WRAPAROUND SERVICES IN PHILADELPHIA SCHOOLS: AN ANALYSIS OF WRAPAROUND AGENCIES' MONITORING PRACTICES OF THERAPEUTIC STAFF SUPPORT TREATMENT INTEGRITY

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ABSTRACT

WRAPAROUND SERVICES IN PHILADELPHIA SCHOOLS:
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Therapeutic Staff Support, commonly known as TSS, provide one-on-one direct care (in home, school, and community settings) to children diagnosed with a severe emotional or behavioral disorder. In this dissertation I explore wraparound agencies practices of monitoring Therapeutic Staff Support treatment integrity. Using a qualitative design, 26 participants from three wraparound agencies were selected for this study. Data collection included interviews and documents (treatment plans, progress notes, and psychologist recommendations). Two primary research questions guided my inquiry into wraparound agencies monitoring practices of TSS: How do wraparound agencies monitor TSS treatment delivery? Does monitoring incorporate strategies for targeting TSS misutilization? Two secondary questions were: What are some potential threats to TSS treatment integrity? How do TSS address threats that directly affect students in schools? Findings suggest wraparound agencies use myriad methods to monitor TSS treatment adherence and accountability mechanisms adequately address TSS job performance. Similarly, I find agencies shape treatment document designs (plans and progress notes) to facilitate their use. Findings also point to five categories of issues which serve as potential threats to effective TSS treatment

administration. I also find TSS misutilization was not a factor although there was no method of monitoring it. TSS did, however, find themselves performing multifaceted roles (often in response to threats directly affecting their students) which extended beyond their required roles of treatment agent and data collector; eight roles emerged. Ultimately, findings suggest documentation review and BSC observations are the most common approaches to monitoring TSS treatment integrity. Themes for threats (consistent with those found in other treatment literature) and themes used for TSS typology can be explored in future studies.

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Where no counsel is, [a person] falls:
but in the multitude of counsellors there is safety.
Proverbs 11:14 KJV

As iron sharpens iron,
so one [person] sharpens another.
Proverbs 27:17 NIV

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> *Every time I am tempted (as is often) to give up or excuse myself from 'doing one more thing,' I think of [you]… [Your example] makes me stand up when I want to sit down, try one more time when I want to stop, and go out the door when I want to stay at home and relax.*

Although we have known one another for many years, our relationship flourished in 1997 and was solidified in 2001. Remember? The Lord answered my prayer, you said, "yes," and I have not been the same since.

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Crystal Wilson-Johnson

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CHAPTER 1

INTRODUCTION

Among children ages 9-17, there are one or two with serious emotional problems in virtually every classroom in the country.
(New Freedom Commission on Mental Health, 2002)

Students with severe emotional or behavioral disorders (sebd) enter schools very often with myriad individual adversities which makes them susceptible to low academic achievement. These adversities also pose serious threats to students' healthy social development. Students with these disorders often exhibit a variety of behavioral patterns e.g. "aggression, noncompliance, disruptive verbalizations, withdrawal, tantrums, and inappropriate deficient social skills" (Dunlap & Childs, 1996, p. 125). Schools responses to this vulnerable population has often led to students' educational neglect and school failure due to schools' dismal approaches to addressing students' behavioral and/or emotional health issues in substantive ways. Promising practices in mental health services addressing this population have emerged but these practices have been slow to reach schools. Some states are using creative and substantive approaches to provide mental health services to students with sebd. On a national level, mental health professionals are providing services based on a *wraparound* philosophy; that is, based on a set of policies and practices where a variety of services are offered to children. At the state level (e.g., Pennsylvania), *wraparound services*, are widely used in schools to help these students in meaningful ways.

Statement of the Problem

Over the last 15 years, wraparound agencies in Pennsylvania have utilized wraparound services to provide behavioral health rehabilitation to students with a severe emotional or behavioral disorder. The most widely used wraparound service, Therapeutic

Staff Support (TSS), provide one-on-one direct care to children in home, school, and community settings. In a 2002 School District of Philadelphia survey, it was reported over 1200 TSS, from 71 wraparound agencies, were providing services to students in that school system (Provenzano, 2002). Despite the TSS presence in schools, and the number of agencies utilizing TSS, little is known about the practices agencies employ to monitor how well TSS perform their primary role—treatment delivery. As contracted employees, the TSS presence in schools raises accountability concerns. A critical issue centers on TSS job performance. Since the inception of the TSS service, misutilization (TSS performing in non-therapeutic roles) has been a major issue.

Ievoli (2001) spoke about how TSS were used in non therapeutic ways which stemmed from wraparound agencies' lack of clearly defined TSS roles that led to arbitrary use of the service which, in most instances, resulted in inappropriate uses of TSS. The Department of Public Welfare (2000) found misutilization of TSS services in Pennsylvania. In addressing misutilization, extensive measures have been undertaken to a) standardize TSS roles, b) standardize data collection methods, and 3) monitor TSS treatment delivery. However, no effort has been made to study and/or report on wraparound agencies' implementation of these streamlined practices.

Another issue with the TSS service in schools is teacher cynicism. Educators have been extremely critical of TSS. According to Cautilli and Rosenwasser (2001), "teachers complain that TSS in their classrooms are often nonproductive and sometimes a hindrance" (p. 155). Part of this sentiment expressed by teachers is due to misconceptions of the TSS service. Teachers' perceptions of TSS roles have been likened to "body guard[s]" and "costly babysitt[ers]" (Cautilli & Rosenwasser, 2001; Cautilli, Rosenwasser, & Clarke,

2000). According to Bugaj and Manning (2002), teachers have a difficult time understanding the TSS role which has partly led to negative labeling. The implication of these negative perceptions is that TSS are enveloped in a cloud of suspicion because many teachers are not knowledgeable about what TSS do. Since students' disabilities have implications for their academic progress, educators need to be reassured that TSS are appropriately performing their duties.

School officials also raises issues about TSS. TSS are contracted workers, not school employees. As such they "work independently and without day-to-day support of their agency" (Bugaj & Manning, 2002, p. 88). The unfavorable perceptions of TSS, coupled with their seeming independence, suggests TSS operate autonomously as paraprofessionals. School officials seem to have two primary concerns related to TSS supervision and monitoring job performance. In addressing these two aspects of TSS accountability, this study, unlike any previous effort, reveals the rigor that is attendant to TSS job performance and their reporting practices to the agencies in which they are highly accountable.

In wraparound services literature, there is a dearth of research. Of the four existing studies published on wraparound services in Pennsylvania, none explore wraparound agencies methods of ensuring TSS treatment delivery. Existing studies examine wraparound services treatment integrity in four areas: treatment integrity based on prescribed hours v. actual hours billed (Toffalo, 2000), TSS recommendations of promising non-therapeutic behavioral interventions (Supon & Rowe, 1998), special education teachers' perceptions of TSS utilization (Desmone, 2004), and collaboration, cultural competence, and adherence to the wraparound planning process (MacFalls, 2002).

In the larger behavior literature, previous research on treatment agents has focused primarily on one topic: treatment integrity. Some studies have focused on self reporting results of treatment integrity. Other studies have focused on the psychometric tools for treatment adherence. Few studies have explored monitoring practices apart from "document assessments." Several meta-analyses examined the extent to which monitoring is reported in behavior research (see Billingsley, White, & Munson, 1980; Gresham, 1993; Gresham, Gansle, Noelle, Cohen, & Rosenblum, 1993; Moncher & Prinz, 1991; Peterson, Homer & Wonderlich, 1982). Authors of these meta-analyses found that few researchers reported use of treatment monitoring practices even fewer reported use of specific monitoring practices.

Ultimately, teachers, school officials, and wraparound professionals share common concerns about TSS treatment delivery and accountability, central aspects of treatment integrity. A need exists to study these two critical aspects of TSS treatment integrity by examining wraparound agencies' monitoring practices to determine if they adequately monitor TSS job performance. Ensuring paraprofessionals' quality treatment delivery is a central goal in the field of mental health. There is also a need to explore TSS perceptions' of their roles since misutilization has been an ever present concern. Moreover, learning more about the challenges TSS face helps shed light on how they perform their work. A qualitative study exploring the context of wraparound agencies' monitoring practices can help us better understand accountability methods used to ensure TSS job performance.

Purpose of the Study

The purpose of this study was to explore wraparound agencies' monitoring practices of TSS. Since the primary functions of the TSS service are administering treatment and

collecting behavioral data, I focused on treatment integrity as an integral aspect of TSS job performance.

The "Grand Tour" Question

How do wraparound agencies' monitoring practices address Therapeutic Staff Support treatment integrity?

Four research questions guided this study:

1) How do wraparound agencies monitor TSS treatment delivery?

2) Does monitoring incorporate strategies for targeting TSS misutilization?

3) What are some potential threats to TSS treatment integrity?

4) How do TSS address threats directly affecting students in schools?

Definitions

There are seven key terms used in this study. They are as follows:

Behavioral Health Rehabilitation Services (BHRS) – A range of medically necessary, off-site community-based services for children with sebd, up to age 21 (Hodas, 2004, p. 15).

Emotional or behavioral disorder – the U. S. Department of Education defines emotional or behavioral disorder as follows:

> The term emotional or behavioral disorder means a disability characterized by behavioral emotional responses in school programs so different from appropriate age, cultural, or ethnic norms that they adversely affect educational performance. Educational performance includes academic, social, vocational, or personal skills. Such a disability—
>
> A) *is* more than a temporary, expected response to stressful events in the environment;
> B) *is* consistently exhibited in two different settings, at least one of which is school-related; and
> C) *is* unresponsive to direct intervention applied in general education, or the child's condition is such that general education interventions would be insufficient. (Friedman, Kutash, & Duchnowski, 1996, p. 73)

Psychologist Recommendations – The concluding part of a psychologist's evaluation whereby specific recommendations are spelled out for a treatment team e.g., various types of interventions to be used (e.g., psychological, biological, and social) along with who should provide the interventions, the number of hours for treatment, and where the treatment should take place e.g., home, school.

Progress Note – A form TSS use to collect data on students' behavior; TSS also document interventions they administer to the student.

Treatment Plan – "'A blueprint for change' and a 'work plan,' identifying the strengths of the child and family and identifying areas of functioning to be addressed, desired outcomes, and interventions and services to be used to achieve desired outcomes" (Hansen, 1996, p. 5).

Wraparound Services – Three primary positions in Pennsylvania's BHRS: Behavioral Specialist Consultant (BSC), Mobile Therapist (MT), and Therapeutic Staff Support (TSS).

Treatment integrity – the degree to which treatment is administered as intended (Gresham, 1993). Treatment adherence and treatment administration are used interchangeably with treatment integrity.

Significance of the Study

Wraparound agencies providing TSS services to students in the School District of Philadelphia assist the district in two fundamental ways: manpower and clinical expertise. While there has often been criticism regarding the lack of wraparound agency/school collaboration, wraparound agencies are extremely valuable to schools. District students receive services from over 1200 Therapeutic Staff Support. This number represents 1200 behavioral support employees the district does not have to provide. This is important because

the behavioral support provided by the district in the use of its “one-to-one aides” is mandated by law. In a 1998 federal suit filed by the Education Law Center on behalf of children with behavioral disabilities who were not allowed to attend school without a one-to-one aide (Kellner v. School District of Philadelphia), Education Law Center counsel argued that the School District's practices violated special education law. As a result of the settlement, the school district had to develop and implement policies for providing one-to-one behavioral support services. The terms of the agreement made clear that although the School District of Philadelphia is permitted to utilize wraparound services from community agencies, the entitlement and responsibility remains with the school district (Provenzano, 2001). Therapeutic Staff Support are assets to the district because, unlike one-to-one aides, TSS receive intensive training in behavioral health consultation. Wraparound professionals have clinical expertise for providing behavioral health rehabilitation. Licensed psychologists evaluate students and recommend treatment. Treatment is designed by Behavior Specialist Consultants coupled with wraparound team members and implemented by trained (and many college educated) Therapeutic Staff Support. The district benefits from these valuable resources providing necessary services to students with a severe emotional or behavioral disorder. Students benefit by receiving quality treatment from trained clinicians and paraprofessionals.

This study is significant to teachers and school officials. By exploring the methods wraparound agencies use to monitor TSS job performance, teachers will learn about appropriate TSS roles thus gain a better understanding of what they do, the importance of what they do, the importance of the way they do it, the extent to which they are monitored, how they are held accountable, and why misutilization poses threats to effective treatment

delivery. When teachers and school officials understand mechanisms wraparound agencies have put in place to safeguard students from TSS incompetence, negligence, and poor job performance in general, they can be more assured that TSS do not operate autonomously whereby their behavior goes unchecked.

To wraparound professionals, this study is significant in that findings reveal agencies monitoring practices, how those practices address TSS treatment administration, and ways certain documents shape treatment integrity. The study is also significant because it addresses problems TSS encounter, their responses to those threats, and the quality of TSS data collection efforts. This is important because, in behavior literature, adequate attention has not been given to documenting the integrity of treatment (Billingsley et al., 1980; Salend, 1984). Wraparound services studies and treatment integrity studies on BSC and TSS services are needed to learn more about how treatment protocols are developed, administered and monitored. This helps clinicians design better treatment and provide appropriate training and corrective feedback to help TSS carryout their roles more effectively.

CHAPTER 2

REVIEW OF LITERATURE

Protective factors moderate the effects of individual vulnerability or environmental hazards so that the adaptational trajectory is more positive than would be the case if the protective factor were not operational.
Masten, Best and Garmezy (1990)

Therapeutic Staff Support provide individualized direct care in many settings to children diagnosed with a severe emotional or behavioral disorder (sebd). Historically, the primary educational venues for addressing the educational needs of students with sebd were restrictive settings e.g. special day schools and residential treatment facilities. These traditional venues, many argue, create abnormal behavior controls which deny students realistic opportunities for learning coping strategies in their natural environments (Knitzer, Steinberg & Fleisch, 1990). Similarly, there is concern that restrictive settings serve as merely an arresting function breeding environmental conditions which threaten students' healthy development (Masten, 1994).

In response to addressing problems stemming from restrictive settings, mental health professionals in Pennsylvania developed innovative service delivery approaches to children's mental health by creating wraparound services that enable students with sebd to be placed in their natural settings (aka least restrictive environments), when appropriate, by utilizing TSS to provide one-on-one, intensive treatment. This represents a major paradigm shift not only in terms of venues in which treatment is administered, but it is a significant shift in therapeutic practices from therapists providing treatment to using paraprofessionals. Hence, in a time when mental health professionals are expanding service delivery options undergirded by use of paraprofessionals as treatment agents in non-traditional settings,

treatment integrity takes on added significance. Ultimately, how well wraparound agencies' monitor TSS job performance is foundational to understanding TSS treatment integrity.

Wraparound and treatment integrity literatures shape this research. Section One provides a brief overview of two approaches to mental health services for children with sebd, and a description of one service delivery model. Section Two highlights two issues in wraparound services. Section Three discusses four issues in treatment integrity research. Section Four offers a critique of three wraparound services studies. Chapter Two ends with an internal summary.

Section One. Wraparound

Wraparound Process

While the term *wraparound* is a buzzword in mental health literature, there is more than one wraparound, hence an important distinction of the term wraparound must be addressed. Behar (1986) coined the term wraparound which she described "...as a way to 'surround multi-problem youngsters and families with services rather than institutional walls, and to customize these service.'" Wraparound, as defined by VanDenBerg and Grealish (1996),

> is a process based on a philosophy in which services are highly individualized to meet the needs of children and families. [This process] refers to a specific set of policies, practices, and steps which are used to develop individualized services and supports for children who are experiencing ongoing emotional problems. (p.7)

There are several theoretical frameworks which comprise wraparound. VanDenberg, considered to be a U.S. pioneer of the Wraparound Process, contends that wraparound is a strengths-based, needs-based, ecology-based approach to service delivery. The wraparound philosophy is included elsewhere (Appendix A). One component within wraparound is its strengths-based approach. In this approach, because a child's deficits are clearly obvious,

wraparound uses the child and family's strengths as a starting point for therapy. Wraparound attempts to capitalize on what the child and family do well and then uses those strengths to help design approaches to treatment.

A second component within wraparound is its needs-based approach. This approach essentially examines all the needs of the child and family. For therapy to be successful, the approach essentially proposes that all the needs of the child be addressed. It is individualized in the sense that all services are tailored to meet the needs of a specific child as opposed to fragmented service patterns. That is, if a child requires assistance in several life domains (medical and health, educational and vocational, cultural, spiritual, recreational, etc.) as well as across systems (e.g., education, child welfare, juvenile justice, foster care, health, and mental health) then wraparound provides those services based on the "needs" of the child by identifying and utilizing appropriate strategies and interventions (VanDenBerg, 1993).

The third important component to wraparound is based on an ecological model. Burns and Goldman (1994) contend that "an ecological perspective ...means that development occurs in the context of interactions between the child and his/her environment e.g., home, school, and community, service system(s)" (p. 13). Hence, as opposed to obtaining treatment in a clinical setting, the wraparound process provides necessary supports to treat the child in his/her natural setting.

Finally, wraparound is based on the notion of unconditional care. “Unconditional care,” according to VanDenBerg (1993), "means that if the youth's needs are not met, the individualized program will be changed, and the youth cannot be 'kicked out' when he or she exhibits the very disabilities which stimulated entry into the services in the first place" (p. 250). As Eber, Nelson and Miles (1997) put it, "Rather than concluding that the student 'isn't

able to succeed in the program,' the team assumes responsibility for changing the plan to make it work for the student" (p. 545). The wraparound process as envisioned by VanDenBerg and others is considered to be the premier philosophy of service delivery in children's mental health due to its multidimensional framework and clearly defined guiding principles. This philosophy, which has been translated into guiding principles, has been adopted by states across the country. In one study, eighty eight percent of states reported use of the approach (VanDenBerg, 1999).

Wraparound Services

While the term wraparound is widely used in children's mental health, most mental health agencies do not "operate consistently with the definition, values, elements, and requirements" (Burns & Goldman, 1994, p. 15) of the highly developed wraparound process although a number of states are adopting variations of wraparound's philosophy and guiding elements (VanDenBerg, 1993). The State of Pennsylvania, for example, refers to its Behavioral Health Rehabilitation Services (BHRS) as "wraparound" though the orientation is different. The term, as it is used in Pennsylvania, refers to a specific service delivery model. Addressing the distinction of the wraparound process from wraparound services is important because they are dramatically different. The specific service addressed in this study is BHRS. In Pennsylvania mental health circles, "BHRS has been referred to by other designations …such as 'wraparound services,' 'home and community services,' 'enhanced mental health services,' and 'EPSDT services'" (Hodas, 2004, p. 16). Wraparound services in Pennsylvania are medical assistance fee schedule services designed to provide behavioral health rehabilitation to children.

Unlike the wraparound philosophy, which is a holistic approach to treatment, the wraparound services model is itself limited in scope. The additional supports attendant in wraparound as it was conceived by VanDenBerg are far more comprehensive in its practices and processes than wraparound services. Whereas the wraparound process focuses on myriad services tailored to meet the needs of the child, wraparound services seek to address behavioral health in its strictest sense, that is, children's emotional or behavioral disorders. Also wraparound services actually refer to people (BSC, TSS, MT) who deliver services based on a behavioral consultation service delivery model. The one similarity, aside from the term wraparound, is its principles of children's mental health. The CASSP principles driving Pennsylvania's children's mental health are consistent with VanDenBerg's philosophy and guiding principles in many ways (Appendix B).

Behavioral Consultation

Bergan (1977) conceptualized a theory for addressing mental health issues. Kratchowill and VanSomeren (19985) note the purpose of behavioral consultation "is to design a plan of treatment [for students experiencing behavioral problems] and insure its subsequent application" (p. 227). Elliott and Busse (1993) add this plan of treatment is achieved through "collaborative, systematic-problem-solving activit[ies] between a consultant and consultee" (p. 179). Central to this model is a four-phase problem-solving process: problem identification, problem analysis, treatment implementation, and treatment evaluation.

> In the first stage, *problem identification*, the consultant interviews the consultee to elicit a clear description of the problem the child is experiencing. In this step, the nature of the behavior is clearly defined and operationalized. The second stage, *problem analysis*, involves direct observation of the behavior to determine its characteristics e.g., frequency, intensity, and/or duration of behavior. In the third stage, *plan implementation*, the intervention plan is implemented and monitored.

> Monitoring is both formative, involving on-going data collection and summative, assessing the effectiveness of the intervention. The final stage, *evaluation of the intervention*, assesses the effectiveness of intervention or refinement to ensure treatment effectiveness. (Henning-Stout, 1993, pp. 24-25)

Consistent with behavioral consultation, in BHRS there are consultant and consultee roles. The Behavioral Specialist Consultant and Therapeutic Staff Support are two important services. But the BHRS model differs from the Bergan model in that those roles have been tailored to suit mental health professionals who wish to provide professional services both in and out of the classroom. Initially designed to address problems with a consultant (psychologist) and a consultee (teacher), wraparound professionals adapted the behavioral consultation model to include several personnel. Whereas the psychologist in the school setting was responsible for all four phases of the model, in wraparound services an entire team addresses each stage of the treatment process. The model also is used in home and community settings. There are other model differences particularly in stages one and two that warrant explanation. Although the central stages of behavioral consultation were tailored to accommodate a wraparound services approach to treatment delivery, wraparound professionals do adhere to a four stage problem solving process and two of the four stages are strikingly similar to the original model.

Under the revised model, the *problem identification stage* begins with a psychologist who makes a family assessment, evaluates the child, makes a diagnosis, and recommends treatment. This differs from Bergan's model in that under the BHRS model a licensed psychologist is used to get a "clear description of the child's behavior" as opposed to using a consultee. Additionally, part of the recommendations a psychologist makes is based on staffing needs. This term treatment, when narrowly defined, only focuses on specific interventions to be carried out. However, in the treatment process, all services provided are

considered treatment as well. Services (BSC, MT, TSS) are recommended based on the child's diagnosis which dictates what the psychologist deems are prescribed hours of treatment needed to provide quality services.

In the *problem analysis stage*, under the original model, a consultee collects data on a student's behavior and that information is given to the psychologist who would make an assessment and design a treatment plan. Under BHRS, input from myriad sources based on many factors is given to the consultant, not psychologist, who then writes the treatment plan. A functional behavioral assessment, for example, is used as a starting point for problem analysis. Wraparound clinicians conduct these assessments and use them to help BSCs design appropriate treatment. Ideally, TSS collect data on the frequency, intensity and duration of behaviors a student exhibits in school which is consistent with the problem analysis stage. Both dimensions exceed Bergan's conceptualization of how a student's problems are diagnosed and observed before treatment is developed, implemented, and ultimately assessed. Other pertinent information is obtained from treatment team members, and then a treatment plan is developed. Sterling-Turner, Watson, Wildmon, Watkins, and Little (2001) note, "This represents a departure from traditional BC in that the treatment plan was not constructed through complete collaboration with the consultee" (p. 56).

Plan implementation, in my estimation, can be considered the "treatment integrity" stage. According to Feld et al. (1986),

> [w]hen the [treatment] plan is put into operation, the consultant monitors implementation and data collection and assists the consultee in making sure that the plan is functioning in the proper manner. When the need arises, the consultant works with the consultee to revise the plan to make it function in the desired fashion. (p. 190)

In behavioral consultation, plan implementation is the treatment integrity stage because essentially this is where treatment administration is monitored. This is an important stage relevant to this research because it focuses on consultees' delivery of treatment which calls for accountability. The model takes into account the need to monitor paraprofessionals' treatment administration. According to the literature, there are myriad strategies for monitoring mental health professionals: direct and indirect methods. Direct methods of monitoring include observations, in vivo sessions, supervision, videotapes, audiotapes; indirect methods include various forms of documentation e.g., progress notes, checklists, scales, interviews, self-reporting, manuals (e.g., Bellg et al., 2004; Dobson & Singer, 2005; Gresham, 2005; Perepletchikova & Kazdin, 2005). Direct methods reveal the most useful data because the evaluator can see exactly what is happening whereas indirect methods are based on less reliable information. Ideally, direct observation is the method of choice for determining TSS treatment integrity. Examining stage three helps researchers explore ways wraparound agencies monitor TSS to determine the extent to which they administer treatment as intended.

Another aspect of plan implementation is documentation. We learn that "establishing data collection procedures is a primary goal of behavioral consultation" (Wickstrom, Jones, LaFleur & Witt, 1998, p. 147). The consultee must deliver pertinent information back to the consultant in order for the consultant to make adjustments to the interventions, if for example treatment acceptability is an issue, or to identify problems with improper treatment administration. TSS documentation is important because progress notes should capture student behavior, events that trigger certain behavior, treatment administration, and student's response to treatment. Progress notes should be reflective of what's going on.

Section Two. Issues in Wraparound Services

Major issues in wraparound services literature center on BHRS services. Some issues include reduction in TSS qualifications (Hodas, 2004; Ievoli, 2001), training TSS (Clarke & Cautilli, 2001), and revamping TSS practices (Cautilli & Rosenwasser, 2001). Agencies within this system of care have expressed concern with the ways in which programmatic flexibility has impacted service delivery particularly overutilization (Hodas, 2004). Other issues which bear directly on this research are as follows: Behavioral Specialist Consultant training, and two concerns about TSS: misutilization and treatment integrity. (Note: Treatment integrity is not a part of Section Two. Section Three is exclusively devoted to issues in treatment integrity literature.)

Overutilization

Overuse of wraparound services is a direct result of "the federal Omnibus Budget Reconciliation Act of 1989 (OBRA 89) [which] established that children up to age 21 who are enrolled in Medical Assistance are entitled to medically necessary services, including a wide range of home and community-based mental health services" (Ievoli, 2001, p.1). OBRA 89 mandated states, particularly those receiving federal funding, to provide children's mental health services as an alternative to restrictive placements (Ievoli, 2001). States could develop creative service delivery models using their own discretion and the clinical flexibility OBRA 89 afforded states led to innovative services. Pennsylvania's approach to providing children's mental health services is unique in that service descriptions are fairly broad. Hodas (2004) explains:

> The availability of BHRS in Pennsylvania emanates in large measure from the Commonwealth's conscientious interpretation and implementation of OBRA 89. Although frequently equated with three specific off-site services that have been listed on the Pennsylvania MA fee schedule, BHRS as a service designation can encompass

> a broad range of individualized services for the children. In fact, initially the Pennsylvania Department of Public Welfare (DPW) encouraged providers to submit their own service descriptions for services deemed medically necessary for one or more children with sed…. This approach…recognized and acknowledged the potential variability and flexibility of a service array subsumed under the designation of what we now refer to as BHRS. (p. 15)

No longer bound by limited service options, Pennsylvania wraparound agencies created unique community-based services for children specifically wraparound services (TSS, BSC, and MT). The first of the three services most commonly used was TSS which "served as a parallel, or alternative, to some of the interventions available through the Family-Based Mental Health Services program, allowing more flexibility and intensity than this program could sometimes offer" (Ievoli, 2001, p.2). The TSS service was conceived as a step down from family based therapy (M. Hansen, personal communication, 8.14.2007). The two services, TSSand MT, were the first services. When the TSS service was requested so frequently, there was a need agencies to create other services to accommodate the demand for other services (e.g., BSCs). This presented a problem to wraparound agencies for two reasons. First, when the TSS service was initially conceived, psychologists (those with specialized skills for applied behavior analysis), not BSCs, designed treatment plans. However, with the expansion of services, the BSC service, which was designed to be an "exceptional service," came later (Hansen, 2007; Hodas, 2004) and the problem was that agencies began routinely relying on BSCs due to their limited understanding of the philosophy undergirding the service (Hodas, 2004).

In wraparound services, Behavior Specialist Consultants (BSCs) are members of a wraparound team serving as consultants to professionals (therapists, psychologists), parents, schools, and other community agencies to provide behavioral services to children with sebd. A major concern with this service is BSCs' lack of training in behavioral consultation.

