed Methods

Does the inclusion of qualitative themes explain, or elaborate upon the quantitative results regarding the influence of cultural competence and parental stress upon the wraparound process?

- a. Do caregivers' descriptions of their experiences on wraparound teams differ based upon their facilitator's self-endorsed levels of cultural competence?
- b. What are the wraparound experiences of caregivers who endorse high, or low levels of stress?
- c. How do caregivers who endorse high, or low levels of stress describe the influence of cultural competence relative to the wraparound process?

Hypotheses

The following hypotheses were to be applied to the quantitative phase of this study. First, caregiver ratings of adherence to wraparound principles and satisfaction with the process will be higher for members of teams led by facilitators in the group with high reported levels of cultural competence relative to the reported mean MCKAS scores. Second, caregivers reporting high levels of stress on teams led by facilitators with high reported levels of cultural competence will report higher levels of adherence to wraparound principles and greater levels of satisfaction than caregivers with similar stress levels on teams with facilitators with low levels of self-reported cultural competence relative to the reported mean MCKAS scores.

Philosophical Foundations of this Research

Wraparound is the primary practice used in the systems of care model because it reflects the core values of SOC: (a) SOC are child/family-centered, (b) SOC are community-based, and (c) SOC are culturally competent. Therefore, wraparound practice is consistent with the principles of social justice that seeks to redistribute resources in a more equitable manner through the empowerment of families to be self-

determined regarding the care of their children and charting the course of their lives. The researcher's decision to study factors that were considered as potentially influential to the wraparound process and related outcomes (e.g., cultural competence and parental stress) was based upon this individual's mental model as applied to this project. The term mental model refers to "the set of assumptions, understandings, predispositions, values and beliefs with which all social inquirers approach their work" (Greene, 2007, p. 12).

Graduate fieldwork for a federally funded demonstration project required that the researcher engage in extensive contact with wrap facilitators. These experiences inspired the study. The researcher's interest in measuring cultural competence among wrap facilitators combined with curiosity regarding how participants actually articulate the constructs being measured was consistent with the pragmatic research paradigm.

Pragmatism is the world-view frequently associated with mixed methods designs (Creswell & Plano Clark, 2007; Greene, 2007; Onwuegbuzie & Leech, 2005; Tashakkori & Teddlie, 2003). Creswell and Plano Clark (2007) summarize the pragmatic worldview in Figure 1.

Pragmatism is a transactional approach to addressing research questions (Greene, 2007, p. 84). This approach was grounded in the reality of the circumstances that influence the study (e.g., potential challenges related to speaking with families of children affected by behavioral/emotional disorders to understand their viewpoint of wraparound); and the potential benefits for wraparound practice that may be gleaned from the findings. Thus, pragmatism fit the goals of the study: to measure the prevalence

of cultural competence as a practice element and to discover how facilitators and primary caregivers describe their experiences with wraparound.

<u>Ontology</u> ("What is the nature of reality?")	<u>Epistemology</u> ("What is the relationship between the researcher and that being researched?")	<u>Axiology</u> ("What is the role of values?")	<u>Methodology</u> ("What is the process of research?")	<u>Rhetoric</u> ("What is the language of research?")
Singular and multiple realities	Practicality	Blend objectivity and subjectivity	Collect and combine quantitative and qualitative data	Merge formal and informal writing styles

Note: Adapted from Creswell and Plano Clark (2007).

Figure 1. Pragmatic World View

CHAPTER II

LITERATURE REVIEW

Wraparound Defined

Wraparound is a strengths-based practice for supporting families of children and youth with complex needs who are at-risk of change in placement in one or more settings. Historically, these children were removed from their homes and communities then placed in restrictive settings (e.g., residential schools or psychiatric hospitals). The philosophy of wraparound reflects the standards of humanistic psychology emphasizing respect for all persons and unconditional care. The aspect of unconditional care is linked with the wraparound goal of pursuing multiple strategies to provide treatment within the least restrictive setting whenever possible. When wraparound is implemented with integrity, over time, families are empowered to identify goals for their children and effectively advocate for the necessary supports in order to attain desired outcomes. The reliance upon natural supports (e.g., family, community members) and the focus upon the families versus experts as leaders in the decision-making process are examples of the unique characteristics of wraparound relative to other practices targeting the same population (e.g., multisystemic therapy, an ecological treatment approach originally developed to support juvenile offenders, youth at-risk of involvement with juvenile justice and their families).

Wraparound is grounded in the ecological theory of Bronfenbrenner (1979) Munger's (1998) ecological systems theory and Bandura's (1977) social learning theory. Wraparound recognizes the influence of context on behavior. It is geared toward bringing key persons from different parts of the child's life (e.g., home, school, and community) together to develop an intervention plan spanning each life domain. The goals of a wraparound plan are different from those typically found in educational plans (e.g., IEPs). The goals for wraparound describe quality of life elements (e.g., "Richard will have friends," "Johanna will feel successful while at school"). Adults who are in conflict over the best approach for addressing the child's challenging behavior(s) can be eased toward supporting a mutual vision and process of goal attainment that can be transformative for all team members. It shares aspects of the following philosophies of practice: positive behavior supports, person-centered planning, and self-determination.

Wraparound Principles and Phases

The wraparound model has evolved to incorporate ten principles that articulate the value base and provide the foundation for the implementation protocol (Bruns et al., 2004; Eber & Keenan, 2004; Goldman, 1999; VanDenBerg & Grealish, 1996).

Wraparound is a process, not a service (Eber et al., 2002; Goldman, 1999). It has four recognizable phases (Eber et al., 2009; Walker et al., 2004):

I. Family/team engagement

II. Initial plan development

III. Plan implementation

IV. Transition

Wraparound principle	Definition
Family voice and choice	The family's perspective is heard and respected by all team members. The family's viewpoint is utilized to help set planning priorities.
Community-based	Youth involved in the wraparound process will be supported in the least restrictive environment possible. The strengths and resources of the community are acknowledged. Thus, every effort will be made to provide supports within the family's neighborhood.
Culturally competent	There is recognition of the influence of culture on a family's values and beliefs regarding help seeking. Professionals will earnestly seek out information regarding family traditions, beliefs, and spirituality. They will use reflection to self-monitor for biases stemming from their own cultural orientation.
Strengths-based	The family's resources (emotional, intellectual and spiritual) are validated to foster empowerment.
Individualized	Each family's unique perspective, culture and strengths are used as the basis for plan development. The resulting plan is not driven by pre-existing services and supports.
Team-based	The family selects members who will make a commitment to supporting the youth at the center of the process. Members will strive for consensus in goal setting and treatment planning.
Collaborative	The wraparound team will work cooperatively with agencies and community groups. The team will seek the perspective and support of the community to facilitate successful outcomes.
Emphasizes natural supports	The team incorporates representatives from the family's social network (e.g., family members, church members) to balance the input of professionals and formalized services.
Unconditional support/ Flexible approach/ Funding	Wraparound encapsulates a zero-reject ideology. The process adapts to changing needs of the child and family. Flexible approaches to supporting families are sustained by funding sources that can conform to present need.
Outcomes-based	Goals are established for youth functioning across the home, school and community. Progress toward goals is monitored. The data obtained are used to refine planning decisions.

Figure 2. Wraparound Model

However, these phases are not intended to be linear in execution. Given the mutable nature of child and family needs, a team may progress through the first three phases and return to prior stages. The wraparound process is being implemented with fidelity when the ten principles are evident in practice and there is mindful focus on attaining the goals associated with each phase.

Development of Practice Standards

The roots of wraparound go back to the 1960's. Unlike traditional mental health interventions, wraparound did not evolve from a predetermined theory (Burchard, Bruns, & Burchard, 2002). Burns, Shoenwald, Burchard, Faw, and Santos (2000) allude to the grassroots development of wraparound when they note the development and growth of wraparound practice was driven by the desire to present viable alternatives for children with complex needs other than restrictive placements away from their families and communities. The atheoretical nature of wraparound during the formative years undoubtedly contributed to the lag in the development of practice standards and a treatment protocol. Initial efforts focused on providing community-based alternatives (e.g., group homes) to traditional psychiatric placements for youth with multiple needs and challenging behaviors (Burchard et al., 2002).

The Kaleidoscope Program in Chicago developed by Karl Dennis marked the emergence of features that would distinguish wraparound from the traditional medical model of treatment for children with SED. Dennis expanded the concept of community-based care to incorporate the family as part of the intervention process and utilized in-home supportive services versus residential placement. He is also credited with

integrating the concepts of unconditional support, “no reject, no eject”, and individualization into the evolving practice (Kendziora, Bruns, Osher, Pacchiano, & Mejia, 2001). John VanDenBerg for the Alaska Youth Initiative (AYI) used the Kaleidoscope Program as a model in 1985. It is recognized for adding the component of a child and family team to the process. The AYI likely represents the basis of the “train the trainer” model currently used to disseminate wraparound practice as Dennis served as a consultant on the AYI project. Wraparound implementation soon followed in Vermont, Washington state and Idaho (VanDenBerg, 1999).

As wraparound grew in popularity, its originators sought venues to share the philosophy and emerging practice guidelines with others. For example, the first National Wraparound Conference included a presentation of the wraparound process by Dennis, VanDenBerg, and Burchard (1992). The eight elements (e.g., wraparound is community-based, individualized, culturally competent, family-centered, etc.) provided the reference point for development of practice standards. Some local wraparound initiatives (e.g., Illinois and Milwaukee) developed extensive, formal training programs based on practice standards (Goldman & Faw, 1999). The absence of clearly defined national practice standards reflected the localized, individual nature of the wraparound process. The focus was on increasing the numbers of children and youth with SED who could be treated within the community in the early years of wraparound implementation. The need to develop universal practice standards and training procedures was not considered as a key priority until later when researchers sought to validate the efficacy of wraparound practice relative to standard treatment. One year later, in 1993, five-year grants provided

by Child and Adolescent Service System Program (CASSP) spurred an increase in wraparound implementation. Researchers involved in these grants also began documenting the evidence base for wraparound. They faced methodological challenges when conducting studies since wraparound lacked universally accepted practice standards. In March 1996, wraparound was the featured topic of the *Journal of Child and Family Studies*. This milestone publication added credibility to the developing practice. Additionally, it provided a centralized source for sharing research and implementation guidelines. This issue is particularly remarkable due to inclusion of the seminal article by VanDenBerg and Grealish on wraparound philosophy, values and process. VanDenBerg and Grealish (1996) presented elements of the wraparound process that serve as the foundation for current wraparound principles. Operationalization of concepts such as family “voice” and “ownership”, child and family strengths, was a revolutionary event within the field of children’s mental health. For the first time, experts were asserting the point of view that having a child with behavioral problems did not invalidate families’ rights, their value as persons, or their ability to make recommendations regarding the treatment process. While the authors’ language relative to the family’s role as leaders in the wrap process is not as direct as reflected in current practice literature, it is apparent that their intention was for families to have equal standing with the professionals on the wrap team.

The need for clearly delineated practice standards was compelling by the late 1990s. By 1998, wraparound was being implemented across much of the U.S. serving an estimated 91,237 children (Faw, 1999). However, only 40% of the states implementing

wraparound reported having formal practice standards in place (Faw, 1999). Concurrent with the implementation data, VanDenBerg and Grealish published *The Wraparound Process Training Manual* (1998) identified as the first document providing detailed guidance and preparation for implementing wraparound (Faw, Grealish, & Lourie, 1999). Publication of *Systems of Care Promising Practices in Children's Mental Health 1998 Series, Volume IV* (Burns & Goldman, 1999) documented the framework, practices, outcomes, and systems-level challenges associated with systems of care and wraparound. Volume four of this series is notable for the inclusion of Goldman's "Conceptual Framework for Wraparound." This monograph was the product of a two-day focus group that included key leaders of the wraparound movement (e.g., Karl Dennis, John Burchard, Mary Grealish and John VanDenBerg). The primary goal of producing the framework was to ensure the integrity of the wraparound process given the growth in the number of sites reporting use of this practice. The resulting product provided a definition of wraparound, values and implementation elements that distinguished wraparound from other community-based practices (Goldman, 1999, p. 30).

Since publication of the "Conceptual Framework for Wraparound," there have been several notable publications that have articulated the theoretical basis for wraparound (Malysiak, 1998; Walker & Bruns, 2006; Walker & Koroloff, 2007; Walker & Schutte, 2004). The following sections highlight two research projects that helped to establish the theoretical base and practice guidelines for wraparound.

Malysiak (1998) used a case study research design and collected data using various qualitative methods (observation and analysis of transcripts from team meetings,

semi-structured interviews) to identify the paradigm and theoretical base for wraparound. Her research design used a review of the literature to operationalize two forms of family-centered practice: (a) collaborative model and (b) expert model (p. 16). Malysiak found that the degree of influence that families have in the decision-making process to enhance strengths across multiple settings distinguished wraparound from other family-centered forms of practice. Furthermore, acknowledgement and validation of differing perspectives among team members was another feature further distinguishing wraparound from other forms of family-centered practice. Malysiak described the characteristics of building strengths across multi-domains/settings and attention to multiple perspectives found in the collaborative model as consistent with ecological and constructivist theories.

Establishment of the National Wraparound Initiative created the support needed to generate the research to help build credibility and solidify practice standards. One example of critical research was identification of four phases of wraparound (Walker et al., 2004). Nationally recognized trainers were consulted for feedback regarding a practice model. The model was developed by the research team's review of training manuals and other documentation provided from a variety of sites. Additional data were culled via a Delphi survey of nationally recognized trainers in identifying the four phases. The final product incorporates goals for each phase. The accompanying descriptors provide further description similar to a treatment protocol of the recommended methods for achieving the outlined goals. However, to date, universal adoption of standard training and implementation protocols has not been adopted (Suter & Bruns, 2009).

Treatment Integrity

Treatment integrity refers to the relationship between implementation of an intervention or treatment and the plan or protocol (Gresham, Gansle & Noell, 1993; Perepletchikova & Kazdin, 2005). Three elements (treatment adherence, therapist competence, and treatment differentiation) contribute to treatment integrity (Perepletchikova & Kazdin, 2005, p. 35). Favorable outcomes as measured by higher effect sizes are strongly associated with close adherence to treatment protocols (Gresham & Gansle, 1993, pp. 260-261). Factors related to supervision (e.g., supervisor's fluency with the intervention/treatment, providing weekly supervision) influence treatment integrity (Henggeler, Schoenwald, Liao, Letourneau, & Edwards, 2002; McIntyre, Gresham, DiGennaro, & Reed, 2007). Hence, treatment integrity measures are critical to determining the efficacy of an intervention (Bruns et al., 2005). In the case of wraparound, development of practice guidelines facilitated development of fidelity measures (Burns & Goldman, 1998). Several studies (Bruns et al., 2005; Bruns et al., 2006) have utilized the Wraparound Fidelity Index (WFI) as a fidelity measure to illustrate the link between implementation fidelity and outcomes for youth. Specifically, Bruns et al. (2005) found that adherence to wraparound principles was associated with caregiver satisfaction with the process and their child's progress. In a subsequent study, Bruns et al. (2006) demonstrated that youth served by wrap facilitators operating at higher levels of treatment fidelity (as reflected in scores obtained on the WFI-3) experienced better outcomes than children on teams led by facilitators practicing at lower levels of fidelity. Effland, Walton, and McIntyre (2011) examined the relationship

between wraparound fidelity, local infrastructure to support wraparound and youth outcomes. The WFI-4 was used to measure fidelity. Facilitators and youth were both interviewed. The Child and Adolescent Needs and Strengths (CANS; Lyons, 2009) measure was used to measure youth outcomes. The authors examined the level of systemic supports in place to sustain wraparound using the Strengths-Based Site Assessment (Effland 2009). Results of this study found that the level of systemic infrastructure was related to the degree of wraparound fidelity. Baseline behavioral health needs as measured by the CANS (e.g., impulsivity, depression, anxiety, oppositional, conduct), baseline functioning, and baseline risks and not wraparound fidelity were most predictive of youth outcomes. When the authors examined wrap principles measured by the WFI-4 relative to youth outcomes, the community-based, and outcomes (e.g., use of data) were associated with improved outcomes. However, cultural competency was associated with poorer outcomes. Also, youth of color experienced poorer outcomes relative to their peers. These findings suggest that there may be a need to examine the operationalization of cultural competency on the WFI-4.

Wraparound Facilitators and Team Process

Walker and Schutte's (2004) work provides a basis for examining the desired skill set for wraparound facilitators related to guiding teams through the wraparound process. Walker and Schutte explored the connection between wraparound values, team practices and outcomes. The authors created a model measuring team effectiveness using Hackman and Morris' (1975) input-process-output model for team effectiveness. Inputs are defined as the group's task (e.g., to develop a community-based plan guided by family leadership

and strengths). Walker and Schutte (2004) added practices as an intermediate phase between input and process. The practices phase is defined as “techniques and procedures for defining and prioritizing goals, stimulating the exchange of information, making decisions, obtaining feedback, building an appreciation of strengths, ensuring family centeredness...” (p. 183). Team process refers to the procedure of defining collective activity (e.g., creation and revision of the wrap plan) and collective identity (e.g., establishing team cohesiveness). While output (e.g., outcomes) include results such as “improved quality of life”, “attainment of team goals.” Three challenges to team effectiveness were identified: (a) prioritizing the family’s perspective, (b) building cohesiveness, and (c) developing quality wrap plans.

During the initial stages of the team, the facilitator will typically carry the responsibility for addressing the roadblocks. The facilitator must be aware of how professionals’ attitudes toward families and the tendency to replicate social hierarchies in small groups may impede full family participation especially for minorities. Team cohesiveness hinges upon team members’ sense of psychological safety and belief in equitable decision-making. Setting goals and generating multiple options are key ingredients to high quality plans.

Practices identified to help prioritize the family’s perspective are geared toward shifting the perception among professionals of families as low-status members of team to leaders whose input is valued and respected (Berger, Rosenholtz, & Zelditch, 1980 as cited in Walker & Schutte, 2004, p. 187). Examples of meeting behaviors that support a central focus on the family’s role are: (a) having families report on their actions that

contribute to the team's goal, (b) increasing the amount of time that family members speak during the meeting, (c) altering the team structure to include parent advocates, and (d) including natural supports from the community (p. 187). Team cohesiveness is fostered by the perception held by team members of shared values and equity among members. Walker and Schutte (2004) recommend the following guidelines for interpersonal interaction: (a) clear, consistent procedures for decision-making; (b) demonstration of solid microskills (e.g., reframing, summarizing); (c) maintaining neutrality; and (d) highlighting occasions when the team has demonstrated effectiveness (p. 188). Finally, having goals and/or a mission statement and consideration of multiple options were identified as avenues to increase the quality of wrap plans (p. 189).

Walker and Schutte (2005) tested their model of effective practices in wraparound team processes by investigating the level of quality planning exhibited on wrap teams. The study evaluated the quality of 72 meetings from 26 different teams based on 16 indicators of planning process quality. The authors used data from surveys completed by wrap team members ($N=242$) to determine whether team composition and quality of wraparound process influenced member satisfaction and degree of individualization in plans. The authors developed two measures to collect data for this study. The first instrument was an observation form to collect demographic data on team composition. The form was also used to document the quality of the team decision-making process, degree of team cohesiveness and level of individualization in the resulting plans (p. 256). The second measure was used following team meetings to collect data regarding member satisfaction with the process and their perception regarding interpersonal matters (p. 256).

Major findings from this study showed that meeting attendees typically consisted of at least one parent/caregiver (90%) and human services professionals (100%) while representatives of a community service organization were least likely to be present (1%). Observers noted that acknowledgement of family/child strengths (72%) and review of mission/vision statements (51%) was common meeting elements. Weaknesses were identified in areas related to broadening the range of perspectives shared during meetings participants and establishing a process for setting priorities (Walker & Schutte, 2005, p. 260). Participants indicated that the meeting atmosphere fostered open communication (32%) and people felt hopeful or productive during their meetings (14%; p. 262). Team members also expressed the need to increase attendance of key people at meetings (22%) and to maintain focus and professionalism during meetings (17%; p. 262). Team member satisfaction was generally good; however, the degree of meeting quality is what was associated with the level of individualization of plans (p. 264).

Wright et al. (2006) examined patterns of conflict within wraparound team and the relationship to treatment outcomes. The researchers analyzed team records completed by wrap facilitators for 189 youths who participated in the Dawn Project between 1997-2000 (p. 305). Analyses were completed for teams that had records that were at least 75% intact. The researchers coded instances of conflict using a team approach (Consensual Qualitative Research, CQR) to increase objectivity. The results revealed that teams experienced an average of 8.42 conflicts. Conflicts between families and service providers were most commonly identified (45.1% of teams) among the dyads examined (e.g., family-family, family-wrap facilitator). The most common conflict theme (40% of

teams) was related to interpersonal problems (e.g., “general discord,” intrafamilial issues,” “conflicting communications”). The significant finding that the likelihood of interpersonal conflict is increased for teams supporting minority youth raises the possibility that some team conflict is rooted in cultural differences (p. 309). Wrap teams for minority youths were also significantly more likely to report conflicts surrounding the treatment process (p. 309). Disagreement regarding treatment was also associated with family-service provider conflict. Inability to resolve issues between families and service providers was a predictor of treatment failure. Conversely, conflicts between families and wrap facilitators were associated with positive treatment outcomes. In fact, the teams that were mostly likely to attain treatment goals prior to discharge had White youth who were younger at the onset of program participation and experienced a lengthier period of support. These data suggest the importance of training wrap facilitators in the area of conflict resolution and consensus building (p. 314). There is also an implicit need for fostering cultural competence among wrap facilitators to enable them to anticipate areas of potential discord between families and service providers.

Cultural Competence

In recognition of the growing diversity of the U.S., in the 1980’s the field of psychology began to explore the impact of culture and race on training and practice. The following sections review how the disciplines of counseling and school psychology have approached the topic of cultural competence. The final section summarizes the role of cultural competence within the practice of wraparound.

