Community Mental Health Journal (2019) 55:932–941
https://doi.org/10.1007/s10597-019-00379-8

ORIGINAL PAPER

Putting the Pieces Together: Perceptions of Longitudinal Wraparound, Systems of Care, and Positive Behavior Support Implementation

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Received: 3 October 2018 / Accepted: 15 February 2019 / Published online: 25 March 2019

Abstract
Positive Behavior Support (PBS) was introduced to community-based providers in Kansas in 2012 in response to a federally funded initiative to reduce the placement of youth in psychiatric facilities. As core project activities concluded in 2016, researchers investigated the impact of this comprehensive PBS initiative on youth, families, mental health centers, and other stakeholders. This paper describes how qualitative interviews and focus groups were used to investigate the perceptions of families, advocates, and implementers involved in wraparound (WA), regional interagency collaboration, and the addition of PBS services. Themes reflected the changes occurring over time in statewide WA implementation and how state funding for the PBS effort was used as part of regional interagency collaboration to continue supporting principles outlined in systems of care.

Keywords Wraparound · Systems of care · Positive behavior support · Community mental health · Interagency collaboration

In 2012, the state of Kansas provided funding to mental health centers interested in implementing positive behavior support (PBS) as part of a Psychiatric Residential Treatment Facilities (PRTF) Alternative Grant. The Kansas Mental Health Positive Behavior Support Project (KMHPBS) was conceived and developed as a partnership between the Kansas Department on Aging and Disability Services, the Kansas Institute for Positive Behavior Support, Community Mental Health Centers (CMHCs), and PRTFs. Layered training was provided and included broadly attended awareness-level positive behavior support training; targeted PBS team training for some centers; intensive-level PBS facilitator training for 28 individuals; and regional interagency PBS for select areas in the state. The regional layer of training included additional community stakeholders to address the goal of interagency practice. Funding for PBS was used to enhance interagency collaboration by supporting existing systems of care (SOC) efforts in these communities. This paper describes a qualitative study that informed PBS training at the regional level. Interviews and focus groups that explored the perceptions of implementers, family members, and advocates involved in wraparound (WA) and SOC in Kansas were conducted. Findings and implications for the sustainability of integrated PBS and WA as an infrastructure for improved interagency collaboration within a SOC framework are discussed.

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Wraparound Planning and Systems of Care

Wraparound is a team-based planning process and service delivery model that aims to provide coordinated, holistic, and family-driven care to meet the complex needs of youth involved with multiple systems, at risk for institutional

placement, and/or experiencing serious emotional or behavioral difficulties (Walker 2008). Stroul and Friedman (1996) described WA as the "on-the-ground" mechanism for ensuring that core SOC values guide the planning process, with the goal of achieving outcomes that are individualized, family-driven, and culturally competent. Hernandez and Hodges (2003) define a SOC approach as one using mutable strategies for improving organizational relationships in ways that are intended to provide access to an expanded and coordinated array of community-based services. Service coordination using a SOC approach is improved by forming teams at local, regional, and state levels to implement interagency collaboration (Kutash et al. 2006).

Challenges Implementing Effective Wraparound and Sustaining Systems of Care

Medicaid-covered youth with significant behavioral health issues can cost states five times more than those that only receive primary health care (Pires et al. 2013), leaving states challenged to find a cost-effective approach to care for these high-needs youth. As research continued to support WA as an evidence-informed approach to coordinating care (Schurer Coldiron et al. 2017), states considered ways to fund WA initiatives. *Child and Adolescent Service System Program (CASSP)* grants were funded in ten states initially and expanded nationally in 1989. These grants supported initial SOC efforts to develop capacity for youth services at the community level by providing block funding that allowed for flexibility to create interagency networks that met the needs of each community. Some form of WA developed in nearly all fifty states, but the organizational contexts and funding mechanisms continue to vary, and these variations can impact both the quality of wraparound services and the associated outcomes (Bruns et al. 2006). *Wraparound Milwaukee*, often considered a model program, combined high-fidelity WA practice with pooled, flexible funding that allowed for individualized planning (Kamrandt 2000). Today, a growing number of states use Care Management Entities (CMEs) to provide quality WA services with low coordinator to youth ratios (1:10). Other communities embed trained WA teams within host organizations such as mental health centers, schools, or public health agencies.