BSCs, while are mental health professionals but they were trained under mental health models and sometimes they have challenges changing to a behavioral consultation mindset. (Cautilli et al., 2000). Though BSCs hold advanced degrees in mental health related fields, they are not therapists as such. In wraparound services, the Mobile Therapist (MT) is recognized as the designated therapist who provides treatment to the child and family. BSCs perform a highly defined function (as consultants) that is compromised when they deviate from it and act as therapists.

Due to overutilization, wraparound agencies were literally forced to accommodate families requesting these services before institutional supports were put in place. As a result, many BSCs were hired with no training in behavioral consultation and there were problems with BSCs' case conceptualization which impacted their skill in treatment plan design.

> We find that many BSCs with little training in working from a developmental approach simply go through their 'bag of tricks' without a systematic approach or theory guiding why they would prioritize treatment goals as they do. In order to take a developmental approach, clinicians must be familiar with research on the developmental trajectory or pathway that a child with a particular diagnosis will tend to follow. They must also be familiar with normal child development. The goal of intensive treatments such as wraparound should be to help the child back toward a normal development pathway, as much as feasible. (Cautilli et al., 2000, pp. 43-44)

Providing training for BSCs is critical to their success as consultants. Therefore, being grounded in therapeutic approaches for children is essential.

There is also an issue of poorly designed treatment due to limited knowledge of some behavioral interventions. Cautilli et al. (2000) maintain that because BSCs have received extensive training in some therapeutic interventions, they cannot arbitrarily utilize behavioral interventions on that basis alone. Hence, improper treatment design is potentially problematic when BSCs have not received training in behavioral consultation. Ultimately, while overutilization is a concern to wraparound agencies, due to court rulings which mandate that

these services be made available coupled with the high demand for services, as well as routine bundling as opposed to creating more innovative services, decreased utilization was slow. Toward that end, agencies must focus on extensive training for the two major services (BSC/TSS) to ensure that high quality services are provided.

TSS Misutilization

In wraparound services, Therapeutic Staff Support function as consultees. Based on the behavioral consultation model, a consultee works directly with the child to provide treatment based on a consultant's treatment plan. Historically the TSS service was created as a therapeutic service. There was never an educational focus e.g., teacher's aide; the role has always been therapeutic in nature (Hansen, 2007). However, due to expanded services and lack of clearly established roles, misutilization problems occurred (Cautilli et al., 2000; Hansen, 2007; Hodas, 2004; Ievoli, 2001). Ievoli (2001) explains the problem in this way:

> Since use of TSS was rather flexibly defined, various providers tended to interpret the guidelines in different ways. As a result, TSS workers were soon operating in a wide range of settings, performing functions not initially anticipated. This lack of specificity, or standard of care, in TSS services, has been discussed and debated among providers. At issue was the belief that TSS services were being overprescribed and misapplied. Some providers advocated for the development of a set of guidelines or standards to which all providers could adhere; others favored the flexibility the bulletins afforded each agency to be creative in their use of TSS. (p. 2)

Misutilization became so widespread that the Pennsylvania Department of Public Welfare developed guidelines for appropriate and inappropriate uses of TSS. TSS were used in non-therapeutic roles ranging from respite workers to teacher's aides. This misuse of TSS caused widespread problems in wraparound so much so that the image of this service was tarnished. Efforts were put in place as a countermeasure for the persistent trend of misutilization. Ievoli (2001) references state officials' concerns regarding TSS services. He wrote:

> In 1997, OMAP formed a workgroup to examine and correct problems in the delivery of TSS services. Subsequently, a draft bulletin was released and subjected to public review, revising requirements for provision of TSS, including staff qualifications, supervision and training. (This draft bulletin also addressed mobile therapist and behavioral specialist consultant services.) A series of communications from OMAP addressed appropriate and inappropriate uses of TSS, and the PA CASSP Training and Technical Assistance Institute developed a three-day training sequence for TSS workers and supervisors which was formally endorsed by the Department of Public Welfare (DPW) in a letter to providers in June 1998. (p. 3)

In addition to the training sequence, a document listing "TSS Don'ts" was created as a guide for wraparound providers to use (Appendix C).

Similarly, in order to curtail TSS misutilization, training and supervision of wraparound services (BSC, MT, TSS) took on added significance. While these two dimensions are crucial to providing quality care to children, they were not occurring on a large scale. As institutional supports began to be put in place, training and supervision guidelines became more stringent. Myriad polices and procedures related to these three services were constantly being developed and updated to ensure appropriate utilization.

Training and supervision of TSS is especially important, says Ievoli (2001), because "out-of-office service delivery [using paraprofessionals] presents a plethora of unusual or disruptive occurrences challenging faithful adherence to the treatment plan" (p. 8). BHRS must provide ongoing training and supervision particularly for TSS because paraprofessionals encounter a host of problems they are unable to address because they are not clinicians. BSCs must have training as well to ensure they have a foundational understanding of behavior analysis.

Issues discussed in this section are of particular importance in wraparound services as their impact have implications for the duality of services provided and ultimately for the achievement of the goals of helping children achieve normal developmental pathways. As

wraparound services assumed greater flexibility and accessibility, through federal laws and funding, and created greater access for children with sebd, wraparound providers' philosophical understanding of the service lagged behind. The results were overutilization, misutilization, and compromising of functions and roles since training and offering clear definitions of roles essential to success of the service were not adhered to. These factors point to wraparound agencies' need for strong monitoring practices in order to minimize threats. To ensure program quality and integrity, monitoring measures must be put in place not just to "quality control for discrepancies," as Cautilli et al. (2000:48) have said, but as a system of monitoring treatment integrity.

Section Three - Treatment Integrity

Perhaps the greatest issue facing wraparound providers is ensuring treatment integrity. Given the nature of the wraparound services model, paraprofessionals administer treatment directly to children. Because therapists are not administering treatment in school settings, treatment integrity is potentially diminished. While treatment integrity is a concern in BHRS, there is a limited discussion about it in wraparound services literature. Therefore, it is necessarily for me to use treatment integrity literature to examine issues in treatment integrity research that impact documentation and implementation threats.

Treatment integrity has been defined as the degree to which an intervention is implemented as intended (Gresham, 1989; Kazdin, 1980; Moncher & Prinz, 1991; Peterson et al., 1982; Salend, 1984; Watson, Sterling & McDade, 1997; Yeaton & Sechrest, 1981). In examining some of the central issues associated with treatment integrity, the following factors emerged: (1) lack of reporting treatment integrity data in behavioral studies, and (2)

several threats to treatment adherence. The next section discusses these central issues in greater detail.

Integrity Research

First, the state of treatment integrity in behavioral research has been addressed in several significant meta-analyses (Billingsley et al., 1980; Gresham et al., 1993; Moncher & Prinz, 1991; Peterson et al., 1982). A major issue raised in treatment integrity literature is that few studies systematically assess, monitor, or report the integrity of independent variables (Gresham et al., 1993). These widely cited meta analyses reported that less than 20% of researchers in behavioral journals studied reported monitoring/assessing treatment integrity. These meta-reviews are illustrative of the lack of importance placed on reporting treatment integrity in behavioral research. Peterson et al. (1982) explain it as being a "double standard" e.g., measures of reliability of operational definitions are reported with dependent variable, but are seldom reported as independent variable. Few researchers disclose monitoring practices.

Researchers rarely report assessments of treatment plans. It is understood that treatment plans do in fact drive treatment but there is a dearth of research on treatment plans. When I was contemplating this study, it was practitioners who informed me that in order to get at TSS job performance, I had to look at treatment integrity. As I began to research treatment integrity, treatment plan data was noticeably absent. The literature discussed methods to document the "occurrence and nonoccurrence of treatment components" (Gresham, 1989) treatment agents were observed performing based on permanent products and checklist scales. However, there were no references to treatment plans or how those treatment components were written on the plan. It is generally understood that therapists or

psychologists design treatment and their expertise is not questioned. However, in wraparound services, therapists and psychologists do not design treatment, consultants do. This poses potential problems for wraparound agencies. According to Cautilli et al. (2001),

> Since the consultation model differs substantially from the therapy model, good therapists are not necessarily good consultants. Therefore all BSCs should have formal training in consultation…. Failure to have BSCs who are trained in behavioral consultation leaves open the possibility that BSCs will practice mental health consultation instead of behavioral consultation. (p. 43)

This shift helps explain how treatment integrity is also applicable to consultants. Therefore, a likely starting point for exploring treatment integrity was to analyze treatment plans to determine if descriptions of target behaviors and interventions were written in observable, measurable ways that offer clear instructions for TSS to follow.

One article proved especially useful for analyzing treatment plans. Hansen's (1996), Writing effective treatment plans," was the model for determining essential elements of treatment plans as well as writing examples for target behaviors and interventions. Hansen also included a pertinent discussion on "Pitfalls of writing treatment plans." This article supports the idea of training mental health therapists for behavioral consultation not just in terms of different theories but how to design treatment based on such theories. Although much of the information contained in that article is well beyond the scope of this research, the components needed to analyze treatment plans were on point. Toward that end, given the shift from therapists to consultants as treatment designers, I argue that the nature of work BSCs perform encompasses some aspect of treatment integrity. Therefore, examining the plan itself must precede any analysis of how well TSS follow the plan.

There is an issue in treatment integrity research related to treatment agents and operational descriptions but it is applicable to consultants as well. Operational definitions mean describing the exact way treatment was delivered. How well those designing treatment

define the intervention it is equally important; that is, consultants should describe on treatment plans examples indicating exactly what should be said and done in order for TSS to effectively administer treatment. Treatment integrity researchers often fail to mention the importance of describing treatment that is easy for treatment agents to follow. It is often assumed that treatment plan developers write good treatment plans and if there is a problem with treatment integrity, it is related to the degree to which treatment agents adhere to the treatment plan as opposed to problems with the plan. Both aspects of treatment integrity should be examined. Not doing so poses a potential threat to consultees when they administer treatment. The next section highlights other integrity threats as discussed in the literature.

Integrity Threats

Several threats to treatment integrity are discussed in the literature. Areas identified include client characteristics (Gresham, 1989, 1996; Hennessey & Rumrill, 2003; Perepletchikova & Kazdin, 2005), consultee characteristics (Dobson & Singer 2005; Gresham, 2005; Nezu & Maguth-Nezu, 2005; Watson & Robinson, 1996), training issues (Bellg et al., 2004; Flannery-Schroeder, 2005), monitoring practices (Gresham, 2005; Lane, Bocian, MacMillan, & Gresham, 2004), and environment issues (Hennessey & Rumrill, 2003). The most widely discussed threats to treatment integrity center on four specific aspects of treatment: treatment acceptability, complexity of treatment, therapist's drift, and methodological issues centering on three aspects of documentation: operational definitions, treatment plans, and progress notes.

Treatment Acceptability

Treatment acceptability, "a judgment of the appropriateness and likely effectiveness of a given treatment for a given problem" (Dunson et al., 1994, p. 249) is a major threat to

treatment integrity. An important aspect in behavior literature is building on effectiveness research in terms of behavior interventions. When students are responsive to the same treatment, this suggests a functional relationship between treatment and behavioral changes (Galloway & Sheridan, 1994). However, there are some interventions used where evidence of their effectiveness is not known (generally, those elements added when administering treatment). Hence, the issue of using untested interventions can impact the effectiveness of treatment. Researchers have suggested that when consultees have issues with specific interventions and do not approve of designed treatments, treatment integrity is expected to be generally low (see Dunson et al., 1994; Galloway & Sheridan, 1994; McDougal & Hiralall, 1998). As for treatment integrity, measuring how interventions are administered enables researchers to determine the applicability of effective interventions with diverse populations.

Complexity of Treatment

Complexity of treatment is another threat to treatment integrity. Gresham (1996) observed in examining behavior change, "[a] general principle…is that the more complex the treatment is, the lower the integrity of that treatment is" (p. 101). Multi-component treatments, for example, are problematic because numerous treatment protocols are required. This is where Gresham's framework, based on operationally defining interventions in global, intermediate, and molecular definitions is instructive. When myriad steps are required for an intervention to be implemented effectively, and if that information is not fully articulated in step-by-step terms, treatment agents are likely to experience difficulty with treatment administration and interventions are less likely to be administered as intended or may be abandoned altogether.

Therapist's Drift

Therapist's drift is a problem discussed in the literature. Researchers want to know why consultees alter treatment. In terms of describing specific aspects of treatment (e.g., design, acceptability and complexity) there a host of other reasons why a therapist drifts. Recall, client and consultant characteristics, environmental challenges, training, and time are factors but there may be other factors as well. Therapist's drift is particularly important to the TSS service because these services are unique in many ways. First, as an off-site service, there are myriad problems which pose threats to service delivery. Because consultees work without direct supervision, things can occur that they are not prepared to handle. In the traditional sense, teachers-as-consultees are generally under the watchful eye of a psychologist (consultant) who designs specific behavioral interventions to be used for changing mild behaviors in students, not students with sebd. TSS are faced with the unique challenge of administering treatment (without onsite supervision) to students with sebd who are likely to need numerous interventions in a given day. The impact of administering multiple interventions repeatedly throughout the day is not known either which raises the question, Do TSS consistently implement treatment?

Second, due to the intensive nature of how services are provided, treatment integrity is much more difficult for TSS to maintain. In the literature, studies on consultees administering treatment are short in duration (usually one hour) per day. TSS work with students for several hours per day. Whereas it was reported in studies some consultees found treatment difficult to administer because of time constraints (teachers as consultees in particular), time is not a non issue for TSS in that regard. Time may, however, be a factor when treatment must be administered over a long period of time (e.g., entire school day

versus one hour per day). No one really knows what happens when specific treatments have to be repeated numerous times during the course of a day. TSS are expected to collect data on a student's behavior as well as document each time an intervention is used during the course of a day. So the question becomes, Are TSS so obsessed with capturing a student's behavior that they fail to administer treatment properly?

Documentation

Another issue related to treatment threats deal with three aspects of documentation. One documentation threat is poor operational definitions of treatment. Fraenknel and Wallen (1996) define that terminology in this way: "Operational definitions require that researchers specify the actions or operations necessary to measure or identify the term" (p. 29). If the descriptions of interventions are vague, that is not measurable, those descriptions hinder treatment integrity. Gresham (1989, 1996) and Hansen (1996) have developed frameworks for operationalizing treatment. As was alluded to earlier, Gresham's framework offers two specific approaches to specifying treatment components. One approach is to describe treatment in three ways: in global, intermediate, and molecular terms. According to Gresham,

> A global description of treatment is general and not measurable; an intermediate description involves writing down major steps of treatment; a molecular description is a highly defined task analysis of every aspect of administering an intervention. This description is reserved for the use of highly complex interventions. (1989, p. 40)

Global descriptions are the most common descriptions found on treatment plans. Few consultants provide descriptions with Gresham's second and third level of specificity. Intermediate steps may be described occasionally for cases where explanations point to simple steps but rarely are complex descriptions used on a treatment plan.

A second approach is to describe treatment based on four dimensions: verbal, physical, temporal, and spatial. Gresham's (1993) dimensions determine precisely how the intervention is administered and can be measured with a great deal of precision.

> The temporal dimension refers to the occurrence of undesirable behavior; verbal refers to procedures for administering [an intervention] e.g., time-out by informing the child to of time-out; physical refers to the designated time-out space; and spatial refers to the consultant placing the child in the location. (p. 261)

These two detailed approaches to treatment describes how an intervention is being administered, and when measured, determines the extent to which the treatment was altered. Based on the level of specificity required to ensure appropriate implementation in terms of the complexity of interventions, Gresham's approaches are helpful. However, when simple interventions are used, there may be more appropriate approaches to operationally defining treatment.

The interesting thing about treatment integrity, from this standpoint, is that treatment is designed by one person and then administered by another. It is suggested that treatment plan "designers" use these models to write out interventions but it is not clear if treatment agents are expected to write up how treatment was administered in the same way. Researchers generally include customized documents to capture behavior that lists steps for an intervention (e.g., Gresham, 1989). There is no need to record this information based on a qualitative format. However, most treatment agents do not have the luxury of using customized documents. They must write, in narrative form, the behaviors they observe and how they administered treatment. Hence, if it is important to know the extent to which "treatment is administered as intended," then it seems the same standards for treatment "designers" should apply to treatment agents when they have to collect qualitative data. This makes it even more vital to have operational definitions of treatment on treatment plans. If

plans contain "global descriptions," treatment agents, then, are faced with nebulous definitions which leave room for much interpretation. More concerns with treatment agents' operational definitions will be discussed in the third aspect of documentation.

Another aspect of documentation threats deals with treatment plans. Unlike Gresham (1989, 1996) frameworks which focus solely on how interventions are described on treatment plans, Hansen (1996) addresses each aspect of the treatment plan in detail, because in order to achieve clear insight into treatment integrity, one must begin with the treatment plan. Hansen offers two frameworks that are comprehensive in scope. In a technical assistance paper, "Writing effective treatment plans: The Pennsylvania CASSP Model," Hansen provides "a thorough [description] of how children's mental health is conceptualized and delivered" (1996, p. 2). In this document, Hansen specifies essential considerations for writing treatment plans namely (1) components that should be included on every treatment plan, (2) language describing components, and (3) language describing interventions. These essential considerations serve as a framework for evaluating the quality of treatment plans.

There are two sets of issues quite instructive for evaluation. First, in the section titled "pitfalls in writing the methods section of the treatment plan," Hansen identified 19 common problems BSCs and clinicians encounter when designing treatment plans. This list covers a host of problems that are inconsistent with CASSP principles from ignoring individualized, strengths-based, needs-based approaches to treatment specificity issues (not identifying who, what, when, where, how treatment will be implemented in clear terms). In "pitfalls in writing treatment plans," Hansen elaborates further on specific issues related to writing poor goals and objectives as well as inappropriate use of language (jargon, generic or offensive) for describing problems lacking behavioral dimensions.

The treatment plan is the key document for appropriate treatment implementation. Few researchers offer substantive discussions about treatment plan design despite knowing that a poorly defined treatment plan can be a primary threat to providing quality treatment. There are clear examples of how treatment plans should be written but few researchers have evaluated the overall quality of treatment plans--not just a plan's methods section which describes interventions to be administered. Hence the integrity of treatment is discussed in a narrow sense e.g., how interventions are used, although many other components of a treatment plan are in fact considered treatment as Hansen, quite rightly, points out. Additionally, the information discussed in this document, is in many respects applicable to evaluating progress notes.

A final documentation threat deals with the progress note, another area that is not researched. Progress notes are data collection instruments that serve a two-fold purpose: first, notes capture a student's observed behavior; second, notes include qualitative descriptions of how a treatment agent administers treatment. The instrument used to collect these data requires the treatment agent to describe interventions in ways that are measurable. Due to the relationship between a treatment plan and progress notes, there should be a perfect match. That is, if treatment plans contain interventions that are described in clear detail, the same description of interventions should be contained on progress notes. The expectation is that TSS are taught to describe how they administer treatment using standard language for operationalizing treatment. There should be no ambiguity because each intervention should be clearly spelled out. Hansen also provides a framework for evaluating the quality of progress notes. On progress notes, TSS should specify student's target behaviors,

interventions used, how a student responds to interventions, descriptions of incidents, how goals were addressed, and a brief narrative of student's behavior that day.

The way in which statements are phrased is central to determining treatment integrity. Wraparound professionals stress the importance of using appropriate terminology and writing progress notes in observable and measurable ways. There are several reasons for appropriate terminology use: first, TSS should not to make personal judgments. Only a TSS' clinical impressions should be noted; second, TSS must provide a clear description of student's behavior. This is to capture the occurrence of target behaviors as well as other behaviors that might occur; third, TSS must state interventions used in the context of addressing specific behaviors. Explaining treatment procedures in detail (observable and measurable terms) is treatment integrity; fourth, TSS must describe how the child responded to the interventions.

Examining how wraparound professionals operationally define treatment cannot be overemphasized. For the BSC, it is important to define target behaviors and interventions in a concise manner so TSS have no difficulty in following the treatment. Vague or global descriptions can make treatment administration difficult particularly in the case of employing complex interventions. For the TSS, writing down behaviors in observable and measurable terms helps wraparound professionals evaluate behaviors and make treatment adjustments when necessary. Poor TSS documentation, be it ill-defined treatment delivery or failure to include frequency, intensity and duration of behaviors observed compromises treatment adherence. Therefore, capturing accurate data and writing it appropriately helps establish treatment integrity.

Section Four. Studies on Wraparound Services

In an exhaustive database search, only four studies on Pennsylvania's "wraparound services" emerged: Desmone (2004), MacFalls (2002), Supon and Rowe (1998), and Toffalo (2000). While all four studies address TSS in some way, only three of the studies help inform this research. MacFalls (2002) was excluded because it explored four principles undergirding the wraparound process as opposed examining TSS directly. I begin by analyzing each of the studies in reverse order of importance.

Supon and Rowe (1998) conducted a qualitative study in which twenty two TSS were interviewed. Their study, "Promising behavioral intervention practices in the inclusionary classroom," focused on exploring interventions TSS used that are promising practices for teachers. What I thought was especially promising was the fact that all TSS in this study earned bachelor's degrees in behavior modification. They were not the typical TSS paraprofessionals. They were in a good position, based on their academic training, to provide useful information about treatment integrity. Unfortunately, there was a focus on classroom instruction and not treatment implementation. There were not any recommendations provided for "best TSS practices" which leads one to wonder why behavioral issues were not addressed.

I was hopeful this qualitative study would shed light on TSS perceptions of their role, treatment integrity issues, etc. but it did not. Because the purpose of the study is never mentioned, it is difficult to grasp what the authors sought to study. There are other problems as well. The methodology was quite vague. It is unknown the type of interviews that were conducted (e.g., semi-structured, focus groups), no research questions are stated, and treatment administration is not discussed.

While the role of the TSS seems consistent with the TSS service, "These TSS work one-on-one with an identified student that has been diagnosed by a clinical psychologist as having severe behavior challenges" (p. 3), the emphasis of the study, however, appears to be on ways teachers can use interventions. It is reported what teachers should do to assist students with sebd in terms of creating behavioral and instructional expectations. These recommendations did not come from clinicians but rather paraprofessionals. The authors did not explain how non therapeutic interventions were introduced to teachers nor was there any discussion about why TSS were using non therapeutic approaches to treatment without the consent of clinicians.

Also, there is a major focus on instruction. It is unclear why TSS focused on curricula. This raises a number of questions. How does a curriculum impact the TSS' role? What type of teacher behaviors were observed to suggest a non therapeutic strategy is a best practice? What was the TSS' involvement with instruction? One TSS recommended a manipulative. Why is the TSS making instructional recommendations? How is this instructional manipulative therapeutic? The authors contend "the attempt is to teach the child skill development while not getting bogged down in a worksheet mode" (p. 8) but it is unclear how that relates to a TSS' job. Clearly it seems these TSS were perhaps functioning in non therapeutic roles. The role of the TSS is to provide proactive child management strategies and emotional support not academic support. Not much could else be gleaned from this study.

Toffalo (2000) in his study, "An investigation of treatment integrity and outcomes in wraparound services," examined the relationship between treatment integrity and behavioral outcomes of twenty eight children in central Pennsylvania. The definition of treatment

integrity in this study was "the percentage of service hours prescribed v. received" (p. 351) by BSC, TSS, and MT. Toffalo conducted multiple regression analyses of a Child Behavior Checklist, medical assistance billing slips and logs, and a Treatment Integrity Metric to measure statistically significant relationships between wraparound services (e.g., TSS, BSC, and MT) and behavior outcomes. Results from the statistical tests performed did not indicate any statistically significant effect on treatment integrity and outcomes.

There are some considerable merits to this study particularly Toffalo's discussion on treatment integrity, and specifically identifying, appropriately, wraparound services (e.g., TSS, BSC, and MT services) utilized in Pennsylvania. Unfortunately, Toffalo's choice of methodology seriously undermines his study. Of primary importance is the way in which Toffalo approaches the notion of treatment integrity. Despite his detailed description of treatment integrity, as defined in the literature, Toffalo's method of studying treatment integrity is not consistent with his definition. Recall, treatment integrity is the degree to which a consultee implements a treatment plan as intended. The treatment plan, as all do, consists of behavioral goals and interventions, and roles for all people involved in the treatment process; (prescribed number of hours for each service are generally found on psychologist's recommendations). Toffalo suggested "[t]his study employs an adaptation of a research strategy proposed by Gresham (1989)," namely "the degree of deviation from the number of prescribed treatment hours seen in actual services rendered" (Toffalo, p. 355). Again, fundamentally his understanding of treatment integrity adds little to understanding the quality of care clients receive. To be sure, wraparound services and the assigned number of hours are considered treatment. However, examining the relationship between change in a student's behavior based on the amount of hours a BSC, TSS, and MT works does not

address how treatment was administered. Hence, treatment integrity, in its truest sense, cannot be understood in the context set forth by Toffalo. Based on Gresham's (1989) definition, treatment integrity may best be examined by describing actual interventions (e.g., token economy, modeling, response cost and so forth).

Desmone (2004) studied "Special education teachers' concerns regarding the use of TSS in the school setting." Using a mix methodology research design, Desmone collected data from teacher questionnaires (n=65), teacher interviews (n=13), and classroom observations (n=9). This study bears directly on this research in several ways. First, the "threat" of misutilization is realized when one considers the purpose of this study. Desmone suggests TSS should be utilized in non therapeutic ways which raises the question: If TSS function in a specialized capacity, why would teachers want TSS to be used in ways they are not designed to provide "specialized" services? I am reminded of other professionals working in schools e.g., speech pathologists and reading specialists. Teachers do not raise issues regarding the "utilization" of these professionals. Perhaps teachers perceive paraprofessionals as support personnel for their own purposes--ways teachers deem suitable. But TSS are not typical paraprofessionals. Many hold bachelor's degrees, receive extensive preservice training as well as ongoing training, and they serve a specific function—TSS deliver treatment. It is the type of service delivery that makes the TSS a unique paraprofessional. TSS work is strictly therapeutic! The nature of the study makes one wonder if teachers, particularly special education teachers, have a clear understanding of TSS work.

Second, in examining some of the findings, one significant finding frequently emerged. TSS responded to misutilization by adhering to the roles in which they were assigned. Although Desmone's purpose was to "give voice to special education teachers,"

the findings also give voice to TSS. Consider, for example, TSS responses to teachers' request for them to perform non-therapeutic functions where TSS reminded teachers of the following: "they have their behavior plans they must follow" (p. 53); there is no way we can monitor the behavior of more than our assigned students. We'd get in big trouble for that" (p. 105); "I'm not allowed to do academics" (p. 116).

In addition to TSS standing firm, some teachers made the following comments that supported TSS adherence. One teacher said this: "I had three or four TSS in my classroom and they were very, very diligent about saying this is my child and wouldn't do anything else with another child whether, I mean even if there was an emergency" (p. 83). Another teacher who wanted a TSS to intervene when one of her students was experiencing problems remarked: "this student is not one o[f] their students so they cannot help" (p. 52). Some teachers are clear about TSS roles and do not exercise their authority to coerce TSS into doing things they are not required to do. Desmone, however, does report a couple of instances where misutilization occurs. One teacher said this: "We made it more that our TSS was just part of our team…and work of course with that client, but not exclusively to that person" (p. 72). How the TSS was utilized is uncertain but it is clear some teachers are persuasive enough to entice TSS into performing non therapeutic practices.

Third, another benefit of this study is Desmone provides many descriptions of TSS in action. Although many observations reflecting teachers' unfavorable views towards TSS working in classrooms were reported, the manner in which the data is presented leaves room for much interpretation. There are instances where teachers expressed concerns that "TSS don't do anything" and at the same time report the "student doesn't need a TSS. [His behavior is fine]." Some may interpret this observation, as I do, that the TSS presence might

be making the difference. A TSS should not be "doing anything" if the student is exhibiting positive behaviors. Also, in these descriptions, we find instances where TSS treatment administration is captured. Desmone recounts one example of a TSS responding to a student being off task. The TSS waited for the teacher's response, then she proceeded to prompt the student twice; as a result, the student got back on task. In another example, when a student was extremely disruptive and exhibited violent behaviors, the TSS talked to the student and ultimately the child was removed from the room. To be sure, it was a potentially volatile situation, but the TSS was able to help the student de-escalate. That teacher's response, however, was "To me a TSS who can't restrain a child is pretty useless" (p. 83). Perhaps that teacher was unaware of TSS no restraint policies except in extreme situations. I believe what the TSS did may demonstrate the TSS skill in delivering treatment in a manner consistent with the treatment plan as opposed to what the teacher felt the TSS should do.