Counseling Psychology

The discipline of counseling psychology has made many notable contributions to the topic of cultural competence. An APA, Division 17, position paper includes the first operationalization of cultural competencies based on three components: attitudes and beliefs, knowledge, and skills (Sue, 1982 as cited in Sue, 2001):

- (a) attitudes/beliefs component: an understanding of one's own cultural conditioning that affects personal beliefs, values, and attitudes; (b) knowledge component: understanding and knowledge of the worldviews of culturally different individuals and groups; and (c) skills component: use of culturally appropriate intervention/communication skills. (p. 798)

Sue's definition of cultural competence was extremely important as it provided the foundation for subsequent refinements of the concept (APA, 2003; Arredondo et al., 1996; Sue, Arredondo, & McDavis, 1992) and was utilized to develop measures of cultural competence (Cross-Cultural Counseling Inventory-Revised; LaFromboise, Coleman, Hernandez, 1991; Multicultural Counseling Knowledge and Awareness Scale; Ponterotto, 1997). In more recent publications on the topic of cultural competence, Sue (2007) referenced the significance of context. Etic, or universalistic, and emic, or relativistic, approaches to conceptualizing mental health is an example of the role of context. Traditionally, psychology has relied upon a universalistic philosophy that uses established diagnostic criteria for determining mental health. However, Sue urges consideration of cultural influences on case conceptualization and treatment. This recommendation recognizes how different cultural norms can affect identification of psychopathology. This viewpoint also reflects an ecological perspective (e.g.,

encouraging mental health service providers to capitalize upon family, community, and cultural resources to address emotional problems).

In a seminal publication, a call to the profession was issued to rethink approaches to training, practice, and research relative to the application of a multicultural perspective (Sue et al., 1992). The rationale for adoption of a multicultural perspective include (a) Growing U.S. minority population, (b) Eurocentric curriculum and preparation in training programs, (c) sociopolitical influences, (d) Eurocentric conceptualization of research, and (e) Ethical issues attached to absence of multicultural training. The resulting conceptual framework utilized a 3 x 3 matrix design extending the original work of Sue to incorporate characteristics with the three dimensions of cultural competence. The characteristics of a culturally competent helper: (a) “counselor awareness of own assumptions, values and biases;” (b) “understanding the worldview of the culturally different client;” and (c) “developing appropriate intervention strategies and techniques” are described across three dimensions of cultural competency: (a) beliefs and attitudes, (b) knowledge, and (c) skills.

A subsequent publication (Arredondo et al., 1996) expanded the work initiated in the earlier article. The authors established that multiculturalism focuses on issues related to race, ethnicity, and culture. This definition distinguishes multiculturalism as being a distinct concept from the term diversity. Diversity was defined as “referring to other individual, people differences including age, gender, sexual orientation, religion, physical ability or disability, and other characteristics by which someone may prefer to

self-define” (p. 44). The authors also included explanatory statements to operationally define each concept and to describe the methods for attaining the desired competencies.

The model was further refined to reflect a 3x4x5 design to incorporate (a) racial/ethnic group perspectives (e.g., African American, Asian American, Latino American, Native American and European American); (b) components of cultural competence (e.g., Awareness of attitudes/beliefs, knowledge, skills) and (c) foci of cultural competence representing a range of contexts (e.g., individual, professional, organization and societal; Sue, 2001, p. 793). This version of the model adds the aspect of social justice as it identifies barriers to cultural competence and presents strategies for addressing these obstacles to increasing access to mental health care for minorities.

Development of multicultural competencies was instrumental in revising training and practice guidelines. Initially, students and practitioners were directed to develop cultural competencies by focusing on learning about other cultures. The subsequent requirement to self-examine personal experiences called for students and professionals to analyze how their value system may affect the therapeutic relationship with minority clients. This point is particularly relevant as Sue and Sue (1999 cited in APA, 2003), found that minorities avoided seeking assistance from mental health providers because of “lack of cultural sensitivity of therapists”, “distrust of services” and ethnocentric approaches to therapy that resulted in labeling and pathologizing of minority clients.

School Psychology

The following section will review selected publications from the school psychology consultation literature. Consultation is the primary domain within the field that provides insight regarding research and practice in schools regarding multicultural competence as APA defines this concept. Consultation is an indirect form of service delivery. The goals of consultation can be to address instructional, behavioral, or organizational needs of the client. Mental health consultation addresses the needs of the consultee (e.g., teachers). Consultation is a form of service delivery within the school psychology field that is reliant upon the quality of the relationship between the consultant (e.g., school psychologist) and the client or consultee (Sheridan, 2000). Hence, cultural competence is essential especially given the opportunity to consult with culturally diverse children and families in the school setting.

Ramirez, Lepage, Kratochwill, and Duffy (1998) recommended competencies that parallel those found in counseling psychology: “(a) understanding the impact of one’s race/ethnicity and culture; (b) valuing and understanding the impact of other races/ethnicities and cultures; (c) adapting a culturally responsive consultation style, and (d) adapting culturally responsive strategies during the problem-solving stages” (pp. 484-485). The four stages of consultation: (1) Problem formation, (2) Plan generation, (3) Implementation, and (4) Evaluation, are influenced by factors related to the culture of the consultant, consultee, and the student. Ramirez et al. (1998) note that issues arise from cultural misunderstandings at the problem formation stage when consultants and consultees apply their own cultural lens to student behaviors. Furthermore, consultants

are encouraged to engage minority families in the consultation process. Rosado (cited in Ramirez et al., 1998) cited the “use of family assets, cultural values, and indigenous support systems as instrumental in problem intervention strategies” (p. 495).

Ingraham (2000) developed a multicultural consultation framework that calls for consultants to possess the “knowledge, skills, and attitudes to simultaneously attend to the perspectives of their consultee(s), client(s) and themselves; and to create bridges of understanding that links the distinct perspectives of each.” This model requires that cultural factors be integrated into the consultation process. Consultants are urged to monitor consultees for behaviors that may interfere with their perception of the problem and ability to execute the intervention including, “filtering perceptions through stereotypes, taking a color blind approach, fear of being called a racist, and overemphasizing culture” (Ingraham, 2007).

Sheridan’s (2000) multicultural conjoint behavioral consultation (M-CBC) model discussed the influence of culture in consultation relationships. M-CBC is an extension of conjoint behavioral consultation. However, at least one of the parties involved in intervention planning (e.g., teacher, parent, consultant) differs from the others (e.g., racially, ethnically, SES, physical ability, etc). Similar to Ingraham’s model, M-CBC stresses the saliency of culture throughout the four phases of consultation.

Nastasi (2000, 2005) viewed the ultimate goal of multicultural competency as preparation for parent advocacy efforts on the part of school psychologists. Cultural competency paves the way for becoming aware of racial/ethnic/class disparities in public schools. Skills associated with cultural competence help build trusting relationships with

minority families and the opportunity to guide them through the process of becoming effective advocates for their children. Nastasi (2005) identified six elements of cultural competence:

- (a) Self-reflection about one's own cultural experiences and belief system;
- (b) Willingness to consider diverse viewpoints and learn from others;
- (c) Understanding of the role of culture in human development (e.g., ecological perspective);
- (d) Culture-specific knowledge (e.g., knowledge about specific cultural groups);
- (e) Inquiry skills such as ethnographic or qualitative research methods; and
- (f) A communication style characterized by negotiation and consensus building. (p. 124)

System of Care/Wraparound

The Minority Initiative Resource Committee of CASSP (1989) developed the monograph *Towards a Culturally Competent System of Care: A Monograph on Effective Services for Minority Children who are Severely Emotionally Disturbed* (Cross, Bazron, Dennis, & Issacs, 1989) addressing the need for culturally competent practices and systems within systems of care and presenting a cultural competence model. Several factors were highlighted supporting the need for a model for cultural competence within systems of care: (a) The projected 40% growth in minority populations within systems of care by the year 2000; (b) Statistics showing that African American youth are less likely to receive mental health care than their White peers; and (c) When African American youth did receive care, it was typically outside of their homes and communities and within a restrictive setting (e.g., juvenile justice; p. 19). The authors included the seminal definition of cultural competence,

...A set of congruent behaviors, attitudes and policies that come together in a system, agency, or amongst professionals and enables that system, agency, or those professionals to work effectively in cross-cultural

situations. The word “culture” is used because it implies the integrated pattern of human behavior that includes thoughts, communications, actions, customs, beliefs, values, and institutions of a racial, ethnic, religious or social group. The word competence is used because it implies having the ability to function effectively. A culturally competent system of care acknowledges and incorporates—at all levels—the importance of culture, the assessment of cross-cultural relations, vigilance toward the dynamics that result from cultural differences, the expansion of cultural knowledge, and the adaptation of services to meet culturally-unique needs. (Cross et al., 1989, p. 7)

The authors acknowledged that cultural competence was a process for individuals and systems. A six-phase continuum of cultural competence was included. The phases illustrated the developmental stages of moving from malicious behaviors directed at minorities (e.g., “cultural destructiveness”) to “cultural proficiency”. Individual and systems-wide levels of cultural self-awareness, knowledge of the influence of culture on perspectives on mental health and treatment and practices influence movement along the continuum. Recommendations for practitioners to develop cultural competence mirror the process defined by Sue (2001).

Workers need an awareness and acceptance of cultural differences, awareness of their own cultural values, an understanding of the “dynamics of difference” in the helping process, a basic knowledge about the client’s culture, knowledge of the client’s environment, and the ability to adapt practice skills to fit the client’s cultural context. (p. 47)

Walker (2001) completed a mixed-methods study using program evaluation data for the Robert Wood Johnson Foundation’s Mental Health Services Program for Youth. The goal of this study was to examine the caregivers’ perspective on cultural competence relative to their satisfaction with service provision. The majority of the 286 caregivers were White (67%). The two largest minority groups represented in this study were

African Americans (22%) and Native Americans (9%). The objectives of this study were:

(a) To develop a theory of culture as derived from the views of parents of youth with serious emotional disorders, and (b) To identify if satisfaction with services varied according to the racial/ethnic group membership of the caregiver.

The findings revealed that the majority of respondents (81.8%) believed it was important that mental health service providers recognize the importance of culture in the professional relationship (Walker, 2001, p. 320). However, all of the African American respondents noted the significance of mental health service providers recognizing the influence of culture in the planning and delivery of supportive services. Furthermore, African American and Native American parents expressed more dissatisfaction with service provision in the areas of availability of culturally-specific programs, having access to service providers from their own racial/ethnic group and appreciation of their communities' cultural values and norms (p. 325). African Americans also stated that systemic racial bias/discrimination was an area of dissatisfaction. African American parents recognized and expressed satisfaction when services were tailored to meet their child's specific need versus assigning a child to a program simply because it targets African Americans. Analysis of covariance showed that satisfaction with the cultural competence demonstrated by service providers was a determining factor in minority satisfaction with service provision.

Despite years of studies, reports and commissions, many children and youth with mental health needs remain un-served. The situation is dire for young people of color with un-addressed mental health needs. Unfortunately for many of these children, the first

time that they will actually receive mental health care will be when they have been removed from their homes and communities to enter a juvenile correctional facility.

Wraparound is a process that can be effective when implemented with integrity. However, as reflected in the preceding literature review, the process of defining the philosophy and activities associated with fidelity implementation of wraparound continues to be an evolving process. Consistent with the state of U.S. mental health care, many of children and families supported with wraparound, are ethnic/racial minorities while the majority of the facilitators are White. Hence, exploration of the caregivers' assessment of adherence to wraparound principles, especially the principle of cultural competence, is appropriate.

Examples of Mixed Methods Studies

Buck, Cook, Quigley, Eastwood, and Lucas (2009) explored African American elementary school girls' attitudes toward science using a combination of survey methodology and focus group interviews. Separate quantitative (e.g., "Are there differences that can be categorized to create attitude-toward-science profiles?"); qualitative (e.g., "What aspects of their experiences and understandings contribute to differences in attitudes?"); and mixed methods (e.g., "How can the understandings that emerge from the qualitative data be used to provide a deeper understanding of the attitude-toward-science profiles?") questions were developed. The researchers administered a modified version of the Attitudes Toward Science Inventory (ASTI) (Weinburgh & Steele, 2000) to 89 students at the same school. Two subscales were identified from the survey data: (a) Desire and Value, and (b) Confidence and Anti-

anxiety. Each student was assigned scores based on these two subscales to numerically describe their attitudes toward science. Four groups were identified based upon either having high scores on both subscales, low scores on both subscales, high scores on one dimension and low scores on another dimension. A purposive sample of 30 students (10 students from grades 4, 5 & 6) was selected from the larger group of 89 students to probe the girls for information regarding their experiences and beliefs related to science. The quantitative results reported the majority of the girls displayed attitudes matching the high desire/value, high confidence/anti-anxiety categories (69.7%).

Four themes emerged from the qualitative data: definitions of science, importance of science, experiences with science, and success in school science. Nine qualitative categories (e.g., “science as a process”; “science for school advancement”) emerged from the themes. The authors then integrated the quantitative and qualitative data to create four profile typologies. The typologies were the basis of recommendations for differentiating science instruction for this group of students using the unique experiences, beliefs and school success derived from quantitative and qualitative data.

Another study used a mixed methods design to investigate the relationship between teacher support and student subjective well-being (Suldo et al., 2009). The first phase of the study used survey instruments to measure subjective well-being (SWB) among 401 middle school students at one suburban school. Three instruments were administered to all students during the same class period: (a) Students’ Life Satisfaction Scale (Huebner, 1991), a 7-item self-report measure of students’ global life satisfaction developed for use with youth between 8 and 18 years; (b) Positive and Negative Affect

Scale for Children (Laurent et al., 1999), a 27-item self-report measure developed for use with children in fourth to eighth grade; (c) Child and Adolescent Social Support Scale (CASSS; Malecki, Demaray, & Elliot, 2000), an instrument measuring four types of social support including emotional, instrumental, appraisal, and informational.

Regression analysis showed that teacher support was associated with 16% of the variance in SWB. Student perception of teacher emotional and instrumental support was closely linked with student SWB.

Next, the researchers used purposive sampling to select 50 students from the larger group of 401 students as focus group participants. Results from the CASSS informed the development of focus group questions so that questions related to teacher emotional and instrumental support were used to probe for deeper understanding of students' perceptions related to teacher support. Twelve themes related to high levels of teacher support and 10 themes associated with low levels of teacher support emerged during the focus groups (e.g., "Treats students similarly," "Reliance on a single mode of instruction.") Recommendations for modifying practice to advance engagement of African American female elementary students were presented based on findings from the study.

Both studies (Buck et al., 2009; Suldo et al., 2009) illustrate the advantages of mixed methods design. Mixed methods capitalize on the strengths of quantitative and qualitative methods (e.g., ability to collect data on a large group; access to information related to contextual elements of the phenomenon under study).

The following chapter will describe the study for the process of understanding the influence of culture upon the wraparound process.

CHAPTER III

METHODOLOGY

The purpose of this study was to explore the perspectives of school-based wrap facilitators and caregivers on the role of culture in the wraparound process. Chapter III provides an overview of mixed methods methodology, a description of the instruments that were used to measure the variables in this study, and the data collection and analysis procedures.

Overview of Mixed Methodology

The process of combining methods in a single social science or behavioral study has a lengthy history dating back to the 1930s (Tashakkori & Teddlie, 2003). A number of events are credited with the emergence of mixed methods as a distinct research approach (a) Growing use and acceptance of qualitative research methodology and constructivism in the social science field, (b) Publication of articles on the topic triangulation explored the contribution to validity, (c) Conceptualization of frameworks for mixed methods design, and (d) Publication of multiple studies using mixed methods designs (Tashakkori & Teddlie, 2003). There was also a growing frustration with the limitations of positivist designs related to several areas (a) measurement of human behavior in real world settings, (b) ethical concerns associated with random assignment to field based treatment, and (c) evaluation of government programs (Greene, 2007).

As noted in Powell, Mihalas, Onwuegbuzie, Suldo, and Daley (2008), mixed-method studies are integral to school psychology practice (e.g., observations, interviews, administration of rating scales and cognitive assessments). Kratochwill and Stoiber (2000) encouraged exploration of mixed methods as a research option for describing process and contextual elements contributing to the success or failure of intervention implementation in school settings. Mixed methodology has not been widely used in studies in peer-reviewed publications in spite of the call within the school psychology field to consider this research design. Powell et al. (2008) found between 2001-2005 only 13.7% of the articles in school psychology journals employed mixed-methodology. This study is consistent with the viewpoint of Kratochwill and Stoiber (2000) indicating mixed method studies enhance the accuracy and validity for studies of school practices and processes.

Currently, mixed methods research is recognized as both a research design and epistemology (Creswell & Plano Clark, 2007). The defining characteristic of mixed method study is the blending quantitative and qualitative data collection and analysis in a single study in order to gain a better understanding of the phenomenon being researched (Creswell & Plano Clark, 2007; Day, Sammons & Gu, 2008; Greene, 2007; Yoshikawa, Weisner, Kalil & Way, 2008). Mixed method designs, unlike multi-method designs, *intentionally* integrate quantitative and qualitative methods within a single study to provide a balance to the researcher's findings and the participant's views (Greene, 2007). The following definition of mixed methods was used to guide the research process: "Mixed methods research is defined as research in which the investigator collects and

analyzes data, integrates the findings, and draws inferences using both qualitative and quantitative approaches or methods in a single study or program or inquiry” (Tashakkori & Creswell, 2007, p. 4).

Studies utilizing a mixed methodology require skill in quantitative and qualitative research design, data collection methods and analysis. The analysis process can be challenging as issues related to the merging different forms of data in a meaningful manner might emerge (Creswell & Plano Clark, 2007). This concern may be exacerbated when quantitative and qualitative research phases produce divergent results. Mixed methods studies can be time-consuming (e.g., conducting qualitative studies to help construct a survey (Creswell & Plano Clark, 2007). However, mixed methodology offers benefits that balance the challenges. A mixed methods design was selected because of the advantages this approach offers for addressing the complexities associated with the construct of cultural competence. A mixed method design allowed the researcher to quantify the number of facilitators perceive themselves to be culturally competent, while simultaneously learning how facilitators and families make meaning of culturally competent wraparound practice. The addition of qualitative methods identified contextual elements that contributed to the perception of culturally competent practice. Including qualitative methods also provided an opportunity to inform training for facilitators who work with diverse families.

Quantitative Data Collection and Analysis

Sample Selection: A purposive sample was used to select participants for the quantitative (i.e., survey completion on cultural competence, satisfaction with wraparound process, and level of parental stress) phase of the study. This sampling method was selected in lieu of probability sampling methods to maximize the number of potential responses from the target group for this study, school-based wrap facilitators (Babbie, 1990). Wrap facilitators from Illinois ($N=123$), Iowa ($N=11$), New Hampshire ($N=2$) were recruited for this study. The sampling frame was drawn from the database of facilitators who utilize the Illinois PBIS Network Systematic Information Management of Educational Outcomes (SIMEO) online data management system for students with high level needs including students supported via wraparound. There were also several wrap facilitators from this sampling frame who were also members of the IL-PBIS Network initiative, Tertiary Learning Community (TLC). TLC was developed for the following purposes: (a) to expedite understanding of facilitator's role, (b) to provide more comprehensive technical assistance and support, and (c) to involve practitioners from the field in developing curriculum, tools and systems to support wraparound implementation. The following incentives were provided to TLC participants: (a) technical assistance, (b) opportunities for authorship in state newsletters and as presenters at state/national conferences, and (c) stipends of up to \$500 for completion of a "summary of learning" project at the end of each school year. Wrap facilitators shared information about the study with caregivers from their wraps. Therefore, participation in the study was

accessible to all caregivers in Illinois, Iowa and New Hampshire with data in the SIMEO system.

Researcher's Role

The researcher's position during this study aligned with the constructivist-interpretivist paradigm (Ponterotto & Grieger, 2007). This means that I attempted to be aware of my own biases throughout the data collection and analysis process. To wit, the following self-description is appropriate in terms of addressing the potential biases that I brought to this research study. I am an African American woman who has had varied experiences in the corporate arena (Leo Burnett, USA Advertising), K-12 setting (Chicago Public Schools, and Illinois School District U-46), juvenile corrections and child psychiatric facilities (Louisiana Special School District), and with a state board of education-funded, technical assistance agency (Illinois PBIS Network). I am currently working in Illinois School District U-46 as a school psychologist and with the Illinois PBIS Network as an educational consultant. My duties involve assessment of and intervention with children with current and suspected special education needs. I also co-facilitate a workgroup dedicated to helping schools tackle the issue of disproportionality in student discipline. Therefore, I brought a heightened awareness of the intricacies of class, education and race to this study. Special attention was paid to situations relating to descriptions of the special education process and student discipline, as well as topics related to class and race-related issues (e.g., social reproduction, racism).

Constructs and Measures

This study examined the role of culture competence and the influence of caregiver stress in fidelity implementation of wraparound and caregiver satisfaction with the wraparound process. The following section defines the constructs measured and summarizes the instruments utilized to measure each construct.

Cultural Competence: For the purposes of this study, cultural competence is defined as follows:

(a) attitudes/beliefs component: an understanding of one's own cultural conditioning that affects personal beliefs, values, and attitudes, (b) knowledge component: understanding and knowledge of the worldviews of culturally different individuals and groups, and (c) skills component: use of culturally appropriate intervention/communication skills. (Sue, 2001, p. 798)

The Multicultural Counseling Knowledge and Awareness Scale (MCKAS; Ponterotto, 1997) is a 32-item self-report inventory of perceived multicultural counseling Knowledge (20 items) and Awareness (12 items) was selected as the instrument for wrap facilitators to self-assess their cultural competence. The Knowledge subscale measures “general multicultural knowledge” while the “Awareness” subscale measures “subtle Eurocentric bias” (Constantine & Ladany, 2000 p. 158). The MCKAS is the second most frequently used instrument in quantitative studies assessing individuals' multicultural competency (Dunn, Smith, & Montoya, 2006). The Multicultural Competency (MCC) tripartite model, awareness, knowledge and skills (Sue et al., 1982) was the conceptual base for the MCKAS. The MCKAS utilizes a seven-point Likert scale range ranging from *Not at All True* (1) to *Totally True* (7). The 20 knowledge items are positively

worded and high scores reflect high-perceived knowledge (Ponterotto, Gretchen, Utsey, Rieger, & Austin, 2002). Negative wording and reverse scoring is used for 10 out of 12 awareness items with high scores reflecting high awareness. The range of possible scores is 20-140 for the Knowledge subscale and 12-84 for the Awareness subscale and 32-224 for the total scale. In a study conducted by Ponterotto et al. (2002) the reported mean scores for the Knowledge and Awareness and Skills subscales were 99.20 (4.96) and 60.72 (5.06) respectively. Wrap facilitators were arranged into two groups (e.g., those reporting high and low levels of competence) relative to published mean scores and compared. Per the authors' recommendation, comparisons included subscale and total scores (Ponterotto et al., 2002).