While some states use general state funds or block grants to support WA services, others moved to funding WA through Home and Community Based Services (1915c) Medicaid Waivers. The adoption of WA as a Medicaid service, in addition to its status as a general approach to care, had implications for its implementation as a best practice model. Under this model, practitioners must attend to protocols of Medicaid service delivery including abiding by rules regarding which providers can bill what service when working with a child on the Waiver. When community providers experience periods of tighter funding from other sources, they are dependent on Medicaid reimbursement to keep WA afloat. This can make doing "whatever it takes" to serve a youth on the Waiver challenging, especially in regards to collaboration efforts. Collaboration and team-based planning are key principles of the WA model (Bruns et al. 2004), and these are especially important for youth who are experiencing transitions between settings (e.g., from a PRTF to home) (Cox et al. 2010). However, when billing protocols constrain involvement in the WA process, providers find themselves making difficult decisions about which pieces of a WA plan warrant their participation. Such decisions impact a community's ability to implement WA with fidelity (Bruns et al. 2006). Furthermore, developing the capacity to establish data systems that monitor fidelity and drive decision-making is already difficult for organizations providing WA using limited resources. As the state of Kansas experienced these gaps, an additional framework and new research-based strategies were employed in an attempt to bolster supports for youth at risk for out of home placement.

Wraparound and Systems of Care in Kansas

Kansas was one of the first states to integrate WA into community-based mental health treatment in the 1990s. A successful federally-funded SOC initiative in southeast Kansas gave way to similar state-funded grants in numerous Kansas communities, which brought rich training in WA to practitioners. In 1997, the state's petition to offer WA services through the Serious Emotional Disturbance (SED) Medicaid Waiver was approved. This provided stable funding for WA and put it exclusively in the domain of CMHCs. In contrast to initiatives that utilize pooled funding and collective ownership of WA, the CMHCs (in collaboration with the state) became the gatekeepers of WA. Today, all 26 Kansas CMHCs provide WA to an estimated 3000 youth statewide (Kansas Legislative Research Department 2016). Mental health staff in CMHCs take required online training in order to bill Medicaid for WA. While the federally-funded, in-person SOC and WA trainings of the 1990s were discontinued, there have been recent efforts to revitalize WA training based on the National WA Initiative (NWI) best practice model. Currently, Medicaid constitutes the sole source of funding for WA in Kansas. However, some CMHCs report that the WA approach is used with all families and youth even if they are not formally served by the SED waiver.

Wraparound and Positive Behavior Support

Positive behavior support (PBS) refers to a set of strategies for providing person-centered, inclusive, applied behavior practices for individuals to improve quality of life and replace problematic behavior with more adaptive skills (Carr

et al. 2002). Essential features of PBS include evidence-based practices that incorporate the principles of behavior, biomedical and physiological interventions, individualized value-based practices, and the tenets of systems-change implementation (Carr et. al. 2002). The evidence supporting the effectiveness of this model has been established in schools (Bradshaw et al. 2009, 2010; Horner et al. 2010) and there is emerging evidence in support of its effectiveness in alternative settings such as juvenile detention centers (Sprague et al. 2013). PBS is a three-tiered prevention model applied in schools that promotes prosocial behavior of (a) all students (*primary prevention*), (b) those students at risk for problem behavior (*secondary prevention*), and (c) smaller number of students with intensive behavioral support needs (*tertiary prevention*). The comprehensive WA process is used for implementing tertiary interventions for students with the most intensive needs. The application of school-wide PBS provides a foundation for WA, one that emphasizes the importance of positive and proactive environments for all students while encouraging a school- and community-wide systems approach for early intervention (Eber et al. 2002). PBS strategies are used across a variety of settings beyond education, including family supports, social and emotional skills training, case management, and WA facilitation.

Because of their complementary characteristics, PBS and WA planning have a history of being implemented in a combined fashion (Eber et al. 2011). One important area of overlap is the emphasis on regional interagency collaboration. Cooperation between agencies is especially critical for youth who need tertiary-level supports. The Kansas initiative built upon a foundation of existing WA practices to increase the likelihood of effective PBS implementation at all three tiers within community service organizations and regions. This provided a unique opportunity to observe the impact of WA and interagency collaboration on individuals, families, organizations, and communities.