Fourth, yet another benefit is Desmone reports on TSS data collection efforts. While there was one instance a teacher reported a TSS "wasn't up to code with paperwork," there are a number of other instances where Desmone observed TSS writing in their logs throughout the day as well as prior to leaving school. In terms of the quality of TSS data collection, one teacher said this about a TSS assigned to a student in the class: "She knew how to take notes, she knew how to describe them in behavioral terms, she's extremely observant (p. 86). These examples demonstrate TSS were consistently performing their primary roles delivering treatment and collecting data.

Finally, this study contains a significant amount of rich data that helps us better understand how TSS truly function in classrooms, how they interact with students receiving the service, and how they interact with teachers. We also get a better understanding of

teachers' frustrations with wraparound services particularly from the standpoint of not receiving pre-service training about wraparound services or TSS, not being introduced to TSS prior to them being assigned to classrooms, teachers' misunderstandings about utilization, as well as TSS accountability. This study points to the need for collaboration between wraparound agencies and schools to forge better working relationships with teachers and TSS but it also points to TSS functioning in therapeutic roles.

Review of Literature Summary

Approaches to children's mental health have evolved over the past two decades. Mental health professionals have embraced a new philosophy for providing services to children based on several frameworks that drive highly individualized treatment. The philosophical underpinnings of the "wraparound process" allow for variability in service delivery models mental health professionals use and it does not dictate one best way to offer treatment. It does, however, force those in the profession to consider innovative and/or alternative forms of treatment that is "individualized" in some way. This flexibility led mental health professionals in Pennsylvania to create a unique set of services, based on a school behavioral consultation model, to provide behavioral health rehabilitation to students with a severe emotional or behavioral disorder. By the same token, this innovative form of service delivery, wraparound services, has experienced and continues to experience its share of problems. Overutilization, misutilization, negative perceptions of TSS, and undocumented research attesting to wraparound services effectiveness has raised issues regarding its continued viability. This review of literature has also demonstrated the importance of undertaking a study of TSS treatment integrity. Given the use of TSS with a highly

vulnerable population, the settings in which service is delivered, and the seemingly autonomous nature of their work, the need for more research is clear.

The literature also provides clear guidelines for how a study focusing on TSS treatment integrity, for example, should be undertaken. The different aspects of treatment integrity and its importance in behavioral health rehabilitation was discussed. Few studies have progressed beyond treatment acceptability, complexity of treatment, time required to administer treatment, and specification of treatment protocols for treatment agents. In addressing these areas, much of the literature reviewed indicate the relationship between plan design and plan implementation but stop short of examining the interrelatedness of this relationship. The question that arises, based on the relationship between the consultant and the consultee, is whether the treatment was designed ineffectively or if the consultee failed in some way to implement the treatment as planned. To address these inconsistencies, it is necessary to examine those documents that point to treatment. Due to the many discrepancies in defining treatment and the monitoring process of treatment administration, it is necessary to include these aspects in the treatment integrity/effectiveness scenario.

Wraparound studies, though scarce, have attempted to examine wraparound services in Pennsylvania. Although the four existing wraparound studies all address Therapeutic Staff Support in some way, and signal the need for accountability be it in the wraparound process, use of non therapeutic interventions, specified hours of treatment, or utilization more research on TSS is needed. This present study sought to explore ways in which wraparound agencies monitor TSS treatment integrity.

CHAPTER 3

METHODS AND DATA

> *The epistemological assumption of the qualitative paradigm is based on minimizing the distance between the researcher and the informant*.
>
> Creswell (1994)

This chapter is organized in five sections. I begin with a discussion on the research design used to study TSS treatment integrity. This is followed by a description of participants' profiles. The next two sections discuss data collection (five phases) and data analysis procedures. The last section is an overview of how the analyses were arranged for chapters four through seven.

Research Design

This study was designed to explore how wraparound agencies address TSS treatment integrity. My primary research questions were: How do wraparound agencies monitor TSS treatment delivery? Does monitoring incorporate strategies for targeting TSS misutilization? Secondary questions were: What are some potential threats to treatment integrity? How do TSS respond to potential threats that directly affect students?

A qualitative approach to this research was appropriate based on three factors. First, according to Merriam (1988),

> this type of research is concerned with understanding and describing processes more than behavioral outcomes…. Process as a focus [for qualitative research] can be viewed…as monitoring: describing the context and population of the study, [and] discovering the extent to which the treatment…has been implemented… (p. 31)

By definition, treatment integrity suggests certain processes, and examining the contextual characteristics of these processes enables the researcher to collect data that would provide rich, thick descriptions of the processes under consideration. The process of treatment planning which begins with the BSC designing the treatment plan (after a psychological

evaluation is conducted), provides a major context for monitoring TSS work. Because the BSC's role is to design a student's treatment plan, I was interested in analyzing this document to determine its quality specifically as it relates to descriptions of interventions. Hence, a content analysis of the plan lends itself to qualitative scrutiny.

Second, another major method used for monitoring TSS is the progress note. This document is central to the treatment integrity process as it serves two functions: first, it is a daily record of the student's behavior; second, it is the major monitoring document of how treatment was administered as reported by TSS. Analysis of progress note data should reveal a design that facilitates treatment integrity, data collection quality in terms of capturing observed behavior, and self reports of TSS executing treatment. TSS provide a narrative summary of the student's behavior (e.g., by explaining what occurred with the student during the course of the day) as part of data collection. This, too, lends itself to qualitative scrutiny.

Third, "in order to understand more about an individual's first-hand experience with [treatment integrity] the views of [BSCs and TSS] were solicited" (Creswell, 2007, p. 420). Hence, interviews provide valuable insight into how the service functions. A qualitative design was selected because I was interested in describing how participants view their roles, problems with treatment administration, and how TSS are monitored. Interviews, for example, can capture TSS experiences, their understanding of what is required of them to carry out their work, and their knowledge of behavioral interventions. Similarly, in an attempt to determine potential threats to treatment integrity, particularly as they relate to "therapist drift," it is necessary to use a qualitative approach to capture TSS interpretations of administering interventions. In the quantitative approach, treatment is operationally defined so that it can be measured. With narrative explanations of treatment administration, a

qualitative method allows for understanding the process of execution. This research design, then, is well suited to capture how well treatment is administered from a variety of sources.

Sample Selection

A common sampling approach in qualitative research is known as purposeful sampling. Creswell (2007) states, "in purposeful sampling, researchers intentionally select individuals and sites to learn or understand the central phenomenon" (p. 204) from what Patton (1990) describes as *information rich* phases three and five, this section only contains participants' classifications, demographics, and other relevant data.

In this study, there are 26 "information rich" participants. Eighteen of the 26 comprise 9 BSC/TSS teams, two participants are clinical coordinators, and six additional TSS—those not a part of teams. Table 3.1 represents a profile of participants. For a comprehensive listing comprised of data from each Tables 3.1, 3.4, and 3.5, see Appendix D.

Table 3.1 Participants' Demographics

Participants	Gender	Race	Education	Years of Experience
Clinical Coordinator (2)	100% Female	50% Black 50% White	100% Master's BCBA Cert.	Over 5 years 100%
Behavior Specialist Consultant (9)	33% Male	44% Black 33% White 22% Others	44% Doctorates 55% BCBA 100% Master's	Over 5 years 100%
Therapeutic Staff Support (15)	33% Male	86% Black 6% White 6% Other	93% Bachelor's 6% Associate's 20% Master's	60% 1st year 13% 2nd year 20% 5 years 6% 3rd year
Total Participants (n=26)				

In Table 3.1, percentages of demographic information are provided. Under "Education," 55% of BSCs obtained Board Certified Behavior Analysis. Both clinical coordinators

obtained BCBA certification as well. Whereas only 20% of TSS had five or more years of experience, no BSCs or clinical coordinators had less than five years of wraparound experience. In terms of TSS education, only one TSS (6%) had an associate's degree while 93.3% held bachelor's degrees. In this sample, 66.6% of TSS are female yet 80% of students receiving the service are male. Eight six percent of TSS are black and 87% of students receiving the service are black.

Table 3.2 represents the number of participants selected from each agency.

Table 3.2 Sample by Agency

	WRAP1	WRAP2	WRAP3	TEMP
Clinical Coordinator (2)	1	1	n/a	n/a
Behavior Specialist Consultant (9)	3	3	3	n/a
Therapeutic Staff Support (15)	3	3	3	6
Total Participants (n=26)	7	7	6	6

Three wraparound agencies were used in this study. These agencies are all in metropolitan Philadelphia. From those agencies, 21 participants were selected. The remaining six participants, all TSS, represent one temporary agency. One TSS was interviewed with the first 20 participants (at the time I did not document him as a TSS from a temporary agency. After reviewing comments made in the transcript, I discovered the TSS did not work for the agency per se); five TSS were chosen several months after data collection ended (explanation for additional TSS is discussed under phase five.

Data Collection

IRB Approval/Agency Permission – Phase One

For this research, there were five phases of data collection. Phase one entailed getting IRB approval and agency permission to conduct this research at selected sites. This process began in February 2003 and ended in May 2005. Table 3.3 represents a timeline of events leading to an IRB Certificate of Approval to conduct the study.

Table 3.3 IRB Approval Timeline

Institutional Review Board Approval Timeline	Date
First IRB Proposal submitted	January 2003
First review by IRB committee	February 2003
Second IRB Proposal submitted	May 2004
Third IRB Proposal submitted	May 2005
First Certificate of IRB Approval	May 2005
Second Certificate of IRB Approval (Extension)	May 2006

Obtaining IRB approval was inextricably linked to wraparound agencies granting consent. I was informed by then IRB Coordinator, Mrs. Ruth Smith, I "cannot collect data until IRB receives letters of support to participate in the study" (Smith 2003, February 23). Obtaining "letters of support" from wraparound agencies proved to be an arduous task because wraparound professionals were not interested in participating in the study. (However, after making numerous phone calls to wraparound agencies as well as local and state agencies, in addition to sending dozens of letters of wraparound agencies over a two year period, three agencies granted me permission to conduct my research (for a full discussion, see Appendix E). No information about the agencies for this study will be disclosed.

Bulletins and Meetings – Phase Two

Contact with wraparound managers signaled the beginning of phase two. I met with a manager from each site to discuss a bulletin designed for posting throughout the agency, and to get assistance with promoting the study in agency newsletters or meetings in hopes of securing participants. I was granted permission to post flyers at three wraparound sites. Embossed on the bulletin was the IRB certificate of approval. Wraparound managers designated a staff member from each agency to post bulletins throughout their sites. This process began in July 2005. Over a two month process, I only received two phone calls from TSS. I contacted wraparound managers again in September 2005 and asked for permission to discuss my study at staff meetings. Two agencies allowed me to come and speak; another agency's manager elected to discuss the research at a staff meeting. This strategy was effective in that several employees on this manager's treatment team committed to participating in the study. I was contacted with a list of names and began interviews in October 2005, five months after IRB approval.

Participant Selection/Interviews – Phase Three

A nonrandomized method known as snowball sampling was used to select participants. Baker (1994) explains snowball sampling in this way:

> You first find a few [participants with certain] qualities you seek; you interview them; and then you ask them for the names of other people who they know who have the same qualities... In this manner, you accumulate more and more [participants] by using each [participant] you get as a source of new names for your sample. (p.165)

Getting assistance from wraparound staff proved to be the most effective strategy for selecting participants throughout this phase of data collection. Clinical coordinators served as "gatekeepers" to help me select participants. Aside from volunteering themselves to participate, they assisted me with getting participants. When I asked them to assist with

participant selection, I only asked them to recommend BSCs, not TSS. My reasoning was BSCs would be the more difficult participants to commit to the study. Wraparound professionals felt that if a BSC agreed to participate then a TSS would likely agree because the BSC serves as a "supervisor of sorts" to the TSS. And, again, because both team members must agree to participate I needed to rely on BSCs to make that happen. Consequently, all BSCs were interviewed prior to TSS interviews.

Behavior Specialist Consultants were a valuable resource for getting TSS because they encouraged their colleagues to participate. Initially, BSCs made contact with TSS and provided me with phone numbers for those who expressed an interest in the study. After I made contact, some TSS declined to participate. I then had to go back to BSCs and request additional names. In reviewing Table 3.4, particularly with the first five entries in column one, I conducted five interviews in the month of October for one agency, and another interview with a second agency in October as well. After these six interviews, collection efforts stalled. One of the challenges associated with getting teams of participants is team member agreement. That is the primary reason why I set up interviews beginning with the BSC just in case a TSS later declined. BSCs have multiple cases with many TSS. A TSS works on one individual case so I reasoned if I was able to interview a BSC there was a larger pool of TSS to choose from. That method worked. Even though some of the dates reflect lengthy lags between a BSC interview and TSS interview it was because TSS did not agree to participate and/or BSCs had to further encourage other potential TSS to do so.

Twenty one participants were interviewed over a thirteen month period (For interview protocols, see Appendices F and G). I conducted 20 face-to-face interviews. Interviews were conducted in settings designated by participants. Each participant was contacted by phone to

schedule interviews. The majority of interviews were conducted at school sites. There were five office interviews, one home interview, and 14 interviews were conducted in schools. Also, there was one phone interview. (**Note**: Included in the interview schedule are two clinical coordinators. They were the major "gatekeepers" who helped me navigate their agencies. When the study was explained to them, both clinical coordinators asked if they could be interviewed. Using the Behavior Specialist Consultant Interview Protocol, I interviewed each clinical coordinator.)

Table 3.4 is the coding scheme used to identify wraparound agencies, participants, and documents. There are five characters used in Table 3.4. Rather than using pseudonyms in place of names of wraparound agencies and participants, I chose to use characters to describe participants. The reason for assigning characters as opposed to names was "to withhold descriptors that would lead to the identification of participants and sites" (Creswell, 2007, p. 208).

Table 3.4 Participants' Profile Identification Key

Agencies	W= Wraparound Agency T=Temp Agency
Agency Designation by Number or Letter	W1= Agency 1 W2=Agency 2 W3= Agency 3 T=Temp
Interviewee	CC= Clinical Coordinator BSC=Behavior Specialist TSS= Therapeutic Staff Support
Interviewee Designation by Number	1=BSC/TSS 1st Team 2=BSC/TSS 2nd Team 3=BSC/TSS 3rd Team
Temp Agency & Interviewee Designation	T= Temp X=TSS (range 1 – 6 e.g. X1, X2, etc.)
Example of a combined key	W3TSS2 = Wraparound Agency 3, TSS from Team 2

Table 3.5 represents the interview schedule for all participants.

Table 3.5 Interview Schedule

Participant	**Interview Date**	**Location**	**Participant**	**Interview Date**	**Location**
W1CC	10.1.2005	Office	W3BSC1	6.15.2006	School
W1BSC1	10.24.2005	School	W3TSS1	6.15.2006	School
W1TSS1	10.25.2005	School	W3BSC2	6.12.2006	Phone
W1BSC2	10.25.2005	School	W3TSS2	6.15.2006	School
W1TSS2	10.26.2005	School	W3BSC3	4.1.2006	Home
W1BSC3	3.13.2006	School	W3TSS3	4.1.2006	School
W1TSS3	6.19.2006	School	**Phase 5**		
W2CC	2.17.2006	Office	TTSS1	5.25.2007	School
W2BSC1	3.7.2006	Office	TTSS2	6.1.2007	Email
W2TSS1	3.17.2006	Office	TTSS3	6.1.2007	Text Msgs
W2BSC2	3.15.2006	School	TTSS4	6.1.2007	Email
W2TSS2	9.21.2006	School	TTSS5	6.2.2007	Email
W2BSC3	10.7.2005	Office	***TX6**	**3.10.2006**	**School**
W2TSS3	9.14.2006	Home			

Note: TSS employed by one temporary agency were included in this table. However, they will not be discussed until Phase 5. These TSS were included to show the full interview schedule.

Documents – Phase Four

The primary sources of documents collected were psychologist's recommendations, treatment plans, and progress notes. My rationale for selecting these primary documents as well number of documents collected. Note: This section does not contain document collection procedures. I was not involved in the collection of these documents after I made

the request to obtain them. Wraparound managers had a staff member prepare the materials. Two agencies mailed the documents to me; one agency prepared the documents and allowed me to pick them up. The collection of these documents was a complicated process that involved months of negotiation (refer to Appendix E).

Given the nature of the process from the time of referral to treatment administration, the psychologist plays an integral role in this process; he or she evaluates the student, makes the diagnosis, and recommends treatment. As such, the process of treatment integrity really begins at this stage. It is important to examine this document because the psychologist recommends treatment and, based on that recommendation—the BSC receives the recommendations and develops a treatment plan accordingly; otherwise, true treatment integrity cannot be achieved. Hence, it was useful for me to study the psychologist's recommendations to compare with interventions contained on a treatment plan in order to establish process continuity. Toward that end, I collected psychologist recommendations from each BSC/TSS case.

Treatment plans are critical documents. BSCs design treatment plans in order for the TSS to administer treatment. Without the treatment plan, it is nearly impossible to monitor treatment integrity in any substantive way. I analyzed the treatment plan to ensure that interventions TSS are to employ match. So, in an effort to examine treatment integrity, two documents which point to treatment administration are the treatment plans and progress notes in that they should specifically describe treatment interventions to be used and how they should be administered. Therefore, I analyzed one treatment plan from each BSC/TSS case.

Because treatment integrity is difficult for an untrained novice to capture in observations, I focused on analyzing TSS progress notes in order to get a better grasp of how

treatment is administered. This document is important because it should describe, in detail, which interventions were employed to determine whether interventions were administered as intended (Gresham, 1993). It is extremely difficult to study treatment integrity without the progress notes because that information is crucial to TSS administering treatment and for reporting how interventions are used. Toward that end, I collected five progress notes for each TSS from the original set of interviews. No treatment plans from the Temp agency sample were selected.

In terms of selecting the number of documents, that process was relatively straightforward. Per case, a psychologist only makes written recommendations once during an authorization period (90 days). Similarly, a BSC only writes one treatment plan during an authorization period. As for progress notes, I chose to select five progress notes as opposed to one because this document, when completed, reveals how TSS administer treatment as well as how well data is collected. Toward that end, I wanted notes reflective of data collection at different points in time to show patterns of behavior that may have required more or less TSS intervention.

Additional TSS – Phase Five

Nine months after the initial 21 interviews were conducted, five additional TSS were interviewed. The final participants were selected after it was determined that supplemental information was needed. The initial TSS protocol contained 19 questions. After preliminary analysis of the transcripts, it was discovered that foundational questions were missing e.g., TSS role, job challenges etc. hence the "need to collect new information to best answer [my] research questions" (Creswell, 2007, p. 206). My initial approach was to conduct follow up interviews with several TSS. However, none of the TSS wanted to be interviewed again. Five

new TSS were selected based on convenience sampling. Fraenkel and Wallen (1996) contend, "Many times it is extremely difficult (sometimes even impossible) to select either a random or a systematic nonrandom sample. At such times, a researcher may select a convenience sample. A convenience sample is a group of individuals who (conveniently) are available for study" (p. 99).

I obtained TSS views on what I perceived as six foundational questions overlooked in the initial protocol. None of the questions referred to treatment integrity per se but they were related to problems associated with treatment administration, ways the service is valuable, as well as TSS having a clear understanding of their role(s). Specifically, the questions were as follows: (1) What is your role as a TSS? (2) What do you like most about your job? (3) What are some of the frustrations in carrying out your work? (4) What are some of the challenges a TSS, in general, faces? (5) What is the most difficult aspect of being a TSS? (6) How valuable is the TSS service? Responses to these queries helped me to personalize or better understand the TSS service in order to gain a fuller understanding of the process of treatment administration.

The convenience sampling began with a former co-worker who is a TSS. I contacted this TSS at the school and she agreed to be interviewed. The interview was conducted at the school one week after the initial contact was made. After interviewing her, I explained my challenge with finding more TSS to interview. She referred me to four of her coworkers. She spoke with several coworkers during a weekly supervision meeting. They expressed to her their willingness to participate. She contacted me and provided me with email addresses. After receiving the email addresses, I sent a revised version of the TSS consent and audiotape forms. None of the TSS wanted to go through the formalities of signing consent forms or

being audio-taped but they all agreed to respond to the supplemental interview questions by email. As a result, the four participants were sent six questions via email. The turnaround response time for all participants was less than 24 hours. Participants provided detailed responses to each question. One TSS sent the response back via text messaging. All TSS were employed by one temporary agency.

Data Analysis Procedures

Several methods were used to analyze all data collected. Section one describes the process of analyzing interview data. Section two describes how each document was analyzed.

Interviews

Semi-structured interviews were audio-taped and transcribed verbatim. I conducted and transcribed every interview. Interviews were transcribed within one week after each interview had taken place. After transcribing them, I then went through the process of cleaning the data; that is, once the initial interview was transcribed, I printed a copy of each transcript and proofed it while listening to the audio-taped interview. This was done to minimize typographical errors as well as ensure better transcription accuracy.

Transcripts were examined multiple times to uncover patterns. I read each transcript twice to get a sense of what participants were conveying. For the third read through, I wrote down codes for preliminary themes. Forty codes emerged. In the next read through, as I began to see patterns that kept surfacing, the codes with similar information were classified into smaller themes. This process, known as open coding, refers to naming and categorizing data. Opening coding is a technique used to reduce large amounts of data to manageable parts by looking for similar properties in themes and linking them together (Creswell, 2007). Eight major categories were derived from this process. I then assigned *in vivo code*s, words and

phrases from the data, as labels for each category (Creswell, 2007). This process was only the beginning phase of data analysis because I did not have any other data. I attempted to write up sections of text but it was clear I needed to analyze the documents in order to get a clearer sense of how themes that emerged from the interviews were associated with document data. Without the documents, and supplemental data, this process of coding was incomplete.

Some of the preliminary organization of interview data entailed the following: (1) For each interview question, I cut and pasted all participants' responses from transcripts and made individual files; (2) I created a list of every type of monitoring method participants' reported, calculated frequencies, and designed a matrix for the most common practices. I also categorized practices based on direct and indirect methods; (3) the same process was followed for identifying threats to treatment integrity. I created a list of every type of threat participants' reported, calculated frequencies, and designed a matrix for potential threats to treatment integrity. I also categorized threats based on positive and negative factors. With the supplemental TSS transcripts, the same process applied. Responses were cut and pasted for each question and made into individual files, lists were created, matrices were designed, and responses were categorized. Also, the responses from supplemental questions served as guides for reexamining data from the initial interviews particularly in terms of searching for TSS roles, ways in which the service is valuable to students, and how TSS address threats.

Documents

The analysis of documents occurred in various stages. First, two matrices were designed to compare/contrast components found on treatment plans and progress notes (see Appendices H & I). While there were some differences, much of the information contained on all three agencies' treatment plans and progress notes was similar. After organizing the

data using these matrices, I referred to a model found in the literature and compared components of that model with components found on the three agencies' treatment plans. In "Writing effective treatment plans," (Hansen, 1996) offers an instructive framework which specifies necessary components of treatment plans. From the Hansen model, I was able to narrow my focus for analyzing treatment plan information by focusing on essential components Hansen indicated. Toward that end, a second matrix was designed; this matrix can be found in chapter five, Table 5.2 "Treatment Plan Design Matrix." Treatment plans were analyzed, in the form of a checklist, based on component consistency with the Hansen model.

A second analysis of treatment plans centered on descriptions of treatment delivery. Using the same framework, Hansen (1996) outlines how treatment should be described in observable and measurable terms based the following descriptors: who, what, when, where, and how. I examined each treatment plan and documented whether or not methods were identifiable based on each descriptor. Once the five descriptors were addressed, I then made an assessment of the methods indicated on the treatment plans to determine if they were clear and if the objectives were measurable. Data is found in chapter five, Table 5.8 "Analysis of Treatment Plans." Objectives were analyzed using eight of Hansen's (1996) "objective pitfalls." Data is found in chapter five, Table 5.7 "Objective Pitfalls and Recommendations."

Progress notes were analyzed primarily based on comparisons of document designs, components, and descriptions of interventions. In terms of document designs, I compiled a list of components for describing the physical documents. I then used a progress note matrix to compare and contrast specific components contained on each document. Several tables highlighting similarities and differences of progress note designs are found in chapter five,

Tables 5.3, 5.4, 5.5 and 5.6. TSS summaries of student behavior were analyzed based on Hansen's (1996) examples of behaviors written in questionable v. clear terms. Instead of using that terminology, I use "nebulous behavior" v. "specific behavior." However, I did use Hansen's description on behavior pitfalls for that analysis. Data is found in chapter five, Table 5.9 "Behavior Pitfalls and Recommendations." I also analyzed TSS summaries of how they administered treatment; no tables or rubrics were used.

Methods of Verification

The first technique employed to establish the credibility of this research was triangulation. Creswell (2007) defines triangulation in this way:

> Triangulation is the process of corroborating evidence from different individuals [BSC and TSS], types of data (e.g., fieldnotes and interviews), or methods of data collection (e.g., documents and interviews) in descriptions and themes in qualitative research. The inquirer examines each information source and finds evidence to support a theme. This ensures that the study will be accurate because the information draws on multiple sources of information, individuals, and processes. (p. 252)

After analyzing all of the data, I was able to search for themes. Some of the preliminary themes from the interviews were then compared to information from documents. After reexamining themes from interviews with document designs and component descriptions, four central themes emerged: "Monitoring practices," "Following the Plan," "Integrity Threats," and "TSS roles." These four themes form the basis of analyses for chapters four through seven. Data was triangulated based on TSS/BSC/CC responses, how those responses related to data contained on documents, and document comparisons.

Member checking was the second technique used to establish credibility. Once interviews were transcribed, participants were contacted and asked to review a copy of the typed transcript for the following purposes:

> [G]ive respondent an…opportunity to correct errors of fact and challenge what are perceived to be wrong interpretations; (b) provide the respondent the opportunity to volunteer additional information… [which] may stimulate the respondent to recall additional things that were not mentioned the first time; and (c) puts the respondent on record as having said certain things and having agreed to the correctness of the investigator's recording of them. (Lincoln & Guba, 1985, p. 314)

This is considered a fundamental aspect for establishing credibility. Participants were sent full transcripts electronically and hardcopies via U.S. mail accompanied with a letter reminding them about member checking they were told would occur during interviews. This information was usually sent one week after interviews. The purpose of transcribing the data in a relatively short time was to allow for expedient member checking in terms of getting timely clarification, as well as getting ideas for revising questions. Perhaps a more significant reason I did it was in an effort to demonstrate the integrity of my transcription. The copy sent to participants served as evidence of my transcription accuracy. I cleaned the data before it was mailed; that is, after transcribing, it was necessary to listen to audiotapes while proofreading the transcripts to minimize typographical errors inherent in transcribing before sending a copy to participants.

Participants were given one week to read their transcripts and send a response via email. Only one participant responded. That person asked if I could omit certain repetitive words and things like “ums,” “unt uhs” etc. but no one else commented or raised concerns.

Member checks also served a greater purpose. Creswell (2007) stresses the importance of reporting accurate findings which extends beyond participants’ reviewing transcriptions. Findings are based on themes I created and how data was interpreted. Toward that end, in order to “verif[y] the description and interpretation [of my analyses I gave] a preliminary draft of the [analyses chapters] to select informants for feedback and later incorporate[ed] their comments into the final study” (Creswell, 2007, p. 29). Two

participants were asked to review chapters to determine the accuracy of my interpretations. Two TSS assisted me with reading chapters five, six and seven. I was particularly concerned with how the TSS typology represented realistic roles; I also wanted confirmation that treatment threats were reflective of things TSS encountered. I used two TSS from the temporary agency sample. I contacted them by phone and after talking with them, at their request, I emailed the three chapters. Both TSS contacted me by phone within two weeks of receiving the chapters. Neither TSS raised concerns but both did offer additional input for areas they felt needed more elaboration which happened to be sub themes that I had not fully developed.

