

Theory and Research: Chapter 3.1

How, and Why, Does Wraparound Work: A Theory of Change

Janet Walker, Co-Director, National Wraparound Initiative, and Research Associate Professor, Portland State University School of Social Work

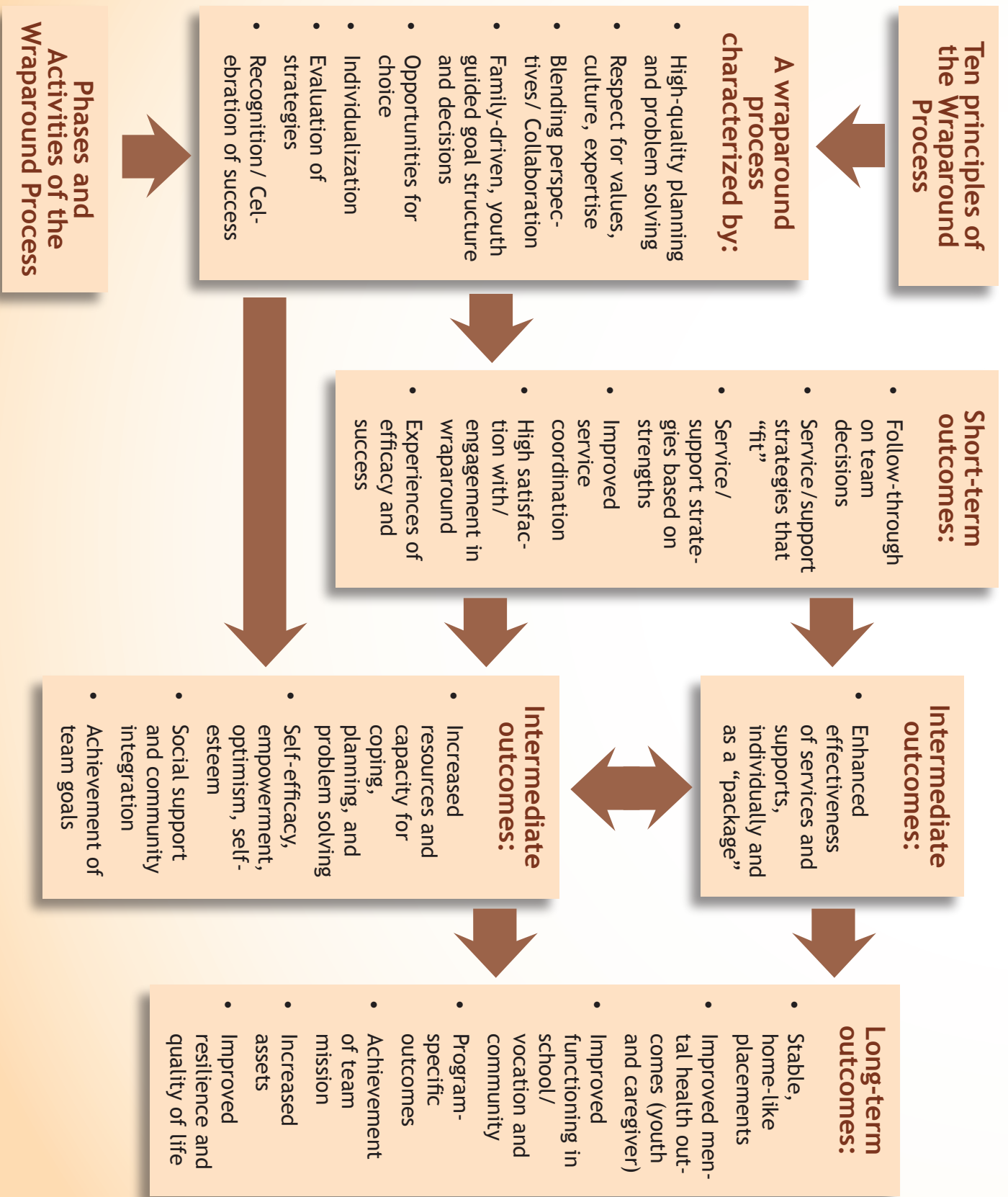


Wraparound has always had implicit associations with various psychosocial theories (Burchard, Bruns, & Burchard, 2002; Burns, Schoenwald, Burchard, Faw, & Santos, 2000); however, until recently only preliminary efforts had been undertaken to explain in a thorough manner why the wraparound process should produce desired outcomes (Walker & Schutte, 2004). Using the foundation supplied by the specification of the principles (Bruns et al., 2004) and practice model (Walker et al., 2004) of wraparound, the National Wraparound Initiative (NWI) has proposed a more detailed *theory of change* to describe how and why wraparound works.

Figure 1 (see following page) provides an overview of this theory. Beginning at the left, the figure illustrates how, when wraparound is “true” to the principles and practice described by the NWI, the result is a **wraparound process** with certain characteristics. Moving across the figure to the right, the various boxes summarize the short-, intermediate- and long-term **outcomes** that are expected to occur. The figure illustrates with arrows several “routes” by which the wraparound process leads to desired outcomes.