There is broad recognition of the importance of interagency collaboration. Hemmelgarn et al. (2006) emphasize the importance of key institutions (e.g. courts, schools, medical providers) working in concert with primary service providers and families to overcome barriers to effective and continuous treatment. Fixsen et al. (2005) state, "broad-based community education and ownership that cuts across service sectors may be critical to installing and maintaining an evidence-based program with its unique characteristics, requirements, and benefits (p 15)." Special attention was paid to the existing regional networks in Kansas as the PBS project was implemented. Some networks expanded in scope and adopted a PBS framework to develop community-wide PBS leadership teams. As with WA planning, community-focused PBS project activities typically dovetailed with the existing regional interagency infrastructure.

Current Study

The current study aimed to capture perceptions of WA and regional interagency collaboration and the impact of the PBS project on both. A qualitative inquiry was conducted that explored any changes in WA and SOC as well as the impact of PBS training and KMHPBS technical assistance efforts. Case study methodology was used (Creswell 2009; Yin 2009) to examine the impact of KMHPBS technical assistance efforts with multiple cases nested within participating regions. This article describes findings that highlight the strengths and challenges mental health providers and stakeholders experienced while continuing to implement WA and SOC within the context of this additional evidence-informed practice (PBS). Helpful strategies that were discovered through the findings, such as the use of PBS principles for building strong interagency relationships that promote improved service coordination for youth participating in WA planning are also discussed. The study and all of its associated protocols were approved by the university's Internal Review Board (IRB). Written invitations to participate and consent forms displaying the IRB approval stamp were given to interested participants and signed consent forms were collected and stored according to IRB protocols.

Methods

Participant Selection

The authors contacted Executive Directors of all 26 CMHCs in Kansas and secured permission to approach their Directors of Community Based Services (hereafter, CBS Directors) about participating in the study. CBS Directors were asked to identify staff within their departments whose roles represented the array of services offered, and these individuals were asked to contact the authors if they were interested in participating in the study. CBS Director, themselves were also invited to participate in focus groups and interviews as were representatives from advocacy organizations, who also agreed to forward an email invitation to families to whom they provided services. Data reported in this study comes from 43 individuals representing eleven different CMHCs, one PRTF, two statewide advocacy representatives, and three parents of youth receiving mental health services. The eleven participating CMHCs were representative of all geographical regions of the state, including frontier, rural, suburban, and urban.

Research Questions

The primary research questions guiding this analysis were: (a) How do service providers describe the strengths and challenges of their existing regional interagency networks in regards to addressing the needs of high-risk youth?; and

(b) What impact did participation in the KMHBPS project have on current collaboration efforts and and/or sustaining SOC practices? Questions asked included the following: (1) How well do the agencies in your region work together to coordinate services to youth who engage in severe problem behavior? (2) What are the barriers to providing effective support for youth who engage in challenging behaviors that result in out-of-home placements? (3) Are there formal SOC meetings in your area (if not, can you describe how agencies in your area communicate)?; and (4) Can you describe how youth receive support when they transition back into their homes and communities?

Data Collection

A total of 43 persons participated in the study through either individual interviews, focus groups, and/or a post-project member check. Table 1 shows a breakdown of the numbers of individuals and types of stakeholders and professionals involved in each of these activities. All interviews and focus groups were audio-recorded with the participants' permission. Twenty-six individual interviews were conducted, ranging in length from 40 to 90 min. Interviews were completed in-person at the agency in which the participant worked or via telephone. The interview type was both structured and unstructured (Merriam 2009). Structured interview questions were developed and researchers allowed for exploration with open-ended questions on topics related to the research questions. Researchers conducted three focus groups in three different regions of the state; each lasting approximately one hour. Focus group sessions were conducted as in-depth interviews with a small group of individuals (3–7 participants) using traditional strategies as described by Krueger (1997). All participants were offered an honorarium ($75 for an interview; $50 for a focus group). However, the majority of individuals declined payment because they were allowed to participate as part of their work day.