A third technique used was peer evaluators who helped interpret treatment documents. As this is not my field of study, I solicited professionals to assist me in understanding how to read psychologist recommendations and treatment plans particularly with regard to goals, target/replacement behaviors, and descriptions of treatment. As a non-mental health professional, I was deeply concerned about inadvertently reporting erroneous information. Toward that end, I relied on one BSC to help assess the accuracy of my interpretations particularly in terms of how I analyzed and reported data obtained from treatment documents. I also needed assistance with gaining a better understanding of the treatment process. Three licensed mental health professionals (two behavior specialists, and one mental health therapist) reviewed the matrices, rubrics and/or checklists I designed to analyze psychologist recommendations and treatment plans. These therapists were selected based on my affiliation with them from an organization in which we are all members. Both BSCs hold master's degrees as well as BCBA certification; the mental health therapist has a

master's degree in education and is working on a second master's degree in clinical psychology.

After creating tools for analyzing documents, copies were submitted to the evaluators to evaluate descriptions of behavioral interventions contained on both documents. These evaluators did not see any of the actual documents. I created the matrices and rubrics and typed certain aspects of documents that I needed interpreting e.g., intervention descriptions, goals and objectives. Before I found the Hansen framework, I was using a criteria developed by Gresham (1989) for determining the extent to which treatment is operationally defined based on global, intermediate and molecular definitions. When these evaluators reviewed my first set of tools, I was told the instruments were not appropriate for analyzing the data primarily because the Gresham framework did not fit. It was explained to me that most of the interventions indicated on progress notes or treatment plans (e.g., verbal praise, prompting/cues) do not require detailed steps for implementation. After revising those matrices, this time I used my own terminology for describing interventions with terms e.g., clear, vague and detailed. Those tools were submitted to the same people and rejected. Because I did not have a firm grasp of treatment terminology, the tools I designed were not accurate. This delayed analyzing documents for some time until I could locate information about proper documentation.

Based on standards for "writing effective treatment plans," I created two tools that contained information relevant to describing interventions and how they should be written. Included were exact descriptions of treatment interventions from treatment plans and progress notes. I submitted yet another revised tool to the three evaluators (see Appendix J).

Everyone was able to respond to each item based on the Hansen criteria. They also wrote comments about the main problems with how the interventions were written.

Similarly, in order to gain more confidence in interpreting the descriptions contained on the treatment plans, I sent a copy of the treatment plan tool including interventions and how I rated them to Dr. Hansen for review. Before discussing my involvement with Dr. Hansen, it is necessary to provide her biographical sketch.

> **Marsali Hansen, PhD, ABPP** is a licensed psychologist. Dr. Hansen is also board certified in family psychology. [For 12 years, she was] Director of the Pennsylvania CASSP Training and Technical Assistance Institute, a statewide program for improving the clinical skills of professionals who work with children with mental health needs. She has authored numerous publications.
>
> (H. Bicksler, personal communication, August 14, 2007)

We corresponded by phone, email, and one face-to-face meeting over a six week period. Dr. Hansen proved to be a valuable resource in several ways. First, her publications on wraparound services were helpful particularly those dealing with treatment plans and TSS in general. Second, because her publications were adopted by the state of Pennsylvania, I was relieved to be using "best practices" in Pennsylvania mental health. Third, her responsibilities as CASSP director led to conducting trainings attended by hundreds of mental health professionals throughout the state. Finally, her assistance in reviewing my data, and explaining why the wording of interventions was problematic, and directing me to "writing effective treatment plans" helped me tremendously. After reviewing my initial interpretations of the interventions, I was informed the tool I created was appropriate to analyze the Methods/Intervention section of the treatment plans. Dr. Hansen also provided me with examples of how to appropriately interpret and write intervention descriptions.

Overview of Analyses Chapters

Chapters four through seven are different facets of the analyses I conducted. The chapters address a single research question. For chapters four and five, one research question is addressed for both. (Note: Chapter four explores wraparound agencies monitoring practices which include documentation review. Chapter five focuses on documentation. I separated these discussions because in analyzing the documents, I discovered how document designs shape integrity. I saw a need to analyze these documents to include them in a separate chapter rather than marginalizing these findings. Toward that end, chapters four and five address the same research question in different ways.)

Chapter four centers on wraparound agencies "monitoring practices." I begin that discussion on agencies' adherence to state standards. When this study was designed, I was unaware that many of the monitoring practices are required by the state e.g., training, supervision, recordkeeping practices etc. Once I discovered this information, my focus shifted to not merely reporting the monitoring practices but how those practices are aligned with state standards. In addition to reporting the monitoring practices, some of the participants' interpretations related to favorable as well as unfavorable aspects of monitoring practices were incorporated as well.

Chapter five is devoted to documentation findings centering on "Following the plan." The chapter is divided into two sections: document designs and content descriptions. In the introduction, I frame this chapter by TSS and BSC statements based on the theme "following the plan." This is followed by one section that compares/contrasts wraparound agencies treatment plan and progress note designs, and another section which focuses on the content of documents e.g., how BSCs and TSS document various facets of treatment. Treatment

plans and progress notes are analyzed on the basis of descriptions of objectives, interventions, and summaries of how observable behaviors were documented. (I chose to devote a chapter to "documentation data" because documents are a substantial aspect of monitoring.)

The sole focus of chapter six is "Risk factors." Throughout treatment integrity research, invariably three terms are mentioned: threats, barriers, or violations. Often used interchangeably, these terms refer to problems that impact effective treatment delivery; they are "risk factors" resilience researchers talk about. After analyzing the types of problems participants expressed, risk factors were organized into five categories. These five categories were assigned labels according to types of risk factors related to treatment, documents, people, environment, or service; mostly all are consistent with treatment integrity literature. Documents were included here based on how the designs serve as potential threats. I did not include that information in the previous chapter because other things about documents were pointed out that distracted from how I wanted to organize that chapter.

In chapter seven "TSS Roles," I offer TSS perceptions' of their roles that extend beyond their primary roles. Toward that end, a TSS typology was created to show other facets of TSS work apart from their two central roles as treatment implementer and data collector. Eight additional roles emerged. As I studied this information, it occurred to me that in many instances, TSS assumed certain roles based on their response to classroom threats that affected students receiving the service. After considering what the data revealed, I explored many of the roles from that standpoint.

Chapter eight, "Discussion and Implications," concludes with how the findings from this study relate to broader knowledge about wraparound services. There is some discussion

about the “Limitations” of the study as well as recommendations. I end the chapter with an “Epilogue” reflecting on my completion of this research.

CHAPTER 4

MONITORING PRACTICES

Standards are only useful if they are specific, cover significant aspects of service delivery, and are used as part of a monitoring or licensing process.
Knitzer (1982:54)

Treatment integrity is maximized when there is on-going monitoring.
Thurman (2007:16)

The epigraphs for this chapter represent two important considerations when examining monitoring practices. Sometimes monitoring is done as a perfunctory activity. In other instances, there is a systematic approach to monitoring where standards are developed and translated into practice. A primary research question in this study is, How do wraparound agencies monitor TSS treatment delivery? In this chapter, I explore wraparound agencies' monitoring practices to determine what they are, whether they are reflective of clearly defined standards translated into practice, how closely agencies adhere to those standards, and what monitoring practices of TSS reveal.

Recall, I discussed elsewhere the various types of monitoring practices mental health professionals use; they are restated here. Direct methods of monitoring include observations, in vivo sessions, supervision, videotapes, audiotapes; indirect methods include various forms of documentation e.g., progress notes, checklists, scales, interviews, self-reporting, manuals (e.g., Bellg, 2004; Dobson & Singer, 2005; Gresham, 2005; Perepletchikova & Kazdin, 2005). Direct methods reveal the most useful data because the evaluator can "see" exactly what is happening whereas indirect methods are based on less reliable information. Wraparound agencies utilize several indirect and direct methods of monitoring treatment integrity (see Appendix K). Interpretations of the four points of exploration will be

incorporated throughout this chapter. Monitoring practices e.g., document review, observations, training, supervision, and cell phone usage will be discussed.

Documentation review is one common method of monitoring TSS treatment integrity. The progress note, used to collect behavioral data on students, is the main source of documentation review for TSS. This method, according to BSCs, is used for monitoring BSC/MT progress notes as well. TSS, BSCs and MTs are required by the state to complete progress notes every time they are working with a client. BSC and TSS alike reported wraparound agencies consistently adhere to this state requirement.

According to participants, documents are reviewed by several sources. Clinical coordinators routinely review treatment plans, for example, during treatment plan supervision. This type of documentation review is conducted moreso to guide treatment as well as spot discrepancies. Clinical coordinators also review treatment plans and BSC/MT monthly summaries (Cautilli et al., 2000). In two agencies, it was reported that senior level officials review documents weekly. And, of course, for utilization review, students' medical charts are reviewed by state officials.

Documentation review is important because it uncovers problems in treatment design and well as documentation challenges. Two participants had this to say:

> You see a lot of weaknesses in notes…. Some of them, you know, write notes where where it just repeats. It's the same note over and over again. W2CC

> There are some that I've run across that I feel like no matter how much training I could give them, I feel like I could never get them to the point where I would be satisfied with their work or their paperwork. And I don't feel like the position is one that's gonna teach people how to write a sentence or write a grammatically correct paragraph or some of it is just poor documentation skills. They just—they don't know how to write. I don't know how to put it any more frankly than that…. That's the main issue and so if they can't write a paragraph just on anything its very hard for them to write behavioral notes and document incidents in an objective format. W2BSC3

One clinical coordinator shared an example of what happens when BSCs don't write good progress notes.

> You see a lot of weaknesses in notes even with the BSC and the—and the MT there's Daily Notes. Every time you see a client you fill out a note which is called a Progress Note. So you can read that note and get an idea of what's going on. Maybe the MT really doesn't know how to address post traumatic stress disorder. Maybe they're doing something on that note that's like whoa! Whoa! Whoa! Whoa! You know that's gonna cause the client further distress. So you can catch it [when you review it and]…bring them in and have supervision based upon that note. (W1CC)

TSS, for example, often spoke about how inaccurate documentation causes problems for them. One TSS said this: "If you turn in jacked up paperwork, they don't pay you. Somebody looks at your stuff weekly and if you don't fill out those notes properly, you don't get paid." And, not only do TSS not get paid on time, they are required to come in, sit down with a clinical coordinator, and discuss problems with documentation. They must be able to identify their errors as well as discuss how they have been administering treatment. This is done to ensure that TSS have a full understanding of treatment administration as well as understanding how to properly document student behaviors.

Documentation review is critical to monitoring treatment integrity. As these examples demonstrate, documentation uncovers problematic aspects of treatment delivery. This is why highly skilled professionals are utilized because they can detect problems. In response to identifying problems, the standard practice suggests contracted employees are notified ("if there's a mistake they give you a call—you have to respond immediately" (TTSS6). After receiving notification, employees must meet with clinicians to discuss their poor documentation. Based on participants' responses, it is clear document review is taken seriously.

Direct observation is another way of monitoring TSS treatment integrity. For the majority of BSCs, direct observation is the method of choice for determining how well TSS are "doing what they're suppose to do." According to one BSC, information captured from observations reveals a "full, true and clear picture" of what's happening. Some TSS like this method as well. Here's what four participants said:

> I think the observation certainly helps. I think its important. I think if your BSC is never in there seeing how you interact with your client that they're not really knowing what you're doing because yeah, maybe I'm really good at fibbing paperwork and—and I make it all up as I go along which isn't the case but maybe I do. You know. HA! HA! HA! And maybe I'm horrible with my client. Because I think this is a good indication to see what the full picture is but I think you can't get at true picture until you're there examining and---observing, I should say what I'm doing with my client and see how I interact and how I affect him. (W3TSS1)

> Well part of what I do is direct observations to see if they're doing what they're suppose to do. Like in the classroom, you know, if a child's not compliant are they [TSS] intervening or are they letting the teacher intervene…. I'll observe them in the home to see what they do. Are they just sitting there watching tv? Or are they, you know, intervening when they need to intervene. (W2BSC3)

> Basically the observation gives you a clear picture of what's going on. (W1CC). First of all, just from watching you can tell whether someone is doing what they're suppose to be doing or not. (W2BSC2)

> I look to see whether or not the kid is being disruptive or I look for how well interventions are being carried out—if any have been carried out at all. (W3BSC3)

During observation, BSCs can determine exactly what is happening in terms of environmental dynamics e.g., the teacher intervening instead of the TSS or TSS/client interactions. Observations also reveal how well TSS document treatment. Some BSCs talked about "popping in" on TSS. The purpose is not necessarily to surprise TSS and catch them being slack in their duties but to keep them focused on carrying out their work consistently particularly in terms of data collection. Here's what two BSCs had to say:

> That's why I like the hourly datasheet 'cause if I go in and pop in on a TSS—I don't like to tell them when I'm coming either 'cause I wanna make sure [its unannounced].

> I should be able to look at your datasheet and if its 10:00 it should be filled out up until 10:00 and if its not why isn't it? And, how are you gonna fill it out now when the time is passed? (W2BSC3)

> I show up to see my TSS every week so if I see him on Tuesday, for example, what happened yesterday? I want to see the notes…. I just have to see. If I didn't see any [notes] it means you are not working. (W1BSC1)

Observations not only shed light on whether data is being collected but how it is being collected. This is an opportunity for BSCs to check to see if behaviors are being captured accurately. Two BSCs said this about their monitoring practices during observation:

> You sit down with the TSS, you may say to them you take this progress note and for the next hour we're gonna just be looking at one particular behavior which is a goal on that child's treatment plan. We're gonna look at this one particular behavior for one hour. You're gonna mark it down and I'm gonna mark it down. When we get back together then we will make our comparisons and then discuss it. (W3BSC3)

> Well sometimes…you don't even have to let them know that you're doing it…They're filling out their datasheet for an hour that you're there and you fill out your own and then maybe do an inter-rater reliability check to see if you're both seeing and observing the same things. Then if not you know if they saw the child off task 20 times and you only saw it 5 times then you know you're obviously looking at 2 different sets of behaviors. You know we have to get on the same page. (W2BSC3)

This approach is instructive because it reveals the extent to which a BSC and TSS capture the same behaviors. Throughout the study, BSCs addressed the problem of TSS frequently missing certain behaviors. With observations, BSCs can quickly assess any discrepancies and provide corrective feedback. The standards of practice for observing TSS is BSCs required to conduct weekly site visits to observe TSS.

Training is yet another method of monitoring TSS treatment integrity. According to participants, TSS receive "a lot of training" (W1TSS1). What constitutes "a lot"? Well, one TSS suggested, "Its not something you can cover within a day. A lot of agencies…devote about two to three days for the training." All TSS reported training hours that exceeded the

minimum 15 hour requirement designated by the state. All three agencies had practices which met the required training standards and one exceeded those requirements. During initial and ongoing trainings, while several topics are covered, it is clear documentation is important. Two participants had this to say:

> They have a lot of TSS training on notetaking and I've seen the sheets they give them with the specific words and phrases and what it means that they can use to help them write treatment notes…. And I know they have handouts on the progress notes--how they're supposed to be done. (W2BSC2)

> I've done extra I think it was three or four hours on top of the regular 15 hours and they spent a lot of hours during those 15 hours telling us how to fill out our paperwork and how not to. (W3TSS1)

In addition to adhering to training hours, I also found wraparound agencies adhered to trainer standards. Throughout the literature, one recommendation is that "paraprofessionals should always be trained and supervised by qualified professionals, especially when implementing behavior plans and collecting data that will be used to determine the effectiveness of an intervention" (Fiorello, 2001, p. 41). Consistent with this recommendation, along with wraparound standards which stipulate that master's level professionals train TSS, each agency uses clinical coordinators for all TSS trainings.

One clinical coordinator described a TSS training she conducted on TSS roles in this way:

> I just went through a group discussion on the role and function of TSS. Everything from treatment planning to data collection to social skills training to consultation, and goal setting. [I raised the following questions:] What is the TSS's role? and we kinda went around and defined [for them] their role in functional assessment. What's your role in this procedure? and different like response calls. What would the TSS' role be in direct language training? What would the TSS' role be in self management techniques? And, you know, just kind of sharpening their skills. And then they would talk about what they would do. [I'd also ask] what's your role with the family? What are you supposed to do? And a lot of TSS don't even know that…. They're suppose to sit down with the treatment team and provide input. Like they don't know that

> they're suppose to have input…. That training was really good. Its good for them, you know, if they understand like what they do with that process. (W2CC)

This was a training targeted for TSS about TSS roles as well as the skills they need to utilize in order to perform services. Some of the information seems fairly technical e.g., direct language training, social skills training, consultation, and goal setting. During the training, based on TSS responses, the clinical coordinator was able to identify TSS who may have had skill deficits, misinformation, or lacked information regarding TSS roles. This training seemed to address several substantive aspects of the TSS service.

Not only are TSS trained and supervised by qualified professionals but BSCs are as well. Clinical supervisors conduct trainings for BSCs, MTs and TSS. Despite BSCs' and MTs' academic training, wraparound agencies provide ongoing training to them. BSCs are trained, for example, on how to write treatment plans. According to one BSC, "Each year we receive intensive training on doing treatment plans." BSCs are trained in behavior techniques as well as case management conceptualization.

Perhaps the most significant aspect of BSC training is based on behavioral analysis. One participant said this:

> If you want to be a behavioral specialist consultant you need to be able to have training in behavioral analysis because that will equip you with tools—equip you with tools that you need to be able to do your job. (W1BSC1)

Though formal training in behavioral analysis is not required, agencies do strongly encourage BSCs to pursue formal training. Wraparound professionals stress that BSCs become Board Certified Behavior Analysts (BCBA). This recommended standard ensures that BSCs have received formal training in behavioral interventions. In this study, 66% of BSCs are BCBA certified as well as both clinical coordinators.

Supervision is another common method for monitoring TSS treatment integrity. Standards of supervision are primarily based upon regulatory requirements which stipulate that BHRS conduct several types of supervision (the length and type of supervision is set by state regulations). Supervision is vital because it guides treatment. Participants discuss the various types of supervision occurring within their agencies.

> If you're a BSC this is what you have to do…You're supposed to meet with me once a month. I'm the clinical supervisor. Then you're supposed to come once a month to the BSC group—it's a group supervision for BSCs—it's a treatment plan supervision…. [Y]ou know regular supervision with all team members um that's how we define like whether you know you can tell if there's treatment integrity or not just by speaking to all team members… (W2CC)

> Supervision. We have what we call team administrative supervision as well as individual and group where we review cases on a weekly or bi-weekly basis depending on how many hours that they're authorized to work. (W1CC)

Standards of supervision not only include the specified hours for each wraparound personnel and the type of supervision to be conducted, but also things that should occur during supervision. Moncher and Prinz (1991) note "Supervision can take the form of weekly research meetings, review of taped sessions, or role-playing of how to handle difficult situations" (p. 252). Meaningful supervision incorporates multiple formats. The data revealed various aspects of supervision. One BSC offers a glimpse of what supervision looks like for TSS and BSCs.

> They have weekly meetings with TSS. First of all, they go over the treatment plan and they ask TSS what did you do with this goal? What interventions did you use? Did you meet with your behavior specialist? What did you talk about? What data do you have for this plan? They do the same thing with us too. We go over our its biweekly actually—meetings with the supervisors. We go over the treatment plans and they say okay they randomly pick a treatment plan you know not the one you know that you want to choose. They say, let's go over it and see what we're doing. They record this data and then when they meet with the TSS' they pick the same treatment plan and they say, okay so what do you have to say about this? (W2BSC1)

> They document in supervision actually what's working and what's not working and then they have to communicate that back to each clinical coordinator for us to kinda follow up on the integrity or if they feel that something is not quite meeting the standards of what treatment integrity would be then they have to report that back to the clinical coordinator as well as to the administrator—clinical administrator. (W1CC)

Supervision serves myriad purposes. It allows BSCs and TSS an opportunity to discuss successes and failures with treatment. They review documentation, both treatment plans and progress notes, to monitor how well BSCs and TSS interpret goals, objectives, and interventions. Clinical supervisors also incorporate other strategies e.g., role playing, rehearsal, etc. As one participant notes, "you need really good and effective supervision to make the integrity stay strong." Supervision also uncovers what could be called "innocent errors" TSS and consultants alike have a tendency to make. Some TSS inadvertently misapply treatment "and they don't even know like they may be accidentally reinforcing behaviors that they're trying to, you know, replace or extinguish and they wouldn't even know if you didn't meet with them and talk about what they're role would be in a particular situation."

Another way to monitor TSS is via cell phones. Though not a required practice in wraparound agencies, the reference to cell phones as a means of keeping in contact with TSS frequently emerged. All BSCs reported phone contact with TSS. Because BSCs are prescribed a small number of hours for each case and this limits contact with TSS and families, and because they cannot "be there" in person, they can and do monitor via cell phone. BSCs stress the importance of frequent communication with TSS to make sure there are no problems. One clinical coordinator reported she encourages BSCs and MTs to contact her. Here is how some participants expressed the need for cell phone usage:

> I always tell [TSS] if something comes up call me on my cell phone, leave me a message, I'll get back to you. It may not be that minute, I may not pick it up that second but I will get back to you. I don't—I don't like hearing about emergencies and crises a week after they've occurred. I want to know what's going on now. If someone's getting 302ed call me, you know, let me know this is an emergency. (W2BSC3)

> But then outside of supervision I have a cell phone unlike the other clinical coordinators in my department agency. I have a cell phone that I make available to my clinicians from 8:00 am to 8:00 pm because when we leave work at 5:00 they're still out there and they need support. So there are times that I'm on the phone and they're calling me in between supervision times to get supervision on a case or you know while they're in a moment or throwing out ideas so that they can find out what's the next steps and what's the best interventions to take from there. (W1CC)

> The most important, crucial element for me is that they are available when I need to talk with them because sometimes I haven't had that kind of rapport but the one I have now she's excellent. I can call her whenever and she's there for me. (W1TSS2)

> Inasmuch as I expect my TSS to be clinically grounded in what we are doing, I would expect them to give me a call if he finds himself or herself in some crisis situation—this is what is going on and this is what I'm trying to do…. Because the interventions in the treatment plan may not actually suffice in that context, so I would expect him or her to give me a call to say this is going on. I say, okay what are doing? Okay, you can go ahead and do this and do this and do this…. If you didn't call me then that's a violation then you need to explain to me why. (W1BSC1)

There are times when clinicians and BSCs make themselves available but there are also time when they use monitoring to check in on BSCs/MTs and TSS to determine if things are going well in the field, if assistance is needed, or just to see how the client is progressing. Cell phone use is also important because it demonstrates a willingness to help out colleagues. BSCs and clinical coordinators encourage others to contact them when they're in the field to get assistance or just to talk about a case. That shows a sincere effort to be supportive to those "on the front line" as well as to be accessible. TSS talk about the importance of having access to BSCs, a crucial factor given that BSCs only meet with TSS for one hour per week.

Summary

Findings reveal that all wraparound agencies in this study use multiple methods of monitoring TSS treatment integrity. Direct methods include observations, training, and supervision. Indirect methods include documentation review and cell phones. Supervision is a common way of monitoring TSS treatment integrity verbally. During supervision, TSS are asked to role play; they also must discuss specific client issues e.g., client's behavior, which interventions were used, how client responded to interventions, as well as explaining problems with executing interventions. Clinicians are able to determine, to some degree, how TSS are performing their roles and administering treatment. BSCs observing TSS is another way of monitoring TSS. Not only do BSCs observe TSS in action, they are able to make assessments, and offer corrective feedback. BSCs are able to provide immediate feedback, model interventions, review progress notes, and observe TSS/client interactions. The most common indirect monitoring method is documentation review. There are a number of people involved in reviewing documents although the primary responsibility rests with clinical coordinators and clinical administrators. We learn from participants the importance of documentation as well as some of the consequences of shoddy documentation. In this regard, documentation of both treatment design (treatment plans) and treatment delivery (progress notes) are closely scrutinized.

Most monitoring practices meet state requirements. In terms of standards, which is used here loosely, there are few formal methods wraparound agencies use to ensure quality treatment administration. The closest practice that fits would be observations by skilled clinicians but even information obtained from observations may well be subjective. What has been revealed in analyzing the monitoring practices is that TSS are, in fact, monitored in a

number of ways by a number of people. Wraparound professionals tend to rely on skilled clinicians who monitor the treatment process by ongoing supervision, ongoing training, ongoing observations, and ongoing documentation review. It is in this vein that we come to understand the second epigraph of this chapter, *Treatment integrity is maximized when there is on-going monitoring* (Thurman, 2007:16).

CHAPTER 5

"FOLLOWING THE PLAN"

There should be a relationship between progress notes and treatment plans so that the child's progression through treatment can be followed.
Hansen (1996:26)

I honestly think out of everywhere I've worked they do the nicest job as far as linking the treatment plan to this progress note for the TSS so that they don't have to make any leaps or generalizations.
Behavior Specialist Consultant

In chapter four, one of the most common monitoring practices wraparound agencies' employ is documentation review. That discussion merely highlighted documentation review as a practice and what it can uncover. This chapter expands on that discussion by examining two of the documents referred to in the previous chapter. In examining the documents, it became clear document designs shape treatment integrity in fundamental ways. Here, I analyze designs to compare standard components, show how designs hinder or enhance treatment integrity, and then discuss the quality of BSC and TSS documentation practices. The chapter is divided into three sections: "all about the plan," document designs and documentation content descriptions for goals, objectives, interventions, and behaviors.

"All about the plan."

The value of a treatment plan can never be overstated. One BSC referred to it as "the guiding force for all treatment." Another BSC stated "it's the map that helps us reach goals." A clinical supervisor said this: "To me it's a framework for treatment…it just gives you the framework and the thing that I like about it is someone told me this a long time ago…that it's a contract. You use the treatment plan as a contract" (W2CC). The treatment plan serves a number of critical purposes. It helps consultants set goals, it provides direction for those involved in treating the child, and it serves as a contract for clients and parents. According to

Hansen (1996), a treatment plan can be classified as "a blueprint for change," "a work plan," and "an instrument of accountability" (p. 5). The notion of a treatment plan as "an instrument of accountability" is particularly relevant to the study of TSS treatment integrity because two critical components of the plan are directly linked to treatment administration: the identification/description of target behaviors and interventions —"things that tell TSS what they are suppose to be doing" (W3TSS2).

The title of this chapter, "Following the plan," exemplifies TSS' accounts of treatment integrity. When asked three important queries relevant to treatment administration, most TSS and BSC responses centered on the treatment plan. In response to one query, What is treatment integrity? most participants defined it as the need to "follow the treatment plan." Similarly, responses to a second query, What are treatment violations? primarily centered on "not following the treatment plan." And, when asked a third query, what is your role as a TSS, references to treatment plans surfaced again. Table 5.1, on the next page, contains TSS statements to the first two queries. Note the prevalence of the terms "treatment plans" and "following [not following] the plan."

Most TSS had a clear understanding of the phrase "treatment integrity" and they understood their job entailed following the treatment plan. What's interesting to note is that when TSS were asked about their role, several responded to that query this way:

> My role as a TSS is to provide therapeutic staff support to students or one student in a classroom setting. We basically *implement* treatment plan procedures… we basically execute the plan implementing all of the things we should do. (TTSS5)
>
> My role as a TSS is to *intervene* with [interventions that help create] a positive replacement behavior when the client is exhibiting a problem behavior as defined in his/her treatment plan. (TTSS1)
>
> My role is to assist the child in achieving specific goals designated by the treatment plan. (TTSS2)

These TSS cited following the treatment plan as their central role. Clearly, the treatment plan figures prominently in all three queries. There does not seem to be any role confusion or misunderstanding of what TSS are expected to do.