The coefficient alphas for both the Knowledge and Awareness subscales of $\alpha = .85$ (Ponterotto et al., 2002) demonstrate good internal consistency. Adequate convergent validity was identified between the MCKAS-K scale and Multicultural Counseling Inventory (MCI) Knowledge, Awareness and Skills subscales with correlations of .49, .44 and .43 respectively (Ponterotto et al., 2002). The MCKAS Awareness and Skills subscale and the Multicultural Counseling Inventory Relationship subscale were correlated ($r = .74$; Ponterotto et al., 2002). The Awareness subscale did not correlate ($r = 0.07$) with social desirability scales (Constantine & Ladany, 2000; Dunn et al., 2006; Ponterotto et al., 2002). Among the instruments assessing cultural competency, social desirability has the least influence on MCKAS scores (Constantine & Ladany, 2000) and was one of the primary reasons for selecting this instrument for the study.

A brief demographic section was included at the end of the survey to capture the following information on each wrap facilitator who completed the MCKAS: (a) gender, (b) age, (c) racial/ethnic group membership, (d) educational level completed, (e) date of receipt of highest academic degree, (f) work setting, (e.g., public school, alternative school), (g) age group of students served (h) job title (e.g., school social worker, school counselor, school psychologist), (i) years experience as a wrap facilitator, and (j) multicultural coursework/professional development.

Caregiver Stress: Caregiver, or parental stress is defined as caregiver burden, or the Objective Strain, Subjective Internalizing Strain and Subjective Externalizing Strain associated with parenting a child with Serious Emotional Disorder (SED; Brannan & Heflinger, 1997). The Caregiver Strain Questionnaire (CGSQ) is a 21-item self-report instrument completed by the primary caregiver of a child/youth with SED. The CGSQ was selected to help measure the level of stress parent participants associated with rearing their child who was being supported with wraparound. The CGSQ measures the three dimensions of caregiver strain (i.e., Objective Strain (11 items); Subjective Internalizing Strain (6 items); and Subjective Externalizing Strain (4 items) with items rated on a 5-point Likert type response scale of *Not at all* (1) to *Very much* (5).

The alpha coefficient for the Objective Strain was $\alpha = .92$, $\alpha = .74$ for the Subjective Externalizing Strain subscale $\alpha = .74$, and for the Subjective Internalizing Strain subscale $\alpha = .86$. The alpha coefficient for the total scale was $\alpha = .93$ (Brannan & Heflinger, 1997, p. 216). The CGSQ demonstrated adequate divergent validity based upon negative correlation with subscales of the Family Assessment Device (FAD) an

instrument measuring family functioning. Evidence of convergent validity was demonstrated when the *CGSQ* was found to correlate with the Brief Symptom Inventory (BSI) a measure used to assess the psychological well-being of caregivers.

The subscale and overall scores were examined and compared on the *CGSQ* given that individual variables (e.g., subjective strain) are predictors of the type, location and length of services (e.g., community-based versus residential, short-term versus extended in-patient stays) that children and youth with ED may receive (Brannan et al., 2003).

A section requesting demographic information for the caregiver was included at the end of the *CGSQ*: (a) gender, (b) age, (c) race/ethnicity, (d) household income, and (e) number of children residing in the household.

Wraparound implementation fidelity: The Wraparound Fidelity Index-4 (WFI-4; Wraparound Evaluation and Research Team, Bruns, & University of Washington, 2006.) Caregiver form is a 40-item interview based on the four phases and 10 principles of the wraparound process. The purpose of this instrument is to measure adherence to wraparound principles and practices through the collection of data from multiple sources (e.g., caregivers, facilitators, team members and youth) on their assessment of The WFI-1 was initially piloted in 1999-2000. Subsequent revisions were made to improve the validity of the instrument, reduce ceiling effects and operationalize constructs. Administration procedures for the WFI-4 permit either in-person, or telephone interviews with the participants. The WFI-4 may be administered after 30 days. However, it is recommended the interviewee has had three months experience with the wraparound process in order to provide more in-depth responses. Researchers using the

WFI-4 are required to complete training to demonstrate fluency with the instrument as well as knowledge of wraparound principles and activities.

There are four versions of the WFI-4 (facilitator, caregiver, team member and youth form). All of the adult versions of the WFI-4 have a total of 40 items assessing the ten wraparound principles (four items per principle) and is organized by the four phases of wraparound: Phase one, Engagement, six items; Phase two, Plan Development, 11 items; Phase three, Implementation 15 items; and Phase four, Transition, eight items. The caregiver version was used to collect data from parents on their assessment of implementation fidelity of their wrap. Per the WFI-4 administration manual, caregivers were asked to recall their entire wraparound experience from the initial contact to the current status of their wrap. Interviewee response options are: 1. Agrees = "Yes"; 2. Partially agrees = "Somewhat," or "Sometimes"; and 3. Disagrees = "No." Responses are scored on a scale of 0-2 with a score of two indicating high fidelity and a score of zero indicating low fidelity. In most cases, a "Yes" response is synonymous with high fidelity and receives a score of two. However, a few items are reverse-coded. There are also separate codes for the following circumstances: 1. Items that are not applicable, 2. Interviewee refusal to respond to a query, 3. Interviewee does not know an answer, and 4. Missed items.

Results from the 2006 pilot of the WFI-4 using a 49-item caregiver form, found the internal consistency of the instrument to be sound with a Cronbach $\alpha = .84$. The *alpha* coefficients for the four subscales were as follows: 1. Engagement, Cronbach $\alpha = .51$; 2. Planning, Cronbach $\alpha = .62$; 3. Implementation, Cronbach $\alpha = .86$; Transition,

Cronbach $\alpha = .79$. In comparison, the Cronbach α the WFI-3 version of the Caregiver form was .91.

Fidelity benchmarks from a study using the WFI-3 (Bruns, Suter, & Leverentz-Brady, 2008) were used for arranging caregivers for this study into groups according to their WFI-4 scores. In Bruns et al. (2008) preliminary benchmark scores for wraparound were established using the WFI-3. The benchmark for high fidelity was established based on *total* scores of 85% and above based upon findings that sites attaining this score or higher achieved better outcomes for families and had more systemic supports than sites with lower scores (Bruns et al., 2008, p. 247). Benchmark scores for other categories are as follows: a. Above average = 80%-84%; b. Average = 75%-79%; c. Below average = 70%-74%; and d. Non-wraparound, or in need of significant improvement = 69% and below (p. 247). These benchmarks were used as guidelines for determining the degree of fidelity implementation based on the caregivers' assessments.

Per the WFI-4 administration protocol, total scores were used to assess level of implementation fidelity and subscale scores were reported for descriptive purposes.

Caregiver satisfaction with the wraparound process: Four additional questions using a five-point Likert scale to measure caregiver satisfaction with wraparound were included at the end of the WFI-4 interview: 1. 'How would you rate your level of satisfaction with reduction in the risk in change of placement for your child?'; 2. How would you rate your level of satisfaction with your child's behavior intervention plans and supports since engaging in wraparound?'; 3. "How would you rate your level of satisfaction with wraparound with supports provided to help reduce the level of stress

associated with caring for your child?"; 4. "How would you rate your overall satisfaction with the wraparound process?"

Quantitative Procedures

Wrap Facilitators: A multimode approach using postal mail and web-based (e.g., www.Surveymonkey.com) surveys was employed to recruit potential participants within the sampling frame. Internet surveys are cost-effective relative to both postal mail and mixed-mode survey approaches (Greenlaw & Brown-Welty, 2009). However, mixed-mode methods tend to yield higher response rates than postal mail or internet-based surveys especially among school personnel (Shih & Fan, 2008). The participants were informed of the survey by postal mail, via email, and during TLC forums.

Postal Mail Data Collection Procedures

A packet containing a cover letter on Illinois PBIS Network letter from the statewide director describing the study (including the request to give a sealed envelope containing information about the study to each of their caregivers), a hard copy of the MCKAS, and a postage-paid envelope was mailed to individuals within the sampling frame. A code (e.g., JB123) for each wrap facilitator was typed on the MCKAS to track facilitators who elected to complete the hard copy. The cover letter also contained a unique link (to track responses) for facilitators to access the online version of the survey.

Internet Data Collection Procedures

After the initial distribution of the survey materials via postal mail, two follow-up emails were sent to each facilitator within the sampling frame. The email was an electronic version of the cover letter originally sent via postal mail. Each facilitator was

assigned a unique link to the online survey which allowed the researcher to track responses. Email was selected as the follow-up procedure to the initial postal mail. This procedure was based on research demonstrating that pre-notification of a survey delivered by someone that the potential respondent knows (e.g., the initial postal mailing including the letter on Illinois PBIS letterhead from the statewide director) tends to generate higher response rates for web-based surveys (Hoonakker & Carayon, 2009; Shih & Fan, 2008).

Participation in the survey was optional and did not affect the technical support facilitators receive from the IL-PBIS Network. Three follow-up reminders were sent via email after the initial contact to encourage response (Hoonakker & Carayon, 2009).

Confidentiality Procedures for Wrap Facilitators

The researcher substituted codes for facilitator names to help maintain confidentiality. The researcher maintained a master file linking names with codes in a locked cabinet. The associated data were secured in a separate locked file. The file containing the identifiers and the list linking them with the codes were destroyed at the completion of the study to render the data anonymous. Facilitators received a \$15 gift card to a coffee shop (e.g., Starbucks) for return of a completed MCKAS.

Caregivers

The caregiver survey packets contained a cover letter briefly describing the study. The facilitators were directed in their cover letter to give the sealed packet included in their mailing from the researcher to their caregivers and state that it contained information regarding a research project. Facilitators were instructed to inform their

caregivers that study participation was voluntary and would not affect the wraparound process, or the supports provided for their child. The Loyola University Chicago Institution Review Board prohibited the researcher from contacting caregivers directly to eliminate any potential coercion. Therefore, the cover letter directed interested caregivers to contact the researcher directly via the email, or cell phone number provided in the cover letter. The caregiver cover letters included a description of incentives for study participation: (a) a \$20 gift card to a “big box” store (e.g., Wal-Mart) for completing an initial round of interviews, and (b) the opportunity to receive a \$150 gift card if they elected to participate in a follow-up interview. Once the parent contacted the researcher, arrangements were made for administration of the CGSQ, the WFI-4, the satisfaction and demographic questionnaires. All instruments were administered to the caregiver via phone interviews. The researcher employed an interviewer conducting the initial round of interviews (e.g., administration of the WFI-4 and the CGSQ) trained by the lead author of the WFI-4 and had approximately six months of experience interviewing caregivers and scoring the instrument. This person reviewed the conditions of the Loyola University Chicago IRB regarding data collection and maintenance of participant confidentiality.

Confidentiality Procedures for Caregivers

Caregiver names were replaced with codes with the data and identifiers maintained in a separate locked file. All data were entered in a password-protected excel spreadsheet to organize caregivers by facilitator. All information linking participants to this study was destroyed at the conclusion of the study.

Research Design and Analysis

Statistical analyses of all survey data obtained from facilitators and primary caregivers were conducted using Statistical Package for the Social Sciences (SPSS) version 20.0.

Research Question #1: To what extent, if any, do wrap facilitators perceive themselves to be culturally competent?

Descriptive analysis was completed to identify the mean MCKAS scores on the *Knowledge, Awareness* scales and the total MCKAS score for the study participants. These scores were compared to the published mean scores (Ponterotto & Potere, 2003) for each respective category

Research Question #2: What is the primary caregiver's assessment of adherence to wraparound principles and level of satisfaction based on their experience with the process?

Descriptive analysis was completed to identify the mean total WFI-4 scores obtained from participating caregivers. These scores were compared to published benchmark scores (Bruns et al., 2008) to categorize the degree of fidelity wraparound implementation as assessed by each caregiver (e.g., high fidelity $\geq 85\%$). Satisfaction was measured using the researcher-developed Caregiver Satisfaction Questionnaire. Total points were compared based on the following guidelines: a. Very satisfied = 20, Satisfied = 16-19, Somewhat dissatisfied = 10-15, Dissatisfied = 7-9, Very dissatisfied = 4-6.

Research Question #3: What is the primary caregiver's perceived level of stress?

Descriptive analysis was completed to identify the mean scores from the CGSQ for the Objective Strain, Subjective Internalizing Strain, Subjective Externalizing Strain scales, and the Total combined scale score. The mean scores obtained from participants in this study were compared to the means from published clinical studies.

Research Question #4: Is there a difference in caregivers' assessments of adherence to wraparound principles and degree of satisfaction with wraparound between those working with facilitators in the group reporting high versus the group reporting low levels of cultural competence relative to the reported mean scores for the MCKAS?

One-way ANOVA was selected to determine whether the group means on the dependent variables, WFI-4 and caregiver satisfaction scores, differed based on the facilitator's perceived level of cultural competence as measured by the MCKAS.

Research Question #5: When controlling for caregiver stress, is there a difference in caregivers' assessments of adherence to wraparound principles and level of satisfaction between those working with facilitators in the group reporting high versus the group reporting low levels of cultural competence relative to the reported mean scores for the MCKAS?

ANCOVA was selected to determine whether there was a significant difference in the population means for wraparound fidelity as assessed by caregivers via the WFI-4 and caregiver satisfaction, when adjusted for differences on the covariate, caregiver stress.

Qualitative Data Collection/Analysis Methods

Data were collected via semi-structured telephone interviews conducted by the researcher. The interviews were taped and transcribed. A system for coding categories (Bogdan & Biklen, 2007) and Computer Assisted Qualitative Data Analysis Software (CAQDAS; e.g., Nvivo9) was utilized to organize the qualitative data. Discourse analysis was used for understanding the caregivers' perspective on the role of culture in the helping relationship. Discourse as described by Bogdan and Biklen (2007) is "institutionalized ways of understanding relationships, activities, and meanings that emerge through language (talk, rules, thoughts, writing) and influence what people in specific institutions take to be true." Leech and Onwuegbuzie (2008) describe discourse analysis as viewing "language as a function of the action being performed" (p. 591). Examples of how language represents action are: (a) Accountability, or the subjective recounting of an event and persons; (b) Positioning, or role identification (i.e., outsider vs. insider); and (c) Discourses referring to the jargon and lexicon used within a field (p. 591). Once the transcripts were completed for the interviews, the researcher used the Auto Coding function in the Nvivo9 software to code sections and place text into Nodes, or storage areas for emerging themes. The researcher also used a Word Frequency search to identify key words and the associated context to identify any possible themes, or relationships that may have been overlooked during the initial coding process.

The researcher used several types of validity to ensure the credibility of the qualitative data. Validity in qualitative research has been referred to as resting in the veracity of the reported account (Maxwell, 1992, p. 283). The following forms of validity

are drawn from descriptions of validity in qualitative research: (a) *Descriptive* validity is accurate representation of the subject's interview responses; (b) *Interpretive* validity relates to the subject's concepts, beliefs, or ways of understanding their world); (c) *Theoretical* validity refers to application of theory to the study; (d) *Generalizability*, relates to the ability to apply a theory to similar persons/settings; and (e) *Evaluative* validity refers to application of an evaluative framework to research (Maxwell, 1992).

The strategies that were used to confirm the validity of the findings are: (a)

Triangulation, (b) *Member-checking*, (c) *Use of rich-thick description*, (d) *Addressing researcher's bias*, (e) *Use of peer debriefing* (Creswell, 2003). The researcher used two forms of triangulation, data and investigator (Mathison, 1988). First, multiple sources of data (data triangulation) were used to understand the results (e.g., caregivers' interviews were compared with quantitative data from the MCKAS, the WFI-4, and the CGSQ). Second, additional investigators (investigator triangulation) were involved in the data collection process. Member-checking, or sharing the researcher's interpretation of the qualitative data with the respondents, was used to confirm validity and the intentionality of the respondent's message as interpreted by the researcher. Corrections were made, when necessary, to accurately represent the respondent's views. Detailed descriptions of each caregiver interview were used to provide a picture of what is relevant to the respondent (e.g., rich-thick description). The researcher used self-monitoring to check subjectivity that might have lead to bias and decreased analytical rigor (Peshkin, 1988). Peer debriefing was used to address potential issues in the areas of validity, bias, and ethics. The primary role of the peer debriefer was to provide an outside, objective view of

the research process and the interpretation of data. Pseudonyms were used in any quotations, or descriptions and identifying information was altered to preserve the anonymity of the participants.

Mixed Methods Data Collection/Analysis Methods

This study used the development approach defined as “methods that are implemented sequentially with the purpose of using the findings from the first round of data collection to inform development of the second method” (Greene, 2007, p. 102). Data collection proceeded in a sequential process, or the “QUAN” + “QUAL” paradigm with the quantitative data collected first primarily via survey instruments from facilitators and families. A diagram of the mixed methods research design is provided below:

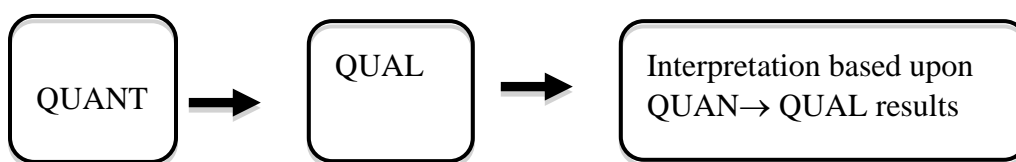


Figure 3. Mixed Methods Research Design

The original data collection plan was to select a subset of primary caregivers of facilitators who endorsed high or low levels of cultural competence as indicated by the relationship of their MCKAS scores to published mean scores were to be selected for the second qualitative phase of the study. However, the limited number of caregivers who responded to the study (n=6) and the close grouping of MCKAS scores for their respective facilitators required a change in the data collection process. The researcher employed a maximal variation sampling technique (i.e., “individuals are chosen who hold different perspectives on the central phenomenon” (Creswell & Plano Clark, p. 112,

2007). The data-collection process was modified to conduct follow-up interviews with caregivers from each racial/ethnic group represented in the group of caregivers (i.e., Whites, African Americans and Hispanics). Hence, the researcher contacted three parents. The first parent who is White was paired with a facilitator who had one of the highest scores on the MCKAS (Total score= 168). The second parent, who is Hispanic, was paired with another facilitator with a MCKAS score that was higher than the mean (Total score= 165). The third parent, who is African American, was paired with a facilitator with a MCKAS score lower to the other two parents contacted for the follow-up interviews (Total score= 159). The researcher decided not to interview a second Hispanic caregiver who was paired with the facilitator with the highest MCKAS score (Total score= 189) in an effort to reduce bias (the wrap facilitator and the researcher are now employed at the same job site and work together closely). Although three caregivers originally agreed to participate in the follow-up interviews, one of the caregivers could not be reached at the agreed upon times for her interviews. Multiple attempts were made to contact this caregiver to reschedule her interviews were unsuccessful. However, one advantage of having two subjects for the follow-up semi-structured interviews was that it allowed for more focused data analysis (e.g., closer scrutiny of transcripts during the coding process) than if there had been a larger group of caregivers included for the follow-up phase of the qualitative data collection. This data collection approach is also consistent with guidelines for minimizing threats to validity as described in Figure 4.

<u>Data collection issues:</u> <ul style="list-style-type: none"> • Participant selection • Sample size 	<u>Minimizing the threat:</u> <ul style="list-style-type: none"> • Use the same participants for the QUANT and QUAL study phases • Use large sample for QUANT and small sample for QUAL phases
<u>Data analysis issues:</u> <ul style="list-style-type: none"> • Selection criteria for QUAL follow-up • Not addressing validity issues 	<u>Minimizing the threat:</u> <ul style="list-style-type: none"> • Select significant results or strong predictors to follow up on • Address QUANT and QUAL validity

Note: Adapted from Creswell and Plano Clark (2007).

Figure 4. Guidelines for Minimizing Threats to Validity

The transcript excerpts featured in the dissertation reflect the caregiver's natural speech patterns including grammar, pauses and non-lexical responses (e.g., un-huh, hmmm, and laughter). Also included were description of the caregiver's tone of voice (e.g., she stated 'angrily') as this provides a thick, rich description of the caregivers, thereby increasingly the validity of the data presented in the dissertation.

CHAPTER IV

RESULTS

Study Description

The goal of this study was to understand the perspective of wrap facilitators and their caregivers regarding the role of cultural competence in the wraparound process. An explanatory, sequential mixed-methods study design was utilized to address the research questions. During the first phase of the study, wrap facilitators were contacted via postal and email and invited to participate in this study by completing a self-assessment of cultural competence using the MCKAS. Wrap facilitators also provided demographic information. Caregivers were recruited for this study via receipt of a package containing a brief description of the study and the researcher's contact information. The wrap facilitators gave the recruitment packages to caregivers. Participating caregivers were interviewed using several research tools to measure their perception of wraparound fidelity (WFI-4), caregiver stress (CGSQ), and satisfaction with the wraparound process. A brief demographic questionnaire was also completed.

Description of Study Participants

Facilitators: The majority of wrap facilitators participating in this study (n=58) are White (86.2%), females (76.9%) who fell within the 21-40 year-old age range (60.3%). Most facilitators reported having a graduate degree (81.5% had masters degrees). There was a mix of early career professionals (21.5% reported being between 0-5 years post

receipt of a graduate degree) and more experienced facilitators (40% were individuals reported 6-10 years of professional practice). Most school-based facilitators were employed as social workers (61.5%) in public school settings (87.7%). Almost half of all respondents (47.7%) stated that they had one to three years of experience facilitating wraparound. Interestingly, almost all of the participants indicated taking some form of multicultural coursework (86.2%). Table 1 presents the descriptive data for facilitators.