Table 1 Study participant by role

Participant (N = 43 unique participants)	Interview participants (N = 26)		Focus groups (N = 21)	
	Pre	Post	Pre	Post
Community-based services directors	5	3		
Program managers/supervisors	2	4	8	1
Front line staff*	2	1	9	3
Clinicians/clinical supervisors	2	1	1	
Parents of youth in services/family advocates	4	2		
PRTF directors	1			

*Front line staff included case managers, parent support workers, and wraparound facilitators

A member check was completed that included representation from all levels of mental health administration as well as family members. One unique participant (PRTF director) was also included

Data Analysis

A team of six researchers and research assistants were responsible for data collection and analysis. Interviews and focus groups were recorded and transcribed by this team. Participants were assigned pseudonyms and specific community references such as place names and agency names were de-identified in the transcripts. The written transcripts were then analyzed and coded by major themes. Qualitative data analysis methods defined by Creswell (2009) were used to understand the meaning individuals ascribed to a particular issue. In qualitative research, data collection and analysis activities are completed by researchers concurrently (Glaser and Strauss 1967; Strauss and Corbin 1990). Using this emergent method, researchers predetermine the process but may not be aware of specific questions or topics related to the primary research questions. Thematic analysis begins at the start of data collection, is ongoing throughout the study, and steers the research team in the identification of additional research questions, participants, topics, and working hypotheses (Merriam 2009). Themes and ideas are exhaustively explored using a concurrent triangulation method (Creswell 2009). As more data are collected, the process intensifies until all potential categories and themes are identified, organized, triangulated, and prioritized according to the research questions (Merriam 2009; Creswell 2009).

Two project staff facilitated interviews, focus groups, and member checks, and participated in discussions related to coding and analysis, providing additional insights and experiences that occurred while gathering data. A different staff member then completed the initial coding and analysis of transcripts. Together, the three researchers completed the qualitative thematic analysis, organizing themes and subthemes by research question and creating an initial draft of the overall findings. Primary and secondary findings were extracted and organized within an electronic presentation format. To ensure credibility of findings, researchers followed the process described by Merriam (2009) and conducted two member-check focus groups and one member-check interview. Member check participants had findings presented to them and then commented on the reliability and validity of those findings. Each member check activity was recorded and transcribed. The authors analyzed the transcripts and identified any issues of trustworthiness (Lincoln and Guba 1985) that required action. Another function of the member check activities was to conduct one final screen for themes or sub-themes which might have been excluded from the findings. No significant new themes were identified and

member check participants confirmed researchers' findings. To ensure the overall rigor of the findings, an audit trail was developed as recommended by Lincoln and Guba (1985) and a full collegial review was done by a fellow researcher who was not involved in the project but who is experienced and knowledgeable about services for youth in this state.

Results

Results are based on information shared by the 43 participants representing administrators, service providers, advocates, and family members of youth receiving services (See Table 1). Finding are organized into three categories based on the primary and subcategory themes that emerged. Those categories include: (1) issues related to WA planning, (2) barriers to effective service provision and transition planning, and (3) improving regional interagency communication and service coordination. A primary theme that emerged was one that identified and described *Important Features of Interagency Collaboration Systems*. Data included in this theme referred to cooperation and interagency coordination of services. A subcategory of findings related to interagency collaboration was *Barriers to Effective Collaboration and Communication*. This subtheme referred to transitions that high-risk youth experienced while moving between home and out-of-community placements (foster care or juvenile detention). As a result, a second subcategory that related to interagency collaboration was referred to as *Transition Plan Implementation*. The third major theme related to the research questions, *Communication between Stakeholders* referred to comments that focused on communication between individuals and across agencies.

Issues Related to Wraparound Planning

The majority of participants in the study were staff from CMHCs. Their descriptions of on-the-ground interagency collaboration efforts often included mention of case management and WA meetings. These were the most cited mechanisms for collaboration. Integral to CBS is Targeted Case Management (TCM) and as one focus group participant described, "they [targeted case managers] do a ton of coordinating services, keeping in contact with schools, DCF [Department for Children and Families], you know, the core, parents, anybody and everybody that they need to, to [assist] the main goal of keeping kids in their home and community." WA was introduced to Kansas mental health practitioners in the 1990s through early SOC initiatives, and has sustained as one of the primary mechanisms for serving youth with SED in Kansas. Funded through the SED Waiver since 1997, mental health professionals were familiar with WA as an SED service:

> ….we have wraparounds. You know, we can pull them together whenever we need to. Of course, we have specific guidelines, but we can do them at any time and pull the team together to make decisions about increasing services or adding additional services or what you need to, if we see that we're having trouble with a case. -*[focus group participant]*

Most of the professionals interviewed described features relatively close to the formal, research-based definition of the WA approach. However, these providers shared challenges related to the collaborative feature of WA, describing, as one focus group participant did, a "decline of who really participates in the treatment plan of the child, be it wraparound or be it the treatment plan."