Table 5.1 TSS Perceptions of Treatment Integrity

What is treatment integrity?	What are treatment violations?
Treatment integrity? You respect the treatment plan because basically *you would treat the child based on the treatment plan* that you've been given and um basically adhere to the guidelines and goals that you've been given to treat the child… Um integrity basically you do what you're supposed to do… (W2TSS1) Treatment integrity would mean that I follow the plan that is laid out before me by my team like my BSC. (W3TSS1)	Going against the treatment plan. (W1BSC2) To me a treatment violation would be not going along with the treatment plan. (W1TSS2) Like if they're violating the treatment um I guess like well maybe not abiding by like the agency's rules as far as the order of maybe the psychiatrist or following the treatment plan. (W1TSS3)
That the TSS *carries out* the treatment plan as it is stated and then discussed and elaborated on by the BSC.	I think what you are trying to get at is the treatment is not strictly enforced as delivered. (W2TSSx)
If the treatment plan has been formulated and written out, in some part, is the *execution*, you know, just to execute the treatment plan. Not to amend it, not to tamper with it, not to, you know, do anything about it. So we are talking strictly about execution here. (W2TSSex)	Treatment violations are when the TSS is just not following the treatment plan .(W2BSC2) Well my own understanding would be if we have certain interventions put in place and then the TSS has to go outside that to do something else then that would be a violation probably.
Following the treatment plan and when you have questions about it don't take it upon yourself to change it, delineate from it, or add your part to it. (W3BSC2)	Treatment violation has to do with well first the treatment plan is not carried out the way it was suppose to. (W2BSC1)
Follow[ing] the outline description [treatment plan] … and do it the way I'm suppose to do it. (W2TSS2)	If the—I guess if the TSS don't follow the treatment plan. (W1TSS1)

One "instrument of accountability" to ensure TSS "follow the plan" is the plan itself. But another "instrument" would be daily documentation (progress notes) of how and when TSS administer treatment. As Hansen (1996) reminds us in the epigraph, this demonstrates

the relationship between recommended and actual treatment administration. In order to show this relationship, it is necessary to discuss wraparound agencies' treatment plan and progress note designs. The next section focuses on wraparound agencies' document designs in two parts: I discuss treatment plan designs followed by a discussion on progress note designs.

Document Designs

Documentation design is an important consideration for establishing treatment integrity. These designs can enhance or hinder how well team members deliver treatment. If the design is user friendly, information contained on the documents should be easily identifiable. A user friendly treatment plan is one that highlights essential components in specially marked sections. Because several people are given copies of a child's treatment plan e.g., treatment plan team (BSC, TSS, MT, Parent), specially marked sections allow each member reading the treatment plan to zero in on the section relevant to his/her specific role.

The standardized components (similarities) facilitate our understanding of ways to enhance treatment integrity for all treatment team members. The uniqueness (differences) of each design allows wraparound agencies to express creative ways to capture information without compromising component standards. It is an "instrument of accountability," particularly for wraparound agencies because it guides Behavior Specialist Consultants—those who write the treatment plan. If the design of the treatment plan is nebulous or limited, this can greatly hinder team members' accurate interpretation of their roles thus hindering the integrity of treatment administration.

Treatment Plan Design Similarities

In analyzing treatment plan designs, all three wraparound agencies share numerous similarities. Each treatment plan has similar formatting features. The first page of every

treatment plan begins with a section describing client information (e.g., name, age, dob, address, admission date, parents, and 90 day service dates) as well as services (BSC, TSS, MT), and type of treatment plan (initial or review). There is also relevant information about the child's diagnosis.

Another formatting feature is headings. Table 5.2 contains a description of standardized components found in all three agencies' treatment plans.

Table 5.2 Treatment Plan Design Matrix

Component Checklist.	WRAP1	WRAP2	WRAP3
Description of Child	○	○	○
Reason for Referral	○	○	○
Child's Strengths	○	○	○
Family Strengths	○	○	○
TARGETS FOR INTERVENTION			
Child Concerns.	○	○	○
Family Concerns.	○	○	○
Child's Needs.	○	○	○
Family Needs.	○	○	○
GOAL #1.	○	○	○
Objective(s)	○	○	○
Problem Behavior	○	○	○
METHODS/INTERVENTION			
Who	○	○	○
What	○	○	○
TARGET DATE.	○	○	○

Treatment Plan Matrix devised from narrative descriptions in: Hansen, M. (1996). *Writing effective treatment plans: The Pennsylvania CASSP Model*. Harrisburg: PA CASSP Training and Technical Assistance Institute.

One heading focuses on a description of the child and how he/she is progressing under the current treatment. Two headings support the strengths-based, needs-based approach to treatment. Strengths-based treatment "form[s] the basis for all service delivery" (Hansen,

1996, p. 2). Rather than designing treatment based on deficit models, the principles undergirding treatment are based on the child and family's strengths. In needs-based treatment, "Services are planned to meet the individual needs of the child, rather than to fit the child into an existing service" (Hodas, 2001). One way this is achieved is by offering services in settings where manifested behaviors are most prevalent.

The section under the heading "Goal" is critical to treatment integrity. There are three primary goals in each treatment plan. Each goal is separated by a number; that is, "Goal One" has subheadings pertaining to that goal. "Goal Two," a separate section from "Goal One," has subheadings related to that goal; the same applies to "Goal Three." (Note: Only "Goal One" was included in Table 5.2). Under this section, there are sub headings labeled "Objectives," "Problem statement," and "Interventions/Methods." There are two areas that refer to methodological considerations: "objectives" and "methods." Objectives describe attainable goals and methods indicate "the specific roles and activities of involved professionals and the family [as well as] modalities and specific services" (Hansen, 1996, p. 12). All agencies had clearly distinguishable team roles labeled e.g., BSC, MT, TSS, Parent, Child. Also, the interventions or "activities" for each designated role were listed as well. All three agencies have detailed sections under each goal.

Due to wraparound agencies designs, major components were clearly distinguishable by bold headings. In reviewing the treatment plans based on the Hansen checklist, one could effortlessly identify all of the components. If anyone was looking for a specific component e.g., a parent, information could be located easily because all three designs are user friendly. However, differences can be found based on each agency's unique approach to treatment plan design.

Treatment Plan Design Differences

While several components germane to treatment integrity were found on all three treatment plans, there were some aspects of the treatment plan designs that differed. One difference centered on how methods were described. Designs for Wrap One and Two contain a section titled "Intervention." Under that section, the team roles and interventions were combined in sentences e.g., "TSS will… or MT will …" The design for Wrap Three was different. Table 5.3 illustrates two major differences.

Table 5.3 Wrap 3 "Methods" Section.

Role	Interventions used	Utilizing Interventions
TSS		
MT		
Parent		

The Wrap Three treatment plan contains a "Methods" section with three columns separated by grids. One column contains the treatment team member's designated role e.g., TSS, parents, MT etc. Another column contains a section titled "Intervention(s) used." For each team member, the recommended intervention(s) are merely listed. Column three contains a section titled "Utilizing interventions." This section describes "when" and "how" each intervention should be used. The value of all three designs is that if a team member needs to know what to do he/she can go directly to the role description without having to sift through nebulous descriptions where several roles are combined. The Wrap Three plan further facilitates identification because each intervention is described separately from how it should be administered. This is one key section for establishing TSS treatment integrity.

This difference actually mirrors other aspects of the plans. That is, the Wrap Three design has several distinctive features e.g., grids separating headings and sections, single line listings, and elements with open ended paragraph formats. Essentially, the Wrap Three

design is a formatted template where the BSC only needs to fill in appropriate boxes. In contrast, Wrap One and Two designs do not contain grids. Wrap One is completely open ended except for client/team information in the top section of the plan. There is a structured format where the BSC consistently listed the same headings and sections but there are no grids, no lines, and no boxes. Wrap Two shares similar features with both plans. There is a clear template, and there are open ended paragraph formats (lined); however, there are no grids or boxes.

Another difference refers to what the treatment team hopes will happen. Wrap Three contains the heading "Expected outcome." That is, based on the treatment provided to the client, there should be a change in client's behavior, a future projection. Wrap One and Two agencies document progress. Wrap One's heading "Progress/Discussion" is more reflective in nature. It summarizes how the client has progressed. Wrap Two, under the heading "Minor Goal Progress," identifies progress as well. Not only is the information reflective, the information also contains quantitative data highlighting the frequency, intensity, and duration of decreased change based on specific target behaviors. Under the heading "New Goal," this section actually discusses the "expected outcome" of client's behavior similar to that of Wrap Three.

Standardized components, designated headings, and use of grids make treatment plan designs quite user friendly. Whereas nebulous treatment plans can significantly hinder interpretations of treatment, user friendly plans enhance treatment administration. The same rationale applies to progress note designs. In the next section, I analyze wraparound agencies' progress note designs in the same manner in which treatment plans were analyzed.

Progress Note Design Similarities

Progress notes are data collection tools designed to capture specific student behaviors. Progress notes should be designed based on a highly structured format that is user friendly for data collection particularly when treatment agents are required to observe a child's behavior for several hours per day. These notes need not have identical designs but they should include standardized components similar to those found in treatment plans. (Note: In analyzing progress notes, although I discuss components of the notes, consistent with the discussion on treatment plan designs, there is also a lengthy discussion based on the physical description of progress notes. My rationale for doing so is that although both documents shape TSS treatment integrity, the design of the progress note as a data collection instrument reveals more aspects of treatment integrity than the treatment plan.)

In analyzing progress note designs, all three wraparound agencies share two design similarities. First, progress notes for all three agencies contain standardized components e.g., treatment objectives, target and replacement behavior definitions, interventions, student's responses to treatment, and summaries. Another commonality is that all three agencies' notes are designed to capture student behavior using hourly time slots. However, there are numerous differences in wraparound agencies' progress notes.

Progress Note Differences

There are a number of differences between each agency's progress notes. One difference is how progress notes are designed. Wrap One and Three share a similar design in that both notes are double-sided, landscaped documents. Side one of both agencies notes contains a grid of identical information. Table 5.4 is a description of side one of progress notes for Wrap One and Three.

Table 5.4 Progress Notes – Side One

Treatment Goals/ Objectives:	Target Behavior / Replacement Behavior		8:00	9:00	10:00	11:00	12:00	1:00	2:00
Goal 1									
Goal 2									
Goal 3									
Target/ Replacement Behavior.	**Full Definition of Behavior**:								
Objective 1									
Objective 2									
Objective 3									

In the top half of the note, there are columns labeled "treatment goals/objectives," "target/replacement behavior," and hourly time slots. In the bottom half, there are two columns labeled "target/replacement behavior" and "full definition of behavior." This side of Wrap One and Three's progress note is user friendly. In the first two columns, those items are described. This information was taken verbatim from corresponding treatment plans. TSS can familiarize themselves with the goals/objectives and target/replacement behaviors by referring to definitions on the progress note instead of the traditional practice of referring to the treatment plan. The hourly slots make it easy to mark observed target behaviors during the appropriate time in which they occurred.

On side two, the "treatment goals/objectives" and "replacement behavior" headings are replicated. That is, identical information is repeated on side two. There is a column, within a grid box, labeled "Interventions used." There is also a column labeled "Client's/ Family's response to intervention" as well as "Target/replacement behavior total." Table 5.5 is a replica of the progress notes discussed here.

Table 5.5 Progress Notes – Side 2

Treatment Goals/ Objectives	Target Behavior Replacement Beh.	Interventions Used	Child's Response to Interventions	Totals
	_____			_____
	_____			_____
	_____			_____

Outside this grid, at the bottom of the progress note under "Comments," space is provided for TSS to document "significant events, antecedents, behavioral trends, regressions/ improvements, etc." In this space, TSS can elaborate more on observed behaviors.

The progress note design for Wrap Two is dramatically different in several respects. First, this is a one sided, portrait document. Rather than using a grid template, this note is driven by eight questions. While some of the information is similar e.g., target/replacement behavior, interventions used, and child's response to interventions, there are other questions not addressed in the other two notes e.g., "triggers," "child's progress," "behavior comparisons—reflections," and "future projections." Second, neither "objectives" nor "target and replacement behavior definitions" are included in the Wrap Two note. Third, another major difference is the absence of tally marks.

According to the question that addresses behaviors TSS are to observe and document, TSS must provide a written response to the query: "What inappropriate behaviors did the child display? (Give the behavior, frequency, intensity and duration. (Data)." This information is to be documented in narrative form in the space provided in a table.

Table 5.6 Wrap Two Intervention Chart

Time	Interventions Used (Please describe in detail)	Child's Response to Intervention
8:00		
9:00		
10:00		
11:00		
12:00		

As part of Wrap Two's three columned table, there is a "time" column where TSS are expected to write in the times as opposed to notes with preprinted times. Also, in the other designs, TSS write in tally marks for targeted behaviors observed on an hourly basis. Once behaviors are tallied, they calculate totals for both target and replacement behaviors. Under the Wrap Two design, there is no space for tally marks. The only grid on this agency's progress note addresses interventions. Whereas the focus of the two agencies is to document target behaviors hourly, Wrap Two's focus is to guide treatment by indicating which interventions should be used hourly. Consider its treatment program consistent with the *hour by hour* theme. Cautilli et al. (2001) refer to it as an *activities program*. Although it is an extension to the treatment plan, its design is equivalent to grids for Wrap One and Three. Two participants describe it in this way:

> There are some treatment plans whereby it has been specified what you need to do on an hourly basis. So like if you're working between 9 and 2, those are school hours, there are some treatment plans that specify what you need to do when its 9:00 o'clock, when its 10:00 o'clock, when its 11:00 o'clock up until 3:00 o'clock. (TTSS2)

> We do--there's a policy here at {name of agency} that the behavior specialist has to break down *hour by hour* interventions—*hour by hour* for the TSS worker. (W2BSC1)

This agency uses what clinicians refer to as "an activities schedule." This schedule, also known as a treatment program, identifies every major intervention to be used as well as explicit instructions for how TSS should administer treatment and when they should administer treatment (on an hourly basis). On this grid, each hour block is filled with a specific task the TSS should accomplish. These hourly tasks remind TSS what should be occurring within any given hour. It is a highly prescribed schedule. This agency also uses

progress notes which reflect the hour by hour theme but again TSS are expected to write down which interventions were used—not target behavior.

A final difference is one agency uses a built in severity index on its progress note that captures the intensity and duration of behaviors. The importance of this feature is that a BSC rather than TSS completes the index. That is, the BSC examines the progress note, analyzes the target behaviors, and makes a determination based on the tallies recorded. It is the BSC who makes the recommendation about the child's behavior and in turn adjusts treatment accordingly. The other two agencies did capture frequency data but intensity and duration of behaviors was ignored. Hence, making a slight adjustment in the progress note design to include the intensity and duration of behaviors is a stronger indicator of the child's behavior. Under the current method, TSS from two agencies did not document the intensity and duration of behavior.

In summary, a progress note design that include goals and definition of behaviors enhance treatment integrity because it is a user friendly tool that guides TSS to capture specific behaviors without referring to treatment plans. Progress notes based on a numeric schema where TSS document hourly target behaviors using tally marks facilitate TSS data collection particularly when TSS must observe behaviors for several hours. This method is most useful for tracking the frequency of behaviors.

Another important feature regarding progress notes designs is wraparound agencies' emphasis on components directly related to treatment integrity. In two of the three progress notes, several components match components on treatment plans. The target behaviors, replacement behaviors, definitions of those behaviors, and interventions to be used on progress notes are identical to the same components on the two treatment plans. It is clear

there is a relationship between the information on treatment plans and progress notes. These notes are standardized in that TSS do not complete these sections because they are a part of the progress notes permanent template. The strategy replaces traditional approaches to treatment integrity where treatment agents were given copies of a student's treatment plan and they had to refer to the full plan as a treatment guide. The new strategy these two agencies employ allows TSS to constantly refer to behaviors that are clearly spelled out on progress notes without having to refer to the treatment plan as they had previously done which has the potential to strengthen TSS treatment integrity.

Content Descriptions

The way in which statements are phrased is central to determining treatment integrity. Wraparound professionals stress the importance of using appropriate terminology and writing target behaviors and interventions in observable and measurable ways. The reason for using appropriate terminology is threefold: first, to deter professionals from making personal judgments. Only clinical impressions should be noted; second, to provide a clear description of target behavior and interventions in concise terms so that others can properly implement treatment; third, so that data collected can be measured. Hansen (1996) discusses myriad pitfalls professionals encounter in terms of writing treatment plans in general and methods sections in particular. In examining treatment plans, there are two areas of interest relevant to treatment integrity: objectives and interventions.

Treatment Plan Data Analyses

An analysis of treatment plan objectives, or short-term goals, is an important area of study. Objectives should be highly specific so that TSS can capture the right target behaviors. If they are not able to observe specific behaviors, they will not be able to

administer the right treatment. Sometimes when objectives are written in general terms, TSS may experience difficulty observing specific behaviors. One TSS, who faced that problem, wrote:

> I'm like really on those goals. I'm always really observant of what are those goals. And I'm—and I'm always rereading them and a lot of times I'm going back to my BSC and I'm saying explain to me what you really mean by this goal. We have done this in the past when I thought it meant one thing and then she saw that I was not interpreting it properly and we sat down and talked and she—*no I mean this and when I say impulsive behavior I mean a,b,c,d, & e*. And I'm like oh I never thought that *d* was an impulsive behavior but by her definition it is... When her definition says one thing I may still not interpret it the exact same way that she does and so we have sat down and we have done that [go] over each goal because if I felt it necessary, she felt it necessary and so we've done that and that made me feel so much better that I could better—you know fulfill this treatment plan.

Other TSS talked about how there are times when definitions are not as explicit as they should be; as a result, sometimes they miss certain behaviors because the definition provided on the treatment plan was too limited. Findings revealed that treatment plan objectives were written in ways consistent with treatment plan pitfalls. Hansen (1996) identifies at least eight pitfalls readers are likely to encounter as it relates to how professionals (e.g., BSCs) write objectives. Four of those pitfalls are applicable to this analysis. They are listed as follows:

(1) Objective involves decrease in frequency, or elimination, of negative behavior rather than attainment of positive outcome;

(2) Objective too general – not observable or measurable;

(3) Too many objectives. Objectives should be prioritized;

(4) Objectives stated in negative terms rather than strengths-based terms (p. 24).

Hansen (1996) provided examples of problematic objectives and how they could be revised. Table 5.7 contains examples of questionable objectives and how those objectives can be reworded, useful guides for gaining a clearer understanding of what is to be accomplished.

Table 5.7 Objective Pitfalls and Recommendations

Questionable Objective	Revised Objective
improves self esteem	is able to discuss self in positive ways
develops independence	can complete his daily chores w/o help from parent
reduces depression	can talk to peers w/o crying and verbalizing negative self comments
stops hitting	expresses anger and frustration verbally
improve negative attitude	greets people w/pleasant gestures or remarks
stops badmouthing	expresses concerns w/o the use of negative or derogatory comments

Source: Hansen, M. (1996). Writing effective treatment plans. Copied verbatim.

In Table 5.8, I identify several "questionable objectives" contained on treatment plans in this study which seem to fit the criteria for three of Hansen's "objective pitfalls."

Table 5.8 Objective Pitfalls of Behavior Specialist Consultants

Questionable Objectives	Pitfall #
Will be able to initiate and respond positively to social interactions and communication with his peers and parents.	3
Will be able to sustain his attention throughout an entire instructional period	2
Will increase social skills with others, as evidenced by sitting, talking and participating in recreational and structured activities with peers and adults at the school and in the community	3
Will express feelings effectively	2
Will verbalize angry feelings effective on 3 out of 5 occasions about what is upsetting him, rather than shutting down or being hostile	3
Will reduce impulse acts by 20%	1,4
Will eliminate episodes of highly impulsive behavior	1,4
Will reduce tantrum episodes when angry or frustrated less than 2x per week	1,4
To give appropriate social cues to interact with parents and adults	2
Will develop the self regulation skills to manage frustration, understand his anger, and cope with these feelings effectively	3
Compliance to 50%	1,4

Many of the pitfalls contained in Table 5.8 refer to objectives being written in terms that focus on negative behaviors. To be sure, all of the behaviors are problematic, but the approach to them should be based on positive outcomes e.g., "expressing one's self without the use of negative or derogatory remarks," or "doing daily chores with help from parent."

Using reduction or elimination terminology and numbers without understanding how to reduce the behaviors is difficult to interpret. There are also examples of objectives that are excessive. One BSC wrote an objective this way: "Will develop the self regulation skills to manage frustration, understand his anger, and cope with these feelings effectively." This seems to be multiple things the BSC wants the student to accomplish. Perhaps this objective should be broken down in a way that is would be more understanding to the TSS and student. It seems too much is happening in this objective. Another BSC wrote this: "Will express feelings effectively." What does "effectively" mean? This objective does not seem to be observable or measurable. Overall, to an untrained novice like myself, I found the objectives written on treatment plans were not easily understood.

Another aspect of treatment plan content descriptions is treatment. Writing good descriptions of interventions is key to treatment integrity. How BSCs define treatment determines, to a large extent, how well TSS implement interventions. If treatment is described in observable and measurable terms, TSS have a clear guide for accurate treatment administration. Table 5.9 summarizes data obtained from treatment plans on based on BSC descriptions of interventions (see partial raw data in Appendix J).

Table 5.9 Analysis of Treatment Plans.

Standard Criteria for Adherence	W1P1	W1P2	W2P1	W2P2	W2P3	W3P1	W3P2	W3P3
Methods specify who is responsible	Yes	No	Yes	Yes	Yes	Yes	Yes	Yes
Methods specify what will be done	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Methods specify when they will be implemented	Some	No	Rarely	Some	Some	Some	Some	No
Methods specify how long they will be implemented	No	No	No	No	No	No	No	No
Methods are clear	No	No	No	No	No	No	No	No
Objectives are measurable	No	No	No	No	No	No	No	No

This table was created using criteria for good treatment plans (Hansen, 1996). From this table, we find BSCs generally specify each member of the treatment team by role. They also identify which interventions will be employed. However, based on the results, there are several treatment plan problems. There were eighty eight interventions listed on the seven treatment plans used in this study. None of the methods, as written, are measurable. The methods are stated but they are not described (see Appendix J). Another problem found on two treatment plans was that multiple interventions were used for the same objective but none of them explained how each should be used. That is, on two treatment plans, you would see perhaps four interventions mentioned e.g., TSS will use praise, prompts, reinforcement, and redirection under one description. There were a multiple interventions listed but none with descriptions. Hence, for the first two criteria, BSCs did well. For the third criteria, there were instances where the BSC would indicate "when" certain interventions should be used, but this was not documented frequently. There were no instances of "how long" interventions would be implemented. As for the final two criteria, the methods documented were not clear nor were the objectives written in measurable terms.

Progress Note Data Analyses

TSS documentation is important because these progress notes capture a major part of student's behavioral change. Hence "…the information that TSS collect on a daily basis is vital to the wraparound team" (W3BSC1). Progress notes should reflect "what's going on." A good indirect method of determining treatment integrity is analyzing TSS progress notes to see if they are, as one TSS suggested, *darn good notes*. What constitutes "darn good notes"? The key factor is the written description of how treatment was executed. To be sure, it is necessary to collect data on the child's behavior where frequency, intensity and duration of

behaviors are documented on an hourly basis, in an effort to observe trends in behavior patterns. Collecting this information is important because with this knowledge treatment adjustments can be made when the severity of a child's behavior is known. But, to get at integrity, the TSS must describe, in sufficient detail what those behaviors were and how they were addressed in observable and measurable terms. When TSS progress notes were analyzed, most of the descriptions were not written in observable and measurable terms.

One TSS indicated on a progress note the names of six interventions used during the course of that day. However, not all of them were described and for the two that were those descriptions of the interventions were lacking. This is how W1TSS1's documentation read: "Was asked to walk" and "Told him don't touch anything he can't buy." The context in which the TSS intervened was based on following problem behaviors exhibited that day: "[Client] was running, [client] was touching things in the store, [client] showed bad self control, and too much playing around." Finally, the TSS' overall assessment was the child "Did better later in the day." In analyzing W1TSS1's other four progress notes, there were similar examples e.g., "Was very wild when I got there," "Yelling for no reason" even though the client "Did better as day went on. Not as wild as before." The way these progress notes were written is problematic for a number of reasons. First, TSS are not to make judgment statements. Phrases such as "very wild," "showing bad self control," and "too much playing" are not clinical impressions. The TSS only needed to describe the child's behavior in observable terms. Second, descriptions of the interventions "Was asked to walk" and "Told him don't touch anything he can't buy" were problematic as well. We can surmise the behaviors the child was exhibiting but we do not know the context of what was occurring. When was the child running? Why was he running? are questions that would help us

understand the child's behavior. Also, the "told him don't touch anything he can't buy" is unclear as well. This TSS wrote in his progress notes that he and the child were "at the mall." Why was this TSS "at the mall" with the child?

Table 5.10 contains nebulous behavioral terms found on TSS progress notes. In one column, the behavior is identified. In the other column, I raise questions about the behavior. I did not venture to interpret the nebulous behaviors because I did not observe the behaviors. The examples demonstrate how problematic TSS documentation is in terms of describing behaviors they do observe.

Table 5.10 Behavior Pitfalls and Recommendations

Nebulous behavior	Specific behavior?
Client was all over the place	What was the client doing?
Client seemed very nostalgic	How do you observe "nostalgic" behavior?
Client tantrumed throughout the day	What type of tantrum?
Client was very wild	Wild? How is "wild" defined?
Client showed bad self control	What was the "bad self control"?
Client's behavior was up and down	"up and down"?

Progress notes of the TSS who boasted of having *darn good notes* were analyzed as well. Although W3TSS1 wrote more descriptive phrases than W1TSS1, there were many judgment statements as well. Phrases such as "[client] was all over the place," "When asked to do something, client insisted on doing what s/he wanted to do," and "client seemed to be very nostalgic." Again, there is a lack of clinical impressions. None of these statements tell, in observable terms, what the client is doing. W3TSS1 also wrote the following: "I prompted client through his/her activities," and "client tantrumed throughout the da*y*." In terms of the prompting, there is no mention of which activities and how client was prompted using either verbal or non verbal cues etc. As for the client *tantruming* all day, the TSS did not indicate which interventions were used and what was done to curtail the *tantruming*.

In examining each progress note, it was clear all of the progress notes contained judgmental statements, nebulous behaviors, and unmeasurable descriptions of how interventions were administered. However, there were a few instances where observable behaviors were captured. None of the progress notes contained substantive narratives of the student's observable behaviors. Even though the recording of targeted behaviors was high, the written account was limited. Throughout the course of one full school day, TSS documented, in five sentences or less on average, a summary of the child's behavior. TSS seem to do well with observing and documenting targeted behaviors but they fall short in writing what was actually observed, how treatment was administered, and the child's response to treatment.