Table 1. Wraparound Facilitator Demographics

Characteristic	<i>n</i>	Frequency	Cumulative %
Gender			
Male	2	3.4	3.4
Female	56	86.2	100.0
Age			
21-30	12	18.5	20.7
31-40	23	35.4	60.3
41-50	15	23.1	86.2
51-60	5	7.7	94.8
60+	2	3.1	98.3
Prefer not to answer	1	1.5	100.0
Race/ethnicity			
White	50	76.9	86.2
African American/Black	3	4.6	91.4
Asian	1	1.5	93.1
Hispanic/Latino	2	3.1	96.6
Prefer not to answer	2	3.1	100.0
Education			
Bachelors'	1	1.5	1.7
Masters'	53	81.5	93.1
Doctorate	4	6.2	100.0

Table 1 (continued)

Years since graduation			
Recent graduate	3	4.6	5.2
Three-five years	11	16.9	24.1
Six-ten years	26	40.0	69.0
11+ years	18	27.7	100.0
Work setting			
Public School	57	87.7	98.3
Alternative School	1	1.5	100.0
Job title			
Social worker	40	61.5	69.0
Counselor	6	9.2	79.3
Psychologist	2	3.1	82.8
Teacher	2	3.1	86.2
Administrator	3	4.6	91.4
Other	4	6.2	98.3
Prefer not to answer	1	1.5	100.0
Experience as a facilitator			
Less than one year	9	13.8	15.5
One to three years	31	47.7	69.0
Four or more years	17	26.2	98.3
Prefer not to answer	1	1.5	100.0
Multicultural coursework			
Yes	56	86.2	96.6
No	2	3.1	100.0

Caregivers: Only a small group of caregivers responded to the survey. All of the caregivers are female ($n=6$). Approximately half are young (between the ages of 25-34), White women with annual household incomes of \$25,000, or less. The caregivers have one to two children. Table 2 presents the descriptive data for caregivers.

Table 2. Caregiver Demographics

Characteristic	<i>n</i>	Frequency	Cumulative %
Gender			
Female	6	100.0	100.0
Age			
25-34	3	50.0	50.0
45-54	2	33.3	83.3
55-64	1	16.7	100.0
Race/ethnicity			
White	3	50.0	50.0
African American/Black	1	16.7	66.7
Hispanic/Latino	2	33.3	100.0
Annual Household Income			
< \$15,000	1	16.7	16.7
\$15,000-\$25,000	2	33.3	50.0
\$25,000-\$35,000	1	16.7	66.7
\$45,000-\$55,000	1	16.7	83.3
Prefer not to answer	1	16.7	100.0
Number of children living in household			
One	2	33.3	33.3
Two	2	33.3	66.7
Three	1	16.7	83.3
Four, or more	1	16.7	100.0

Quantitative

The original plan to conduct quantitative analyses (descriptive statistics, ANOVA, and ANCOVA) was revised. The low number of caregivers ($n=6$) who responded to the study restricted the usefulness of using ANOVA and ANCOVA to complete the analysis for research questions four and five as proposed. This section presents the means

obtained for the MCKAS, WFI-4, Caregiver Satisfaction Questionnaire, and the Caregiver Strain Questionnaire and responds to research questions 1-3.

Research Question #1: To what extent, if any, do wrap facilitators perceive themselves to be culturally competent?

Descriptive statistics were completed to determine the mean and standard deviation obtained across all wrap facilitators ($n=58$) who completed the MCKAS for this study. The MCKAS survey yielded a 43% response rate. These data were compared to the reported mean for the 32-item MCKAS instrument ($M= 159.9$; Ponterotto et al., 2002), the Awareness ($M = 60.7$; Ponterotto et al., 2002), and the Knowledge/Skills ($M = 99.2$; Ponterotto et al., 2002) subscales.

Table 3. Wraparound Facilitators Self-assessment of Cultural Competence

Category	<i>M</i>	<i>SD</i>
MCKAS-Awareness	63.64	6.43
MCKAS-Knowledge/Skills	101.31	15.92
MCKAS-Total	164.94	19.08

The MCKAS measures perceived multicultural competence on two scales, Knowledge and Awareness on a range of scores from 1-7 (1=low and 7=high). The mean score on the Knowledge score was 5.08 and the mean score on the Awareness scale was 5.31. Therefore, on a scale of 1-7, respondents in this sample rated themselves highly in terms of both their multicultural knowledge and awareness. Ten items in the Awareness

Scale are reverse-worded. Hence, scores on these items were reverse-coded prior to analysis so that high scores reflect high awareness. The authors stated that the “nature of the subtle biases and attitudes reflected in the Awareness subscale support this reverse-wording format (Ponterotto et al., 2002). Six of the twelve items on the Awareness Scale indicate lower levels of awareness (i.e., items with scores between 1.0-3.0). Items 4, 7,10,11, 20, 24, 25 are highlighted in Table 4.

Table 4. MCKAS Item and Scale Mean Scores for Wraparound Facilitators

Item	<i>M</i>	<i>SD</i>
1. Clients should maintain eye contact	5.88	1.31
2. I check up on my cultural skills	4.86	1.49
3. Minority Clients receive “less preferred” forms of counseling	4.82	1.65
4. Clients who do not discuss intimate aspects of their lives are being resistant	1.76	.844
5. Certain counseling skills transcend culture	4.91	1.34
6. Familiar with the “culturally deprived” depictions of minority mental health	4.98	1.58
7. Recent attention directed toward multicultural issues is overdone	1.60	.877
8. Aware of individual differences	5.91	1.20
9. Minority clients are more likely to be diagnosed with mental illness	4.98	1.58
10. The nuclear family is the ideal social unit	2.19	1.27
11. Highly competitive and achievement orientation goals	2.22	1.38
12. Nonverbal communication	5.74	1.23
13. Impact of oppression and racism in mental health profession	5.07	1.26

Table 4 (continued)

14. Problem conceptualization, goals and counselor credibility	5.12	1.42
15. Psychology and promotion white power and status	4.19	1.59
16. Knowledge of acculturation models	4.16	1.40
17. Role of culture and racism	5.53	1.22
18. Importance of objective and rational thinking	4.68	1.32
19. Awareness of culture-specific counseling models	3.76	1.57
20. Patriarchal structure is ideal	1.55	.976
21. Barriers and benefits of cross-cultural relationship	5.26	1.25
22. Comfortable with differences	6.17	.861
23. Awareness of institutional barriers	5.83	1.23
24. Client psychological mindedness and sophistication	2.39	1.22
25. Counselor endorses middle-class white norms	1.43	.652
26. Awareness of white privilege	5.53	1.83
27. Major schools of counseling and client conflicts	5.10	1.42
28. Minorities' view of counseling	5.62	1.41
29. Challenges faced by minorities	5.88	1.32
30. Clients view themselves as primary responsibility	3.91	1.80
31. Sensitive to circumstances	5.66	1.13
32. Counselors and non-academic program choices for students	4.23	1.74

Research Question #2: What is the primary caregiver's assessment of adherence to wraparound principles and level of satisfaction based on their experience with the process?

Descriptive statistics were calculated to obtain the means across all caregiver participants ($n=6$) and standard deviation for the total WFI-4 score based on their

assessments of the wraparound process. Preliminary benchmark scores (Bruns et al., 2008) were used to provide a metric for comparison: High fidelity = 85%, Average fidelity = 75%-79%, Below average fidelity = 70%-74%, Non-wraparound, or in need of significant improvement = 69% and below. Based on the mean score ($M = 66.67\%$), caregiver ratings fell within the non-wraparound, or in need of significant improvement range.

Table 5. Caregivers' Assessment of Fidelity Implementation of Wraparound Total Scores

	<i>M</i>	<i>SD</i>
WFI-4 Total score	66.67	7.50

The maximum possible score for each of the ten wrap principles measured by the WFI-4 is eight. A review of the means presented in Table 6 shows that the following principles: Persistent ($M = 8.0$); Collaborative ($M = 7.7$); Culturally Competent ($M = 7.7$); Family Voice/Choice ($M = 7.2$); and Strengths Based ($M = 7.0$), were rated highest. The principles of Natural Supports ($M = 5.7$); and Outcomes Based ($M = 5.3$); and Individualization ($M = 4.7$) were rated lowest.

Table 6. Caregivers' Assessment of Wraparound Principles

Wrap Principle	<i>M</i>	<i>SD</i>
Family Voice/Choice	7.2	1.32
Team Based	6.8	1.60
Natural Supports	5.7	2.33
Collaborative	7.7	.516
Community Based	6.7	.816
Culturally Competent	7.7	.516
Individualized	4.7	1.75
Strengths Based	7.0	1.09
Persistent	8.0	.000
Outcomes Based	5.3	.516

Item scores are assigned on a range of 0 (describes low fidelity) to 2 (describes high fidelity). A review of individual items shows high fidelity ratings for multiple items including item 1.4, 'caregivers' selection of team members' ($M = 2.0$); item 2.7, 'team members consider multiple ideas' ($M = 2.0$); and item 2.10, 'caregiver has highest priority on the team' ($M = 2.0$). The items with the lowest mean scores include the following: item 4.1, 'transition plan is discussed' ($M = .0$); item 2.3, 'plan includes mostly professional services' ($M = .50$); item 2.8, 'crisis plan is in place' ($M = .80$); item 2.5, 'plan includes activities to help child get involved with activities in their community' ($M = 1.00$); and item 3.6, 'there is a friend, or advocate on the team' ($M = 1.00$).

Table 7. Caregivers' Assessment of Wraparound Activities

Item	<i>M</i>	<i>SD</i>
1.1 Shared strengths, beliefs, and traditions	1.67	.516
1.2 Explained process	1.50	.837
1.3 Shared past successes	2.00	.000
1.4 Selected team members	2.00	.000
1.5 Team member attendance	1.83	.408
1.6 Identified crisis situations	2.00	.000
2.1 Written plan of care	1.83	.408
2.2 Developed mission, or vision statement	1.33	1.033
2.3 Plan includes mostly professional services	.50	.548
2.4 Supports, services are connected to strengths	2.00	.000
2.5 Plan includes community based activities	1.00	.000
2.6 There are members without a role	2.00	.000
2.7 Team considers multiple ideas	2.00	.000
2.8 Crisis, or safety plan in place	.80	1.095
2.9 Believes that the team can keep the child in community	1.67	.816
2.10 Caregiver has highest priority on team	2.00	.000
2.11 Team understands the family's values	2.00	.000
3.1 Decisions are not made without caregiver present	2.00	.000
3.2 Team identifies resources	1.83	.408
3.3 Child is involved in activities	1.33	1.033
3.4 Increases support from friends and family	1.33	1.033
3.5 Members are held accountable	1.83	.408
3.6 Friend, or advocate is on team	1.00	1.095
3.7 Team comes up with new ideas	2.00	.000
3.8 Supports are difficult to access	2.00	.000
3.9 Members have assigned tasks	1.83	.408
3.10 Members use language that the caregiver understands	2.00	.000
3.11 Positive atmosphere	2.00	.000
3.12 Everyone participates	2.00	.000
3.13 Possibility of discontinuing process too soon	2.00	.000
3.14 Team members respect the family	2.00	.000
3.15 The child has opportunity to express ideas	1.67	.816
4.1 Transition plan is discussed	.00	.000
4.2 Process has helped child develop positive friendships	1.33	1.033

Table 7 (continued)

4.3 Process has helped child solve their own problems	1.50	.548
4.4 Team has prepared family for major transitions	1.67	.816
4.5 Believes that process can be 're-started' if needed	2.00	.000
4.6 Process has helped the family strengthen Relationships	2.00	.000
4.7 Believes that family can survive without Wraparound	2.00	.000
4.8 Believes that some members will support them when process has ended	2.00	.000

Total points for the Caregiver Satisfaction Questionnaire were compared based on the following guidelines: a. Very satisfied (20), Satisfied (16-19), Somewhat dissatisfied (10-12), Dissatisfied (7-9), Very dissatisfied (4-6). Ironically, while caregiver assessments of wraparound fidelity indicated a need for improvement (i.e., obtained WFI-4 score=66.67% compared to range of average WFI-4 scores=75-79%), the mean score on the Caregiver Satisfaction Questionnaire, fell within the high end of the satisfaction ratings ($M = 19$).

Table 8. Caregivers' Assessment of Satisfaction with the Wraparound Process

	<i>M</i>	<i>SD</i>
Caregiver Satisfaction Questionnaire Total score	19.00	2.00

Research Question #3: What is the primary caregiver's perceived level of stress?

Caregiver stress levels were calculated using the Caregiver Strain Questionnaire (Brannan, Heflinger, & Bickman, 1994). The mean scores for the three subscales: Objective Strain, Subjective Externalizing Strain and Subjective Internalizing Strain and a Global score were calculated. Table 9 shows the mean scores for each subscale and Global score across all participants.

Table 9. Caregivers' Perceived Level of Stress

Category	<i>M</i>	<i>SD</i>
Objective Strain	2.33	.69
Subjective Internalizing Strain	3.11	.36
Subjective Externalizing Strain	1.50	.45
Total Caregiver Strain	6.94	1.05
Global Caregiver Strain	2.31	.35

Caregivers in this study reported a slightly higher level of Objective Strain relative to five published studies with clinical samples of children and youth (Brannan & Heflinger, 1997; Brannan & Heflinger, 2006; Brannan, Heflinger, & Foster, 2003; Sales, Greeno, Shear, & Anderson, 2004; Taylor-Richardson, Heflinger, & Brown, 2006). For example, the highest mean Objective Strain score from the published results was $M=2.31$ (Sales et al., 2004). While the lowest mean Objective Strain score was $M=2.0$

(Brannan, Heflinger & Foster, 2003). Objective Strain captures the impact of caring for a child with challenging behavior on finances, family relationships and the mental, or physical health of the caregiver (Brannan & Heflinger, 1997). Results for Subjective Internalizing Strain, a measure of anxiety related to the effect of the child's behaviors on the family and concerns for the child (e.g., 'In general, how much of a toll has your child's emotional or behavioral problem taken on your family?', 'How worried are you about your child's future'), are comparable to the means from the published studies. To illustrate this point, the highest mean for the Subjective Internalizing Strain was 3.4 (Brannan, Heflinger, & Foster, 2003) while the lowest published mean on this subscale was 3.07 (Brannan & Heflinger, 2006). Conversely, the caregivers in this study reported lower levels of Subjective Externalizing Strain (e.g., resentment toward their child) compared to published results. The highest reported mean on this subscale was 2.3 (Brannan, Heflinger, & Foster, 2003) while the lowest reported mean was 1.86 (Heflinger & Taylor-Richardson, 2004).

Qualitative Results

The objective of including qualitative data was to understand the influence of cultural competence from the perspective of the caregiver. The overarching research question for the qualitative portion of this study was:

How do primary caregivers describe their facilitator's cultural competence, the stress associated with parenting a child with challenging behaviors, and/or emotional problems and their overall impression of the wraparound process?

Unfortunately, a small number of caregivers ($n=6$) contacted the researcher to express interest in participating in the study. Assigning caregivers to a ‘high’, or ‘low’ group according to the groupings as described in the original research design was not possible because the caregiver sample was not large enough to detect significant differences in the corresponding MKCAS scores of the facilitators. Descriptive analysis identified the range and mean MCKAS scores for the wrap facilitators of the participating caregivers (Highest score = 189, Lowest score = 152, $M = 165$); the range and mean of WFI-4 scores (Highest total WFI-4 score = 74.0, Lowest score = 55.0, $M = .66.67$); the range and mean of CGSQ scores (Highest Total CGSQ score = 2.84, Lowest score = 1.95, $M = 2.31$); and caregiver satisfaction with the wraparound process (Highest total satisfaction score = 20.0, Lowest score = 15, $M = 19$).

These data were used to learn about the available caregivers’ perspectives regarding the role of culture and the wraparound process. Maximal variation, a form of purposive sampling, was used to capture perspectives from caregivers who varied widely in terms of race and social economic factors (i.e., type of employment, and educational background) on the wraparound process (Creswell & Plano Clark, 2007). Three caregivers from different racial/ethnic groups (White, African American and Hispanic) were contacted regarding follow-up interviews. Ultimately, two caregivers (one White and one African American) completed the follow-up interviews. Identifying characteristics of the participants were altered to maintain confidentiality. Names and general descriptors were created for the purpose of clarifying responses as their remarks are shared and discussed in upcoming sections of this chapter.

‘Barbara,’ a White, middle-aged (the participant reported being between 45-54 years-old) married mother of two lives in a middle-class suburb near a major metropolitan city. She has a graduate degree and was employed as a corporate trainer. Currently she is a full-time homemaker following a job loss. The family’s household income is between \$40-\$45K. However, she describes her family as ‘middle class’ (i.e., both parents are college-educated and were employed in professional fields).

She describes her son, ‘Alex’, as ‘exceptionally bright (e.g., ‘he has a genius-level IQ’) and mentioned that he ‘has always done well in school’. A review of the data found her facilitator’s self-assessed cultural competence fell within the average range (facilitator’s MCKAS total score = 165 was equal to the group mean of 165). ‘Barbara’s perspective on her wraparound process was that it was being implemented with extremely low fidelity. Her WFI-4 score of 61 was low relative to the group mean score of 66.67. This score also falls within the non-wraparound, or in need of significant improvement category compared to larger samples (Bruns et al., 2008). ‘Barbara’ reported feeling generally stressed regarding caring for her child (Global Caregiver Strain score = 2.84). She specifically reported feeling highly stressed in terms of the impact of her child’s needs on the family (CGSQ Objective Strain score = 3.18). She is very concerned about her child’s future (CGSQ Subjective Internalized Strain score = 3.33). ‘Barbara’ also endorses a level of negative feelings (CGSQ Subjective Externalized Strain score = 2.00) about her child (e.g., resentment, poor relations) that is comparable to levels reported within published clinical samples (Brannan & Heflinger,

2006; Brannan, Heflinger & Foster, 2003; Heflinger & Taylor-Richardson, 2004). Her wraparound satisfaction score of 15.0 was low relative to the group mean of 19.0.

‘Janice’ is a middle-aged (reported being between the ages of 45-54 years-old) African American, single grandmother. She is raising her son’s daughter, ‘Essence’ in a mid-sized city after he moved away to find employment out-of-state. ‘Janice’s’ household income was \$15,000 when she was a cook for a local branch of a national non-for-profit organization. She’s currently unemployed and collects disability for herself and her granddaughter. ‘Janice’ estimates that her current income is roughly \$14,000 annually. She reported that she dropped out of high school a few months before completing 12th grade due to conflicts with her mother.

Her facilitator’s total MCKAS score of 159 is low relative to the group mean of 165 but is comparable to the mean from published samples ($M = 159.9$; Ponterotto & Potere, 2003). ‘Janice’s’ scoring of the fidelity of implementation associated with her wrap is high relative to the group mean (total WFI-4 score of 74.0 vs. $M = 66.67$). Relative to published criteria for wraparound fidelity, this score falls within the below average range (Bruns et al., 2008). Overall, ‘Janice’s’ reported level of caregiver stress is within the average range compared to the group mean (CGSQ global score = 2.31). The impact of caring for her granddaughter on her daily living (Objective Strain score = 2.27; e.g., missing work) is comparable to clinical samples (Brannan & Heflinger, 1997; Brannan, Heflinger, & Foster, 2003; Heflinger & Taylor-Richardson, 2004; Taylor-Richardson, Heflinger, & Brown, 2006). Her concerns about her granddaughter’s future (Subjective Internalizing Strain score = 3.67) are also comparable to clinical samples

(Kang, Brannan, & Heflinger, 2005). However, her level of negative feelings (e.g., resentment, anger, embarrassment) as measured by Subjective Externalizing Strain was lower than the group mean (1.0 vs. $M = 1.50$) and clinical samples.

Semi-structured interviews were completed via telephone using the following guiding questions:

Questions about the wraparound experience:

1. What did you enjoy (dislike) about the wraparound process?
2. Please describe what it was like, overall, working with your facilitator.
3. Please explain how your facilitator demonstrated respect (disrespect) for your family's cultural background (e.g., shared beliefs about what is appropriate and acceptable behaviors and attitudes within your family, neighborhood, or racial/ethnic group)?
4. Please describe how your facilitator handled racial issues that may have occurred during wrap meetings, or in the process of developing interventions for your child.
5. What do you think are some of the positives (negatives) of working with a facilitator from a different (racial/ethnic/economic) group?

Questions about parenting a child with behavioral/emotional problems: Think back to the time before the wraparound process began and please describe what it was like caring for your child then, to what it is like now.

Based on the caregivers' responses, there was a noticeable difference between the descriptions of wraparound experiences as expressed by the two respondents during the follow-up interviews. Analysis of the data collected during the qualitative phase of this

study also resulted in identification of eight themes providing a more in-depth description of race and culture as these factors relate to the wraparound process.

Table 10. Themes of Caregivers' Responses

Theme	References
Race	56
Help	28
Wraparound	32
Behavior	18
Teams and roles	18
Family Voice	
And Choice	18
Social Reproduction	12
Parental Stress	11

Behavior: Each caregiver began the interview by describing their concerns about her child's behavior and the impact on the caregiver and other family members.

'Alex', 'Barbara's son: He was so mad. And it didn't wear off. And that was very unusual for him that it didn't wear off. Volatile maybe. But he had been even more volatile. All of the characteristics that we loved in him (e.g., the quiriness and the goofiness were actually getting in the way)...He gets serious, he doesn't get perturbed. He doesn't get mildly pleased, he gets excruciatingly happy. So it's exhausting. If he's in a bad mood it's exhausting. It's almost more exhausting if he's in a good mood.