It is important to remember, however, that this figure is a highly simplified representation of an extremely complex process. The various routes to change described here are not independent. They interact with and reinforce one another. Furthermore, the changes that emerge as a result of wraparound do not come about in a linear fashion, but rather through loops and iterations over time. Thus, an intermediate outcome that apparently emerges from one of the various “routes” may stimulate or reinforce a short-term

Figure 1. A Theory of Change for Wraparound: Overview



outcome that promotes changes through a different route. Finally, because wraparound is a highly individualized process, the various “routes” to change outlined here will operate to a different extent with different families and youth. After discussing the characteristics of the wraparound process and the main theoretical routes or mechanisms of change, we will offer some specific examples of this complexity.

Process: Effective, Value-Driven Teamwork

The theory assumes that, when wraparound is undertaken in accordance with the principles and the practice model specified by the NWI, the result is an effective team process that capitalizes on the expertise and commitment of all team members while also prioritizing the perspectives of the youth and family. Various strands of research provide a rationale for why this should be the case.

Research on teamwork across many different types of contexts provides strong evidence about what makes teams likely to be effective in reaching the goals they set for themselves. Specifically, a team is more likely to be successful when team members have decided on an overall, long-term goal or mission for the team (Cohen, Mohrman, & Mohrman, 1999; West, Borrill, & Unsworth, 1998), and when team members have clearly defined a set of intermediate goals specifying the major strands of activity that need to be undertaken to reach the long term goal (Latham & Seijts, 1999; Weldon & Yun, 2000). With this goal structure in place, effective teams work carefully to choose strategies for reaching the intermediate goals.

It is crucial that teams structure strategy selection deliberately, and that team members consider several different strategies before choosing one (Hirokawa, 1990; West, Borrill, & Unsworth, 1998). Research on collaborative problem solving clearly shows that groups and teams have a propensity to jump to strategies and solutions too quickly, without considering a range of options. Generating several options before choosing one is important for at least two reasons. First, options that are generated first tend not to be of as high quality as those generated subsequently; and second, the process of generating options helps

team members gain a clearer understanding of the “problem” to be solved. Working through options in this manner enables groups and teams to be more creative and competent than individuals working separately at solving complex problems (Hirokawa, 1990; O’Connor, 1998; West, Borrill, & Unsworth, 1998).

Once strategies have been selected, effective teams set and use clear, objective criteria for judging whether or not the strategies are helping the team reach its goals (Cohen & Bailey, 1997; DeNisi & Kluger, 2000). Using these criteria, the team can then monitor whether or not a strategy is working, and can replace unsuccessful strategies with different ones. Finally, team effectiveness is also enhanced when teams acknowledge and celebrate success (Latham & Seijts, 1999).

The NWI’s practice model for wraparound (Walker et al., 2004) prescribes activities consistent with the elements of effective teamwork described above. Teams must develop a team mission or family vision for the future (long-term goal) and prioritize a small number of needs or goals (intermediate goals) to work on. They generate options and select strategies, which they monitor regularly using indicators of success. When strategies are not working, teams are to select and then monitor different strategies. The principles of wraparound (Bruns et al., 2004) add further expectations to the process of developing goals and strategies. For example, the principles specify teams should focus on developing community- and strengths-based strategies for the plan. These criteria are specific to wraparound (as compared to teams generally), but are easily accommodated within a framework of practices associated with effective teamwork.

Not surprisingly, there is more to team success than simply having these elements of effective planning in place. Other research points for the need for teams to be collaborative—for team members to share the same goals and to feel that their perspectives have an impact in the decision-making process. Collaborativeness is enhanced when teams have clear expectations for how members should interact (Cohen, 1994; Cohen & Bailey, 1997), and when decision making is equitable (Beugre & Baron, 2001; Cohen & Bailey, 1997; Korsgaard, Schweiger, & Sapienza, 1995). Collaborative teams are more effective

than teams whose members do not feel invested in the team goals (Beugre & Baron, 2001; Cohen & Bailey, 1997; Korsgaard, Schweiger, & Sapienza, 1995; Tjosvold & Tjosvold, 1994). Team members who feel that their perspectives are not respected during the decision-making process tend not to follow through on tasks that the team asks of them, thus making the team as a whole less effective (Cropanzano & Schminke, 2001; Kim & Mauborgne, 1993).

Within wraparound, the principles call for a special sort of collaboration. The principle on collaboration emphasizes the general idea that the wraparound process should be characterized by a sharing and blending of perspectives such that all team members feel that their ideas and expertise are respected. Additionally, however, the principles further specify that the wraparound process is driven by family and youth “voice and choice.” Essentially, this means that the perspectives of the youth and family are to have a greater impact on the wraparound process than other perspectives, and the youth and family must have the opportunity to make choices about the goals and strategies included on the plan.