Participants indicated it was challenging to consistently get both natural supports and stakeholders outside of the agency to come to WA meetings,

> The true definition of wraparound is getting all of the positive influences in that child's life, be it parent, clergy, teacher, aunt, uncle, brother, sister, friends—everyone to wrap around this child for success… sadly, I don't see that as much. Now I see wraparound facilitator, maybe the parent, and sometimes a case manager is able to be there…we're losing that piece. [*focus group participant*]

While the drift from traditionally more diverse WA planning meetings was identified as an issue, the meetings still often achieved collaboration with school partners, as school staff were often present at WA meetings or, at least, aware of the WA plan.

> We do have wraparound meetings as part of a regular part of our programming here. And the schools are invited and our case managers are regularly invited to IEP (Individualized Education Plans) meetings. So, that does occur in the context of wraparound. [*interview participant*]

In addition to WA meetings that focused on the target youth, many professionals described interagency meetings that occurred in their communities. Many of these had historic roots in the Family-Centered SOC meetings that were started in the 1990s.

> ……there's like JJA [Juvenile Justice Authority] there and the law enforcement there, and mental health's there, and the county attorneys are there. There's a monthly meeting that happens, just in terms of functionality. No individual cases are discussed, but how we work together as the system. -*[focus group participant]*

These systems provided a backbone of support within the communities that often sustained over time and stakeholders referenced the ability to rely on such partners for on-going information-sharing and mutual support.

Barriers to Effective Service Provision and Transition Planning

Despite some of these systems being in place, participants in all regions described challenges "catching" kids as they moved between systems. These transition issues were characterized by youth reappearing back in the community with little or no knowledge on the part of the CMHC staff,

> ...if they were placed, say, in [town name] and they were coming back to [town name], and they were being reunified, we might not always know that until the parent called in to make an appointment. We've had that happen many times, and sometimes then it can be a month or two or three in between them coming home and us finding out they're even there. 'Cause maybe we knew them before; maybe we didn't… *[focus group participant]*.

Mental health staff helping kids transition between PRTFs reported mixed experiences. The fact that most CMHCs had someone in the specific role of PRTF liaison meant there were some existing protocols in place, such as allowing the liaison to attend at least one transition meeting at the PRTF. This was not always the case with kids in juvenile detention settings,

> …I went and did an intake and this girl has been to several different places, was at the detention center, and everybody agreed she needed therapy. She came in today for an intake – come to find out she'd left the detention center six weeks ago. She's been in our community for six weeks with absolutely no mental health support… *[focus group participant]*.

On the other end of the spectrum, professionals describe hasty transitions that allowed little to no time to prepare the family or youth.

> ....a parent will call me and say, so-and-so's getting out today. And they have no prior warning. Or they had a meeting and they're looking at next week...for me, transition means a step-down type program, getting us involved, you know, and getting supports in place. Sometimes we don't have that opportunity. It's real quick and you're strangling [sic]. So, I think where we are more reactive, you cannot do the same quality work as when you have a few minutes to pull everybody together and, or even pull up your plan of care and start again. But, there's no step-down process. It's hospital. Home. *-[focus group participant]*.

Communication problems across organizations and agencies were described by one interview participant as a natural challenge for transition planning: "...but for some of the kids—particularly foster care kids– if they're coming back to our area, we may not even know that they're getting discharged 'til they land on our doorstep." In some cases, the communication issues related to transition were sporadic: "…sometimes, you know, we'll get a heads-up that somebody's coming home from the contractor, and sometimes we won't." *–[focus group participant]*.

Another participant indicated that:

> ….we have so many different agencies. We have these individuals. So some of them do work well with us, and some of them have a very different outlook on this child and so then we run into difficulties with the parents trying to pick, you know, 'who do I listen to…? *[focus group participant]*.

Barriers above and beyond transitions and communication were identified as themes. These barriers included logistical issues such as scheduling, as well as funding, and physical distance between sites. Funding streams particularly posed a system-level challenge to effective interagency collaboration. One person interviewed indicated that the community viewed collaborative community-based work as important but that, "…basically, if the child is not physically in my office or physically in the building, I can't get paid for working on the child's case." As mentioned earlier, some communities across the U.S. structure WA efforts using pooled funding to encourage shared buy-in by all agencies and to offset the costs associated with collaboration. In the absence of such structures, providers are forced to choose between attending a collaborative meeting or clocking a billable hour of service,

> …the problem is for us that the therapists' schedules are booked up so far in advance that the IEP is usually just set like a week ahead, and the therapist has no flexibility in their schedule at that point, and they are now confronted with, okay, do I cancel out of my client or I go to the IEP? *-[interview participant]*.