‘Essence’, ‘Janice’s granddaughter: She was in foster care. Me and my son had to go to court to get her. It took 2 1/2 years and we finally got custody. When she came to me she was already diagnosed with ADHD...She came with a bottle of Concerta and that’s the bottle I took to the doctor and she’s still on that but they upped the dose. She’s now up as high as she can go on it....Oh man I had a time cause ... I couldn’t figure out why she couldn’t do stuff. I’d tell her to do stuff and she would do different stuff and she would just trash the whole room and she’d have those outbursts. And I’d go in and she’d just be crying in her room. And I didn’t know what was going on....It was just totally different I had never had no kid like that. She would just do things. She would just be into stuff and wouldn’t sit down.

Wraparound: ‘Barbara’s response about wraparound highlights her perspective that the process is strengths-based and encourages the school to understand the whole child.

Frankly I was surprised to hear about it. Here is a process that we use that takes into account more of a 360 degree thing. We recognize and value your child’s part in the community, in the family, in things outside of the school building and we don’t get a lot of stuff like that. ..I was impressed but also thankful that we were talking about strengths as much as we were talking about needs because that’s what’s missing in any discussion about a care component.

‘Janice’s introduction and earliest impression of wraparound was rooted in the experience of an emergency situation regarding ‘Essence’s frequent run-ins with school personnel and conflicts with her grandmother at home. Her perception was that wraparound offers a positive alternative to traditional special education process.

So tell me about how you came to find about wraparound? How was it introduced to you?Ok when she was at school they had her in a IEP and they/we were having so much trouble with everything we were trying to do it just wasn’t working and they decided to get together. ‘Ms. Hill’, ‘Mr. Karl’ and all of them came together and said if maybe we could do something like a wrap it might help her. .. I guess it was different because the IEP meeting a lot of the time we were coming because it was stuff she

did, she had referrals and we were going over stuff she did and how could we change this and that.

‘Janice’ also relates wraparound to improved outcomes for her grandchild. In her case, there has been parallel implementation of the wrap and special education. It was implicitly stated that wraparound has had a profound impact on helping ‘Essence’ transition out of special education because of the range of supports and the influence of those supports on her behavior.

...she’s doing really well. So they took her IEP away from her yesterday and said that she’s doing so well in school she’s had a complete turnaround....boy it’s amazing how well she handles things and she gets good grades and she’s got the athletic and academic.

For ‘Barbara’, wraparound offers flexibility relative to the traditional special education process that provides the supports that her son needs to manage his day with less stress. There is the message that special education with its rigid guidelines may be too formulaic to address the needs of children who are not failing academically.

....they were a little confused because we didn’t give them something that they have matrices for. It doesn’t seem that it fits within one of the 13 categories that the federal government defines as a disability. So they’re really set up for he has a problem. Here’s the problem so he’s getting ‘Ds’ in his class. Hold on! We have a spreadsheet for that! Which is good because you need to have measurable goals. His 504 goal ... is to be happy. Is to make his stay at his school/ his schoolwork to make him a happy child. Which is the least measurable thing in the universe but is exactly what we needed to have happen.

‘Barbara’ mentioned data collection for use at team meetings. However, it appears that the data collection process was similar to the traditional format of having the caregiver and others complete paperwork. Illinois PBIS Network wrap facilitator trainings encourage facilitators to use a conversational approach when using the data

collection tools (e.g., Home, School, Community Tool; HSC-T; Illinois Statewide Technical Assistance Center, Systematic Information Management for Educational Outcomes , 2011).

I filled out the form and since this was the summer, his teacher from the year before filled out the form. In the community component, I had our next door neighbor fill out the form because she's known him forever and also because she's been an OT in the public schools so that she can pull herself away. So we were able to put the home, school and community component together....So here was this triangulation tool and we plug it in. We had a meeting yesterday and they graph everything out.

However, 'Barbara' stated a belief that, perhaps, the facilitator had not gained fluency with the tools and the procedure.

I felt that the provider didn't have a real grasp on the items because it was asking me about safety, 'is safe from violence.' I'm like this is a difficult thing to say that it was a strength because it was a yes, or no question. It was a yes, or no question because of where I live. Because if I drive ten miles north, I would have a different answer. The spiritual and health questions were close. I had some questions about how to interpret it in order to fill it out. And I didn't feel like she was prepared to answer those questions.

Later in the interview, 'Barbara's desire for a more experienced facilitator was repeated. She also expressed a need for someone more knowledgeable to be guiding the team.

Well I'm glad that she young because she has that enthusiasm and I can save the world thing about her which is great. But there have been times when I've wished that she's had more years under her belt because I need to look to her for the wisdom of her experience. And like she doesn't have that much experience...

Teams: 'Barbara' and 'Janice' both had positive impressions of their teams.

'Barbara' liked the idea of having persons representing multiple perspectives and the concept of shared responsibility reflected on her son's team.

'Barbara': I think that it's been a really well-rounded team. We have a reading aide. He doesn't need help in reading but she has a perspective of kids who need help in a certain areas. We have the district nurse, well his issue is partially a health issue she has a health perspective. I feel like it's really well-rounded. It not just like everybody said oh that's the social worker's problem and just dumped it on her.

'Barbara' also signaled that the other team members respected her and her husband.

'Barbara' recognized the facilitator's view of the family as integral to the team. "So she's always considered us as components of the team, not just we're the people that they're working for."

'Janice's impression of her team's effectiveness reflected her perception that the members go the extra mile to help support her granddaughter.

They come and even beyond their duty in that wrap session. They take 'Essence' and do stuff with her that they don't even have to do.

However, upon further discussion, it is clear that largely professionals and parents staff 'Barbara's' and 'Janice's' teams. This fact is contrary to the principle of wraparound that emphasizes inclusion of natural supports. 'Barbara' even expressed a desire to expand her team's membership to include community members.

There are no members from the community, or the student's family, neighbors on the team. I don't know if they had asked. When we first started talking about community, they asked "do you want to have your pastor involved?" But we don't have a pastor so we said "no." I don't remember if they asked again. I think that it would be kind of cool to have a community member on the team.

Help: ‘Barbara’ and ‘Janice’ indicated that the wraparound process had been very helpful to them especially since it facilitated forming a partnership with the school to help support their children. This partnership has generated a sense of relief that they don’t have to shoulder the burden alone anymore.

‘Barbara’: I now know that if he’s extra moody at home, I can contact the school and get info in context of what I need to hear in order to support my child....When I call his teacher, or the vice-principal, or the social worker, I will get the information needed to help me. Having someone else who’s attuned to these things besides the people in this house has been tremendously helpful. It’s been tremendously helpful for him as well.

Help can be viewed as supporting parent-identified concerns as in the case of ‘Barbara’.

If he cannot recognize what’s going on, we need you to. It is difficult because we’re not asking them to adhere to a step-by-step plan, that they already know. We’re asking them to pay attention....One of our son’s largest problems is that he cannot identify that he’s overwhelmed until he’s crossed the line. (e.g., he has difficulty recognizing when he’s overwhelmed and he has a meltdown). We need help. We need help from somebody! (emphatic, voice rises) teaching him to learn how to identify that.

‘Janice’ also identified another area of helping related to putting supports in-place that improved the quality of life for ‘Essence’ and for her.

And I liked how they helped her this summer. The wrap and all. You know how they help you. They got her into the “Y” They got her swimming. And you know she just loves that she can go swim. ...Almost everything they went for me and ‘Essence’ they got approved. Without all of that, we couldn’t have gotten any of that done without them. Like I said, they helped me and I appreciate it.

‘Janice’ also acknowledges that she wouldn’t have been able to access services without the financial support provided via the wraparound process,

...I couldn't get a ride and they just made it much easier for me to handle it, bus passes, or whatever, to get me and 'Essence' to out there and all that...The cabfare got to be a little too much expensive so they got approved for Access bus to take it to the doctors, etc. So we do that that way now. It used to cost \$30 each way out to the behavior center (via cab) It was starting to get expensive. With the budget they couldn't keep getting me cab passes. Other people needed it too. It had gotten to be too expensive, like \$29.50 round-trip. That's a lot of money on a cab.

Family Voice and Choice: Family voice and choice (e.g., the family's perspective is heard and respected by all team members) is a key principle of the wraparound process. 'Barbara's description of her experience fits the goal of this principle (also sometimes called 'family-centered team leadership'). This principle is supported based upon her input of who should be on the team "I specifically asked for the district nurse and the gifted nurse to stay. I felt like I was able to customize the team." To the facilitator's deference to the family's point-of-view in setting priorities:

She has always been given the respect that we know our family and that we know our son. And if something looks like a problem to us but it doesn't look like a problem to them. Then, it's still a problem.

'Barbara' referred to self-awareness as a component of family voice and choice. "We (she and her husband) know who we are. We know what our son's needs are and what it's like to raise him....Know what you want before you open your mouth. People will respond to not only the logic of your request but to the expectation attached to the request."

However, when 'Janice' encountered a problem with the principal at her granddaughter's school (i.e., at one point, 'Essence' was placed in the rear of her classroom surrounded by gym mats), the team intervened on her behalf.

Ok. When I told 'Ms. N' and some of them about it, ok well they told me

“are you sure?” and I told them that I was about to come up to the school about it. And they were like ‘we’ll see about it.’ Then, the next thing I know, they go to the school and then they call and told me they took care of it....And when I went there like yesterday, they were telling me during the meeting, that they (the mats) were down. They took care of it where she’s is back up there with the class. I guess they did what they did and they had it removed so that I didn’t have the problem no more. ...Ok, they help me do it instead of me having to (come up to the school) and I guess go to the principal and have a conversation, I mean have a confrontation. They took care of it. I just relayed how I felt and then they took it to them.

In this example, family voice and choice is exemplified by ‘Janice’s’ expression of her concerns to the team who address the issue directly with school staff.

‘Barbara’s comments about family voice and choice alluded to a relationship between income and the willingness to express one’s point of view, “Money buys choices. The less money you have, the more you feel if you ask for something, the more you worry that people will take things away.”

‘Barbara’ raised the concept of caregivers as ‘experts’ in her explanation of why few caregivers responded to this study as an opportunity to exercise family voice.

Well, there’s a vestige of the ‘doctor is your doctor’ model. Parents are used to being the person that services are directed at and not the person who the services are for....They may feel that they don’t know any of the stuff.... Maybe they don’t really feel like that part of the team. They don’t feel like they’re an expert on their child, they don’t feel like an expert on anything including a study. They need to feel like they’re the expert so that their opinion is valued.

Parental Stress: The theme of parental stress was clearly communicated throughout the caregivers’ descriptions of the wraparound process and parenting their children. The strain of caregiving evolved from having to constantly manage difficult

behaviors either at the sacrifice of one's own emotional well-being, or without having the tools to properly relate to the child to re-direct, or de-escalate them.

'Barbara' describes the relief of getting a medical diagnosis, then having the school join the family in addressing her son's behaviors.

And we hadn't realized this. He's trying so hard to keep it together at school that he'd come home and he would just explode. It took a doctor to help us understand that he wasn't doing this on purpose to relieve a lot of that tension...before we started working with the school, caring for him was exhausting because when caring for someone who is so emotional, you have to be less so. Or, at least that's how I deal with it. There's only 100 'crazy points' allowed in a room and if he's taking up 90 of them then I only get 10. So if he's super loud, then I'm super quiet. It's just the way I react to him. So that after a while I feel that I have to under-react to everything so that I can get to a level where it will work. So that was also exhausting.

'Barbara' communicated in a powerful way the level of shame associated with having a child whose behavior is difficult to manage.

When it's just the two of us my son and my daughter in the house, then every reaction and everything that happens with that child, and that everything that that child does is a reflection of your parenting skills, good and bad. You don't want your child to be a bad child so you put it back on yourself.

The feelings of being overwhelmed by their child's intense emotional reactions and disruptive behavior were extremely stressful on a personal level as a parent. 'Janice' describes how a successful behavior management strategy can impact multiple areas of the family's life (e.g., frequency of school discipline, or holding a job).

'Janice': I didn't know what I was going to do when I first got her. I was stressed out a lot and I didn't know what was going on. She's not paying attention. She's not doing what she's asked to do?...I couldn't figure out why she couldn't do stuff....The (school) was calling me almost every day. I almost lost my job. Almost every day I had to come to the school

and get her...

Social Reproduction: Social reproduction (Bourdieu et al., 1990) is the framework for explaining how class structures are maintained on an intergenerational basis. Central to this framework is the 'activation,' or use of different forms of 'capital.' In reviewing sections of the transcripts, the following examples of how 'Barbara' activated her cultural and social capital were identified .

Cultural capital: I can be a very difficult parent to be up against in a school setting because I have high expectations and I do have some background, I can be more difficult to deal with. I have a masters in curriculum design. I have the ed. Psych background in how to motivate people and how to get people to learn....She (the social worker) says that Fridays are really hard for her. I think that I'll have to follow up with the vice-principal about it.....We have the vocabulary for this and it's extraordinarily powerful to bring the right words to a situation.

Social capital: The first call that I made was to our vice-principal I knew that he'd had a very limited special ed. background. I said I need to know who do I talk to first and how is this supposed to get off of the ground. Especially since I had previously been told by parents whose children had been receiving special needs help.

Symbolic violence, as defined by Bourdieu, Passeron and Nice (1990), is the mechanism for maintenance, or perpetuation of class structures associated with social reproduction. The following description of the school's response to 'Essence's' challenging behavior illustrates this concept.

'Janice': And then one time they had put her in the back of the class because she was acting up and she had those mats around her like the kind you use in gym on the floor. They put mats around her like she was caged in. They said it was because she would be talking and I said no, take them down.

Another example of symbolic violence is provided in ‘Janice’s’ description of the principal’s behavior during a recent IEP meeting.

She said that she just had to step out for a minute but it was during the part when they was all praising her (‘Essence’) and congratulating her. And how proud they were of her and how she’s come a long way. And all the teachers were talking about how pretty she is and what a beautiful girl she is. And they was going on and on and I was kinda wanting them to stop. But ‘Ms. N’ pulled up a picture of her on the computer to show the lady at the junior high school where she’s going to going and everyone was like “she’s darling, she’s a doll.” And ‘Ms. K’ was saying that “she’s come such a long way” and how she just wants to be heard and seen and when she talks to you she likes you to listen to her.” And she (the principal) was like, “she (Essence) won’t listen! And she’s like this and that” she got up and came back in about five or ten minutes (later). And she just sat down and didn’t say anything. Then she got up again toward the end of the meeting. At the end she said, “Always good to see you” and I just said, “You too.”

Race and Culture: Questions referring to race were difficult for ‘Barbara’ and ‘Janice’ to answer. When asked ‘How would you describe your facilitator? Would you say that you’re pretty well matched in terms of education, income, racial/ethnic background, or would you all say that you’re different?’, ‘Barbara’ responded by saying, “ Well, she’s young and I’m not. Well I’m glad that she young because she has that enthusiasm and I can save the world thing about her which is great”. When the researcher asked the question directly (i.e., ‘But would you say that you’re pretty much from the same education background, SES, racial/ethnic group?’) ‘Barbara’ made the following response, “Yes, I’d say that there’s an educational match and an ethnic/racial match—not that that makes a difference.” Yet, after additional probing from the researcher, ‘Barbara’ did admit that culture does play a role in interactions between

caregivers and facilitators. “If your background is similar to the provider, then you tend to have similar experience and shared vocabulary.”

‘Janice’ responded in the following manner when the researcher asked her the following direct question about respecting her family’s culture.

Researcher: Can you explain to me how your facilitator demonstrated respect for your family’s cultural background? Meaning what your family believed was appropriate, acceptable behaviors within your family. Or, even within your ethnic group. Because I see where you checked off (on the questionnaire) that you’re African American, right?

‘Janice’: Yes ma’am

Researcher: ‘Ms N’. is White. So how did she demonstrate respect for your family’s culture?

‘Janice’: I don’t know what you mean by that.

When asked a follow-up query related to obtaining her perspective on working with a facilitator from a different racial/ethnic group, ‘Janice’ became flustered.

I mean that I never had a problem, like that with her (with emphasis). She was always respectful. I mean I know that you guys like to do different things I don’t know what to say. I don’t know really what the problem is...She wasn’t disrespectful or anything like that (with emphasis).

‘Janice’s follow-up comments focused on the extra efforts demonstrated by members of her granddaughter’s wrap team.

‘Janice’: (Speaking rapidly now) They take her to church with her. They took her to their homes for the big family dinners. They took her to that um fair, you know what I’m saying? ‘Ms. N’ took her to the MLK, Jr. dinner and ‘Ms. N’ is white. You know they take her to church and they made valentines with her at church. Then they passed them out with all the convalescent and nursing homes. And they do stuff. Like ‘Ms. P’, they come and get her after school and after hours and do stuff with her.

‘Janice’ continued in her explanation to describe the deep, personal connection

that 'Essence' had established with members of the wraparound team.

They were really good people. They were just as sweet as they could be. And they helped with everything. And 'Essence' loved them. And there was nothing that they didn't/wouldn't do. Like they said, they treated her like she was one of their own. They would invite her to shows and stuff that they didn't have to do out of school. ... They were all just really nice....And I been around some that aren't like this. They just 'fakey' and you can tell they be doing stuff behind your back. All the ones in my group are really sweet.

When 'Janice' was asked another direct question about race, "How did your facilitator handle racial issues that may have occurred during wrap meetings or in the process of developing interventions for your child?" She initially denied that there had been any issues either within the team, or at school that she perceived to be associated with her race, "Ok. That really never came up. But I guess that she handled it well. And I never really had a problem like that with none of them."

However, after further discussion, it became quite clear that 'Janice' did experience some conflicts that she believed may have been racially-motivated. "The only one that I felt like that had a problem with blacks, or with 'me and Essence' was that principal."

When prompted to explain her statement about the principal, 'Janice' angrily recalled a few unpleasant interactions that she and 'Essence' had with the school principal. 'Janice' recalled how the principal ignored her during a recent IEP meeting.

(Speaks quickly without taking a breath) That lady at the school (the principal), she just came in (during the IEP meeting) and sat during the meeting and didn't really say that much. She don't really speak to me. She just say 'bye'.

'Janice' recalled how the principal inferred that 'Essence' was not being held

responsible for her behavior. 'Janice' remembers the principal informing her during a team meeting that she had no difficulty with punishing 'Essence'.

One time she came in and said, "the rest of them let her have her own way and make excuses, but I know....And she, she, she sees (speaking faster here, voice rising) her for what she is and what she does. And I mean I just nail her and I tell her "you get in my office! And I'll make her." I guess she say that 'Ms. N' and the rest of them are too easy with her. She don't make excuses for her or do little special things for her. ... (Her speech is very rapid and the words begin to run together) She (the principal) say, "if she does this and that then she needs to get punished and I tell her do it. And I feel like if she does it then she deserves the punishment. I tell her to get into there into my office and I tell her to do this and that."

'Janice' also described an incident when the principal shamed 'Essence' in front of other students by implying that she needed medication to function appropriately.

She said that she (the principal) would call her in the hall and say "My God! Have you had your pill today?" in front of the kids and they (the kids) would start teasing her.

According to 'Janice', the principal would not address the inappropriate behavior of another student when asked by 'Essence'. In fact, the principal affirmed the student's comment about 'Essence'. 'Janice' described an incident when 'Essence' said that another student told her that was she in 'slow class', or special education and she said "no, she ain't" and she asked the principal to get the girl to stop teasing her about it. And she said that the principal said "that is what you in."

Summary

This study examined the roles of culture competency and parental stress in caregivers' assessment of fidelity and satisfaction with the wraparound process. An explanatory, sequential mixed-methods research design was utilized. Quantitative data

using survey research methodology was collected during the first phase of the study.

Qualitative data was collected using semi-structured interviews in the second phase of this research.

Descriptive data presenting the mean scores for the MCKAS, WFI-4, Caregiver Satisfaction Questionnaire, and the Caregiver Strain Questionnaire were used to address research questions 1-3. Due to the small number of caregivers who participated in this study, it was not feasible to complete the ANOVA and ANCOVA to address research questions four and five.

Eight themes (behavior, wraparound, teams and roles, help, family voice and choice, parental stress, social reproduction, race and culture) were identified during analysis of the qualitative data.

A discussion of how the findings relate to the research questions and the literature follows in Chapter V.

CHAPTER V

DISCUSSION

This chapter provides a discussion of the findings resulting from this research study. This information is presented in the following sections: (1) discussion of the findings relative to the research questions, (2) limitations of the study, (3) recommendations for future research, and (4) implications for practice.

Discussion of Findings

Until recently, most of the research in the field of wraparound has focused on client outcomes. There has been a trend toward examining fidelity of implementation of wraparound and factors associated with adherence to the principles of this process. Furthermore, the majority of the research has focused on clinical samples obtained through community mental health service programs, or juvenile justice facilities (Anderson et al., 2008; Bruns et al., 2005; Carney & Buttell, 2003; Clark et al., 1998; Hyde et al., 1996; Mears et al., 2009). There has been limited research on wraparound implementation within K-12 settings (Eber et al., 1996; Eber et al., 2002; Eber et al., 2009; Eber et al., 2011; Eber & Nelson, 1997). This study sought to understand the role of culture in the wraparound process. An explanatory, sequential mixed-methods research design was used to measure the self-assessed cultural competence of wraparound facilitators in K-12 settings. Then, caregivers were asked to assess the level of fidelity to

the wraparound process, the level of stress associated with rearing a child with challenging behavior, or high needs, and their satisfaction with the wraparound process.

Research question 1: The self-assessed cultural competence of wrap facilitators who participated in this study was comparable to earlier published results obtained on the Multicultural Counseling Knowledge and Awareness Scale: a) Awareness, $M = 60.7$; b) Knowledge/Skills, $M = 99.2$ (MCKAS; Ponterotto & Potere, 2003). Previous studies using the MCKAS to measure self-assessed cultural competence have been sampled from the following professions/groups: marriage and family therapists, multicultural counseling experts, school counselors, predoctoral interns, and counseling psychology students (Ponterotto & Potere, 2003). The current sample of individuals who completed the MCKAS was primarily comprised of social workers (61.5%, $n = 40$). However, this sample also included counselors (9.2%, $n = 6$) and school administrators (4.6%, $n = 3$). In a review of instruments designed to measure multicultural competence, Dunn, Smith, and Montoya (2006) noted that only 17% of the articles published since 1990 ($n = 137$) used a quantitative tool to assess the multicultural competence of their samples. Therefore, this study adds to the limited body of research regarding the multicultural competence of mental health workers.