The principles also specify that the wraparound team should learn about the values, culture, and strengths of the youth and family and incorporate these into the goals and strategies for the plan. Various activities in the wraparound practice model are intended to reinforce this special form

of collaboration; however, skilled facilitation, including a knowledge of group processes and participatory decision making, is essential to make this family- and youth-driven form of collaboration come to pass (Walker & Shutte, 2004).

In sum, when the wraparound process is carried out with fidelity to the principles and the practice model, it is an engagement and planning process that promotes a blending of perspectives and high-quality problem solving, and is thus consistent with empirically supported best practices for effective teamwork. Additionally, the wraparound process is driven by the perspectives of the youth and family. The team learns about youth and family values, strengths, and culture and actively uses this information in the planning process. Youth and family members also have the opportunity to make choices about the goals and strategies for the plan. These essential characteristics of such a wraparound process are summarized in the larger box at the left of Figure 1.

Routes to Outcomes

High-quality wraparound teamwork is characterized by collaboration and blending of perspectives, creative problem solving, and respect for each team member’s expertise and background. As noted above, teams that adhere to best practices tend to come up with good solutions to problems, and team members are likely to follow through on decisions that the team makes. Adherence to these best practices thus is expected to directly promote “achievement of team goals” (shown as an intermediate outcome in Figure 1) and, ultimately, “achievement of team mission” (shown as a long-term outcome).

Because the mission and goals¹ in wraparound are selected by youth and family, it is assumed that achieving these goals will contribute to improved family quality of life, as well as other long term outcomes. Wraparound’s underlying philosophy also makes it likely that certain particular types of goals will be included in the plan, and that outcomes reflecting these goals will be part of the plan. For example, the wraparound principle of

1. There are variations in terminology for certain elements of wraparound plans. Some wraparound trainers and programs emphasize a “family long-term vision” (rather than a team mission) as the central long-term outcome for the wraparound process. Similarly, identifying and prioritizing needs (rather than goals) sometimes represents the intermediate steps on which a team focuses its efforts.

“community based” stresses the importance of promoting family and youth/child integration into home and community life. This principle (which usually reflects family and youth priorities anyway) means that wraparound plans are often focused on increasing stability in relationships and living situation, and helping the youth and families live and thrive—just like their more typical counterparts—in their homes, communities, and other “natural” settings. Similarly, the principle of “strengths based” encourages teams to create goals or missions that reflect building family and youth/child assets, capacities, and resilience. Thus the wraparound team effort will generally include, if not prioritize, these general areas, and related outcomes will be realized through the various routes to change described below.

Additionally, team goals and mission are likely to be significantly influenced by the expectations for the specific wraparound program. This is because wraparound programs or initiatives are typically designed to meet particular needs of their target populations and since agency representatives will bring into the wraparound process perspectives that reflect the goals of the agencies and organizations that sponsor the program. Thus, for example, wraparound teams that are sponsored through a child welfare agency almost always include a focus on child safety, and wraparound that is implemented with youth with co-occurring disorders will likely include a focus on treatment for substance use.

Beyond this general result of achieving team goals, a faithfully implemented wraparound process can be expected to lead to desired outcomes through two main routes (illustrated by the two separate boxes labeled “intermediate outcomes” in Figure 1). In one of these routes, key features of wraparound process contribute to **enhancing the effectiveness of the services and supports** included in the plan, thus promoting desired outcomes. The second route highlights how increasing family and youth/child empowerment, optimism, and efficacy leads directly to positive outcomes (i.e., independently of therapeutic services/supports provided in the plan) by **developing capacity and resources for coping, planning and problem-solving**. As noted above, these routes are not independent from one another, and outcomes of different types may have impact on oth-

er outcomes and through several routes. After we describe the main routes, we will provide some examples to illustrate these interactions and iterations.

Enhancing the Effectiveness of Services and Supports

One of the main routes to outcomes proposed in this theory is that using the wraparound pro-



cess to select and organize services and supports actually enhances the effectiveness of the chosen service/support strategies. For several reasons, the wraparound process is expected to lead to relatively high levels of youth and family motivation to fully engage in, and continue with, the services and supports that are included in the wraparound plan. Engagement and retention are perennial challenges in the delivery of children’s mental healthcare, and this is particularly true for children with the most severe problems (Kazdin, 1996). No-show rates to first appointments range from 15-35%, and families who initiate treatment have been shown to drop out prematurely at rates as high as 60% (Morrissey-Kane & Prinz, 1999). Not surprisingly, outcomes for children’s mental healthcare tend to be better when families are engaged and retained in services (Huey, Henggeler, Brondino, & Pickrel, 2000; Tolan, McKay, Hanish, & Dickey, 2002).