Summary

After analyzing documents, it is clear document design is a valuable approach to enhancing treatment integrity for all three agencies. It is difficult for BSCs and TSS to get confused about how to document information because the customized templates serve as guides for not only what to document but where that information should be documented. Similarly, there does not seem to be a problem with TSS "following the plan." Only one TSS was displeased with part of the treatment plan for her student. When asked about how interventions are described on the treatment plan, W3TSS2 said: "Actually on the treatment plan that I have for my client its no {pause} no they don't give you any, {long pause} what do I want to say, I do it all on my own." However, when I reviewed the treatment plan, there were interventions listed. They were not described in observable terms, but they were on the treatment plan. Another TSS did confirm that interventions were not fully described on the treatment plan she used for her student but she offered a reason why: "Okay, [the BSC] may

not necessarily have written okay 'first, try ignoring him, second remove stimuli, or three' you know…[the BSC] is not gonna write all of that down. They're not the kinds of things that you would have to write steps about (W3TSS1)." And, in reviewing that treatment plan, the interventions were listed in "global" terms. Aside from these two TSS, the other TSS said they believed BSCs provided detailed interventions that they could understand and follow. When posed the same question, some of the TSS had this to say:

> Each intervention is spelled out. (W2TSS3)
>
> Yeah. It depends from one treatment plan to the other. There are some treatment plans whereby its been specified what you need to do…. But there are some that are just generalized. They give you the basic things to do then they leave you to work it out on your own. (W3TSS2)
>
> Most of the time its explained thoroughly on the treatment plan…. Its in terms of steps of what you need to do. Um they'll give you an example if the child gets out of the seat you have to do such and such and such. I can't think of any—a better example right now but basically its step-by-step. Its defined for you. (W2TSS1)
>
> Um no they—no they don't just say timeout. No, they define it so that's then of course we as TSS can implement different things to go along with what they have stated. (W2TSS2)

In analyzing BSC responses to how they defined interventions, the findings were somewhat mixed. Some BSCs responded to queries (question was not always posed the same way) related to how interventions on treatment plans are defined by making the following statements:

> My treatment plans enable them to write their treatment notes I think more specifically because I have a lot of interventions. (W2BSC2)
>
> I would write token economy and define what that is because that could mean various difference things depending on the individual that you are addressing. (W1BSC3)
>
> I explain—explain—yeah I explain. Of course on my treatment plans if you had the chance to look at you'll see that I explain the token economy too. I

> write it on my treatment plan. My treatment plans are usually 18 pages long so its clearly defined on the treatment plan what the TSS—how the TSS carries out token economy. I don't just put there token economy. (W2BSC1)

> I describe my interventions…. Oh I define what it is…. When I write mine I actually probably sometimes put more because I try to—if I say you know praise I always try to put an example of it or this is how it should be. Or I'll put this intervention that everyone should be doing anyway so I'll put it in there so the TSS sees it even though he would basically just redirect automatically but it should be in there. (W2BSC2)

There were other BSCs who fully acknowledged that interventions they wrote on treatment plans were not clearly spelled out. A few of them had this to say:

> The treatment plan—no. In the--it is in there but not those specific terms. But that's what will be detailed when I explain it to them. (W1BSC1)

> I—I do to a limited extent. Um I would say several years back when I worked at [agency] I used to write very long treatment plans that spelled out how they were even to provide like *labeled* verbal praise and how you conduct the time out, and how many minutes and where they sit, and I feel like the agencies have moved towards standardized treatment plans where it's a limited amount of space. I just see the interventions not being spelled out to that level of detail and so that's where meeting with the TSS every week comes into play. Like you may write in your treatment plan that a token economy is to be delivered but you really don't have room or spell out exactly how to do that. (W2BSC3)

> I'm not gonna write down the whole [thing ever]…. Sometimes it boils down to like there are all these interventions on the treatment plan but maybe you're only doing one or two [because] that's all you need to do. Some of the other things you just do for—at least for me you're gonna just probably do automatically anyway [e.g.,] its just standard redirection, praise, consequences, stuff that you would [normally] do. (W2BSC2)

> You know our treatment plan is very elaborate and a lot of times people don't lay out every step. It could be you know 50 pages long if you do that. (W2CC)

After analyzing the treatment plans, and comparing query responses with interventions contained on treatment plans, the descriptions were consistent with those BSCs who said they only described interventions "to a limited extent." Conversely, findings from BSCs who

reported they "defined" interventions were inconsistent with descriptions contained on their treatment plans.

The quality of BSC and TSS documentation raises concerns, in one sense, about how well these services truly function. Given the extensive training they receive, particularly training on writing treatment plans, progress note documentation, and ongoing documentation review, the findings paint less than flattering picture. In another sense, one has to take into account other factors e.g., perhaps generalizing descriptions of interventions is an accepted practice because there are many other ways clinicians can determine BSC or TSS skills apart from documentation; observations may carry more weight than documentation. Clearly, direct monitoring methods allow clinicians to see people "in action"; because we learned in documentation review, BSC and TSS are routinely called in about poor documentation, perhaps wraparound agencies approaches are to retrain, provide sample documents as guides, and encourage staff to review materials on "how to write effective treatment plans" and progress notes. It is difficult to make sense out of these findings. Does it mean TSS can delivery quality treatment in spite of intervention descriptions fraught by objective pitfalls and unmeasurable interventions? Does it mean TSS did not administer treatment appropriately because they fell prey to behavioral pitfalls and superficial summaries? From the monitoring evidence, we do know these employees receive ongoing training, supervision, and documents are reviewed routinely by clinicians. In light of all of resources available to BSCs and TSS, its unclear why the documentation is lacking.

CHAPTER 6

"RISK FACTORS"

The impact of situational constraints is implicit in patterns of access, challenge, control, demand, expectation, opportunity, reinforcement, and threat.
Gordon and Song (1994:33)

For students with a severe emotional or behavioral vulnerability, there are myriad risk factors that act as barriers to their healthy development. The most obvious risk factors for this population are being undiagnosed and untreated. Another major risk factor can center on mental health professionals' approaches to treatment e.g., inappropriate service delivery models (deficit driven v. than holistic models emphasizing strengths, needs, and ecology based approaches), use of unqualified staff, and inadequate monitoring practices can pose potential threats to students. We also know, as was discussed in the previous chapter, how document designs and poor documentation can serve as risk factors as well. In this chapter, I discuss the importance of determining threats TSS encounter during the course of their work. The chapter corresponds to the research question, "What are some potential threats to treatment integrity?" You will note there is a "documentation issues" category. Unlike the previous chapter's discussion, another set of issues related to documentation is addressed.

A major assumption in integrity research is that treatment agents will implement treatment as intended (Gresham, 1993); however, many factors challenge that assumption. This chapter discusses factors which emerged from the data that can be significant threats which impact TSS treatment delivery. These factors, mostly consistent with threats identified in treatment integrity literature, center on five categories: (1) treatment issues; (2) people issues; (3) documentation issues; (4) environmental issues; (5) service interruption issues.

Table 6.1 contains the five major categories as well as sub categories that will be discussed in this chapter.

Table 6.1 Potential Threats to Treatment Delivery

Treatment Issues	**Documentation Issues**	**People Issues**	**Environment Issues**	**Service Issues**
Resistance/Adherence	Global descriptions	Parents	Classroom	Finances
Acceptability	Design problems	Teachers	School	Restaffing
	Untimely notes	People issues center on three areas: (Role Confusion) Resistance Poor data collection		Treatment delivery

Treatment issues

The most significant risk factor that threatens quality treatment delivery is agents not following the treatment plan. Although most TSS understand the importance of treatment adherence, some just do not like to follow the plan. In this study, one TSS' rationale for why some TSS do not follow treatment plans was expressed in this way:

> People have…their own ways of doing things. We're not robots… everybody don't follow the plan. I mean like in life period. I mean everybody's gonna do something their way anyway so you know you're not gone [follow it]. Like, say you're goin' [to take] the bus—a bus has to follow this certain route. You don't. If you're driving a car you don't have to follow that certain route with the bus; you're gonna go your way so that's how it is. (W1TSS1)

The idea of your "own way of doing things," is extremely problematic. This TSS does not offer any reason for not following the plan other than not wanting to follow the plan. Clearly the mindset here is resistance. There is little regard for principles undergirding quality treatment delivery and this action is considered a major treatment threat. Another TSS took issue with following treatment plans as well:

> You have to do it by the way of the company and that sometimes gets in the way… They want you to stick to the plan—the plan that the behavior specialist wrote. That['s] the hardest thing…you kinda have to stay in a box to do your work… (TTSS1)

Neither of these TSS provided a reason for why they did not feel it necessary to stick to the treatment plan. Even though both clearly understood their roles and the importance of following the plan, they spoke against following it. "Staying in a box," as the TSS put it, suggests the difficulty with conforming to the demanding nature of TSS work. Statements like "we're not robots" and "staying in a box" reveals TSS naivete about treatment. When the TSS talked about "people having their own way of doing things," this TSS went on to say the TSS job

> is just basically all common sense and how good you are with children… just basically, well, common sense. I don't really, you know, I study what they say you know the behavioral stuff they be usin'. You know, I just go on common sense on what the child needs (W1TSS1)

Treating a student with sebd is far more complicated than taking a "common sense" approach to addressing behavior disorders. This view suggests the "behavioral stuff they [clinicians'] be usin'" may not be any better than his "common sense." In other words, this TSS reasons anybody can provide therapeutic support if they have "common sense," know "what the child needs" and are "good with children."

In analyzing TSS responses, two themes emerged that seem to be interrelated to TSS resistance to treatment plan adherence based on TSS' perceptions of treatment. One theme centers on the notion of "the professional" and the other "see[ing] different things."

> [TSS] think that they know the child better and they're the ones with the child all the time so they feel they can make these determinations 'cause you're [the BSC] only in here one day a week—what do you know? (W2BSC3)

> I think sometimes like—like if the doctors or psychiatrist has to issue the treatment or the diagnosis and stuff—I think they just go off of what they think it appears to be—they don't see the kids everyday like we do. They just go off what they see a couple of times, they see them, and then they just diagnose them (this and that). So I think as a TSS you know basically just I'm in there with him everyday all day so we see different things. (W1TSS1)

> Being a TSS you see different things happening. Sometimes the behavior specialist may not pick up on what we pick up on… (TTSS1)

Both themes surfaced throughout the data. TSS talked about being with a student everyday as opposed to others on the treatment team who see the student far less frequently. And, even though TSS regarded the BSC and psychologist as professionals, many still felt what they saw happening daily was at least equal if not more significant than professionals' limited observations. This view seems to discount professional expertise. To be sure, TSS observations are in fact quite significant to wraparound clinicians but findings based on TSS observations are used to inform future treatment efforts and not for them to take it upon themselves to alter treatment. Because TSS "see different things" by no means should it suggest they are experts at assessing behaviors and/or designing treatment.

This notion of "seeing different things" also surfaced in a coordinator's comments about observing consultants and therapists in action. This clinician said:

> Basically the observation gives you a clear picture of what's going on in the family. Then sometimes the clinician, like me being a supervisor, the clinician may not be able to see because they're in the trenches. You know and because they're in the trenches they're so caught up with what treatment plan they wrote, what the crisis is that's going on, and what the insurance company says. I'm coming in with what they told me from those three areas; however I may see something that they're not seeing because they're in there everyday and I'm able to step back and say 'okay we need to, you know, once we get through this—this moment we need to look at this, that and the other.' (W1CC)

This supervisor raised the issue of seeing things those "in the trenches" are likely to miss because they are deeply engrossed in their work. Hence, "seeing different things" does not necessarily mean "seeing" the right things or being better able to assess behavioral issues than those who have the expertise. W1CC reports that even clinicians can experience difficulties they are not aware of "because they're in there everyday" and might minimize or inadvertently overlook essential details that could potentially hinder treatment. Similarly,

being with a student all day, “everyday” can also create conditions for TSS complacency. TSS raised the issue of boredom, particularly when their students were adjusting well to the intensive treatment they were receiving. Perhaps TSS want to “spice things up” by doing things their way because students are responsive to treatment and, as a result, TSS feel bored. There is an inherent danger in this because TSS may begin to use non-therapeutic practices that could run counter to treatment approaches designed by clinicians. However, there are instances where TSS perceptions of treatment are accurate. The next section discusses treatment acceptability issues.

Treatment acceptability has been defined as “a judgment of the appropriateness and likely effectiveness of a given treatment for a given problem" (Dunson et al., 1994, p. 249). There are times that certain interventions or services are not effective for clients. But there are those who continue treating clients when it is sometimes best to acknowledge services are not working, abandon the effort, and refer clients to more appropriate treatment.

“Just Dead Wrong.”

Some clinicians recognize that wraparound services are not the right services for every student with sebd; consequently, some students must be placed in more restrictive settings. Sometimes that fact is not always known until students are placed in less restrictive settings before discovering they pose a significant threat to others and are not able to function in their natural environment. In other instances, the “bundling of services” could result in overutilization rather than addressing each client individually and making an appropriate determination based on assessment data as opposed to use of a service delivery model because of its popularity. Not all treatment works for all children and two wraparound professionals articulated treatment acceptability issues quite nicely:

> It could be a misconception of what the kid needs—what kind of service the kid needs and it might not be TSS' fault. Somebody told him to work with that kid and then he's doin' what he's suppose to do, everything is going fine but no improvement. It might not be our—we might not be the right service for this kid. (W2BSC1)

> I mean something's not working, parents aren't buying into it, data's showing that its not changing the behavior, it could be adverse—its just not working for that child, and based upon the child's history or reinforcement or just they're history of what's happened to them you might start a treatment then you find out that you were just dead wrong. (W2CC)

In these instances, clinicians voiced their concerns about treatment acceptability centering on the wrong service delivery model. At other times, other acceptability issues emerge. One TSS shared an experience when a BSC designed the wrong treatment and, as a result, the child regressed. That problem was explained in this way:

> Most of the time I don't have a problem with the treatment plan at all because the person is like right on the mark. I've only had an experience maybe only twice that it wasn't on the mark and it needed to be altered but when it was altered it was altered inappropriately for the child. In one particular case the child was nonverbal and we were trying to get him to be verbal and they wrote a treatment plan—well they didn't write it they tried to implement a treatment on nonverbal actions to a child that we're trying to get to be verbal. And so it defeated the purpose. It kept the person in a nonverbal mannerism instead of helping that person to come out of their phobia, out of their fear and to be able to talk more and read out loud more. Now they've shut the person down and that's inappropriate for a BSC [because]…it literally closed him up and kept him where he is. (W2TSS3)

Based on this TSS' assessment, the nonverbal treatment was "just dead wrong." Another acceptability concern raised by TSS, based on the theme "I didn't see that" was the absence of certain target behaviors.

"I didn't see that."

Target behaviors are the central focus of TSS work. When a student's target behaviors surface, the TSS administers treatment in an attempt to stop or reduce the behavior. Essentially, specific interventions are to be employed when a certain behavior is displayed. But what happens when target behaviors are not displayed? There were a number of

instances where TSS talked about target behaviors not being observed. Consider the following statements:

> They put a lot of things down that he was, you know, he had ADHD and violent, wanted to fight all the time; this and that. I didn't see that. None of them—none of those things occurred at all. (W1TSS1)

> My treatment plan to me is way off… And a lot of the behaviors that are on there are not pretty much what the kids does. (W1TSS3)

> And another thing would be tantrums. Well I haven't seen them tantrums. So that shouldn't be a goal... (W3TSS1)

> Why are we working here [when] he's not having these problems any more. Let's work with the problems that he's having. (W3TSS3)

Some of the target behaviors identified on treatment plans and progress notes were not manifesting in students. Based on participants' responses, we learn there are myriad reasons why treatment is unacceptable. The most common, positive responses include: certain behaviors stop, goals are fulfilled and new goals must be set, students regress, and new behaviors emerge. Participants also reported treatment adjustments are always necessary due to human nature. Whatever the case, not "seeing" behaviors is a clear sign to make treatment adjustments.

People Issues

Many participants expressed their concerns with groups of people that are sometimes viewed as threats to effective treatment delivery. While the extent of these relationship issues is unknown, TSS spoke a great deal about encountering problems periodically with others. TSS most often cited concerns with parents and teachers.

Parents

Generally speaking, throughout resilience literature, it is a widely held view parents "are a child's first protective agents" (Wang, Haertel & Walberg, 1998, p. 17). However,

there are certain parental characteristics that are risk factors to children's development e.g., poor parenting skills, addiction, mental illness, domestic abuse, etc. (Masten, 1994). In treatment integrity literature, while some groups of people have been studied (clients, agents, consultants) few studies have explored parental characteristics that serve as threats to treatment. Hodas (1995) discusses the importance of what he calls "parent-professional collaboration." This type of collaboration requires shared power and when power is not shared, as in cases where parents relinquish control with the expectation that professionals will do the work, this poses significant challenges to the treatment process.

In this study, there was a general consensus among participants that "a lot of times parents are barriers to treatment" (W1BSC3). One BSC reported, "sometimes [they] don't get anywhere with the family." When BSCs go to conduct home visits, several mentioned how the parents would "play games" by pretending not to be home, not letting them in the home, or getting frustrated by their presence and telling them to "Go away! Get out!" Although parents are an integral part of treatment the major relationship issue participants felt was a significant threat to a child's development was their interaction with parents. As one coordinator noted, many TSS believe:

> [T]he biggest problem…we have is that sometimes you could do a lot of stuff in the school that would get undone at home… We could have a kid who's perfect in school and is doing stuff at home. [In order for treatment to work, we must find answers to two specific questions to help us design better treatment:] What are the contributing factors to the behavior [at home]? What needs to be altered? (W2CC)

In gaining a better understanding of why participants perceived parents' actions as barriers, I looked at the responses and formulated a theme of parental resistance. Resistance can be traced in three specific problem areas: (1) lack respect for specific BHRS roles in the

treatment process, (2) parents resistance to treatment in terms of acceptability, and (3) failure to adhere to treatment.

"Role confusion?"

Cautilli et al. (2000) discuss consumer role confusion. Parents come across as not fully understanding wraparound roles (BSC, MT, TSS) particularly the role they are expected to play in their child's treatment. Parents are expected to be heavily involved in their child's treatment. It appears some feign ignorance or misunderstanding about this fact. However, upon closer examination, the problem seems to be more directly related to resistance. One coordinator said this:

> You know there are some families who have had services for years who don't even understand what the BSC role is… That's something that's very important. You know the family—the consumers have to understand what you're supposed to be doing. A lot of them don't even like [know] like I would get assigned to a family who had services for 2 or 3 years and I'd say, so what does a BSC do? [They would say] why are you asking me questions? What do you mean I have to sit down and write the treatment plan with you? Just give me your paper and I'll sign it. (W2CC)

This clinician was referring to past experiences dealing with parents while working as a BSC. The coordinator's practice, when encountering new families, was to always review team roles to ensure that parents had a good understanding of each treatment team members' responsibilities. In reviewing everyone's role, this heightened parents' awareness of what team members were doing as well as what they were not suppose to be doing. Initially, to the BSC, it seemed as though the parents were not aware of everyone's role but parents' responses revealed other things. The fact that parents did not want to be a part of the treatment process demonstrates their resistance rather than role confusion. TSS also encountered similar problems.

"We bump heads."

TSS expressed concerns regarding parents' "confusion" about TSS roles when in fact parents' responses seem to indicate problems resulting from them not respecting TSS roles.

> If the parents was more educated as to our position [that would help us carryout our work better]. You know they need to be more educated as to realize that our position is not coming in the home or in the school to really mold your child. Our job—we're your helpers so to speak; we're your support and I think when I was working in the home my parent felt like "that's yours." When I used to walk in, "that's yours." See I think they need…all the parents of these kids [need] to go to the team so the team can talk as a group. [The team needs to explain] why we have these TSS in your home and in schools and [parents need to be given a] description of what [TSS] are suppose to do. They need to be [given this] 'cause we, we bump heads. A lot of TSS—I just so happen to have had some good ones [parents] or maybe because of my experience I know how to deal with them. But listening to a lot of TSS—well before I got a good rapport with my parents we did bump heads but I had to let [them] know I know my job and I'm fit to do it. But a lot of things like I said, she didn't like some things [about me because I wouldn't do whatever she said do]; but after she got to know me and know that this lady is here to do a job then she lightened up a lot… But they need to be more aware of what we're in that house for and the school. (W2TSS2)

> I think…the parents in the home setting probably need to be informed about the jobs of a TSS. Like sometimes when a TSS gets a home assignment the parents expect that okay somebody has come for—I mean somebody else comes around to do some kind of babysitting jobs for them and that is not the job of a TSS. You can't babysit, you know, and sometimes they expect that okay they need to dash out somewhere when you are closing for the day [and the parent asks 'can you give us a ride?] You know a TSS is not supposed to do all of that for parents or the child and when you turn down the request sometimes they don't like it and they want to make you know things more difficult for you…. So I think the parents...need to know what TSS job descriptions are…. [T]hey need to know that this TSS worker is just coming around to help us not to do our work for us. (TTSS2)

> Well, they're just like—'if you sick leave me alone. I don't have nothin'—you know fix him, go to school and tell him what to do and what not to do. He's not listening to me so you tell him.' (W1BSC2)

These excerpts shed light on tension between wraparound staff and parents. This problem does not stem so much from role confusion but perhaps role imbalance or the absence of shared power. As one TSS expressed, the parent's position was "that's yours" which can be translated "you are here and are responsible for helping my child. I am no longer involved."

One TSS put it this way: "[I get the sense parents feel like] you're the professional expert so do what you do." Another TSS expressed the same concern:

> Some of the frustrations can be sometimes the parents thinking that you're like the babysitter or just like kinda throw[ing] them off, throw[ing] the kid off on you. Or sometimes their expectations, and it may be because of what a previous TSS may have done, but their expectations that this is what you're suppose to do and [its] outside of the realm of what I'm really there to do. (TTSS3)

The parent, in this case, wanted to use the TSS as a respite worker instead of therapeutic support. Hodas (1995) discussed how when power is not shared, this creates a certain tension. Sinclair and Ghory (1987) note "parents often depend upon the professionals and their delivery of services, rather than provide a preventive, corrective, or supportive environment in the home" (p. 143). The real problem seems to be that parents often place demands on wraparound staff that are not consistent with their roles; as a result, there is a tension between staff and parents created by parents' resistance to respect roles. Participants talked about parents being savvy and trying to get staff to do things they should not do. Perhaps it has been expressed in terms of consumer role confusion, when in actuality that might be a more diplomatic way of raising the issue of resistance.

"No, I don't like it."

Parents' acceptability issues are another concern. The term "acceptability," as it is used here, does not reflect effectiveness per se rather it suggests whether or not the parent approves of the treatment. Despite clinicians explaining to parents specific approaches to treatment, some parents reject suggested treatment.

> If we have implemented certain tasks or whatever with a client and the client went home to say certain things to the parent 'cause I was in the home for about three years dealing with a client—sometime the parent doesn't like or approve of certain interventions or certain things and sometimes I have to take that back to my BSC or the team and say well like one of my parents she said 'well I don't agree with my child's blah, blah, blah.' Then sometimes they may have to even talk to the parent

> and say why [the staff person] is doin' this. We feel like its gonna work for the client. Just give it a little time. And sometimes the parent may say no I don't, I don't like it. (W2TSS2)

> Parents. Very resistant. Yeah, I mean its normal. You know you go into a situation and they're not doing nothing. People will be resistant. People will just be like 'well that's not gonna work because of x, y and z or we've done that before.' 'Well, did you stick with it? Did you try it this way?' [Then the parent will say] 'oh, but he makes me so mad and I'm—I'm sick of this. I can't, you know, and what you're just gonna come in and tell me what to do with my own kid?' And yeah, there's resistance. (W2CC)

This is an extremely sensitive situation when parents decline certain treatment because they do not feel it is acceptable. The TSS job becomes much more difficult to perform particularly for TSS who work in the home. If the TSS does not exercise diplomacy and rely on the BSC or MT or clinical coordinators to address parents' resistance, relationships will become strained and, in the end, the client suffers.

"Very, very difficult."

In order for treatment to work, one participant stated: "Treatment integrity has got to be parallel. You have to work with the family" (W2CC). Parents are responsible for taking part in the treatment process. In the home setting, they are expected to carryout certain interventions as well as other members of the team. However, treatment adherence, for parents, is problematic and broaching the subject is touchy. One participant raised an important question regarding the touchy nature of getting parents involved: How do you alter parents' responses to [their child's] behaviors and get them to stick with it until they actually see change? One BSC explains why parental adherence is difficult to address:

> If you want the parents to follow up with certain clinical interventions and they're not able to do it—it is difficult to actually you know—how do I put it? Um, you know get them to do it because you don't want to offend them too much because some parents are very, very defensive. You make any little observation they will come and start telling me how to take care of my case. I know you have to be diplomatic because if you are not they won't sign your papers and you won't—you won't get paid. So I

> don't know what we can do to sort of tackle this kind of problem…. There are times when parents are very, very difficult and if you want to insist [on them carrying out certain treatment] you know there will be some problems. (W1BSC1)

If parents view wraparound professionals as the experts, then they are less likely to be engaged in the treatment process. This creates problems for wraparound staff because treatment integrity is not parallel. There is also the issue with parents and documents. Parents are expected to collect data on the child's behavior as well TSS but that too is problematic. One BSC expressed her reluctance to use information obtained from parents:

> If you're relying only on the family for data that's a whole nother problem because most families don't collect very good data for you. I will ask them every week, 'Well how many times have you seen such and such?' but its—to me it's a very subjective report and you know its something—its better than nothing but you have to kinda take it with a grain of salt sometimes. (W2BSC3)

Parent-professional relationships are important and when parents are not engaged in the treatment process, the risk for their child's healthy emotional development is greatly increased. Similarly, the inability to forge healthy teacher-professional relationships in schools threatens the student's behavior as we will observe in the next section.

"First line of fire?"

Traditionally, in behavioral consultation, the teacher was the primary treatment agent. Treatment integrity studies reveal findings where teachers were likely to compromise the integrity of implementation based on several factors e.g., treatment complexity, time required to implement an intervention, and lack of materials and resources (Gresham, 1989). Few studies reported consultant/consultee relationship problems between psychologists and teachers. In wraparound services, teachers' roles are different. Teachers are expected to develop relationships with TSS who are often perceived as "intruders." There is no clear understanding of what the teacher-professional relationship approach should be where the

teacher and TSS share power to promote a student's emotional development. Sometimes there is role confusion particularly as it relates to the teacher's role in addressing discipline. One BSC put it this way: "Teachers are the first line of fire, not the TSS, but often the teachers want the TSS to be the first line of fire and that's not how it's suppose to go" (W1BSC3). In some cases, teachers relinquish authority and fail to address any issues the student may be experiencing rather than working with the TSS. The teacher takes a "that's yours" kind of position one TSS was referring to about placing all of the responsibility of a student's behavior on the TSS. The other extreme, as we will see in the next section, has the opposite effect and poses a different set of problems.

"I'm trumped."

There are instances where teachers are resistant to the TSS presence, and when the student gets off task, the teacher intervenes instead of the TSS. Consider, for example, the dilemma one TSS faced:

> As a TSS I'm not the only one in charge of that child. You've got a teacher, you have an assistant teacher, you have—sometimes you have a couple of aides, you know, or whoever else is in the room. There might be another TSS. So…sometimes I'm trumped. Sometimes I don't get to say what I really wanna say or I don't always get to make the decision as to what—how that child's behavior is handled which sometimes bothers me but I gotta deal in the system with what I'm put in. And sometimes I feel like I'm supposed to be handling his behavior modification but sometimes I'm not able to do that because I'm not given the opportunity. You know when I can I assert it but there's times when I can't... Sometimes a teacher or somebody will just go okay they see this happening and they're the teacher so what they say goes…. But I know that this is the way I believe his behavior is supposed to be handled according to his treatment plan but they have other ideas and so they're gonna do what they're gonna do and I'm sort of in a position where I don't have rank. You know what I mean? I'm the TSS but its not my classroom so you've gotta give up power, relinquish power to the higher ups, if you will, for lack of a better way to put it. So there's times when I don't get to always--I mean most of the time I do I think but--there are times when I think interventions happen that I don't approve of and I don't think they belong. They do not coincide with the treatment plan as I understand it…. And I can't argue with them about that because they're the teachers.

This TSS understands the power struggle that sometimes ensues between TSS and teachers. The decision to "give up power" presents the dilemma one is faced with when dealing with teachers who may not fully respect the TSS role. When target behaviors are displayed and a TSS is "not able to [administer treatment] because I'm not given the opportunity," this can potentially comprise treatment. The TSS also raises the issue of teachers using interventions that are non-therapeutic which can cause the student further distress. Taking the position of not arguing with teachers about behavior modification is the right approach but this concern should be shared with wraparound clinicians. Other examples of teachers' lack of respect for the TSS position emerged. One especially sensitive issue is declining teachers' requests. "A slippery slope."

The threat of misutilization is always present. TSS raised concerns about teachers' expectations of using them to do things that are not related to their job function. Some TSS reported that teachers place demands on them to provide academic assistance to their client or to assist them [teachers] in the classroom.