A review of the literature found that cultural competence might be linked with completion of multicultural coursework (Constantine & Yeh, 2001) and with the stage of White racial identity. A majority (96.6%) of respondents in this study have had multicultural coursework. Previous research has shown that this training typically results in professionals who are, relative to those who have not had multicultural coursework,

more aware of their own cultural background, have greater knowledge and understanding of persons from a culture different than their own and are sensitive to the potential impact of their own cultural biases within the helping relationship (Constantine, 2002). A study conducted by Vinson and Neimeyer (2000) on cultural competence demonstrated a positive relationship between cultural competence and racial identity development. The concept of identity development is an accepted psychological model that began with Erikson's (1993) seminal work describing how personality develops transitions through 'crises' that arise during the lifespan. Marcia (1980) extended Erikson's work with the creation of the adolescent development model consisting of four stages reflecting developmental 'tasks' based on cultural norms, physical and emotional maturation and life goals: Identity Diffusion, Identity Moratorium, Identity Foreclosure, and Identity Achievement.

More recently, Helms (1995) developed a framework for examining the racial identity development of people of European ancestry. The White Racial Identity Model describes six stages, labeled as 'statuses.' These stages would likely impact an individual's world view and influence their interactions with minorities shaping their conceptualization of client issues and approaches for assisting persons within the helping relationship. Briefly, the six statuses are: (1) Contact, satisfaction with the 'status quo', (2) Disintegration, individuals may experience anxiety and discomfort when confronted with information about racism, (3) Reintegration, behavior is characterized by dismissal and even intolerance of other racial groups, (4) Pseudoindependence, individual displays a surface level appreciation and tolerance of other racial groups and may express a desire

to 'help' disadvantaged minorities, (5) Immersion/Emersion, this stage is characterized by efforts to understand racial/cultural differences and an emerging activism to address racism, (6) Autonomy, acknowledgement of the advantages afforded by White privilege. Willing to make life sacrifices (e.g., job choice) in order to avoid settings that support, foster oppression of minorities (Vinson & Neimeyer, 2000, p. 180). Conversely a study by Holcomb-McCoy (2001) of 76 elementary school counselors in a northeastern metropolitan school district found no difference in the perceived multicultural competence between counselors who had taken courses and those who had not. Furthermore, since the MCKAS is a self-report measure, there are limitations to the capacity of the instrument to accurately assess cultural competence. For example, it is difficult to ascertain the respondent's frame of reference during completion of the instrument. An individual could be thinking of their skills when working with one minority group and not of their skills with working with clients from a variety of ethnic/racial groups (Kitaoka, 2005). Or, the individual may have interpreted the author's items differently than were intended (Constantine, 2002). Finally, a high score on a cultural competence assessment tool does not automatically translate to successful helper-client relationships (Ponterotto et al., 2002).

Research question 2: There were only six caregivers who participated in the study. Therefore, the results are not generalizable. This study represents these specific respondents' assessment of fidelity and perception of satisfaction with their wraps. The caregivers' assessment of wraparound indicates that the fidelity of implementation is at the baseline level ($M = 66.67$). However, the caregivers also reported being highly-

satisfied with the process ($M = 19.0$). Caregiver satisfaction in this study was measured by asking caregivers four questions: (1) How would you rate your level of satisfaction with reduction in the risk of change in placement for your child?, (2) How would you rate your level of satisfaction with your child's behavior intervention plans and supports since engaging in wraparound?, (3) How would you rate your level of satisfaction with the supports (e.g., respite care) provided to help reduce the level of stress associated with caring for your child?, and (4) How would you rate your overall level of satisfaction with the wraparound process? Responses were rated on a scale of 1-5 with 1= Very Dissatisfied and 5 = Very Satisfied. Although parents rated fidelity of wraparound implementation at baseline levels, they were quite satisfied with the process. This result suggests that when parents experience improvement in their child's functioning as experienced via reduction in risk of change in placement and they feel less anxious about their situation, they are likely to be satisfied with the process. This may mean that the process does not have to be perfect in order for it to be successful in the eyes of the parent. This finding is consistent with results from a recent study examining the relationship between fidelity, system infrastructure and youth outcomes (Effland et al., 2011). The baseline functioning of the children in the Effland et al. study was more predictive of improvement than wraparound fidelity. Based on this outcome, the degree of functional impairment prior to implementation of wraparound, or any intervention may correspond with the efficacy of the intervention. It is urgent that children with the highest needs improve quickly. The likelihood of change in placement (e.g., removal from their local school, home, or community) is associated with the absence of improvement.

Furthermore, an earlier study examining the relationship between wraparound fidelity and outcomes (i.e., restrictiveness of placement, emotional and behavioral functioning) found that caregivers' Wraparound Fidelity Index (WFI) ratings may reflect the influence of systems-level factors, or facilitator actions (Bruns et al., 2004). One example of this is the rating for item 2.3 on the WFI-4 (i.e., 'Does your wraparound plan include mostly professional services?', $M = .50$). Within a school setting, families may select a teacher, a social worker, or another staff member with whom the child and family have developed a relationship. School-based wrap teams may be skewed toward staff members (e.g., a principal) because they are critical to successful implementation of any behavior plans. Hence, a school-based wrap may tend to be staffed mostly with 'professionals.' While having a school-based team may be a necessity at the onset of wrap, this result may signal a need to increase the level of natural supports over time. This action is critical especially for single-parent households with limited, or no family support. Without a network of friends, neighbors and community members, these caregivers are at risk of remaining isolated. Isolation may decrease the ability to cope after the wrap has ended, or if new stressors arise. Returning to the ecological systems theory (Bronfenbrenner, 1979), one of the goals of developing healthy people is to strengthen relationships at multiple levels. While improving the relationship between home and school strengthens the mesosystem, it does not address the need to strengthen the ties within the exosystem (i.e., parents' workplace, the community).

Research Question 3: Caregivers in this study reported levels of Objective Strain, or stress associated with the impact of child's functioning on daily living (e.g., making

personal sacrifices because of your child's needs) that was comparable to levels found in clinical samples (Brannan & Heflinger, 1997; Brannan & Heflinger, 2006; Brannan, Heflinger, & Foster, 2003; Sales, Greeno, Shear, & Anderson, 2004; Taylor-Richardson, Heflinger, & Brown, 2006). This finding suggests that the caregivers in this study had high needs for assistance that would provide an immediate, positive impact on their quality of life. The caregivers also reported levels of Subjective Internalizing Strain (e.g., feelings of worry and anxiety) that approached levels found in the clinical samples. This indicates that these caregivers probably welcomed any support that effectively addressed their child's needs. The sense of relief that caregiver no longer had to 'shoulder the entire burden alone' was clearly expressed by 'Barbara' when she said, "I now know that if he's extra moody at home, I can contact the school and get info in context of what I need to hear in order to support my child." For the caregivers interviewed in this study, having support may have decreased their feelings of fatigue associated with rearing a child with high needs. Furthermore, changing the caregiver's perception of their level of Objective Strain and Subjective Internalizing has significant ramifications for the ability for the child to remain in the home. The levels of Objective Strain and Subjective Internalizing strain are the two strongest predictors of a child receiving increasingly more intensive levels of support and significantly increasing the likelihood of placement in a residential, or psychiatric facility (Brannan, Heflinger, & Foster, 2003).

Further, the parents in this study reported low levels of Subjective Externalizing Strain (e.g., resentment toward their child) relative to levels in published studies. One interesting result is that the African American caregiver reported the lowest level of

Subjective Externalizing Strain within the group. This is consistent with findings from published studies on parental stress (Stueve et al., 1997).

Discussion of Qualitative Results

The central question addressed within the qualitative portion of this study was, “How do primary caregivers describe their facilitator’s cultural competence, the stress associated with parenting a child with challenging behaviors, and/or emotional problems and their overall impression of the wraparound process?”

Interviews with two of the caregivers produced data that were organized into eight themes relating to this central question: (1) Behavior, (2) Wraparound, (3) Teams and Roles, (4) Help, (5) Family Voice and Choice, (6) Parental Stress, (7) Social Reproduction, (8) Race and Culture. The following sections summarize each theme and illustrate the connections between the findings of this study and the related literature.

Behavior: Caregivers participating in the second round of in-depth interviews described their children’s behavior as challenging, disruptive and labile (‘Janice’: “...and she would just trash the whole room and she’d have those outbursts;” and ‘Barbara’: “He gets serious, he doesn’t get perturbed. He doesn’t get mildly pleased, he gets excruciatingly happy”). Both children characterized in the qualitative portion had behavioral problems stemming from neuropsychological conditions that contributed to emotional dysregulation (e.g., ADHD). The caregivers in this study were initially at a loss of how to handle their children’s challenging behavior as ‘Janice’ recalls, “Oh man, I had a time ‘cause...I couldn’t figure out why she couldn’t do stuff.”

These results are consistent with the prevalence of mental illness/emotional disturbance among children. The seminal MECA study (Shaffer et al., 1996) found that disruptive disorders accounted for 10% of children and youth presenting with moderate to severe levels of impairment. The more recent NHANES prevalence study (Merikangas et al., 2010) found that ADHD (7.8%) was the most commonly occurring disorder with severe impairment. A review of the wraparound literature indicates that the most commonly occurring disorders are oppositional defiant disorder, mood disorder and ADHD (Bruns et al., 2005; Cook & Kilmer, 2010; Copp, Bordnick, Traylor, & Thyer, 2007).

Wraparound: Wraparound was described as a strengths-based process that leads to an understanding of the whole child. This concept as articulated by the caregivers is consistent with the strengths-based principle as defined in the wraparound model (Bruns et al., 2004; Eber & Keenan, 2004; Goldman, 1999; VanDenBerg & Grealish, 1996). It is also a key characteristic that distinguishes wraparound from the special education process and also other intervention strategies designed to support families with children experiencing mental health/behavioral challenges. Caregivers indicated that wraparound offers a positive alternative to the special education process that can lead to improved outcomes for children. ‘Barbara’ remarked that, “Frankly I was surprised to hear about it. Here is a process that we use that takes into account more of a 360 degree thing. We recognize and value your child’s part in the community, in the family, in things outside of the school building and we don’t get a lot of stuff like that. ..”

There are a small number of experimental design studies (Clark et al., 1996; Clark et al., 1998; Evans et al., 1996; Evans et al., 1998) that demonstrate how the wraparound process can contribute to positive changes in family adjustment, improvement in externalizing (e.g., acting-out, disruptive) behaviors, and decrease the risk of change in placement. A meta-analysis completed by Suter and Bruns (2009) indicated a medium effect size (.40) for outcomes experienced by youth supported via the wraparound process. Effland et al. (2011) found that 60.7% of youth in their study demonstrated decreased behavioral health needs, improved functioning and reduction in the risk domain as measured by the CANS (Child and Adolescent Needs and Strengths) instrument. Kazi, Pagkos, and Milch (2011) found that 79% of youth engaged in wraparound demonstrated improved outcomes as measured by the Child and Adolescent Functionality Assessment Scale (CAFAS).

The use of data is integral to the wraparound process (Effland et al., 2011). Therefore, there is a need to provide additional training to better support facilitators in data collection and interpretation with families and teams.

‘Barbara,’ the caregiver who holds a master’s degree and has work experience in a technical field, was particularly attuned to the appropriate use of data. She references the use of statistical analysis tools such as spreadsheets in her description of how schools pair special education programs with the needs of children, “Here’s the problem, so he’s getting ‘Ds’ in class, Hold on! We have a spreadsheet for that!” ‘Barbara’ was perceptive enough to sense her facilitator’s lack of fluency with the Home, School, Community Tool

(HSC-T, Illinois PBIS Network, 2012): “I had some questions about how to interpret it in order to fill it out. And I didn’t feel like she was prepared to answer those questions.”

An analysis of national trends in wraparound implementation (Bruns, Sather, Pullmann, & Stambaugh, 2011) also found that respondents believe that training was essential to fidelity implementation of wraparound. However, a review of the literature (Bertram, Suter, Bruns, & O’Rourke, 2011) revealed that the relationship between training and skill development has not yet been documented. Furthermore, data collection is critical to insuring treatment integrity during implementation of interventions identified by the team as necessary to attain goals (Bruns et al., 2011).

The caregivers’ impressions of team effectiveness were shaped by their perception of the degree of effort put forth by individuals in support of the child. ‘Janice’ commented, “They come and even beyond their duty in that wrap session. They take ‘Essence’ and do stuff with her that they don’t even have to do” illustrates this point. This finding is consistent with the effectiveness model for wraparound teamwork identified by Walker and Schutte (2004) where supportive relationships between families and service providers are indicative of efficacious teamwork.

The qualitative results demonstrate that inclusion of natural supports on teams remains a challenge. For example, ‘Barbara’ seems to long for a more diverse team that includes people outside of the school staff and the parents when she says “There are no members from the community, or the student’s family, neighbors on the team.”

Increasing the participation of non-professionals (e.g., family members, friends, clergy, etc.) on teams has been noted in the literature as needed to improve alignment

with the principle of natural supports. Walker and Schutte (2004) found in their observation of 72 wraparound meetings that 44% of the meetings were attended by human services professionals (i.e., mental health case manager). A study comparing wraparound fidelity in teams within the North Carolina Multiple Response System and the System of Care indicated that one out two system of care meetings were staffed with professionals and the primary caregivers (Snyder, Lawrence, & Dodge, 2011). An examination of caregivers' descriptions of their support sources found that spouses, partners, family, friends and service providers were the most frequently accessed. Nevertheless, caregivers' commented that the level of support received was limited and they expressed a desire for more support overall.

Help: The caregivers interviewed for this study described help in the following ways: (a) Assistance in forming home-school partnership to support families and children: 'Barbara': "When I call his teacher, or the vice-principal, or the social worker, I will get the information needed to help me." (b) Interventions designed to address parent-identified concerns: 'Barbara': "One of the accommodations that he needs is with note-taking. If there are copies of the notes, then give them to him." (c) Identification and installation of supports that can lead to improved quality of life for the child: 'Janice': "They got her into the 'Y.' They got her swimming. And you know she just loves that she can go swim."

This study provides an initial exploration of what elements are most meaningful, or impactful to caregivers in their own words. Typically, assistance for children and families within the wraparound literature uses quantitative studies to measure response

based on outcome measures (e.g., changes in CAFAS scores over time). Hence, there is limited caregiver feedback on what is most important to them.

A search of the terms ‘wraparound’ and ‘qualitative research,’ ‘mixed-methods,’ ‘caregiver perspective’ yielded three published studies (Painter, Allen, & Perry, 2011; Walker, 2001; Walker & Koroloff, 2007). Painter et al. (2011) identified themes that were similar to those found in this study. Their interview of 40 caregivers of children between the ages of 8-13 years old found that ‘learning new skills’ (e.g., implementing behavior management strategies) was one of the biggest benefits of the wraparound process. Acquisition of techniques to problem-solve and effectively address challenging behavior is important to successful parenting after the wrap process has ended.

Family Voice and Choice: In wraparound, the family had the opportunity to select team members and their point-of-view has first priority. Caregivers in the Painter et al. (2011) study reported feeling ‘empowered’ by the wraparound process. The sense of empowerment may stem from having the ability to control the agenda relative to setting priorities for intervening with their child.

However, in the case of ‘Janice,’ the professionals on the team became her ‘translators.’ ‘Janice’s wrap team interceded and actually discouraged her from directly voicing her concerns about how the principal was treating ‘Essence’: “...They were like “we’ll see about it.” Then, the next thing I know, they go to the school and then they call me and told me they took care of it.” In this situation ‘Janice’ may have benefited from being supported by having team members present in a meeting with the principal. It was a lost opportunity for ‘Janice’ to exert her parental authority and begin to advocate directly

on her granddaughter's behalf. This scenario demonstrates the challenge for school staff of adhering to the principle of family voice and choice. The team was faced with the how to balance respecting the family's perspective and managing a delicate political issue (i.e., supporting a parent's challenging their colleague's professional practice). However, they opted to intercede with the school versus undertaking the task of helping 'Janice' make the transition into becoming more independent.

Parental Stress: Parents can experience a great deal of shame relative to their child's needs, or behaviors. They may also question their parenting skills as in the case of 'Barbara' who said, "every reaction and everything that happens with that child... happens to be a reflection of your parenting skills". Meeting the demands of a child with challenging behaviors can impact multiple areas of the caregiver's life. 'Janice' was faced with multiple demands due to her granddaughter's challenging behavior, "The (school) was calling me almost every day. I almost lost my job..."

Forging an effective home-school partnership and implementing efficient interventions are critical to helping reduce the level of stress experienced by caregivers. Objective Strain (e.g., the stress associated with feelings of isolation, or missing work due to the demands of raising a child with high needs) has been identified as a key factor in decisions to move children to restrictive placements (Brannan et al., 2003; Brannan & Heflinger, 1997; Lambert et al., 1998). The caregivers interviewed in this study experienced levels of objective strain that was comparable to those found in clinical samples. Wraparound may have reduced the level of objective strain for these caregivers by decreasing feelings of isolation and providing them with strategies of interacting with

their child that would reduce problem behaviors that were interfering with daily living (Painter et al., 2011).

Notably, 'Janice' reported the lowest level of Subjective Externalizing Strain (e.g., feelings of resentment, or embarrassment) among caregivers in this study. This finding was consistent with the literature (Brannan & Heflinger, 2001; McCabe, Yeh, Lau, Garland, & Hough, 2003; Taylor-Richardson et al., 2006) showing African Americans as exhibiting lower levels of Subjective Externalizing Strain than other groups.

Social Reproduction: For parents possessing cultural capital that is valued by the school, wraparound provides another avenue for ensuring that their children are afforded the resources necessary to maintain their position in society. Parents whose cultural capital is not perceived as valuable by school staff (e.g., parents with minimal education, few financial resources, and challenges with self-expression) may be reliant upon their team's ability and willingness to advocate for their child.

'Barbara's cultural, (social and economic capital) were manifest in several forms (Lareau & Horvat, 1999). First, her family had the background knowledge to realize that their son's behavior was inconsistent with that of typically developing children. They had a network of other parents and professionals that could provide them referrals for diagnostic services. Finally, 'Barbara's family had the financial resources to afford an expensive outside diagnostic process. 'Barbara' enacted her cultural capital by approaching the school in a manner that she knew would elicit the type of response necessary to obtain the support her son needed to be successful within his school

environment. The transactional relationship between home and school in responding to cultural capital was made clear with the apparent ease at which the parents' requests for assistance were recognized and accommodated. The school was willing to liberally apply the guidelines of one federal act (e.g., Section 504) in order for 'Alex' to get the supports the family—not the school, identified.

Conversely, while 'Janice's team listened to her concerns and advocated on her behalf, the fact that she was not allowed to directly address her worries ("Well, they did the talking to her. They wouldn't let me talk to her.") regarding how the principal was treating her granddaughter was an interesting decision. It is possible the professionals may have perceived that she may not have had the appropriate tools (i.e., the ability to rein in her anger) to influence the principal's behavior. Lareau and Horvat (1999) noted that "display of parental concern and involvement through anger and criticism was deemed unacceptable and 'destructive' by the educators" (p. 43).

However, the principal's actions: labeling the student in front of others (e.g., "that is what you in, slow class"), physically isolating her using the gym mats as a partition in her class, ignoring 'Janice' during team meetings (e.g., "She don't really speak to me. She just say 'bye.'") meets the definition of symbolic violence. Furthermore, the principal legitimizes her treatment of 'Essence' by claiming her right to "see her for what she is and what she does." The principal engages in behaviors that communicate her role as a member of the dominant social class to determine the parameters of acceptable behavior. The principal's actions and the response of the wraparound team reproduce, or perpetuate the social class structure of the larger society where often members of the subordinate

class are expected to accept instances of symbolic violence, or hope that another member of the ruling class will intercede on their behalf.

Race and Culture: It is difficult to discuss race, culture and social reproduction separately since racial and cultural differences can be linked to various forms of capital (cultural, social, and symbolic). Symbolic violence often uses subtle, unconscious actions to communicate the superiority of the cultural capital of the dominant group in schools and reproduce the social order of the larger society (Ferguson, 2001). Today, people who engage in racist behavior don't typically display overt forms of discrimination. Color-blind racism (Bonilla-Silva, 2006), subtle and often covert behavior, is more characteristic. Individualism and meritocracy are used to explain the failure of Black and Brown people to advance without examination of the larger context of how institutional policies are designed to attain the objective of maintaining white privilege (Bonilla-Silva, 2006). Hence, social reproduction theory and racism can help describe the systematic approach for retaining a particular social order for the benefit of a specific group.

Direct references to racial and cultural differences were minimized or avoided. 'Barbara' side-stepped the question regarding the match between her and her facilitator in terms of racial/ethnic background. When the question was posed again, 'Barbara' quickly dismissed the relevance, or significance of race ("Yes, I'd say that there's an educational match and an ethnic/racial match---not that that makes a difference"). 'Barbara's response was consistent with the minimization of race and racial discrimination that can be consistent with the color-blind view of race (Bonilla-Silva, 2006).

In comparison, 'Janice', the African American caregiver emphasized the 'good

works' of the team and the positive impact on her child quickly dismissed any in-depth exploration of the interaction between caregivers and team members of different races. However, there were occasions when 'Janice' perceived that her granddaughter, 'Essence' was being treated unfairly because of her race. 'Janice' understands the principal's behavior as a form of racism because she sees the principal (who is White) using her authority to treat her granddaughter (who is African American) in an unfair manner. A review of the interactions between the principal and 'Essence' demonstrates the intersection between race and social reproduction. The punitive, sometimes exclusionary discipline, degrading verbal communication (e.g., "have you had your pill today?") and dismissive non-verbal behaviors (e.g., ignoring 'Janice' during the IEP meeting and repeatedly leaving during team discussion) are all examples of symbolic violence executed by the principal toward 'Essence' and 'Janice'. The similarity between racism and symbolic violence is rooted in the common characteristics of behaviors that often appear subconsciously, or that are explained as 'natural' reactions based upon the norms and standards of the dominant group (Herr & Anderson, 2003; Ponterotto, Utsey, & Pedersen, 2006).