Choice and motivation. Within wraparound, decisions about what services and supports to access are made on the basis of family and youth

voice and choice. There is a wealth of research that compares the experiences of people who feel they are acting by their own choice and those who feel that they are externally controlled. People who feel they have chosen an activity or option tend to have more committed to the course of action and to have more success. (See the review in Ryan and Deci, 2000.) This result has also been found for people who are part of groups or teams.



People who feel included as part of a decision making process are more likely to follow through on their roles in the team plan (Maddux, 2002). Thus the collaborative, family-driven process of determining needs and selecting and monitoring strategies can be expected to lead to relatively high levels of youth and family commitment to the services and supports that are selected for the plan.

Relevance and feasibility. Additionally, the wraparound process works carefully to match services and supports with needs (as defined by the youth and family). This increases the likelihood that families and youth will find the individual services and supports, as well as the total “package” of services and supports in the plan, relevant and feasible. Parent perceptions of the relevance and feasibility of treatment has been linked in several studies to better outcomes from treatments (Kazdin, Holland, & Crowley, 1997; Morrissey-Kane & Prinz, 1999). Perceptions of service relevance and feasibility may be particularly important for families from minority populations, and thus participation in wraparound, with its careful attention to community-based and family-driven care and overall cultural competence, may be particu-

larly valuable for them (Morrissey-Kane & Prinz, 1999). Finally, since the entire wraparound plan emerges in a structured way from youth and family perspectives, the wraparound process should result in family and youth perceptions of service coordination. Perceptions of greater coordination of services and supports have been linked to improved retention in services and enhanced outcomes (Bickman, Lambert, Andrade, & Penaloza, 2000; Glisson, 1994; Koren et al., 1997).

Shared expectations. Wraparound teams select service and support strategies to meet specific needs, and the success of a strategy is determined by how it impacts objective indicators of success that the team has chosen. Thus the team establishes clear, shared expectations for treatment—what it’s for, what outcomes are anticipated—that can be shared with service providers. Often, providers become members of the wraparound team, and are thus part of the collaborative effort to define the purpose of service/support strategies. Even when providers do not join the core team, the team often facilitates communication with providers, aimed at clarifying the purpose of services and the criteria by which the success of the service/support is judged. There is evidence supporting the proposition that having shared parent-provider expectations for treatment increases the likelihood that parents will be engaged in/continue with treatment for their children (Morrissey-Kane & Prinz, 1999; Spoth & Redmond, 2000).

Similarly, there is clear evidence that shared client-provider expectations about treatment (as should be the case when children and youth are involved in making decisions for their wraparound plans) also contributes to treatment effectiveness (Dew & Bickman, 2005). Taking this line of reasoning one step further, there is also reason to expect that wraparound will enhance treatment effectiveness when, as often happens in wraparound, the team works with providers to tailor the services and supports to better fit child/youth and family needs. There is evidence that retention in and outcomes from mental health treatment interventions are enhanced when treatment is modified to reflect family concerns and needs (Morrissey-Kane & Prinz, 1999; Prinz & Miller, 1994).

Strengths-based understanding of behavior.

The wraparound process models and communicates a strengths-based understanding of difficult or troubling behavior to team members, including youth and families. This helps youth and families to see that behavior is malleable, rather than dispositional, which in turn increases motivation to engage in therapeutic interventions and contributes to improved outcomes from intervention (Morrissey-Kane & Prinz, 1999).

Whole-family focus. Wraparound may also impact service/support engagement, retention, and outcomes by virtue of its focus on the needs of the family as a whole. Providing support to whole family, particularly mothers, appears to improve treatment initiation/retention and outcomes (Morrissey-Kane & Prinz, 1999).

Capacity and Resources for Coping and Planning

This route to change highlights wraparound's potential to increase family and youth resources and capacities related to planning, coping, and problem-solving. These resources and capacities are seen as contributing directly to positive long-term outcomes. In other words, these outcomes may arise directly from participation in wraparound, and do not result only from participation in services and supports (though services and supports may also contribute to these outcomes). These long-term outcomes include increased resilience and developmental assets, higher quality of life, improved mental health, and increased ability to initiate and maintain health-promoting behavior change.

Self-efficacy, empowerment, and self-determination. The experiences of making choices and of setting and reaching goals contribute to the development of key human capacities of self-efficacy, empowerment, and self-determination. In fact these three constructs are interrelated, and have at their core the sense of confidence that people have about their ability to overcome obstacles in their lives and to reach goals they set for themselves (Snyder, Rand, & Sigmon, 2002). People develop these capacities in large part because of having successful experiences of achieving personally meaningful goals. Increases in self-efficacy, empowerment, and/or self-determination arise from several types of situations that are central

parts of the wraparound process: participating actively in planning, directing services and supports, making choices, and experiencing success in reaching personally meaningful goals (Byalin, 1990; Curtis & Singh, 1996; Foster, Brown, Phillips, Schore, & Carlson, 2003; Maddux, 2002; National Council on Disability, 2004; O'Brien, Ford, & Malloy, 2005; Worthington, Hernandez, Friedman, & Uzzell, 2001). While much of this research focused on adults, similar findings have emerged from the smaller body of research with children and adolescents (Peterson & Steen, 2002), including specifically those with emotional, behavioral, cognitive, learning, and other disabilities (Chambers et al., 2007; Wehmeyer & Palmer, 2003; Wehmeyer & Schwartz, 1997).