> I think the teachers in schools …probably need to be informed about the jobs of a TSS… [I]n the school setting a teacher sometimes expects that okay when a child is not doing his assignment in class they think its for the TSS to make the child do the work. You know the word—the acronym TSS has to do with support staff. You know you come in to support…the teacher… In the school setting you are coming into the classroom to help a teacher {pause} you know in modifying the behavior of their student…. You know so I think the…teachers need to know what TSS job descriptions are. (TTSS2)

> I have helped do small things but it was always understood that it would be on my terms. That as long as it is not interfering with my job then I'm—then I'm happy to help. I might use it as a learning experience…but in those situations it was under my terms and they understood that I'm going above and beyond and maybe I shouldn't be doing that you know but I'm helpin' out and—but there are other times when other situations they'll try to take advantage of you and that's a slippery slope that a TSS has to balance on. (W3TSS1)

> Some teachers do not appreciate TSS workers and become offended that one would have to come into their environment everyday disciplining one of their children. (TTSS3)
>
> The teacher would look at me to carry out her job. For example, she would expect me to go with the kid to recess and not take a break on a daily basis. However, my job was to only monitor his behavior in the classroom. (TTSS4)

To some teachers, an extra human resource becomes a potential disciplinarian, materials manager, or adult presence rather than a support for individualizing the experiences and improving the quality of school for one student at great risk of academic failure. Perhaps in that context the notion of a TSS does not seem worth the investment, to teachers, if the TSS cannot be used as a resource for them as well. There are cases where TSS got caught up in non-therapeutic activities e.g., "watching the class while the teacher stepped out, helping students with group work, monitoring during recess" etc. and these actions pose as potential barriers to treatment delivery because TSS are not able to carryout their role effectively.

It is also a "slippery slope" when TSS want their clients to do things that may compromise treatment delivery. The literature refers to this as forming "dual relationships." TSS dual relationships.

The potential for child/TSS dual relationships has not been studied. The major threat is developing a relationship with the child in ways that cause TSS to use non therapeutic practices. Two themes addressing the notion of dual relationships are based on removing the child from a designated environment, and becoming less professional and more "friendly." "Taking the kid out."

A major practice in the early years of wraparound services was TSS taking children away from the home to provide "recreational activities." Cautilli et al. (2000) termed this practice "McDonald's therapy" where TSS would take their clients, for example, to

McDonald's and other unauthorized places as a way of "treating the kids." Taking the kid out is a gross form of misutilization. As a result, the TSS role was stigmatized because terms e.g., "body guards" and "babysitters" became associated with TSS because they compromised their therapeutic roles by engaging in various duties they were never intended to perform. Some of the participants spoke to the issue of TSS taking the kid out:

> The earlier people--the pioneers of the program messed it up. [Their attitudes were like] its okay let's just get the billing because it was all this money like coming in and nobody was really like 'oh well [the TSS] takes the kid out.' W2CC

> You now I know that [we're] moving away from TSS taking kids out to Mcdonald's or taking them to the movies. That is not a therapeutic activity; that's more of a recreational leisure thing and, in my opinion, we're doing clinical work so we need to be, you know, if the services are in the family's home then you need to be in the family's home coaching and teaching the family how to get through the evening routine with improved behavior and not just taking the child out and avoiding the whole family situation. I see that occurring all too often. Those people are comfortable with let's get the kid and let's go out. Well that's not what this is. W2BSC2

> …the parents are savvy. See the problem is like for the parents…they feel entitled to having somebody take the kid out of their hair for a little bit. W3BSC1

It is interesting that TSS do not discuss taking the kid out but BSCs and coordinators spoke freely about it happening. Because all of the BSCs and coordinators in this study have been in wraparound services for several years, they remember the pervasiveness of TSS misutilization. Most talked about more stringent guidelines being a deterrent (or at least it is not as widespread as it once was) but they indicated taking the kid out still occurs. BSCs talked about savvy TSS who are secretive about engaging in recreational activities. However, in the progress notes, I discovered instances where TSS indicated taking the kid out. One TSS "took the kid to the mall, a local convenience store, and playground" but according to the treatment plan, there was no mention of the TSS working with this client in the

community setting. The practice of "taking the kid out" also raises the question of TSS professionalism.

"Staying professional."

A challenging aspect of working with students with sebd is professionalism. TSS expressed concerns with keeping a safe distance from students when the one-on-one interaction encourages a nurturing relationship. Some TSS found it difficult to build a positive rapport with the student yet at the same time guard their communication.

> You have to remain a professional with kids that basically even from just the description of why they're even in this program is they need someone personal in their life to help them out and you can't be personal with them. You have to always be professional with them and that's just really not reality for anyone growing up—being professional all the time. Sometimes you need to just tell the kid "hey, you know what [things like] what their parent or big brother would tell them. They need to hear from a real perspective instead of a professional perspective because that's not reality. (TTSS1)

TSS must be careful the way they talk to their clients. Not only should they be respectful and understanding, but they must be careful about interjecting their own views about how the client should behave which may not be consistent with treatment plan interventions. The temptation to use what a TSS might deem as "common sense" or being "real" with a child must be brought under subjection and TSS must refrain from offering advice in ways that might be confusing or counterproductive.

Documentation Issues

While wraparound agencies' efforts to design comprehensive, treatment plan compatible, and user friendly documents are commendable, there is one issue that surfaced repeatedly—spacing. Greenberg et al. (2005) posit "the design and format of [documents e.g., progress notes] may have a significant impact on the quality of program delivery" (p. 35). If a document poses serious writing constraints, treatment agents are not able to

accurately describe observed behaviors and how students responded to interventions. This, in turn, could possibly lead to poor documentation.

"Its so tiny."

One of the key features of progress notes is the section for describing behaviors and interventions used. TSS are expected to write information pertaining to a student's behavior in a space space. Although progress notes contain many headings, the TSS have little space in which to document what he/she is expected to capture.

> Like @ [name of agency] they just have to write—I mean the square is so tiny you couldn't write more than 2 or 3 sentences if you write very small. (W2BSC3)
>
> They don't give you enough spaces for each particular behavior under the objectives. (W2BSC2)
>
> They don't really give 'em a whole lot of room. They give them one line or two lines that they can write it in and I think its all about wording and interpretation. (W3TSS1)

There are spacing concerns with each agency's progress notes; some problems are more serious than others. One agency in this study has a section on its' progress notes labeled "interventions." Under this section, the TSS is expected to write down all interventions used during a one hour period as well as the child's response to treatment. Table 6.2 represents a portion of this agency's progress notes that supports TSS statements regarding spacing limitations.

Table 6.2 Wrap Two Treatment and Responses

Time	Treatment	Student's response to treatment
8:00-9:00	TSS discussed daily schedule.	Student said, "yes."
9:00-10:00	TSS prompted student to go outside.	Student said, "Let's go."
10:00-11:00	TSS praised student for completing assignment.	Student said, "I know."
11:00-12:00	TSS prompt[ed] and token[ed]	Student received tokens.
12:00-1:00	TSS used social skills	Student interacted with social skills
1:00-2:00	TSS monitor[ed] and prompt[ed]	Student was off task all day.
2:00-3:00	Rewarded compliance	Complied with directives

Table 6.2 represents TSS descriptions from three progress notes. For each hour of the day, the accounts listed interventions TSS used. Given the space constraints, TSS cannot accurately capture in any detailed manner, what they did and how the child responded to treatment. This information does not reflect what the child did "hour to hour." Any behavioral concerns such as one TSS' statement that "student was off task all day" were not explained. Although this agency's progress note includes several headings that address specific behaviors, a TSS cannot provide a strong description of student's behavior and how it was addressed given these space constraints.

Wrap two and Wrap three progress notes, which share identical designs, reflect similar space constraints. Table 6.3 represents a partial section of both notes. One TSS stated use of interventions in four of the six descriptions. However, none of the treatment descriptions explain why interventions were used nor do they state, "in sufficient detail," what the student was doing prior to the intervention being delivered and what was said/done after treatment was administered.

Table 6.3 Wrap One and Wrap Three Agencies' Treatment and Responses

Treatment	Student's response to treatment
Verbal Cues/Verbal Praise	Went to the mall. [Student] was focused most of the time.
Verbal Cues/Verbal Praise	Didn't do much without permission.
TSS provided verbal praise for being compliant in school.	Student responded well to verbal praise.
Positive interventions and praise was given to student for engaging in positive behavior.	Student was pleased with verbal praise.
Student received verbal praise and also several prompts.	Student was pleased with verbal praise.
No manifestation of inappropriate behavior.	Student remained seated and worked quietly with group.
Teacher asked student to put work on bulletin board and hand out materials.	Student complied and was respectful to classmates.

Based on the space allotted, TSS are able to document the treatment administered but not how it was administered and under what conditions.

Hodas (1995) contends service delivery is compromised due to "inadequate attention to documentation [which] reflects and in turn influences the quality of treatment" (p. 12). Perhaps Hodas was referring to some agencies' low data collection standards. His assertion, however, is also applicable to how agencies design documentation materials. Spacing issues can sometimes hinder TSS from documenting behaviors throughout an entire school day. Consequently, TSS "repeat the same interventions over and over again" and fail to accurately describe behaviors in ways that are clearly discernible. Even if TSS have exceptional writing skills (those able to write succinctly), "the space is so small that you would have to write tiny" and that is particularly difficult if a student is exhibiting a number of behaviors the TSS is expected to observe and document. Also, there are only four to six places designated for documenting "interventions used" and "child's response…" On an average day where the student displays target behaviors throughout the day, the TSS must be selective about what to include and what to exclude (in documenting behaviors) because of space constraints. TSS are forced to make choices and a lot of important information is excluded. While the progress note designs do have considerable merit, all three wraparound agencies fall short in terms of providing ample space for TSS to document observations of student behavior.

Another issue that consistently emerged with BSCs was the problem with getting TSS progress notes or TSS summaries. Although most BSCs reported reviewing TSS progress notes during site visits, they generally see the notes collected for only that day. Because BSCs are required to write monthly summaries, they feel it would make their job much easier if they were provided TSS progress notes. This is one of the reasons why BSCs give TSS their personal data collection forms apart from progress notes so that they can capture specific behavioral data they use to write their BSC summaries in an effort to write more

accurate assessments of clients' behaviors. While BSCs have access to TSS progress notes once they are submitted to agencies, sometimes document retrieval is difficult (some agencies require setting an appointment to review the documents; some agencies require written requests for specific documents; no agencies allow BSCs to routinely view progress notes at their leisure).

Environmental Issues

"This class needs a TSS."

Classroom climate can positively affect or negatively influence student behavior. When kids in the class are "off the hook," because of poor classroom management, it disrupts the ecology of the classroom. For a student with sebd who is already experiencing significant behavioral problems in schools, sometimes the classroom itself can have a deleterious effect on the student. When a student is negatively influenced by environmental factors, the TSS work becomes much more difficult. One BSC explains how the classroom setting can be problematic for TSS:

> Because you might have a classroom that is so out of control, I mean and you have those, [it affects] the child, the TSS, everybody because the child could—other kids in the class may taunt the TSS, that questions the TSS' authority and its just a problem. Not only that, but there are so many situations like that and the fact that you're trying to get this child to behave in a crazy, chaotic classroom is hard. (W1BSC3)

A TSS recounted an experience where the classroom atmosphere was so chaotic, the TSS client remarked, "This class needs a TSS!" Even the student receiving wraparound services was able to recognize that something was wrong with the class. This type of environment is bound to pose some type of threat to students with sebd. Many TSS shared how poor classroom management often serves as a trigger for their clients' behaviors. Other students' behavior creates real dilemmas for a TSS and his/her client as one participant duly notes:

> If you're working with a kid and you are trying to calm him down you know you're trying to let him know he needs to be quiet in class and stay on task, what about if the other students are coming around yelling at him, cussing him, hitting him, and pulling his stuff? He will want to fight because he is being provoked. (TTSS3)

Others believe the school environment is a greater threat than the classroom. One BSC talked about the lack of school structure and a chaotic school climate which he argues serve as triggers for his client's behavior.

> I had a kid that I worked with and…the kid is very defiant, the kid walks out of the room, he kicks chairs, he curses, he punches others but the problem with that kid is not the way that we're dealing with him. The problem with the kid is the school that he's in. There's no structure in that school and that's where we—its not the classroom. If it was the classroom that's something I can work with; it's the school itself. I'm not gonna mention the name of the school. If the school itself has no structure, if that behavior in that school…is perceived as 'okay we can live with it' then when he goes out there and says 'you know what, this is not okay.' If you have 10-15 kids in the hallway running around, and that's an elementary school, and cursing and punching each other you say 'you know what this has become a lifestyle.' If we have this lifestyle in the school imagine what could happen on the street. So we're here to model good behavior…we're not here to maintain those behaviors. Or maybe we would reinforce those behaviors by not doing anything. So imagine what's going to happen on the street. And this is happening. (W2BSC2)

The school climate, or "lifestyle," exposes students in general to risk factors that hinder students' successful school adaptation. TSS are required to provide proactive strategies in this type of environment. This can be a challenging feat given the pervasiveness of behavioral problems in some schools. Fortunately, TSS are there "to model good behavior" so they are in a unique position to provide some form of damage control, if you will, where this type of support would not otherwise be available without the TSS presence. Nevertheless, chaotic classrooms and schools do pose a threat to TSS treatment delivery.

Service Interruption Issues

The number one issue TSS spoke about is the problem with breaks in service. Services interruption issues impact both TSS and their clients. Treatment is compromised

when there is a high turnover of TSS. This creates conditions that breed disruptions in treatment for those receiving services. As independent contractors, wraparound professionals (BSC, TSS, MT) work on a fee for service basis. Consultants and therapists are rarely affected by service interruption issues because they tend to work on multiple cases whereas TSS are faced with myriad service issues because they are only permitted to work on one case per agency. Most TSS expressed three significant frustrations caused by service interruptions. Each frustration will be briefly explored.

"Out of a paycheck."

Compensation is a major concern for most TSS. Few agencies offer full-time TSS positions with benefits. As such, working as an independent contractor, loss of wages profoundly impacts TSS particularly those working in school settings where holidays, staff development days, winter and spring breaks, and client absences account for loss of wages.

> Another frustration would be the fact that if the child is not in school that day or school is not in service, then the TSS does not get paid. This becomes frustrating when you have bills and a family, the inconsistency of pay does not help which is bad because it causes some TSS workers to slack in their duties. (TTSS1)

> Another challenge that TSS face is not having job security or stability. If the parents of the client don't like you, you can lose that case and be out of a paycheck until another case is available. Also, if the client does not come to school, you also don't get paid for the day. (TTSS2)

"Restaffing over and over."

Chronic restaffing issues due to TSS leaving wraparound services poses a tremendous threat to clients. The literature discusses the threat of multiple trainers in the treatment process and note the diversity in trainers' skill sets and delivery styles may impede treatment delivery. It follows then that if multiple trainers pose a threat to the treatment process, using

multiple treatment agents must be a threat as well. One TSS talked about the importance of TSS stability in a child's life especially if the TSS works well with the child.

> I mean summer vacation or spring break or whatever or even during winter break when the schools are not in session the TSS can't work unless you're working with a child at home or within the community setting. So if you are working with a child at school, if the school is closed you are not going to work throughout the period… And during that period a TSS might be looking for some other jobs. Before the school comes back into session the TSS might be gone. Its not for the best of the child when you're kid changes a TSS from one person to the other, you know. It affects the stability of the treatment plan you are trying to execute. It affects the child too, you know, and it affects the agencies as well because they keep staffing and they're restaffing and restaffing over and over again. So I think if they try to keep a TSS on assignment until, you know, the child is in the proper position, you know. I mean I'm talking about the situation when the when the child will no longer need a TSS. So if you're trying to encourage the TSS financially and otherwise if he can stay with a child for as long as needed I think [the agency] would be better off than you know trying to work several TSS workers into a child's life. (TTSS3)

Each time a child changes a TSS, which according to participants this happens frequently, there is a gap in service for the child; also, there is an adjustment period between the new TSS and child. In many cases, the child may go through several TSS before one suitable match is found because the TSS is unable to establish a positive rapport with the child. Similarly, restaffing creates problems for wraparound agencies who are constantly having to "retrain over and over" (Cautilli et al., 2000).

Many TSS crave job stability and continuity in pay but the nature of wraparound services does not offer that kind of security. Participants expressed a sincere interest in remaining in the field while at the same time they are constantly seeking stable employment that will not threaten their job security and steady income.

Summary

An important consideration in studying TSS treatment integrity is identifying potential threats that impede effective treatment administration. In analyzing responses,

threats resulted from treatment issues, people issues, document issues, environmental issues, and service interruption issues. Many of the threats are adequately addressed in wraparound agencies' monitoring practices. Two threats, however, that participants do not feel have been addressed are based on people issues—relationships between parent/TSS, and teacher/TSS. Both relationships pose problems for TSS because of role confusion and power issues. In terms of role confusion, TSS talked about parents and teachers not fully understanding the TSS role in the treatment process. This often leads to parents/teachers expecting TSS to perform non-therapeutic activities which would result in misutilization. These demands by parents/teachers create uncomfortable dilemmas for TSS. TSS believe wraparound agencies can do a better job of explaining TSS roles to parents/teachers so that these issues are minimized. As for other threats, wraparound professionals effectively address them by developing strong document designs, interactive supervision, scrupulous review of progress notes, and frequent feedback.

CHAPTER 7

TSS ROLES

Perhaps no single fact emerging from resilience research is more important than the finding that having contact with a genuinely caring adult (*beyond the family*) *is important to every child.*
Reynolds (1994:136)

Due to the nature of some home and school settings, I, like many TSS workers, go beyond our prescribed work; tutor, mentor, counselor, and disciplinarian are all common roles that I've had to take on.
TSS (2008)

Protective factors must be potent in the presence of risk.
McCord (1994:112)

Chapter six was devoted to discussing categories of treatment integrity risks. One of the major categories centered on "people issues." Recall, parent/TSS and teacher/TSS barriers were highlighted. Whereas in that chapter I noted concerns specifically related to TSS, in this chapter, roles that seem to support students experiencing problems with others in class. This chapter addresses the research question, How do TSS address threats directly affecting students in schools?

In analyzing the data for this study, certain characteristics of clearly identifiable roles emerged based on examples TSS shared when their students encountered problems. By examining multiple TSS roles, a more comprehensive and intimate understanding of the functions they perform emerged. It became clear when TSS talked about myriad aspects of their job that their perceptions of being TSS were much more complex than treatment agent/data collector. I viewed many of the roles as ways TSS address some threats that affect students. Several unexplored dimensions of the TSS service are discussed.

Eight Common Therapeutic Staff Support Roles

Following the scholarship of Creswell and Brown (1992), Creswell (2007), and Stake (1995), a typology of TSS roles was developed based on TSS responses. This typology is used to shed light on how these unexplored dimensions add depth to the TSS service. Given the nature of TSS work, identification of roles is important to understand how the TSS is a potent protective factor. In many ways, TSS serve as potent protective factors because they intervene to help students when, without the TSS presence, no other assistance would be available. Many roles address threats affecting students.

Aside from the primary treatment roles as implementer and conduit, Table 7.1 features eight additional roles TSS may assume when providing wraparound services. Each TSS role displays ways in which client's development is strengthened.

Table 7.1 TSS Typology.

Broad Categories	**Category**	**Properties**
Treatment Roles	Implementer	By using intervention
	Conduit	By collecting and reporting behavior
	Informal Trainer	Transfer skills to teachers/parents
External Roles	Advocate	For mental health For client
Interpersonal Roles	Protector	By speaking up for client
	Encourager	By verbal praise
	Attendant	By assisting in personal care
	Peacemaker	By negotiating with teacher
	Tutor	By assisting with schoolwork
	Role Model	By using healthy language By exercising patience By positive interactions w/others

Modified from Creswell and Brown (1992).

TSS as Informal Trainer

The role of the TSS as an informal trainer is not given much attention in wraparound literature but part of the TSS job is to help parents and teachers use interventions.

> As a TSS worker I am responsible for transferring interventions to the parents and or teachers of youth with various behavioral disorders. (TTSS6)

> The TSS is there to transfer the skills to the family….We're supposed to be transferring the skills to the parent and family members. (W2CC)

When parents and teachers confer with TSS about ways to help the student improve, TSS are in a position to "offer/introduce" various approaches to treatment. Because many of the interventions TSS use are simple e.g., verbal praise, redirection, prompts etc., TSS can explain to parents and teachers what to do when certain targeted behaviors are exhibited. Also, when TSS have established a good rapport with parents and teachers as TSS observe how they interact with the student, the TSS can offer strategies for what helps the student and what triggers certain behaviors.

TSS as Advocate

Teacher skepticism of students with severe emotional or behavioral disorders was an issue study participants frequently discussed. BSCs and TSS spoke about how some teachers are in denial when it comes to children having mental health issues. Students experiencing significant behavioral problems are reduced to being, according to BSC accounts, "bad @$$ kids" or "off the hook kids." Teachers with these short sighted characterizations of students also believe use of punitive measures, as opposed to proactive strategies, are what is needed to correct undesirable behavior. At the same time though, some teachers also believe these students are better served in special education/emotional support classrooms. If these students are merely "off the hook," why should they be placed in a special setting rather than

being dealt with using proactive strategies? The fact that some teachers do not believe many of the students TSS serve have severe problems is a dangerous assertion to make. Unfortunately, this skepticism places TSS in a position where they must defend children's mental health services in general and wraparound services in particular. TSS must advocate on behalf of mental health services to help educate uninformed teachers about vital services students should be receiving. Some TSS, especially those with academic training in behavioral science, spoke about how they have to explain to teachers why the services students receive are important and why many of these students receive services in general education classrooms rather than being "dumped" into special education. The major problem teacher skepticism poses for students is that if teachers do not believe they have legitimate behavioral disorders, there is likely to be a low level of teacher sensitivity due to teachers' lack of understanding. Fortunately, students have advocates who inform teachers about "why they do what they do" to help students.

There were other instances where TSS had to advocate on behalf of children because teachers got quite demanding and expected more than what the child could do.

> Sometimes some classroom teachers are hard on a child with a TSS because they expect much more from a child with a TSS than other kids who don't have a TSS. But basically kids are still kids whether a kid has a TSS working with him or not--kids have to be kids. But when you are demanding too much from a child because there's a TSS working with him you're going to kind of make life more difficult for the child. (TTSS2)

This comment demonstrates the need for TSS to advocate on behalf of students. The child should not be expected to increase his/her academic performance with a TSS presence. If the student has academic deficiencies, they will not just disappear because he/she has a TSS and demanding more from a child receiving TSS services ignores the function of the service.

Again, TSS are in a position to explain behavioral health rehabilitation services to teachers thus reinforcing their role as therapeutic support as opposed to academic support.

TSS as Protector

There is a general consensus among TSS that it is often useful for their clients to have an authority figure protect them from teachers as well as students. TSS spoke about their clients receiving unfair treatment. One TSS had this to say:

> Sometimes, in a classroom setting, the child who has TSS support is made to be the scapegoat for other students' bad behavior. Instead of chastising the student who may have initiated the disruption, the teacher may catch the supported child's reaction only and assumes that s/he has the full story. Because of teaching professionals' current workload and schedule, s/he does not always have the time or desire to hear an explanation of the supported child's side of the story. As a TSS, I do not like to have my client unfairly targeted every time something goes wrong in the classroom. (TTSS3)

This TSS also shared that it is necessary to address teachers (privately) when the client is "unfairly targeted." When TSS discuss a student's behavior, it puts the teacher on notice that unfair treatment will not be tolerated. Also, it provides the TSS with an opportunity to share ways in which his/her client's "targeted behaviors" are being addressed therapeutically. With the TSS presence and intervention, the student has a greater chance of receiving fair treatment.

TSS also protect their clients from other students. According to several TSS, their clients are often teased in school because they have a TSS. In some instances, students deliberately do things to antagonize the student receiving TSS services so that child can react and then "get in trouble." While most children do not do this to be mean spirited, the fact is it happens quite often. TSS are able to use these incidents as teaching opportunities to help their client take a proactive stance although it is challenging in a class full of "off the hook" students.

TSS as Encourager

In order for treatment to be effective, TSS must be encouragers. When replacement behaviors occur, for example, TSS invariably encourage students when they demonstrate desirable behavior. Verbal praise is perhaps one of the most common interventions used in behavioral research. All of the treatment plans and progress notes in this study identified verbal praise as an intervention. Progress notes provide numerous instances where TSS praised students' behavior in myriad situations. One TSS put it this way:

> Saying 'good job,' giving high fives or pounds (by knocking tight fists) with clients for doing the right thing assures the client that s/he is on the road to success. It also serves as a personal bond between the TSS and client which is very important to establish. Many clients are impulsive and need to practice raising their hands and waiting patiently to give an answer or state a comment. [When they are patient, they should be commended for their patience]. (TTSS1)

Verbal praise helps students feel good about themselves especially when they respond favorably to treatment. Words of encouragement build students' self confidence and serve as a constant source of positive reinforcement. A very moving example of one TSS encouraging a client was recounted. Dealing with a highly sensitive issue, the TSS was able to offer advice to the client without being judgmental and at the same time offer words of encouragement.

> [My] client…had been accused of molesting his younger foster sibling. I became aware of this situation from the agency and privately discussed the matter with my client. I did not accuse him of the allegations but [told] him that that kind of behavior [by anyone] was wrong. I gave him positive advice such as move forward and stated, regardless of what everyone else is saying about you, I know that you are a good person and have a lot of potential. (TTSS4)

This example clearly demonstrates how "nicely" TSS talk to their clients because the "TSS role is to intervene with a positive replacement behavior when the client is exhibiting a problem behavior" not to chastise the child.

TSS as Personal Attendant

Because a student with sebd receives one-on-one services, that student is made to feel special because of the "undivided attention s/he receives at all times." As a result of this personalized attention, TSS reported frequently assisting clients in other ways. The notion of TSS being a client's personal attendant surfaced when one TSS talked about the relationship which was articulated in this way:

> I'm just there for him. Like he knows I'm there for him. I help him do everything. I meet him in the morning at the bus, I get him off the bus and help him up the stairs into the class. I sit with him all day. When he needs something, he comes to me. I don't have to do that but I just feel he likes for me to help him do these things.

This TSS is especially attentive to this six year old client and this personalized attention clients receive sometimes compels TSS to provide support in myriad ways. Other TSS spoke about being helpful to students by gingerly discussing issues e.g., personal hygiene. One of the persons who provided member checks wrote that I should discuss this issue. She said this: "I would suggest adding in addressing personal hygiene issues. I've had to do that with the client and it's a very sensitive issue because you don't want to offend the client or the parent/guardian." TSS talk to their clients about hygiene issues especially when they get teased for wearing soiled clothing, having body odors, unkept hair etc. This TSS went on to say "Being accepted as a whole person and not just a diagnosis or "bad kid" is also an important aspect of the 'personal attendant' side."

TSS as Peace Maker

TSS understand the importance of their role in administering treatment which, in turn, "enhances the peace in the classroom environment so that the teacher can teach properly." Aside from that, TSS serve as peacemakers when there is conflict particularly between the student and teacher. Several TSS talked about interactions between teachers and students

with sebd. The teachers' view in dealing with students is generally discipline oriented. Power struggles ensue because the teacher wants the student to "behave" and when challenged feels it necessary to assert authority over the student which often creates conflict. One TSS explains in explicit detail an altercation between a teacher and student where he had to intervene as a peacemaker to help resolve the issue.