Considering 'Janice's responses, it appears as though she evaluates the significance of racial, or cultural differences based on the degree of conflict within the relationship and upon her perception of being treated fairly. She saw her team members as "good" because they made sure that 'Essence' was treated appropriately at school, she received supports throughout the year (e.g., a pass to go swimming at the "Y" during the summer), and the team involved 'Essence' in extra activities that went beyond their job

duties. 'Janice' does not analyze her relationship with her team in terms of a power differential hence she is satisfied. An alternate explanation for 'Janice's responses is her sense of indebtedness to her team (e.g., "...and they've done so much for me I felt like yeah I'll do it for you. Why not?").

Overall Implications

The study demonstrated that most wraparound facilitators who participated in this research considered themselves to be culturally competent practitioners. These data are important given that minority children are underserved by current mental health care systems. The limited number of culturally competent providers has been identified as one of the factors impeding access to treatment for minorities (USDHHS, 2001, p. 4). Since schools have been identified as a primary source of mental health care for children (Burns et al., 1995) it is encouraging that school-based wraparound provides an opportunity for children and families of color to receive much needed mental health and behavioral supports.

Although the sample of caregivers was small ($n = 6$), it was evident that they were experiencing extreme levels of stress associated with raising a child with significant needs. Caregivers viewed wraparound positively and were satisfied with the process because it gave them a platform for expressing their needs and developing effective interventions for helping their children. The caregivers also viewed wraparound as serving to improve the quality of life for the child and family.

Furthermore, it was evident that issues related to race and class may influence the experiences of caregivers with wraparound. Admittedly, it is not possible to make

generalizations based on the interviews of two caregivers, the available data based on their experience would suggest that the wraparound process may be affected by contextual factors such as subtle biases along class and racial lines.

Practical Implications

There was an overarching theme for the need to improve the training and fidelity of implementation for wraparound. This theme echoes the discussions in the literature calling for standardization of training and implementation practices. On a local level, school districts engaged in wraparound could benefit from closer supervision of facilitators for adherence to wraparound principles.

Based on the results of this study, facilitators may benefit from additional support and training in developing family voice and choice, use of natural supports and outcomes using data. One way of addressing training needs/fidelity measurement would be to complete a fidelity measurement tool such as the WFI-4. The Wraparound Integrity Tool, Version 2.0 (WIT; Illinois Statewide Technical Assistance Center, Systematic Information Management for Educational Outcomes, 2011) is a self-assessment instrument specifically designed for school-based wraparound facilitators to use with families and team members on a quarterly basis. Also, using a tool such as the Assessment of Social Connectedness (Cook & Kilmer, 2010) to assess level of natural supports is recommended.

Student diversity in development and learning is one of the 11 NASP Domains in of School Psychology Training and Practice. A sample competency in this domain is, “Recognition of subtle racial, class, gender, cultural, and other biases in self and others

and identification of the impact of these biases on decision making, instruction, behavior, and long-term outcomes for students” (Harrison & Prus, 2008, p. 80). Providing coursework utilizing the Multicultural School Consultation Framework (Ingraham, 2000) would help students acquire the skills to address ingrained biases. Teaching consultation using a culturally competent framework such as Sheridan’s multicultural conjoint behavioral consultation (M-CBC) model is also indicated by the findings.

The efficacy of interventions is a critical factor associated with caregiver satisfaction with the wraparound process and consultee satisfaction in the consultation process. Therefore, the importance of carefully reviewing intervention research for demographic information on the study sample should be communicated to all pre-service and current school psychologists. Inclusion of the targeted minority group in the research sample should be considered as minimal evidence of effectiveness.

Implications for Policy

Given the improvements associated with implementing wraparound, it is important to ensure that families have the supports to be able to problem-solve and identify solutions after the professionals are no longer involved in their lives. Hence, the role of natural supports is vital in ensuring long-term success. One possibility would be training parents who have transitioned out of the wraparound process to become parent advocates and team members. The impact of having a parent who has similar experiences is powerful and may be effective when attempting to engage ‘resistant’ parents. It would also provide a good transitional support once the wrap team has formally disbanded to

have someone in the community that caregivers could contact for information, advice, or just a ‘listening ear.’

The role of administrators and classroom teachers is vital in working with children and youth with challenging behaviors, or high needs. There is a need for helping school staff to reframe interactions with ‘difficult’ caregivers and students with ‘behavior problems.’ Beginning with district leadership teams, policies for interfacing with challenging families need to be made transparent (e.g., explaining what family engagement is, describing the advantages of family engagement) and viable options for engagement with families like wraparound need to be shared with building administrators as alternatives to the traditional school-home conference.

Acts of symbolic violence (e.g., ignoring parents during meetings, labeling of students) were identified during this study as a possible roadblock to building constructive home-school partnerships. Again, district-level intervention is needed to address the ingrained biases of administrators, educational and clinical staff regarding families who don’t look or sound as they do. Two resources available to interested districts are The Equity Alliance at Arizona State University (formerly the National Center for Culturally Responsive Educational Systems; NCCREST) and the Pacific Educational Group (PEG). The Equity Alliance provides research, literature and online training regarding culturally responsive pedagogy. PEG provides consultative services for K-12 school districts regarding issues related to institutional racism. Glenn Singleton, president of PEG, is also the co-author of *Courageous Conversations: A Field Guide for*

Achieving Equity in Schools (Singleton & Linton, 2006) a text designed to help support teams in addressing racial issues associated with the achievement gap.

Strengths and Limitations of the Study

Cultural competence has been identified as one of three core values of the system of care and one of the ten principles of wraparound. However, there has been limited research regarding practice relative to this principle. This study adds to the body of wraparound literature in the following areas. First, it is one of a limited number of studies directly addressing culture and wraparound.

Second, the use of qualitative research methods in this study makes it one of the few studies actually engaging caregivers in the research process. Supporters of wraparound and researchers have sought to build the evidence base for wraparound as a necessary pre-condition for securing grant funding as an evidence based practice. Therefore, much of the wraparound research has focused on child and youth outcomes. However, regular, systematic data collection from the caregivers, children and youth who participate in the wraparound process could inform how fidelity implementation is measured. These data would also be informative for wraparound facilitator curriculum development and training.

Third, the study used validated instruments to measure perceived cultural competence, wraparound fidelity and caregiver stress. The MCKAS was selected because it is one of the most widely-used instruments for measuring of perceived multicultural competency. Cultural competency is associated with social desirability (Dunn, Smith, & Montoya, 2006). However, multiple studies found that the MCKAS was not significantly

associated with measures of social desirability (Constantine, 2000; Constantine et al, 2001; Constantine & Ladany, 2000; Ponterotto et al., 2002).

While this study does inform wraparound practice, there are several limitations. First, use of self-assessment and survey methods to measure cultural competence of wrap facilitators may have influenced responses. Participants may have misinterpreted the questions and it is difficult to determine whether respondents were describing how they practice with a specific group, or across a diverse group of families (Kitaoka, 2005).

There were also limitations associated with the sample. The small sample of caregivers affected the ability to execute the planned research design. During the qualitative phase (e.g., data collection using semi-structured interviews) despite repeated attempts on the part of the researcher, the participant group did not include a Hispanic/Latino caregiver. Hence, the qualitative responses are not representative of the study sample. The researcher relied on the facilitators to inform caregivers about the study. Hence, it is possible that facilitator bias may have influenced the data collection process. For example, the study did not include caregivers with whom the wraparound process was started but never completed due to failure to fully engage the family in the process. Furthermore, results are not generalizable due to small sample size and lack of geographical representation.

Researcher bias is a concern especially when conducting qualitative research (Ponterotto & Grieger, 2007). Realizing that my identity as an African American woman may influence interpretation of the qualitative data, use of peer debriefing and member-checking strategies were employed. The researcher used a White post-graduate student of

psychology as a peer debriefer to address potential racial bias. This reviewer listened to the interview audiotapes, read transcripts, and coded qualitative data. Her data analyses were discussed and considered in reporting of results and conclusions. Additionally, the researcher contacted each caregiver who participated in the semi-structured interviews and read her the transcripts to confirm content.

Future Research

Future studies may explore aspects of cultural competence that were beyond the scope of the current study. Cultural competence is a core system of care value and one of the ten principles of wraparound. However, the research base regarding cultural competence is limited within the field of wraparound. Researchers could consider replicating the current study using a more geographically diverse sample of facilitators and caregivers. Increasing the number of participants and providing a more geographically representative sample would help increase the likelihood of producing generalizable results.

A follow-up study including interviews of the facilitators who completed the MCKAS and a focus group of select facilitators would build a research base regarding facilitators' knowledge and implementation of culturally relevant practice. Results from this type of study could be useful for training and refinement of practice standards.

Conversely, a study using focus groups of families to extract more information regarding how they view cultural competence may also contribute to refinement of assessment of the principle of cultural competence.

A more challenging, but interesting study would involve families that did not complete the wrap around process to research reasons for the failure of teams to engage families.

The results of this study suggest that there is a need for similar research within the field of school psychology. A study using either the MCKAS, or another validated measure of cultural competence could measure the perceived cultural competence of pre-service and current practitioners. Data could help inform university training and professional development topics.

Rogers and Ponterotto (1997) developed the Multicultural School Psychology Counseling Competency Scale (MSPCCS) tool for school psychology trainers to assess the multicultural counseling competencies of their students. However, there is no evidence regarding how school psychology training programs are using the tool nor has the National Association of School Psychologists (NASP) developed an assessment tool based on practice standards for training programs. Recently, Malone (2010) called for the need to develop a cultural assessment tool for training programs that integrate the elements of cultural competence with the role and function of school psychologists. Additionally, development of a parallel self-assessment tool for pre-service and current practitioners would be useful for providing a basis for self-reflection and measurement of progress regarding the skill set associated with culturally competent practice.

Summary and Conclusions

Application of the concept of cultural competence [a] awareness of the potential bias of one's own beliefs, values and attitudes, [b] knowledge of other cultures, and [c] knowledge of and skills with application of culturally-appropriate interventions) is critical to the practice of mental health professionals. It is well documented that children of color are underserved in regard to mental health services. A barrier to receiving services for these children is access to practitioners who are able to provide unbiased, culturally relevant treatment and supports. Schools are the primary provider of mental health services for the majority of children and youth. However, most school psychologists report that they lack the skills to work with diverse groups. Given that by the year 2050, racial and ethnic minorities will make up the majority of the U.S. population, universities and K-12 settings must begin earnestly engaging in training pre-service and current practitioners to utilize a culturally competent framework.

The purpose of this study was to understand the perspective of school-based wrap facilitators and caregivers on their teams regarding the role of cultural competence in the wrap process. An explanatory, sequential mixed-methods study design was used to measure the perceived cultural competence of wrap facilitators, caregivers' assessment of fidelity and satisfaction regarding the wraparound process. Measurement of caregiver stress and qualitative strategies to extend quantitative findings were incorporated to help better understand the influence of cultural competence.

The findings demonstrated that most facilitators perceived themselves as culturally competent practitioners. Despite reporting high levels of stress and relatively

low fidelity wraparound, caregivers were satisfied with the process. It was not possible to detect significant differences due to the small sample of caregivers ($n = 6$). However, the qualitative data suggest that gaining strategies to address problem behaviors and having a team to support their parenting are instrumental in reducing caregiver stress and increasing perceptions of satisfaction with wraparound. Qualitative data, while not generalizable, points to the significance of class and race as factors in developing home-school partnerships and implementation of interventions at schools within this study. Hence, practitioners and researchers are encouraged to examine interventions and studies for evidence of cultural relevance, or measures of culturally competent practice.

APPENDIX A

MULTICULTURAL COUNSELING KNOWLEDGE AND AWARENESS SCALE

(MCKAS)

Using the following scale, rate the truth of each item as it applies to you.

1	2	3	4	5	6	7
Not at All true		Somewhat true			Totally true	

1. I believe all clients should maintain direct eye contact during counseling.

1	2	3	4	5	6	7
Not at All true		Somewhat true			Totally true	

2. I check up on my minority/cultural counseling skills by monitoring my functioning—via consultation, supervision, and continuing education.

1	2	3	4	5	6	7
Not at All true		Somewhat true			Totally true	

3. I am aware some research indicates that minority clients receive “less preferred” forms of counseling treatment than majority clients.

1	2	3	4	5	6	7
Not at All true		Somewhat true			Totally true	

4. I think that clients who do not discuss intimate aspects of their lives are being resistant and defensive.

1	2	3	4	5	6	7
Not at All true		Somewhat true			Totally true	

5. I am aware of certain counseling skills, techniques, or approaches that are more likely to transcend culture and be effective with any clients.

1	2	3	4	5	6	7
Not at All true		Somewhat true			Totally true	

6. I am familiar with the “culturally deficient” and “culturally deprived” depictions of minority mental health and understand how these labels serve to foster and perpetuate discrimination.

1	2	3	4	5	6	7
Not at All true		Somewhat true			Totally true	

7. I feel all the recent attention directed toward multicultural issues in counseling is overdone and not really warranted.

1	2	3	4	5	6	7
Not at All true		Somewhat true			Totally true	

8. I am aware of individual differences that exist among members within a particular ethnic group based on values, beliefs, and level of acculturation.

1	2	3	4	5	6	7
Not at All true		Somewhat true			Totally true	

9. I am aware some research indicates that minority clients are more likely to be diagnosed with mental illnesses than are majority clients.

1	2	3	4	5	6	7
Not at All true		Somewhat true			Totally true	

10. I think that clients should perceive the nuclear family as the ideal social unit.

1	2	3	4	5	6	7
Not at All true		Somewhat true			Totally true	

11. I think that being highly competitive and achievement oriented are traits that all clients should work toward.

1	2	3	4	5	6	7
Not at All true		Somewhat true			Totally true	

12. I am aware of the differential interpretations of nonverbal communication (e.g., personal space, eye contact, handshakes) within various racial/ethnic groups.

1	2	3	4	5	6	7
Not at All true		Somewhat true			Totally true	

13. I understand the impact and operations of oppression and the racist concepts that have permeated the mental health professions.

1	2	3	4	5	6	7
Not at All true		Somewhat true			Totally true	

14. I realize that counselor-client incongruities in problem conceptualization and counseling goals may reduce counselor credibility.

1	2	3	4	5	6	7
Not at All true		Somewhat true			Totally true	

15. I am aware that some racial/ethnic minorities see the profession of psychology as functioning to maintain and promote the status and power of the White Establishment.

1	2	3	4	5	6	7
Not at All true		Somewhat true			Totally true	

16. I am knowledgeable of acculturation models for various ethnic minority groups.

1	2	3	4	5	6	7
Not at All true		Somewhat true			Totally true	

17. I have an understanding of the role culture and racism play in the development of identity and worldviews among minority groups.

1	2	3	4	5	6	7
Not at All true		Somewhat true			Totally true	

18. I believe that it is important to emphasize Objective Strain and rational thinking in minority clients.

1	2	3	4	5	6	7
Not at All true		Somewhat true			Totally true	

19. I am aware of culture-specific that is culturally indigenous, models of counseling for various racial/ethnic groups.

1	2	3	4	5	6	7
Not at All true		Somewhat true			Totally true	

20. I believe that my clients should view a patriarchal structure as the ideal.

1	2	3	4	5	6	7
Not at All true		Somewhat true			Totally true	

21. I am aware of both the initial barriers and benefits related to the cross-cultural counseling relationship.

1	2	3	4	5	6	7
Not at All true		Somewhat true			Totally true	

22. I am comfortable with differences that exist between me and my clients in terms of race and beliefs.

1	2	3	4	5	6	7
Not at All true		Somewhat true			Totally true	

23. I am aware of institutional barriers, which may inhibit minorities from using mental health services.

1	2	3	4	5	6	7
Not at All true		Somewhat true			Totally true	

24. I think my clients should exhibit some degree of psychological mindedness and sophistication.

1	2	3	4	5	6	7
Not at All true		Somewhat true			Totally true	

25. I believe that minority clients will benefit most from counseling with a majority counselor who endorses White middle-class values and norms.

1	2	3	4	5	6	7
Not at All true		Somewhat true			Totally true	

26. I am aware that being born a White person in this society carries with it certain advantages.

1	2	3	4	5	6	7
Not at All true		Somewhat true			Totally true	

27. I am aware of the value assumptions inherent in major schools of counseling and understand how these assumptions may conflict with values of culturally diverse clients.

1	2	3	4	5	6	7
Not at All true		Somewhat true			Totally true	

28. I am aware that some minorities see the counseling process as contrary to their own life experiences and inappropriate or insufficient to their needs.

1	2	3	4	5	6	7
Not at All true		Somewhat true			Totally true	

29. I am aware that being born a minority in this society brings with it certain challenges that White people do not have to face.

1	2	3	4	5	6	7
Not at All true		Somewhat true			Totally true	

30. I believe that all clients must view themselves as their number one responsibility.

1	2	3	4	5	6	7
Not at All true		Somewhat true			Totally true	

31. I am sensitive to circumstances (personal biases, language dominance, stage of ethnic identity development) that may dictate referral of the minority client to a member of his/her own racial/ethnic group.

1	2	3	4	5	6	7
Not at All true		Somewhat true			Totally true	

32. I am aware that some minorities believe counselors lead minority students into non-academic programs regardless of student potential, preferences, or ambitions.

1	2	3	4	5	6	7
Not at All true		Somewhat true			Totally true	

Thank you for completing this instrument. Please feel free to express in writing below any thoughts, concerns, or comments you have regarding this instrument:

APPENDIX B

WRAPAROUND FACILITATOR DEMOGRAPHIC AND CAREER QUESTIONS

In the following section, please tell us about you:

What is your gender?

☐ Male

☐ Female

What is your age?

☐ 21-30

☐ 31-40

☐ 41-50

☐ 51-60

☐ 60+ years old

☐ Prefer not to answer

What is your race/ethnicity? Please check all that apply:

☐ White

☐ African American/Black

☐ American Indian, or Alaska Native

☐ Asian

☐ Native Hawaiian, or Pacific Islander

☐ Bi-racial, or multi-racial

☐ Hispanic/Latino

☐ Prefer not to answer

What is your highest degree?

- ☐ Bachelor's degree
- ☐ Master's
- ☐ Doctorate
- ☐ Prefer not to answer

When did you receive your highest degree?

- ☐ Recent graduate (1-2 years)
- ☐ Three-five years ago
- ☐ Six-ten years ago
- ☐ 11 + years ago
- ☐ Prefer not to answer

Which of the following choices best describes your place of employment?

- ☐ Public school district
- ☐ Private school
- ☐ Charter school
- ☐ Alternative school
- ☐ Residential school
- ☐ Mental health/community agency
- ☐ Prefer not to answer

Which grades, or age groups have you worked with during the past year? Please select all that apply:

- ☐ Pre-schoolers (2-5 years old)
- ☐ Early elementary (k-3rd grade)
- ☐ Mid-upper elementary (4th-6th grade)
- ☐ Middle school/junior high (6th-8th grade)
- ☐ High school (9th-12th grade)
- ☐ Prefer not to answer

Which of the following best describes your current position?

- ☐ Social worker
- ☐ Counselor
- ☐ Psychologist
- ☐ Clinician/therapist
- ☐ Case manager
- ☐ Teacher
- ☐ Administrator
- ☐ Other
- ☐ Prefer not to answer

How long have you been a wrap facilitator?

- ☐ Less than one year
- ☐ One to three years
- ☐ Four or more years
- ☐ Prefer not to answer

Have you taken courses, or had training (e.g., professional development, continuing education courses) in multiculturalism, or cultural competence?

- ☐ Yes
- ☐ No
- ☐ Prefer not to answer

APPENDIX C
CAREGIVER STRAIN QUESTIONNAIRE

Please think back over the past six months and try to remember how things have been for your family. We are trying to get a picture of how life has been in your household over that time.

For each question, please tell me which response (which number) fits best.

1. Interruption of personal time resulting from your child's emotional or behavioral problem?

1	2	3	4	5
Not at all	A little	Somewhat	Quite a bit	Very much

2. You missing work or neglecting other duties because of your child's emotional or behavioral problem?

1	2	3	4	5
Not at all	A little	Somewhat	Quite a bit	Very much

3. Disruption of family routines due to your child's emotional or behavioral problem?

1	2	3	4	5
Not at all	A little	Somewhat	Quite a bit	Very much

4. Any family member having to do without things because of your child's emotional or behavioral problem?

1	2	3	4	5
Not at all	A little	Somewhat	Quite a bit	Very much

5. Any family member suffering negative mental or physical health effects as a result of your child's emotional or behavioral problem?