There is robust research showing that people who believe that they can achieve the goals they set for themselves experience a variety of positive outcomes, including a variety of outcomes related to mental health and well-being. People with higher self-efficacy tend to be more optimistic and hopeful, and they persist and try harder in the face of obstacles (Maddux, 2002; Ridgway, 2004; Snyder, Rand, & Sigmon, 2002). In turn, people who are more optimistic experience a variety of positive mental health outcomes, and hope is strongly linked to successful psychiatric recovery among adults with serious mental illness (Ridgway, 2004; Russinova, 1999; Snyder, Rand, & Sigmon, 2002). More generally, people who believe they can solve problems in their lives have better general mental health and well-being, and they are more likely to avoid depression (Heppner

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& Lee, 2002; Maddux, 2002, Russinova, 1999, Snyder, Rand, & Sigmon, 2002; Thompson, 2002).

In general, people with higher self-efficacy cope better with stressful life circumstances. They are also more likely to take action to protect their health, to adopt new, healthy habits, and to maintain behavior change (Maddux, 2002; Thompson, 2002). Children and adolescents who are trained in problem-solving have more optimism and avoid depression (Peterson & Steen, 2002). Adolescents who are optimistic tend to do better in school and college, abuse drugs less, are less angry, have better health and fewer social problems including fewer externalizing problems (Roberts, Brown, Johnson, & Reinke, 2002).

Social Support. Social support is seen as an important resource that aids people's efforts to deal with stress and adversity. There is a large body of research that demonstrates that people who are involved in supportive social relationships experience benefits in terms of their morale, health, and coping (Cohen, Underwood, & Gottlieb, 2000; Cutrona & Cole, 2000; Walker, 2006). Conversely, low levels of social support have been repeatedly linked to poor physical and mental health outcomes. A common element of models of community-based mental healthcare—including wraparound—is the emphasis on strengthening youth and family ties to supportive people within the family's social environment (Cox, 2005). Within wraparound, the inclusion of family friends, neighbors, and acquaintances on the wraparound team represents an important effort to create and strengthen social support.

This theory of change includes the hypothesis that increasing social support contributes to the positive outcomes mentioned above. Some studies document the role of social support in recovery from psychiatric difficulties or general life troubles (Ridgway, 2004; Werner, 1993; Werner, 1995), and participants in wraparound anecdotally report that the social support offered through the team and its work is an important part of wraparound's positive impact in their lives. However, to date, there is a lack of definitive research showing that increasing social support for people who lack it actually leads to positive outcomes (Walker, 2006).

Conclusion: The “Positive Spiral” of the Wraparound Process

The dynamic complexity and the looping, iterative nature of the wraparound process is most obvious in the planning process itself, with the child/youth and family, together with the rest of the team, participating in an iterative process of creating, implementing, evaluating, and adjusting successive versions of the wraparound plan. The looping nature of change—and interactions between the various “routes” to change—play out in other ways as well, for example, as improved coping and problem solving contribute to increased self-efficacy, which in turn leads to more opportunities to experience success within the wraparound process, which in turn reinforces self-efficacy.

In this way, wraparound produces a sort of “positive spiral.” Since people with higher self-efficacy are better able to adopt and maintain healthy behaviors and behavior change, and to apply what they have learned from treatment (Maddux, 2002), it can be expected that increases in self-efficacy enable families and youth to profit more from therapy and other services and supports. Conversely, people who experience less stress feel more self-efficacy, so people for whom services and supports are working could be expected to contribute more actively and confidently to the wraparound process in general. Parents who have more optimism are more likely to engage in services (Morrissey-Kane & Prinz, 1999); thus increasing self-efficacy and empowerment through the wraparound process represents another route to making services more effective.

Essentially, wraparound can be seen as a driver of a positive, change-promoting spiral that reinforces itself through multiple mechanisms or routes. This seemingly fortuitous confluence of positive impacts occurs not so much because discrete activities or elements of the wraparound philosophy just happen to reinforce one another, but because the whole “package” of wraparound springs from a single, coherent posture or mode of helping that is fundamentally respectful, optimistic, and empowering. The diagram and explanations presented here are thus simultaneously both too simple and too complicated to explain how and why wraparound can be expected to work.