Improving Regional Interagency Communication and Service Coordination

A number of participants discussed creating a common language across settings to improve communication during interagency meetings. A person interviewed stated that this would likely have to be accomplished at the regional or community level because this was not something available at a state level…

> … you have to create a common language… a common purpose…I don't know that that happens…via state-wide coordination.…that's not necessarily a state-wide initiative to…create…a seamless system and…get rid of any kind of geographic variability and in how services are delivered and in how effective they are. -*[interview participant]*.

One mental health professional emphasized the importance of using a common language to increase consistency: "If we're using it [common language], home's using it, the school is using it…then…that consistency… if everyone's on the same page… he's [the youth] absolutely going to benefit from that."

Some participants shared that interagency meetings could be used to apply newly acquired PBS skills to address the underlying functions maintaining the problem behavior before a child entered a PRTF. One person stated,

> …it's probably going to be a routine question in my interagency [group] now, you know, that you guys determine the function of this behavior...there's probably some work that needs to be done before we just say, 'yeah, they need to come into a more restricted environment. -*[interview participant]*.

Another individual expressed concern that education, mental health, and other human service professionals need to work together to ensure social, emotional, academic, and quality of life outcomes are the primary focus for teams supporting youth at risk for out-of-home placement. This interviewee indicated that, at times, professionals focus on what jobs they *can* provide rather than on collectively implementing the interventions that children *need* to successfully stay in school to improve social and academic outcomes.

Awareness among participating agencies of one another's PBS efforts (school-wide, center-wide) was seen as especially helpful in regards to transitions that youth face (e.g. in and out of juvenile justice facilities or psychiatric residential treatment facilities):

> [building on the PBS perspective of other agencies in the community] …just strengthened my optimism about where it's going to go and what we're going to do and how we can get PBS language kind of all throughout our agency and terms with community partners as well, to be able to have the same kind of language to talk to kids and talk to teachers…and parents and schools and in other places. You know, within PRTF facilities and hospitals and stuff like that…. -*[focus group participant]*

Professionals described how important family involvement was for ensuring youth were successful living in their home and community. One individual stated that "...because without that [family involvement], you know, we...just really spin our wheels. We can… do brilliant work. But if it's not transitioned to the home, it's really...ineffective." Several individuals interviewed described how the unique perceptions of the community can lead to increases in out-of-home placements in some areas of the state. The perceptions that administrators, judges, and even family members have about out-of-home placement can make it more challenging to advocate for youth staying in the community. One person stated that:

> ____County court system is not very tolerant and their perception...is...that...yanking a kid from the home or recommending a PRTF placement is the way to go. That's kind of the perception of the judges here. So, we've been really working hard on trying to change some of those attitudes and perceptions. –*[interview participant]*

One family member said that there was a local police officer who knew her son and who she could contact when her son was experiencing challenges because she knew that he understood disabilities and would be supportive and helpful.

> Most of the time, I was lucky enough the police officer that mainly was on call during the times that I did call, he had a brother who has disabilities, so he… knew how to talk to [son's name] and how to get him to see the right side, without having to do anything other than just talk. That was one of the good things that I liked, was if I called in, my first question is to dispatch, "is so-and-so officer working? If you could please dispatch him here." And the minute he would hear the name and everything, he knew exactly what he was walking into. He knew how to approach [son's name]; he knew what to do - *[interview participant]*

Coordination of planning processes was mentioned as an important part of interagency collaboration. Some participants mentioned trying to streamline processes by scheduling Individualized Education Plans (IEPs) and WA meetings together and having goals that "match".