1	2	3	4	5
Not at all	A little	Somewhat	Quite a bit	Very much

6. Your child getting into trouble with the neighbors, the school, the community, or law enforcement?

1	2	3	4	5
Not at all	A little	Somewhat	Quite a bit	Very much

7. Financial strain for your family as a result of your child's emotional or behavioral problem?

1	2	3	4	5
Not at all	A little	Somewhat	Quite a bit	Very much

8. Less attention paid to other family members because of your child's emotional or behavioral problem?

1	2	3	4	5
Not at all	A little	Somewhat	Quite a bit	Very much

9. Disruption or upset of relationships within the family due to your child's emotional or behavioral problem?

1	2	3	4	5
Not at all	A little	Somewhat	Quite a bit	Very much

10. Disruption of your family's social activities resulting from your child's emotional or behavioral problem?

1	2	3	4	5
Not at all	A little	Somewhat	Quite a bit	Very much

11. How isolated did you feel as a result of your child's emotional or behavioral problems?

1	2	3	4	5
Not at all	A little	Somewhat	Quite a bit	Very much

12. How sad or unhappy did you feel as a result of your child's emotional or behavioral problem?

1	2	3	4	5
Not at all	A little	Somewhat	Quite a bit	Very much

13. How embarrassed did you feel about your child's emotional or behavioral problem?

1	2	3	4	5
Not at all	A little	Somewhat	Quite a bit	Very much

14. How well did you relate to your child?

1	2	3	4	5
Not at all	A little	Somewhat	Quite a bit	Very much

15. How angry did you feel toward your child?

1	2	3	4	5
Not at all	A little	Somewhat	Quite a bit	Very much

16. How worried did you feel about your child's future?

1	2	3	4	5
Not at all	A little	Somewhat	Quite a bit	Very much

17. How worried did you feel about your family's future?

1	2	3	4	5
Not at all	A little	Somewhat	Quite a bit	Very much

18. How guilty did you feel toward your child's emotional or behavioral problem?

1	2	3	4	5
Not at all	A little	Somewhat	Quite a bit	Very much

19. How resentful did you feel toward your child?

1	2	3	4	5
Not at all	A little	Somewhat	Quite a bit	Very much

20. How tired or strained did you feel as a result of your child's emotional or behavioral problem?

1	2	3	4	5
Not at all	A little	Somewhat	Quite a bit	Very much

21. In general, how much of a toll has your child's emotional or behavioral problem taken on your family?

1	2	3	4	5
Not at all	A little	Somewhat	Quite a bit	Very much

APPENDIX D

CAREGIVER DEMOGRAPHIC QUESTIONS

Please tell us about you:**What is your gender?**☐ Male☐ Female**What is your age?**☐ 18-24☐ 25-34☐ 35-44☐ 45-54☐ 55-64☐ 65 +☐ Prefer not to answer**What is your race/ethnicity? Please select all that apply:**☐ White☐ African American/Black☐ American Indian, or Alaska Native☐ Asian☐ Native Hawaiian, or Pacific Islander☐ Bi-racial, or multi-racial☐ Hispanic/Latino☐ Prefer not to answer

What is your household income?

- ☐ Under \$15, 000
- ☐ \$15,000-25,000
- ☐ \$25,000-\$35,000
- ☐ \$35,000-\$ 45,000
- ☐ \$45,000-\$55,000
- ☐ \$55,000+
- ☐ Prefer not to answer

How many children are currently living in your household?

- ☐ One
- ☐ Two
- ☐ Three
- ☐ Four, or more
- ☐ Prefer not to answer

APPENDIX E

WRAPAROUND FIDELITY INDEX 4.0 CAREGIVER FORM

Wraparound Fidelity Index 4

Caregiver Form

July 15, 2009 version



Youth's name: _____

Caregiver's name: _____

Facilitator's name: _____

Interviewer's name: _____

Today's date: Month _____ Day _____ Year _____

Administration method: 1 Face-to-face 2 Phone

Start time: _____ am/pm

Length of interview: _____ minutes

Project ID:	
Youth ID:	
Caregiver ID:	
Facilitator ID:	
Interviewer ID:	
Timeframe:	

1. What is the primary caregiver's relationship to _____ (child's name)? (Check one)

- | | |
|-------------------------|---------------------------------|
| 1 Birth parent | 2 Adoptive parent |
| 3 Foster parent | 4 Live-in partner of parent |
| 5 Sibling | 6 Aunt or uncle |
| 7 Grandparent | 8 Cousin |
| 9 Other family relative | 10 Friend (adult friend) |
| 11 Step parent | 12 Other _____ (please specify) |

If not a birth parent read: 1a. Does one or more of the child or youth's birth parents participate on the wraparound team or in services for [child's name]? Yes No

Details: _____

2. Who has legal custody of _____ (child's name)? (Circle one)

- | | |
|--|----------------------|
| 1 Two birth parents OR one birth parent and one stepparent | 2 Birth mother only |
| 3 Birth father only | 4 Adoptive parent(s) |
| 5 Foster parent(s) | 6 Sibling(s) |
| 7 Aunt and/or uncle | 8 Grandparent(s) |
| 9 Friend(s) | 10 Ward of the State |
| 11 Other _____ (please specify) | |

3. Has your child ever been in the custody of the state? 1 No 2 Yes

Missing Data Codes: 666 Not Applicable; 777 Refused; 888 Don't Know; 999 Missing/Question Was Not Asked

WFI 4- Caregiver Form

July 15, 2009 version

4. Is your child currently receiving Wraparound? 1 No 2 Yes

If Yes, How many months has the youth been receiving Wraparound? _____ months

If No, Has your child received Wraparound in the past?

- 1 No 2 Yes

*If Yes, How many months did your child receive Wraparound?
_____ months*

5. Do you have a "wraparound team"?

[NOTE: Also may be referred to as a 'child and family team,' 'interagency team' or other term. PROMPTS may include asking whether the family has a group of people involved in services for the child or youth that comes together to meet and plan services for the child or youth and family]

- 1 No 2 Yes

*If Yes, We will be asking questions about the team so keep those people in mind as you answer the following questions. Who is on that wraparound team? **List below (Roles, not names)***

_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

If No, For the purposes of this interview, when we ask you about 'the wraparound team,' please consider the people that work with the youth and his or her family to provide services and supports.

Page 2

Missing Data Codes: 666 Not Applicable; 777 Refused; 888 Don't Know; 999 Missing/Question Was Not Asked

WFI 4- Caregiver Form

July 15, 2009 version

I am going to ask you some questions about the services and supports your family is receiving now and has received since you started receiving services through the wraparound process.

Let's start by talking about how wraparound began for you and your family. Can you tell me a little bit about the first time you met (your facilitator)? What were those very first meetings like?

[Note: During this discussion, other prompts may include: What did (your facilitator) tell you about what wraparound would be like? How did you decide who would be on your wraparound team?]



Phase 1: Engagement		Yes	Sometimes Somewhat	No	Missing
1.1 CC	When you first met your wraparound facilitator, were you given time to talk about your family's strengths, beliefs, and traditions?	YES to both questions	YES to only the first question	NO to the first question	666 777 888 999
	Did this process help you appreciate what is special about your family? Circle one: YES NO	2	1	0	
1.2 FVC	Before your first team meeting, did your wraparound facilitator fully explain the wraparound process and the choices you could make?	2	1	0	666 777 888 999
1.3 SB	At the beginning of the wraparound process, did you have a chance to tell your wraparound facilitator what things have worked in the past for your child and family?	2	1	0	666 777 888 999
1.4 TB	Did you select the people who would be on your wraparound team?	2	1	0	666 777 888 999
1.5 TB	Is it difficult to get team members to attend team meetings when they are needed?	0	1	2	666 777 888 999
1.6 OB	Before your first wraparound team meeting, did you go through a process of identifying what leads to crises or dangerous situations for your child and your family?	2	1	0	666 777 888 999

Page 3

Missing Data Codes: 666 Not Applicable; 777 Refused; 888 Don't Know; 999 Missing/Question Was Not Asked

WFI 4- Caregiver Form

July 15, 2009 version

Now I am going to move onto questions about how the planning process went for your child and family. Can you tell me about how the family's wraparound plan was first developed?

During this discussion, other prompts may include: Who participated in this planning? How did you decide what would be in the plan? Did certain people have more input than others?

Phase 2: Planning		Yes	Sometimes Somewhat	No	Missing
2.1 Col	Did you and your team plan and create a written plan of care (or wraparound plan, child and family plan) that describes how the team will meet your child's needs?	YES to both questions	YES to only the first question	NO to the first question	666 777 888 999
	Do you have a written copy of the plan? Circle one: YES NO	2	1	0	
2.2 TB	Did the team develop any kind of written statement about what the future will look like for your child and family, or what the team will achieve for your child and family? (PROMPTS: This statement might be a mission statement for the team or vision statement for the family. It may also be a statement of the ultimate goal for the team. The statement should be a 'big picture' statement and different than individual goals in the wraparound plan.)	YES to both questions	YES to only the first question	NO to the first question	666 777 888 999
	Can you describe what your team's mission says? Circle one: YES NO	2	1	0	
2.3 Ind	Does your wraparound plan include mostly professional services?	0	1	2	666 777 888 999
2.4 SB	Are the supports and services in your wraparound plan connected to the strengths and abilities of your child and family? (PROMPTS: Strengths are the positive things your child and family members do well. Do the strategies in your plan <u>use</u> your child and family's strengths? Do they <u>help build</u> your child and family's strengths and abilities?)	2	1	0	666 777 888 999

Page 4

Missing Data Codes: 666 Not Applicable; 777 Refused; 888 Don't Know; 999 Missing/Question Was Not Asked

WFI 4- Caregiver Form

July 15, 2009 version

Phase 2: Planning (continued)		Yes	Sometimes Somewhat	No	Missing
2.5 CB	<p>Does the wraparound plan include strategies for helping your child get involved with activities in her or his community?</p> <p>Please give two examples of those activities:</p> <p>1. _____</p> <p>2. _____</p> <p><i>*Follow scoring rules.</i> <i>(SUGGESTED PROMPTS: After school activities, activities with a church, volunteer activities, recreational activities with normal peers)</i></p>	Two examples of community activities. 2	One example of a community activity. 1	No examples of community activities. 0	666 777 888 999
2.6 Col	Are there members of your wraparound team who do <u>not</u> have a role in implementing your plan?	0	1	2	666 777 888 999
2.7 Col	Does your team brainstorm many strategies to address your family's needs before selecting one?	2	1	0	666 777 888 999
2.8 Ind	<p>Is there a crisis or safety plan that specifies what everyone must do to respond to a crisis?</p> <p>Circle one: YES NO</p> <p>Does this plan also specify how to prevent crises from occurring?</p> <p>Circle one: YES NO</p>	YES to both questions 2	YES to only the first question 1	NO to the first question 0	666 777 888 999
2.9 CB	<p>Do you feel confident that, in the event of a major crisis, your team can keep your child or youth in the community?</p> <p><i>(SUGGESTED PROMPTS: i.e., not immediately placed in a hospital, jail, residential treatment center)</i></p>	2	1	0	666 777 888 999
2.10 FVC	Do you feel like other people on your team have higher priority than you in designing your wraparound plan?	0	1	2	666 777 888 999
2.11 CC	<p>During the planning process, did the team take enough time to understand your family's values and beliefs?</p> <p>Circle one: YES SOMEWHAT NO</p> <p>Is your wraparound plan in tune with your family's values and beliefs?</p> <p>Circle one: YES SOMEWHAT NO</p>	YES to both questions 2	YES to only one question 1	NO to both questions 0	666 777 888 999

Page 5

Missing Data Codes: 666 Not Applicable; 777 Refused; 888 Don't Know; 999 Missing/Question Was Not Asked

WFI 4- Caregiver Form

July 15, 2009 version

Now I am going to ask you a number of questions about what your services and your team meetings are like. First, you can tell me what team meetings are like currently? How do those meetings go?

Phase 3: Implementation		Yes	Sometimes Somewhat	No	Missing
3.1 FVC	Are important decisions made about your child or family when you are not there?	0	1	2	666 777 888 999
3.2 Ind	When your wraparound team has a good idea for a support or service for your child, can it find the resources or figure out some way to make it happen?	2	1	0	666 777 888 999
3.3 SB	<p>Does your wraparound team get your child involved with activities she or he likes and does well?</p> <p>Please give two examples of those activities:</p> <p>1. _____</p> <p>2. _____</p> <p><i>*Follow scoring rules</i></p>	<p>Two examples of activities youth likes and does well.</p> <p>2</p>	<p>One example of an activity youth likes and does well.</p> <p>1</p>	<p>No examples of activities youth likes and does well.</p> <p>0</p>	666 777 888 999
3.4 NS	Does the team find ways to increase the support you get from your friends and family?	2	1	0	666 777 888 999
3.5 Col	Do the members of your team hold one another responsible for doing their part of the wraparound plan?	2	1	0	666 777 888 999
3.6 NS	Is there a friend or advocate of your child or family who actively participates on the wraparound team?	2	1	0	666 777 888 999
3.7 Per	<p>Does your team come up with new ideas for your wraparound plan whenever your needs change?</p> <p>Circle one: YES NO</p> <p>Does your team come up with new ideas for your wraparound plan whenever something is not working?</p> <p>Circle one: YES NO</p>	<p>YES to both questions</p> <p>2</p>	<p>YES to only one question</p> <p>1</p>	<p>NO to both questions</p> <p>0</p>	666 777 888 999
3.8 CB	<p>Are the services and supports in your wraparound plan difficult for your family to access?</p> <p>(SUGGESTED PROMPTS: Because of scheduling or transportation issues or because services and supports are far away or hard to get to.)</p>	0	1	2	666 777 888 999

Page 6

Missing Data Codes: 666 Not Applicable; 777 Refused; 888 Don't Know; 999 Missing/Question Was Not Asked

WFI 4- Caregiver Form

July 15, 2009 version

Phase 3: Implementation (continued)		Yes	Sometimes Somewhat	No	Missing
3.9 OB	Does the team assign specific tasks to all team members at the end of each meeting? Circle one: YES NO	YES to both questions	YES to only one question	NO to both questions	666 777 888 999
	Does the team review each team member's follow-through on their tasks at the next meeting? Circle one: YES NO	2	1	0	
3.10 CC	Do members of your team always use language you can understand? (NOTE: <u>For caregivers for whom English is not a first language, this may mean that bilingual facilitators, translators, or other means are used to ensure adequate understanding.</u> <u>For English-speaking caregivers, this means that facilitators and team members translate or do not use professional jargon or acronyms that the caregiver does not understand.</u>)	2	1	0	666 777 888 999
	3.11 SB Does your team create a positive atmosphere around successes and accomplishments at each team meeting?	2	1	0	666 777 888 999
3.12 TB	Does your team go out of its way to make sure that all team members – including friends, family, and natural supports – present ideas and participate in decision making?	2	1	0	666 777 888 999
	3.13 Per Do you think your wraparound process could be discontinued before you or your family is ready for it to end? For example, because of time limits, because of your child's behavior, because of a placement change, or a change in funding or eligibility?	0	1	2	666 777 888 999
3.14 CC	Do all the members of your team demonstrate respect for you and your family?	2	1	0	666 777 888 999
	3.15 FVC Does your child have the opportunity to communicate his or her own ideas when the time comes to make decisions?	2	1	0	666 777 888 999

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Missing Data Codes: 666 Not Applicable; 777 Refused; 888 Don't Know; 999 Missing/Question Was Not Asked

WFI 4- Caregiver Form

July 15, 2009 version

OK, we're almost done. I now want to ask you a few final questions about wraparound and the future for your child and family.

Phase 4: Transition		Yes	Sometimes Somewhat	No	Missing
4.1 OB	Has your team discussed a plan for how the wraparound process will end? (<i>i.e.</i> , a "transition plan")	YES to both questions	YES to only the first question	NO to the first question	666 777
	Circle one: YES NO Does your team have a plan for when this will occur? Circle one: YES NO	2	1	0	888 999
4.2 NS	Has the wraparound process helped your child develop friendships with other youth who will have a positive influence on her or him?	2	1	0	666 777 888 999
4.3 OB	Has the wraparound process helped your child to solve her or his own problems?	2	1	0	666 777 888 999
4.4 Ind	Has your team helped you and your child prepare for major transitions (e.g., new school, new residential placement) by making plans to deal with these changes?	2	1	0	666 777 888 999
4.5 Per	After formal wraparound has ended, do you think that the process will be able to be "re-started" if you need it?	2	1	0	666 777 888 999
4.6 NS	Has the wraparound process helped your family to develop or strengthen relationships that will support you when wraparound is finished?	2	1	0	666 777 888 999
4.7 CB	Do you feel like you and your family will be able to succeed without the formal wraparound process? <i>In other words, with the help of family, friends, community supports, and key providers, but without formal team meetings or wraparound facilitation.</i>	2	1	0	666 777 888 999
4.8 Per	Will some members of your team be there to support you when formal wraparound is finished?	2	1	0	666 777 888 999

Page 8

Missing Data Codes: 666 Not Applicable; 777 Refused; 888 Don't Know; 999 Missing/Question Was Not Asked

WFI 4- Caregiver Form

July 15, 2009 version

Thank you for taking the time to complete this interview. Are there any comments you would like to add, like what have been the best things about your wraparound? What has not gone well or could be improved?

Positive feedback:

Negative feedback:

End Time _____, am/pm

Interviewer observations about interview, respondent and any validity concerns: _____

Page 9

Missing Data Codes: 666 Not Applicable; 777 Refused; 888 Don't Know; 999 Missing/Question Was Not Asked

APPENDIX F

CAREGIVER SATISFACTION QUESTIONNAIRE

Please think about your experience with wraparound and the interventions developed to support your child and family. Select the response that fits best describes your level of satisfaction with outcomes related to participating in the wraparound process.

1. How would you rate your level of satisfaction with reduction in the risk of change in placement for your child?

1	2	3	4	5
Very Dissatisfied	Dissatisfied	Somewhat Dissatisfied	Satisfied	Very Satisfied

2. How would you rate your level of satisfaction with your child's behavior intervention plans and supports since engaging in wraparound?

1	2	3	4	5
Very Dissatisfied	Dissatisfied	Somewhat Dissatisfied	Satisfied	Very Satisfied

3. How would you rate your level of satisfaction the supports (e.g., respite care) provide to help reduce the level of stress associated with caring for your child?

1	2	3	4	5
Very Dissatisfied	Dissatisfied	Somewhat Dissatisfied	Satisfied	Very Satisfied

4. How would you rate your overall level of satisfaction with the wraparound process?

1	2	3	4	5
Very Dissatisfied	Dissatisfied	Somewhat Dissatisfied	Satisfied	Very Satisfied

APPENDIX G

CAREGIVER SEMI-STRUCTURED INTERVIEW QUESTIONS

Introductory script:

“When we first talked, I asked you about your experiences with wraparound using a form called the Wraparound Fidelity Index. I also used another form called the Caregiver Stress Questionnaire to talk to you about your current level of stress parenting your child who is (was) participating(ed) in the wraparound process.

Today, I would like to talk to you more specifically about two areas related to your wraparound and parenting experiences. The first area I would like to discuss with you is about your working relationship with your facilitator. The second area relates to some of the challenges of raising a child who has behavioral and/or emotional problems. This interview should take about 30 minutes.

Excerpts from this interview may be included in my dissertation, however your identity will remain anonymous. To protect your identity, you will be identified by a subject code in written transcripts. Yours, your child and facilitator’s names and identifying characteristics will be altered to protect your identities. Your responses will be kept confidential and your facilitator will not know any of the information that you provide in this interview. You have the right to stop the interview at any point, or to not answer certain questions. You also have the right to decline participating in the interview at all. Your participation or refusal to participate will not affect the current or future services provided for your child and family.

If you are willing to proceed with the interview, I will now confirm that you have provided the researcher, Jennifer Rose, with written consent to participate in this study.” (NOTE: Have interviewee’s signed consent form in hand prior to beginning the interview).

Questions about the wraparound experience:

1. What did you enjoy (dislike) about the wraparound process?
2. Please describe what it was like, overall, working with your facilitator.
3. Please explain how your facilitator demonstrated respect (disrespect) for your family’s cultural background (e.g., shared beliefs about what is appropriate and acceptable behaviors and attitudes within your family, neighborhood, or racial/ethnic group)?
4. Please describe how your facilitator handled racial issues that may have occurred during wrap meetings, or in the process of developing interventions for your child.
5. What do you think are some of the positives (negatives) of working with a facilitator from a different (racial/ethnic/economic) group?

Questions about parenting a child with behavioral/emotional problems:

Think back to the time before the wraparound process began and please describe what it was like caring for your child then, to what it is like now.

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VITA

Jennifer Rose received a Bachelor of Science in Speech with a major concentration in Communication Studies from Northwestern University in 1984. During her career at Leo Burnett Advertising U.S.A., Jennifer managed the media planning and execution process for numerous national companies including Heinz, Samsonite and Kellogg.

She received a Masters of Education in Teaching and Learning in 1998 and was employed as an educator in the Chicago Public Schools. Jennifer spent the majority of her tenure as a regular K-8 teacher in inclusive classrooms serving general education and students with behavior and specific learning disorders.

Jennifer completed a Masters of Education in Educational Psychology from Loyola University in 2005. She entered the doctoral program in School Psychology in fall 2005. Jennifer was a member of a research team led by Drs. Pamela Fenning and Hank Bohannon that investigated implementation of Positive Behavior Supports (PBIS) at two Chicago Public High Schools.

Her practicum in school psychology was completed at J. Sterling Morton High School District during the 2005-06 academic year. During her practicum, Jennifer co-led group counseling for a diverse study body including teen mothers and students at-risk for gang involvement.

During the 2006-07 academic year, Jennifer taught two courses at Loyola University Chicago for undergraduate teaching majors covering the topics of child and adolescent development and response to intervention (RtI). She served as a graduate assistant for another Loyola graduate course, Social-Emotional and Behavioral Assessment/Interventions. Jennifer also gained teaching experience as a graduate assistant at a course on exceptional children at the College of Du Page in Glen Ellyn, Illinois.

From 2006-2008, Jennifer completed an externship with the Illinois PBIS Network (IL-PBIS Network). She provided training and coaching in the areas of wraparound and tertiary-level systems support for selected schools within three Illinois school districts. Jennifer also supported schools during implementation of universal screening for behavior by developing presentations, and administering screenings.

Jennifer completed an APA-approved internship in 2008-09 through the Louisiana School Psychology Internship Consortium (LASPIC). As an intern, she provided school psychology services at two locations: Bridge City Center for Youth, a correctional facility for adjudicated youth between the ages of 12-21; and New Orleans Adolescent Hospital, an in-patient psychiatric facility for children from age four through 18 years-old.

Upon returning to Chicago in 2009, Jennifer assumed the position of Tertiary Research and Evaluation Coordinator at the Illinois PBIS Network. Her primary responsibilities included coordinated field-based research activities for a federal demonstration project (#H326S03002) implemented by IL-PBIS Network and the

University of Kansas and program evaluation of PBIS in Illinois schools. In fall 2011, Jennifer began working as a school psychologist in Elgin School District U-46. She was involved in completing psychoeducational evaluations, developing behavior plans and leading social skills groups for children in general education classrooms and students with autism.

Jennifer has co-authored several peer-reviewed articles and a book chapter in the *Handbook of Positive Behavior Supports*. She has also made numerous conference presentations including National Association of School Psychologists, Louisiana Association of School Psychologists, Illinois Children's Mental Health Program, and the PBIS National Forum.