Nevertheless, this theory has clear implications for practice, quality assurance, evaluation, and research. For practice, the theory highlights the importance of adherence to the principles and practice model, since outcomes are predicated on fidelity. For quality assurance, then, measurement of fidelity is essential. Additionally, programs would likely benefit from assessing other key indicators that gauge how well the various “routes” appear to be functioning. Thus, programs might want to consider monitoring plans or assessing team cooperativeness or cohesiveness (for evidence of high quality teamwork and collaboration); assessing family and youth perceptions of service relevance, helpfulness, or coordination (for evidence that the “enhancing the effectiveness of services” route is functioning); and measuring family and youth empowerment, self-efficacy, and/or optimism (for evidence that the “capacity and resources for coping” route is operating).

The most obvious implications of the theory for program evaluation have to do with relevant outcomes. To begin with, the theory places a high level of importance on outcomes that are not often measured in human service contexts. These include the intermediate outcomes mentioned above, as well as long-term outcomes such as quality of life or assets. The theory suggests that evaluation that does not include these outcomes may well understate the effectiveness of wrap-around, since these outcomes reflect the potentially profound impacts that wrap-around can have in the lives of children, youth, and families. Additionally, the theory highlights the fact that wrap-around, because it is an individualized process, will not always be focused on achieving the same outcomes. Prioritized outcomes will vary not only from program to program, but within programs as well. Sometimes the outcomes that are the main focus of a team’s attention will be those that are commonly found on wrap-around plans—stability of living situation, academic/vocational progress, etc.—but sometimes the most highly prioritized outcomes may be completely unique to a particular child and family. Again, this points to the need for program evaluation strategies that can capture the diversity of impacts that wrap-around is anticipated to produce.

And finally, the theory has research implica-

tions simply because it *is* a theory. The routes to wrap-around’s effectiveness are at this point hypotheses in need of testing. In order to support (or disconfirm) the hypotheses, research is needed to test each of the main assumptions that are part of the theory. To do this would require research that measures an appropriate spectrum of the intermediate and long-term outcomes, and that allows for testing assumptions about how these outcomes are interrelated. Knowing more about whether and how these various avenues to wrap-around “work” will in turn provide the foundation for future efforts to refine strategies for practice, quality assurance, and evaluation.

References

- Beugre, C. D., & Baron, R. A. (2001). Perceptions of systemic justice: The effects of distributive, procedural, and interactional justice. *Journal of Applied Social Psychology, 31*, 324-339.
- Bickman, L., Lambert, E. W., Andrade, A. R., & Penalosa, R. V. (2000). The Fort Bragg continuum of care for children and adolescents: Mental health outcomes over 5 years. *Journal of Consulting and Clinical Psychology, 68*(4), 710-716.
- Bruns, E. J., Walker, J. S., Adams, J., Miles, P., Osher, T. W., Rast, J., et al. (2004). *Ten principles of the wraparound process*. Portland, OR: National Wraparound Initiative, Research and Training Center on Family Support and Children’s Mental Health, Portland State University.
- Burchard, J. D., Bruns, E. J., & Burchard, S. N. (2002). The wraparound approach. In B. J. Burns & K. Hoagwood (Eds.), *Community treatment for youth: Evidence-based interventions for severe emotional and behavioral disorders* (pp. 69-90). New York: Oxford University Press.
- Burns, B. J., Schoenwald, S. K., Burchard, J. D., Faw, L., & Santos, A. B. (2000). Comprehensive community-based interventions for youth with severe emotional disorders: Multisystemic therapy and the wraparound process. *Journal of Child and Family Studies, 9*, 283-314.
- Byalin, K. (1990). Parent empowerment: A treatment strategy for hospitalized adolescents.