> ….if we schedule them together, then the parent only has to be inconvenienced one time... Recently, we're trying really hard to get our IEP goals and our area mental health treatment goals to somewhat match so, especially at school and so we can all be working on towards the same thing and it's been very successful. -*[focus group participant]*

Interviewees emphasized the potential of fully-functioning regional interagency teams to address at least some of the barriers experienced by all organizations and to enhance communication and collaboration. In some areas of the state, such interagency teams were described as being sustained from the original Family-Centered SOC efforts. While these

teams rarely staffed individual youth, they worked to maintain relationships between organizations, which was seen as valuable. In other areas of the state, participants indicated that the KMHPBS project assisted with renewing or reconfiguring interagency teams. Some communities have sustained these interagency groups and are using them in innovative ways. However, such groups are not immune to challenges. One participant from a region in which the interagency PBS group not only sustained but grew significantly in size, identified inconsistent attendance as one of the main difficulties. The more diverse the attendance from one meeting to the next, the harder it became to keep meeting topics relevant, sustain on-going interest, and see overall progress. However, they expressed dedication to sustaining the interagency work and continuing towards the application of a community-wide PBS approach. In doing so, they considered ways to make the meetings effective at the local level including having smaller networks that kept each other mutually informed of activities in their respective regions.

Discussion

Both PBS and WA are evidenced-informed effective practices for youth experiencing behavioral or emotional challenges. The KMHPBS project combines both in order to improve outcomes for youth. However, the degree of success in implementation of either practice relies on contextual factors. Limited funding, billing constraints, and lack of infrastructure to support data-driven practice were all barriers identified by participants in the study described in this paper. The ability of agencies to effectively collaborate on behalf of the youth they serve is one of those factors. With its roots deep within SOC thinking, best practice WA depends on the productive collaboration between child-serving agencies. Furthermore, because WA has been defined as the "mechanism" to promote and operationalize SOC values (Stroul and Friedman 1996), it is uniquely situated to serve as the frame of reference for other evidenced-based practices. Effective use of the WA approach promotes the implementation of EBPs and other practices within a flexible, individualized, and family-directed manner. This combination of WA and other proven practices has been shown to lead to improved youth outcomes (Bertram et al. 2014). At the systems-level, the National WA Implementation Center (NWIC) recommends investing in intensive, community-based EBPs that can meet the needs of families. Combining PBS funding and training with existing WA and SOC as described in this paper represented one state's efforts to address the needs of youth with emotional and behavioral challenges in a holistic way. The NWIC also recommends that a community team regularly reviews data on needs and outcomes of youth (NWIC 2015). Likewise, Franz (2008) highlights the importance of an interagency implementation team that ultimately evolves into the *community team* that forms the foundation for WA's integrated services. The interagency networks described by participants in this study could serve such purposes should other fundamental challenges to interagency collaboration be addressed.

The need for effective interagency collaboration as an essential feature of a SOC has been clearly outlined by researchers, policy makers, and practitioners (Stroul and Friedman 1996). While the number of evidence-based practices in children's mental health grows, there continues to be systems-level challenges regarding the contexts in which to provide these interventions. As an evidence-informed approach to care, WA has been successful, especially when provided within a context of a common vision, collective ownership, and blended or flexible funding (Kamradt 2000; Snyder et al. 2012). The current study examined interagency collaboration and WA from the lens of a PBS training project. Using funding from the KMHPBS project to build upon the systems frameworks already existing in Kansas communities allowed for a unique opportunity to examine the elements of WA that have sustained and how PBS may enhance such networks. Effland and colleagues (2011) emphasized the importance of supporting high-fidelity WA for youth and their families in a "recovery focused behavioral health system." Regional teams are now better informed of how a PBS framework can be used to promote a common language and evidence-informed practices between providers, especially in regards to youth transitioning to or from more restrictive placements.

The features associated with effective implementation of evidence-informed practices are becoming better understood over time. A review of research on evidence-based practices (Fixsen et al. 2005) identifies the most important features of effective and sustainable implementation. States implementing SOC, WA, PBS, or other practices will be more effective over time if attention to the principles of implementation can be integrated into ongoing training and technical assistance efforts. Figure 1 represents the embedded nature of SOC, WA, and research-based practices such as PBS.