- Hospital and Community Psychology*, 41, 89-90.
- Chambers, C. R., Wehmeyer, M. L., Saito, Y., Lida, K. M., Lee, Y., & Singh, V. (2007). Self-determination: What do we know? Where do we go? *Exceptionality*, 15, 3-15.
- Cohen, S., Underwood, L. G., & Gottlieb, B. H. (2000). Social relationships and health. In S. Cohen, L. G. Underwood & B. H. Gottlieb (Eds.), *Social support measurement and intervention: A guide for health and social scientists* (pp. 3-25). New York: Oxford University Press.
- Cohen, S. G. (1994). Designing effective self-managing work teams. In M. M. Beyerlein & D. A. Johnson (Eds.), *Advances in interdisciplinary studies of work teams* (Vol. 1, pp. 67-102). Greenwich, CT: JAI Press.
- Cohen, S. G., & Bailey, D. E. (1997). What makes teams work: Group effectiveness research from the shop floor to the executive suite. *Journal of Management*, 23, 239-291.
- Cohen, S. G., Mohrman, S. A., & Mohrman, A. M. J. (1999). We can't get there unless we know where we are going: Direction setting for knowledge work teams. In R. Wageman (Ed.), *Research on managing groups and teams: Groups in context* (Vol. 2, pp. 1-31). Greenwich, CT: JAI Press.
- Cox, K. F. (2005). Examining the role of social network intervention as an integral component of community-based, family-focused care. *Journal of Child and Family Studies*, 14, 443-454.
- Cropanzano, R., & Schminke, M. (2001). Using social justice to build effective work groups. In M. E. Turner (Ed.), *Groups at work: Theory and research* (pp. 143-171). Mahwah, NJ: Lawrence Erlbaum Associates.
- Curtis, W. J., & Singh, N. N. (1996). Family involvement and empowerment in mental health service provision for children with emotional and behavioral disorders. *Journal of Child & Family Studies*, 5, 503-517.
- Cutrona, C. E., & Cole, V. (2000). Optimizing support in the natural network. In S. Cohen, L. G. Underwood & B. H. Gottlieb (Eds.), *Social support measurement and intervention: A guide for health and social scientists* (pp. 278-308). New York: Oxford University Press.
- DeNisi, A. S., & Kluger, A. N. (2000). Feedback effectiveness: Can 360 degree appraisals be improved? *The Academy of Management Executive*, 14(1), 129-139.
- Dew, S. E., & Bickman, L. (2005). Client expectations about therapy. *Mental Health Services Research*, 7(1), 21-33.
- Foster, L., Brown, R., Phillips, B., Schore, J., & Carlson, B. L. (2003). *Improving the quality of Medicaid personal assistance through consumer direction*. Retrieved October 9, 2003, from http://www.healthaffairs.org/WebExclusives/Foster_Web_Excl_032603.htm
- Glisson, C. (1994). The effect of services coordination teams on outcomes for children in state custody. *Administration in Social Work*, 18(4), 1-23.
- Hepner, P. P., & Lee, D. (2002). Problem-solving appraisal and psychological adjustment. In C. R. Snyder & S. J. Lopez (Eds.), *Handbook of positive psychology* (pp. 288-298). New York: Oxford University Press.
- Hirokawa, R. Y. (1990). The role of communication in group decision-making efficacy: A task-contingency perspective. *Small Group Research*, 21, 190-204.
- Huey, S. J., Henggeler, S. W., Brondino, M. J., & Pickrel, S. G. (2000). Mechanisms of change in Multisystemic Therapy: Reducing delinquent behavior through therapist adherence and improved family and peer functioning. *Journal of Consulting & Clinical Psychology*, 68, 451-467.
- Kazdin, A. E. (1996). Dropping out of child psychotherapy: Issues for research and implications for practice. *Clinical Child Psychology and Psychiatry*, 1(1), 133-156.
- Kazdin, A. E., Holland, L., & Crowley, M. (1997). Family experience of barriers to treatment and premature termination from child therapy. *Journal of Consulting and Clinical Psychology*, 65, 453-463.
- Kim, C. W., & Mauborgne, R. A. (1993). Procedural justice, attitudes, and subsidiary top management compliance with multinationals' corporate strategic decisions. *Academy of Management*

- ment Journal, 36, 502-526.
- Koren, P. E., Paulson, R. I., Kinney, R. F., Yatchmenoff, D. K., Gordon, L. J., & DeChillo, N. (1997). Service coordination in children's mental health: An empirical study from the caregiver's perspective. *Journal of Emotional and Behavioral Disorders, 5*, 162-172.
- Korsgaard, A. M., Schweiger, D. M., & Sapienza, H. J. (1995). Building commitment, attachment, and trust in strategic decision-making teams: The role of procedural justice. *Academy of Management Journal, 38*, 60-84.
- Latham, G. P., & Seijts, G. H. (1999). The effects of proximal and distal goals on performance on a moderately complex task. *Journal of Organizational Behavior, 20*, 421-429.
- Maddux, J. E. (2002). Self-efficacy. In C. R. Snyder & S. J. Lopez (Eds.), *Handbook of positive psychology* (pp. 277-287). New York: Oxford University Press.
- Morrissey-Kane, E., & Prinz, R. J. (1999). Engagement in child and adolescent treatment: The role of parental cognitions. *Clinical Child and Family Review, 2*, 183-198.
- National Council on Disability. (2004). *Consumer-directed health care: How well does it work?* Washington, DC: National Council on Disability.
- O'Brien, D., Ford, L., & Malloy, J. M. (2005). Person centered funding: Using vouchers and personal budgets to support recovery and employment for people with psychiatric disabilities. *Journal of Vocational Rehabilitation, 23*(2), 71-79.
- O'Connor, K. M. (1998). Experiential diversity in groups: Conceptualizing and measuring variation among teammates. In D. H. Gruenfeld (Ed.), *Research on managing groups and teams* (Vol. 1, pp. 167-182). Greenwich, CT: JAI Press.
- Peterson, C., & Steen, T. A. (2002). Optimistic explanatory style. In C. R. Snyder & S. J. Lopez (Eds.), *Handbook of positive psychology* (pp. 244-256). New York: Oxford University Press.
- Prinz, R. J., & Miller, G. E. (1994). Family-based treatment for childhood antisocial behavior: experimental influences on dropout and engagement. *Journal of Consulting and Clinical Psychology, 62*(3), 645-650.
- Ridgway, P. (2004). *Resilience and recovery from psychiatric disabilities: Links in concepts and research* (Working paper). Lawrence, KS: University of Kansas School of Social Welfare.
- Roberts, M. C., Brown, K. J., Johnson, R. J., & Reinke, J. (2002). Positive psychology for children. In C. R. Snyder & S. J. Lopez (Eds.), *Handbook of positive psychology* (pp. 663-675). New York: Oxford University Press.
- Russinova, Z. (1999). Providers' hope-inspiring competence as a factor optimizing psychiatric rehabilitation outcomes. *Journal of Rehabilitation*(October/November/December), 50-57.
- Ryan, R. M., & Deci, E. L. (2000). Self-determination theory and the facilitation of intrinsic motivation, social development, and well-being. *American Psychologist, 55*, 68-78.
- Snyder, C. R., Rand, K. L., & Sigmon, D. R. (2002). Hope theory. In C. R. Snyder & S. J. Lopez (Eds.), *Handbook of positive psychology* (pp. 257-276). New York: Oxford University Press.
- Spoth, R., & Redmond, C. (2000). Research on family engagement in preventive interventions: Toward improved use of scientific findings in primary prevention practice. *The Journal of Primary Prevention, 21*, 267-284.
- Thompson, S. (2002). The role of personal control in adaptive functioning. In C. R. Snyder & S. J. Lopez (Eds.), *Handbook of positive psychology* (pp. 202-213). New York: Oxford University Press.
- Tjosvold, D., & Tjosvold, M. T. (1994). Cooperation, competition, and constructive controversy: Knowledge to empower for self-managing work teams. In M. M. Beyerlein & D. A. Johnson (Eds.), *Advances in interdisciplinary studies of work teams* (Vol. 1, pp. 119-144). Greenwich, CT: JAI Press.
- Tolan, P. H., McKay, M. M., Hanish, L. D., & Dickey, M. H. (2002). Evaluating process in child and family interventions: Aggression prevention as an example. *Journal of Family Psychology, 16*, 220-236.
- Walker, J. S. (2006). Strengthening social support: Research implications for interventions in children's mental health. *Focal Point: Re-*

search, Policy, and Practice in Children's Mental Health, 20(1), 3-9.

Walker, J. S., Bruns, E. J., Rast, J., VanDenBerg, J. D., Osher, T. W., Koroloff, N., et al. (2004). *Phases and activities of the wraparound process*. Portland, OR: National Wraparound Initiative, Research and Training Center on Family Support and Children's Mental Health, Portland State University.

Walker, J. S., & Shutte, K. M. (2004). Practice and process in wraparound teamwork. *Journal of Emotional and Behavioral Disorders*, 12(3), 182-192.

Wehmeyer, M. L., & Palmer, S. B. (2003). Adult outcomes for students with cognitive disabilities three-years after high school: The impact of self-determination. *Education and Training in Development Disabilities*, 38(2), 131-144.

Wehmeyer, M. L., & Schwartz, M. (1997). Self-determination and positive adult outcomes: A follow-up study of youth with mental retardation or learning disabilities. *Exceptional Children*, 63(2), 245-255.

Weldon, E., & Yun, S. (2000). The effects of proximal and distal goals on goal level, strategy development, and group performance. *The Journal of Applied Behavioral Science*, 36, 336-344.

Werner, E. E. (1993). Risk, resilience, and recovery: Perspectives from the Kauai longitudinal study. *Development and Psychopathology*, 5, 503-515.

Werner, E. E. (1995). Resilience in development. *Current Directions in Psychological Science*, 3, 81-84.

West, M. A., Borrill, C. S., & Unsworth, K. L. (1998). Team effectiveness in organizations. In C. L. Cooper & I. T. Robertson (Eds.), *International review of industrial and organizational psychology* (Vol. 13, pp. 1-48). New York: John Wiley & Sons.

Worthington, J. E., Hernandez, M., Friedman, B., & Uzzell, D. (Eds.). (2001). *Systems of care: Promising practices in children's mental health, 2001 series: Volume II. Learning from families: Identifying service strategies for success*. Washington, DC: Center for Effective Collaboration and Practice, American Institutes for Research.

Author

Janet Walker is Research Associate Professor in the School of Social Work at Portland State University and co-Director of the Research and Training Center on Pathways to Positive Futures. Her current research focuses on 1) exploring how individuals and organizations acquire capacity to implement and sustain high quality practice in human service settings, 2) describing key implementation factors that affect the ability of organizations and individuals to provide high quality services and treatment, and 3) developing and evaluating interventions to increase the extent to which youth with emotional or mental health difficulties are meaningfully involved in care and treatment planning. Together with Dr. Eric Bruns, Dr. Walker co-directs the National Wraparound Initiative.

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