Limitations

Limitations of this study should be noted. First, while the participation of 43 individuals constitutes a sizable number for a qualitative inquiry, it still represents a small percentage of providers within the state. Slightly less than half of the CMHCs in this state were represented. Participation by CMHCs in the project was voluntary, but funds were provided to centers to offset the loss of productivity during the training period. How this arrangement influenced which centers participated is unknown. Second, while participation was evenly distributed across different regions of the

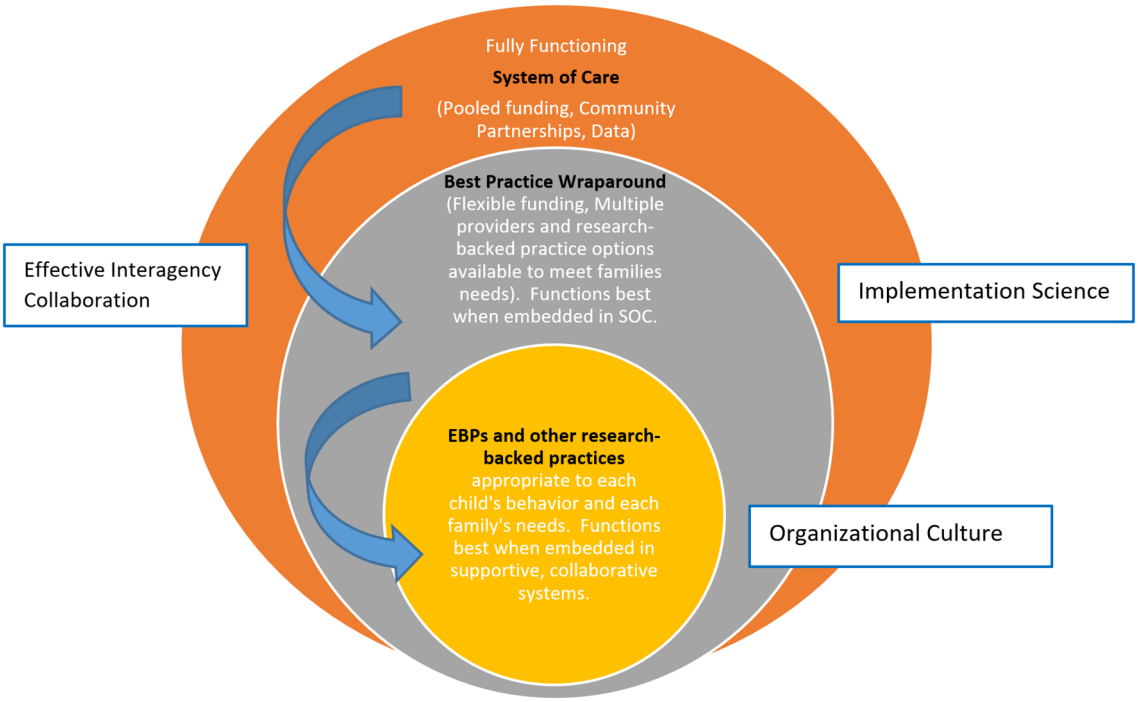

Fig. 1 Embedded systems of care

state, there may be other regional networks and interagency groups functioning across the state that were not represented in this study. Third, the findings mainly represent providers in mental health settings. Providers in child welfare agencies, schools, or other child-serving organizations may have additional insights on interagency collaboration and SOC. Finally, although family members and advocates were included in the inquiry, individual youth receiving services were not included in the interviews.

Conclusion

Implementing WA in an effective manner over time can be challenging for states invested in improving outcomes for youth and preventing out of home placement. One way to establish sustainable practice is to design a statewide training and technical assistance infrastructure that takes into account changes in funding and encourages the use of evidence-informed practices, using WA planning as a foundation for coordination. The use of data for decision making at a regional level can provide those implementing WA with the means to improve collaboration and service coordination over time. Investing in both evidence-informed practices and fidelity systems to ensure proper implementation can pose both budgetary and logistical challenges for many states. This can be mediated by embedding frameworks like WA, SOC, interagency planning, and positive behavior support in collaboration with an emphasis on effective planning and evaluation processes that are contextualized to each community. To do this effectively, further attention needs to be paid to the systems-level challenges identified in this study. Service providers, families, and community stakeholders all have unique and complimentary pieces of the "systems" puzzle. Each are equally important in collaborating with researchers and state leaders to build and sustain effective systems to maintain youth in positive, healthy, and inclusive communities.

Acknowledgements We would like to thank the staff from the Community Mental Health Centers, Psychiatric Residential Treatment Facilities, advocacy organizations, and other regional stakeholders throughout Kansas who took the time to contribute to this research. And we would like to acknowledge the youth and families in Kansas who inspired the KMHPBS project, and who we hope ultimately benefit from this and further research into collaborative best practices.

Funding Funding was provided by the State of Kansas.

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