> One day before I arrived to provide service for my client, a confrontation occurred between [my client] and the teacher that resulted in [my client] being put in the In-school suspension program…When I asked my client what happened in the classroom that got him sent to In-school suspension, he stated that the teacher had pushed him…So I asked him, Are you sure that the teacher pushed you? He said, 'yes.' To discover what really happened, I asked the teacher,What did my client do to get sent to In-school suspension? She answered the question stating that he was playing with rubber bands, refused to put them away and when she took them from him out of anger he called her a [derogatory name]. I told the teacher that my client stated that he called [you a name] because you had pushed him. I then asked her was there any physical confrontation between them. She looked shocked when I asked her this question. She stated that she did reach across his body to take the rubber bands away and when he stood up trying to prevent her from taking the rubber bands he fell backward, but I did not push him. I had explained to my client that although there was a physical altercation between him and the teacher that what appeared as a push to you was just your teacher reaching across your body trying to take the rubber bands from you. We came to an understanding that the teacher did not intentionally push him and that out of frustration her actions might have been aggressive. Then by my request he wrote an apology letter to the teacher for disrespecting her. Hearing both sides of the story I drew my own conclusion that the teacher was aggressive with trying to take the rubber bands from my client which caused him to interpret their physical contact as a push. I asked my client to never bring rubber bands in her classroom again. Because I listened to his story and explained the situation to him from the teacher's perspective, he became calmer. (TTSS1)

Kauffman (1985) admonishes us "When a child has difficulty with teachers, parents, or peers, it is as important to consider their responses to the behavior as it is to evaluate the children's reactions" (p. 4). The TSS did not have to intervene in this situation. He could have accepted the teacher's account of what transpired and agreed with her. Instead, this TSS exercised a peacemaking role by intervening in a volatile situation by getting all of the facts, making an assessment, and explaining to the client about how some actions can be

misinterpreted. The TSS respected the teacher's authority, although the teacher fell short in her approach to addressing the rubber band issue. The TSS also convinced the client to take responsibility for his actions and to "patch things up" with the teacher. This TSS' mediation was a win-win situation for both parties involved in that anger was abated, an apology was offered, and the teacher/student relationship was restored.

TSS as Tutor

TSS reported they routinely assist their clients with schoolwork when they are "stuck." Even though TSS fully understand they are to provide therapeutic support, most could not seem to resist offering assistance when their clients were struggling. The following example is instructive:

> While providing services for my client during math, I noticed that my client had difficulty solving decimal equations. I helped my client by telling him to focus on the numbers right of the decimal point first, and then concentrate on the numbers left of the decimal point. When it came to multiple choice decimal equations, I demonstrated to my client the process of elimination to help him get the answer faster. My client did well and had a better understanding of decimal equations from the personal help I provided him with. (W2TSS3)

In this case, as in other discussions about helping students, TSS intervened because the client was struggling to such a degree it affected his/her behavior. Quite innocently, many TSS while trying to redirect undesirable behavior, learned in the process that academic difficulties were partly the cause of the behavior. By examining the assignment and asking the client does he/she understand how to do it, the TSS was able to identify the academic weakness. In another example, a similar academic weakness was uncovered. The BSC had this to say:

> Wait a minute. The child gets out of his seat because he can't do math. Its poor academic performance. You needed the kid to do something they cannot perform [and he begins acting out]. Not because he's a bad kid but he's—he can't do the work. He wants to escape from that. W2BSC1

Fortunately, in this particular instance, the teacher was informed of the student's academic challenge and was asked to break the assignment down into smaller steps which were more manageable for the student. There were other examples where TSS detected reading deficiencies that teachers often ignored. One TSS took his client out of the classroom, read with the student the assigned text, and then reported to the teacher reading problems with vocabulary, comprehension, etc.

TSS as Role Model

Though discussed lasted, the most important TSS role equal to treatment administration is modeling appropriate behavior. One TSS said this:

> As a TSS, part of our job duty is to role model positive mannerisms and to reinforce and reward positive behavior. This role modeling duty, according to the agency, is important as they feel [wraparound providers] that a TSS' positive behavior may be the only positive behavior that a client of the service may see to imitate.

Role modeling is displayed in various forms. Participants discussed two critical role modeling behaviors: using healthy language and displaying patience.

Using health language is a critical role modeling behavior. Throughout this study, there were myriad instances where participants gave accounts of rampant unhealthy language conveyed by parent, teachers, and other students who all have strong influences on children. One BSC discussed the importance of role modeling to the family to curtail profanity usage.

> I see that there's a lack of motivation you know to use healthy language in the house because parents have, you know, parents us a lot of profanity and then [the client] gets on the street and hears the same thing. That's the only way that this family talks so I'm role modeling a couple of hours there and when I leave I'll send this back to you. So I think I should start with the family session. I have to improve their way of communicating with themselves or others—their kids—by having parents reward themselves for using healthy language. (W2BSC1)

Sometimes adults do not understand the value of using healthy language when dealing with vulnerable populations. One BSC recounted a teacher's remark that they (BSC and TSS) "get

paid to talk nicely to [their clients]." This raises the question, How is an adult expected to talk to children especially those experiencing significant behavioral challenges? When the child is displaying undesirable behavior, if teachers do not understand the child's behavior, and do not know how to intervene properly, they should leave that to the TSS. Otherwise, not-so-nice words may be said out of anger and frustration.

One TSS shared a story where the teacher got into a confrontation with his client and said some ugly things: "oh, you need to be locked up in a mental health hospital; do something, he's violent, he's crazy" (W2TSS3). I concur with the TSS that "those terminologies are, for lack of a better word, [from] ignorant people that have no clue of what the child has been through versus what the child is acting out with that teacher." Not only was this TSS sympathetic to his client's diagnosis, he went further by taking his client out of the room and providing damage control by telling him he's a "good kid who is making steady progress."

When students are exposed to unhealthy language in home, school, and community settings, it is especially important for TSS to model behavior students can emulate. We know "children are particularly likely to imitate the behavior modeled by people who are socially or physically powerful, attractive, and in command of important reinforcers" (Kaufmann, 1985, p. 163). These influences can foster a child's undesirable communication; however, TSS can help children "improve their way of communicating" by explaining the value of and demonstrating healthy language usage.

Exercising patience is another critical role modeling behavior. When asked to describe challenging aspects of TSS work, many TSS spoke about the need for patience.

You have to be patient with your client. That's the difficult part. (TTSS1)

> The most difficult aspect of being a TSS is being able to keep one's cool. Most kids are ADHD, ODD--very rude and disrespectful. At times one may wish that s/he can stoop down to their level and be just as nasty. Then one must remember that…acting in a derogatory way will not solve the issue. You must gain their trust and show them respect. (TTSS5)

TSS deal with challenging clients who test their patience regularly and the manner in which they respond to clients profoundly impacts their clients' development. Hence, modeling appropriate behavior, particularly "keeping one's cool," is a central role. Because TSS deal one-on-one with a student, the TSS' behavior is being observed by the client as well. Some TSS spoke about interaction with clients. It was stated "even though clients will test you to see how far s/he can push you [TSS must always] remain professional [because] believe me clients closely observe our behavior." One of the ways TSS are successful with this population is exercising patience. The TSS' tolerance level needs to be especially high because the behavioral challenges some clients' exhibit is far beyond the normal endurance of an untrained adult.

Summary

Kaufmann (1985) notes, "The most valuable perspective for the [treatment agent] is to examine the present environment of the child in order to detect those factors that contribute to disordered behavior and those that encourage healthy behavioral development" (p. 165). It can also be said one of the most valuable aspects of the TSS service is functioning in multiple roles when various situations arise. TSS observe many dynamics others are not privy to and this places them in a unique position to not only document environmental conditions which hinder students but also to respond in ways that foster students' healthy development. The interpersonal roles discussed in this chapter point to the impact a "genuinely caring adult" can have in the life of a student. TSS do function in truly "potent"

and “supportive” roles by shielding students from unfair treatment e.g., being scapegoated or taunted, assisting with life skills development, offering words of encouragement thus building students’ self esteem, serving as peacemakers when mediation is necessary, providing emotional support, and helping transfer skills to parents and teachers—all roles which reflect the dynamic nature of the TSS service.

CHAPTER 8

DISCUSSION

In wraparound agencies, everybody is monitored.
W2TSS3

The purpose of this study was to explore wraparound agencies monitoring practices of TSS. Since the primary functions of the TSS service are administering treatment and collecting behavioral data, I focused on treatment integrity as an integral aspect of TSS job performance. In response to three issues raised earlier, TSS do not seem to function autonomously, there was no rampant misutilization, and monitoring practices wraparound agencies employ do capture treatment integrity.

Based on findings from this study, it seems clear TSS do not function autonomously. There is a hierarchical chain of command where, though seemingly unsupervised at schools and in other settings, wraparound professionals do keep close tabs on TSS. Findings suggest a high priority wraparound agencies place on monitoring TSS. This is supported by multiple monitoring practices consistently employed across agencies. There is extensive pre-service training, ongoing in-service training, weekly supervision, observations, and document review. BSCs make site visits, frequently meet with teachers, make phone calls, review progress notes, collect behavioral data by spot checking, and offer support as well as corrective feedback.

On the matter of misutilization, as was reported in chapter 5, "following the plan," TSS are clear on their role as treatment agent. Throughout the data, TSS expressed times when they were approached about assisting teachers in classroom matters, some relented and helped at times, not out of obligation but perhaps as a way to form relationships with teachers

in order that the teacher might become more involved with the student receiving the TSS service. TSS, as was discussed in chapter seven, function in a number of roles. Aside from the roles that emerged from this data, there are others. Hodas (1996) speaks about collaboration in this way:

> The TSS role within the classroom involves not just supporting and redirecting the child, but also exchanging information and collaborating actively with the classroom teacher, in the manner identified within the treatment plan and as directed by the BSC. In this way, the TSS worker's efforts not only support the child's coping but also assist the teacher and school in making necessary individualized accommodations to benefit the child over time, so that TSS need not continue indefinitely. (p. 108)

TSS involvement is of course a "slippery slope," as one TSS said, and they certainly have to be selective about how they interact in the class. This represents yet another example of complexities of the TSS service such as multiple roles they must assume in the classroom setting. TSS viewed their roles as multifaceted which extend beyond the required roles of treatment agent and data collector. As collaborator, TSS are expected to be more interactive and engaged with the teacher but there should be BSC intervention and constant communication about what type of demands are being placed on them. Ultimately, these roles highlight ways in which the TSS service can be viewed as a valuable service to students. By the same token, some of them may be threats as well.

But I think the larger issue here is how are collaborative relationships forged between TSS and teachers? Does the BSC serve as a conduit to bring the two together? Is there some type of organic process that happens? These are salient questions particularly in light of what this study uncovered in regard to teacher/TSS conflict. Based on TSS perceptions of issues affecting their job performance, some felt teachers were not respectful of the TSS function. Teachers often made requests for TSS to perform certain non therapeutic duties. When TSS

declined those requests, some of the relationships became strained. A couple of TSS provided job descriptions to teachers in an effort to clarify role misconceptions. Other TSS reminded teachers and parents that certain requests were against the rules and held firm to their positions. This often created situations where TSS "bumped heads" with teachers. Sometimes teachers exercised their authority by addressing a student's behavioral issues by overstepping their boundaries to discipline a student while discounting the TSS role. One TSS felt "trumped" and defenseless because she chose to respect the teacher's authority even though she disagreed with the teacher's disciplinary actions which invariably caused further distress to the student. Understanding this classroom dynamic seems to be addressed by TSS in a firm yet respectful manner. This is perhaps one of the things BSCs watch for during weekly visits. Misutilization is a serious threat but it was not made known how BSCs or clinicians address this problem.

If wraparound professionals are not able to clearly monitor misutilization, they make up for it with treatment integrity. There is also a strong emphasis agencies place on enhancing TSS treatment integrity. Clinicians look for it all the time in training and supervision, but documentation review has to be a major approach particularly in terms of documentation designs. Each agency was intentional about including specific treatment plan information linking descriptions of target behaviors and interventions to TSS progress notes which help facilitate treatment integrity.

In this study, findings revealed BSC and TSS documentation efforts are reflective of what Hansen (1996) describes as pitfalls of written documentation. The major pitfall was that target behaviors and interventions were written in global terms. The central element of treatment integrity is defining behaviors and interventions in concrete, observable terms

(Gresham, 1989; Knapp & Salend, 1984) not only for measurement and replication purposes but to provide clarity for treatment agents. In examining BSC treatment plans, interventions were global, not clear or detailed. For each treatment plan, the interventions were "too vaguely stated to be accurately and consistently implemented" (p. 12). In other words, there is no description of steps involved in delivering treatment. When interventions are described in nebulous terms, there is an increased risk of TSS confusion which often leads to inappropriate treatment delivery. Based on sample descriptions of interventions provided to BSCs and TSS, it does not appear to be a difficult task to write information in observable and measure ways. When BSCs were asked to describe one intervention used on the treatment plan, the language used was consistent with sample descriptions. There were also instances where BSCs, when recounting a specific challenge where they needed to explain to TSS how to properly implement an intervention, they had no problem describing a step-by-step process. All BSCs spoke about reviewing the treatment plan with TSS and explaining the interventions.

TSS progress notes reflected the same problems. Descriptions of interventions used were generally stated e.g., "verbal praise" or "prompting." All TSS identified every intervention to be used but they merely named interventions. Few TSS elaborated on how treatment was administered and, when TSS indicated which intervention was used, it was couched in general or vague terms e.g., "told client to stop talking." This response merely states what was said but neglects to describe the context in which the student was talking or the duration of talking. The TSS also failed to document how the student responded to the intervention. In fact, TSS observed behaviors documented throughout an entire school day, on average, amounted to two to five sentences although numerous targeted and replacement

behaviors were reported. What this means is TSS are selective in their descriptions of explaining the context in which the behaviors were displayed which raises the question, How descriptive should TSS be in documenting observable behaviors?

Despite BSCs and TSS less than flattering notes, there were some high points to be gleaned from the findings. There was compatibility between treatment plan and progress note data (e.g., goals, target behaviors, replacement behaviors). Each of these items was transferred, verbatim, from treatment plans to progress notes eradicating the need for TSS to refer to once cumbersome treatment plans. Documentation compatibility also enables wraparound providers to verify integrity practices easier. The user friendly design of wraparound providers' progress notes allows TSS to constantly refer to places on the document where they can zero in on specific behaviors which minimizes problems of TSS guessing what to write and where to put the information.

Notable aspects of treatment plans: BSCs included myriad interventions which served as a "pool of strategies" clinicians spoke about to help TSS carryout their work more effectively when untargeted behaviors emerge; treatment plans reflected components of CASSP principles; treatment plans provided a clear delineation of each person's role; treatment plans were consistent with recommendations established by psychologists; treatment plans had clear descriptions of target behaviors; treatment plans contained crisis and de-escalation plans; treatment plans were individualized.

Notable aspects of progress notes include: TSS captured behaviors and tallied occurrences; TSS linked, in some instances, goals with behaviors/interventions used; all interventions used were stated; hourly targeted behaviors were documented; an effort was made to summarize student behaviors. One of the things that TSS discussed was keeping

writing logs and/or journals to document behavior. This can be considered a high point as well. TSS understand the importance of documentation and due to space and time constraints they are not able to be precise in completing the agency notes but most TSS do keep some form of journal. They do this because they can "write messy" but because its their personal journal no one else has access to it. This is interesting because now TSS use two sources to collect data. They usually end up going home to process the student's behavior and write in narrative form "important incidents that need to be elaborated on." This is extra effort on the part of TSS. One wonders, are TSS more detailed in explaining what they observed and how they administered treatment and how the student responded by keeping journals?

Limitations

There are several limitations to this study. First, the study was limited to wraparound professionals' perspectives yet parents and teachers' perspectives are essential to broadening our understanding of TSS/student relationships as well as their job performance. Parents are an integral part of the treatment process and whether TSS offer services in home, school, or community based settings, parents are in close communication with TSS. Parents have first hand knowledge of TSS job performance as well as information they receive from their children about TSS. Similarly, teachers see TSS "in action." While their interaction is limited to schools, teachers' perspectives on TSS job performance are especially relevant to monitoring classroom behavior in light of the TSS presence. Just as TSS observe teachers "in action," the reverse can be said of teachers. Teachers have a vested interest in TSS effective job performance; ineffectiveness can profoundly impact treatment which may result in student digression. Also, it is necessary for TSS to function within their prescribed parameters. Some TSS spoke about their communication with other students particularly

when TSS felt the student was being "picked on." It is unknown if TSS cross certain boundaries by engaging in conversations with other students.

Second, gender and racial issues were not considered. Most students receiving the TSS service are overwhelming male which is consistent with national statistics particularly for students diagnosed with conduct disorders. In this study, females represented 20% of cases. The majority of students were African American (87%). In this study, TSS were overwhelmingly African American (95%). While both male and female TSS provided services to students, more females than males were interviewed (66%). Little is known about how gender and race impacts TSS/student relationships.

Third, this study was limited to collecting data based on indirect methods. Not only is direct observation the best method of determining treatment integrity, it is the best way to capture dynamics of TSS behavior. Indirect methods of assessment were selected because I thought documents and interviews would yield sufficient information about monitoring practices of treatment integrity which limited collecting data on other aspects of TSS job performance. Observations reveal true TSS/student interactions as well as environmental conditions that both threaten and enhance treatment administration.

Implications

The findings concerning wraparound agencies treatment integrity promotion and verification practices have implications for future research. First, subsequent research is needed to determine whether the compatibility of treatment plans and progress notes is representative of treatment documentation materials in other wraparound agencies. The compatibility connection between these two documents suggests a practice which promotes treatment integrity. Meaningful components for documents which promote integrity include

consistent descriptions of target and replacement behaviors, sections for interventions used, child's response to interventions, and hour-by-hour tallying of behaviors observed. Similarly, the design of the documents should be user friendly so that issues of space constraints are addressed. The restructuring of TSS progress notes, in particular, might include developing a template that allows TSS ample space to document circumstances surrounding the manifestation of target behaviors and how individual goals were addressed. Also, TSS frequently spoke about the use of notebooks and journals to freely write down behaviors captured throughout the day. This practice lends itself to more accurate documentation without space constraints and then reviewing those notes to assess all behaviors and ultimately transfer the information onto agency designated notes.

This study offers a description of TSS roles that could be explored in future studies. Efforts aimed at studying student/TSS dynamics are especially important for understanding the value of the service for students' healthy psychosocial development. TSS lend support to students receiving their services in myriad ways. Findings from this study suggest that the various roles TSS occasionally assume do, in fact, represent protective factors for students. In the absence of TSS, students might be unfairly targeted for disciplinary action, struggle academically when deficiencies are not detected or are ignored, be provoked to engage in undesirable behavior by peers or poor environmental conditions that breed behavior problems, and be more prone to exhibit target behavior without treatment. Even if the TSS presence was not a deterrent, their observations of classroom, home, and community dynamics can be used to address approaches to treatment in meaningful ways.

The search for threats to integrity seems to center on external rather than internal factors to treatment itself. While TSS' failure or abandonment of treatment is admittedly a

serious threat to treatment integrity, there are indications that external factors such as parents, teachers, classrooms and schools are serious hindrances to treatment integrity. Less attention is given to human factors such as parent inadequacies and misunderstanding of the service, teacher resistance to TSS, and classroom structures. More attention is placed on TSS administering treatment as if external factors do not affect their performance in fundamental ways. As an integral aspect of treatment, there is the expectation of teamwork among the providers of treatment to the client. This expectation while remaining a threat to integrity is never addressed at a deeper level.

Similarly, little is known about the interactions between a student and TSS in the home, school, or community setting. What is it about the TSS presence that facilitates or hinders effective treatment? Is it the individualized treatment students receive? Is it the individualized attention? Are there certain TSS personality characteristics that enhance or thwart relationship development? Future studies focusing on student perceptions of TSS as well as TSS perceptions of ways to develop strong relationships with students are needed.

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APPENDIX A

WRAPAROUND GUIDING PRINCIPLES

The philosophy *includes a definable planning process involving the child and family that results in a unique set of community services and natural supports individualized for that child and family to achieve a -positive set of outcomes* (Burns & Goldman, 1998, P. 13). Central to the wraparound process are its 8 framing elements and 10 practice requirements.

8 Framing Elements for the Wraparound Process

1) Wraparound efforts must be based in the community.
2) Services and supports must be individualized to meet the needs of the children and families, not designed to reflect the priorities of the service systems.
3) The Process must be culturally competent and build on the unique values, strengths, and social and racial make-up of children and families.
4) Parents must be included in every level of development of the Process.
5) Agencies must have access to flexible, non-categorized funding.
6) The Process must be implemented on an inter-agency basis and owned by the larger community.
7) Services must be unconditional. If the needs of the child and family change, the child and family are not to be rejected from services. Instead, the services must be changed.
8) Outcomes must be measured.

10 Practice Requirements

1) Community collaborative structure.
2) Administrative and management organization.
3) Referral mechanism.
4) Resource coordinators to facilitate the process.
5) Strengths and needs assessment.
6) Formation of the child and family team.
7) Interactive team process and formation of a partnership to develop individualized plan.
8) Development of a crisis/safety plan.
9) Measurable outcomes monitored on a regular basis.
10) Review of plans by the community collaborative structure.

APPENDIX B

CASSP CORE PRINCIPLES

Pennsylvania's Child and Adolescent Service System Program (CASSP) is based on a well-defined set of principles for mental health services for children and adolescents with or at risk of developing severe emotional disorders and their families. These principles…can be summarized in six core statements.

1. **Child-centered**: Services are planned to meet the individual needs of the child, rather than to fit the child into an existing service. Services consider the child's family and community contexts, are developmentally appropriate and child-specific, and also build on the strengths of the child and family to meet the mental health, social and physical needs of the child.

2. **Family-focused**: Services recognize that the family is the primary support system for the child. The family participates as a full partner in all stages of the decision-making and treatment planning process, including implementation, monitoring, and evaluation. A family may include biological, adoptive and foster parents, siblings, grandparents and other relatives, and other adults who are committed to the child. The development of mental health policy at state and local levels includes family representation.

3. **Community-based**: Whenever possible, services are delivered in the child's home community, drawing on formal and informal resources to promote the child's successful participation in the community. Community resources include not only mental health professional and provider agencies, but also social, religious, and cultural organizations and other natural community support networks.

4. **Multi-system**: Services are planned in collaboration with all the child-serving systems involved in the child's life. Representatives from all these systems and the family collaborate to define the goals for the child, develop a service plan, develop the necessary resources to implement the plan, provide appropriate support of the child and family, and evaluate progress.

5. **Culturally competent**: Culture determines our world view and provides a general design for living and patterns for interpreting reality that are reflected in our behavior. Therefore, the services that are culturally competent are provided by individuals who have the skills to recognize and respect the behavior, ideas, attitudes, values, beliefs, customs, language, rituals, ceremonies and practices characteristic of a particularly group of people [e.g., the child's and family's ethnic group].

6. **Least restrictive/least intrusive**: Services take place in settings that are the most appropriate and natural for the child and family and are the least restrictive and intrusive available to meet the needs of the child and family**.**

Source: Quoted verbatim from Hodas, G. (2004). *Making the best choice: Service selection in children's mental health*. A CASSP discussion paper. Harrisburg, PA: PA CASSP Training and Technical Assistance Institute.

APPENDIX C

TSS DON'TS

School/Classroom Don'ts

- TSS will not consume food or beverages while in classrooms unless otherwise directed by school personnel.
- TSS will not engage in recreational activities (i.e. sleeping, reading, conversations with other adults/children which cause distraction) while working in classrooms.
- TSS will not engage in purely recreational activities i.e. playing video games
- Never use school property for personal use; e.g., copier, fax, etc.
- Never use personal gadgets in the classroom without permission, e.g., laptops, cell phones, etc.
- Never tell the teacher how to teach.
- Never judge or take sides when a conflict occurs with your client in the school setting. Use mediation skills.
- Never compete with school personnel for authority role.

Physical Don'ts

- TSS may not carry clients in their arms, on their shoulders, or on their backs.
- TSS may not physically restrain child in any way.
- Never take youth to staff's home for activity.
- Never leave school grounds with the student.
- Never transport unauthorized individuals in your vehicle.

Communication Don'ts

- Never use foul language in the presence of the child, youth, family or school personnel.
- Never judge guardians or school personnel as bad.
- Never be rigid or uncompromising in conversations with the child, youth, family or school personnel.
- Never use yelling or disrespectful behavior when working with the child, youth, family or school personnel.
- Never talk down to a child, youth, family member or school personnel or be demeaning in any way.
- Never lie to the child… (however, it is appropriate to evade personal questions).
- Never allow the child, youth, family members or school personnel to provoke you into a defensive or angry posture.

Confidential Don'ts

- TSS will note share progress notes, psychological evaluations, or other sensitive information so school personnel without prior authorization from supervisors and written parental consent.
- Never share information from the home setting with school unless instructed to do so by the parents.
- Never disclose information to school personnel who have no involvement with the child.
- Never talk to unauthorized individuals, including spouses, relatives, school personnel, and colleagues, about therapeutic activities in any manner that could identify the child or family.
- Never discuss personal matters with school personnel during work hours.
- Never discuss the child, youth or family in the faculty room.
- Never discuss other staff's performance with the child or youth with school personnel.

Note: This partial listing of information was obtained from a combination of sources e.g., wraparound agencies in this study, medical bulletins, and Internet websites. The bulk of listings were taken from a *Train the Trainer* workshop for TSS. I organized TSS Don'ts into four categories.

APPENDIX D

PARTICIPANTS' PROFILES

Participants	Gender	Race	Education	Certification	Services Performed	Agency	Status	Service Years
W1CC	F	B	Master's	BCBA	N/A	BHRS	FT	5+
W2CC	F	W	Master's	BCBA	N/A	BHRS	FT	5+
W1BSC1	M	O	Master's	BCBA	SCHOOL	BHRS	PT	5+
W1BSC2	F	W	Master's	BCBA	SCHOOL	BHRS	PT	5+
W1BSC3	F	W	Master's		SCHOOL	BHRS	PT	5+
W2BSC1	M	O	Doctorate	BCBA	SCHOOL	BHRS	PT	5+
W2BSC2	F	W	Doctorate		SCHOOL	BHRS	PT	5+
W2BSC3	F	B	Master's	BCBA	SCHOOL	BHRS	PT	5+
W3BSC1	F	B	Doctorate		SCHOOL	BHRS	PT	5+
W3BSC2	F	B	Master's	BCBA	SCHOOL	BHRS	PT	5+
W3BSC3	M	B	Doctorate		SCHOOL	BHRS	PT	5+
W1TSS1	M	B	Bachelor's	N/A	SCHOOL	BHRS	FT	2
W1TSS2	F	B	Bachelor's	N/A	SCHOOL	BHRS	FT	5+
W1TSS3	F	B	Bachelor's	N/A	SCHOOL	BHRS	FT	2
W2TSS1	F	B	Bachelor's	N/A	SCHOOL	BHRS	FT	1
W2TSS2	F	B	Bachelor's	N/A	SCHOOL	BHRS	FT	5+
W2TSS3	M	B	Master's	N/A	SCHOOL	BHRS	FT	2
W2TSSex	M	O	Master's	N/A	SCHOOL	TEMP	FT	2
W3TSS1	F	W	Bachelor's	N/A	SCHOOL	BHRS	FT	5+
W3TSS2	F	B	Bachelor's	N/A	SCHOOL	BHRS	FT	2
W3TSS3	M	B	Master's	N/A	SCHOOL	BHRS	FT	2
TSS1extra	F	B	Bachelor's	N/A	SCHOOL	TEMP	FT	2
TSS2extra	M	B	Bachelor's	N/A	SCHOOL	BHRS	FT	1
TSS3extra	F	B	Bachelor's	N/A	SCHOOL	BHRS	FT	2
TSS4extra	F	B	Bachelor's	N/A	SCHOOL	TEMP	FT	3
TSS5extra	F	B	Bachelor's	N/A	SCHOOL	TEMP	FT	2

APPENDIX E

ACCESS "ISSUES" DISCUSSION

There were two significant issues that resulted in lengthy delays for gaining access to sites and obtaining documents. Gaining access to sites was problematic because behavioral health services were experiencing tremendous change. During the 1990s, the demand for wraparound services, particularly the TSS service, grew at an alarming rate which led to increased wraparound provider submissions "of their own service descriptions for services deemed medically necessary for one or more children with sed" (Hodas, 2004, p. 15). This approach created overutilization as well as misutilization of wraparound services. Few procedural requirements or standards were put in place to accommodate the massive demand for these services. In 2001, the Pennsylvania Department of Public Welfare began to make significant changes to curtail excessive use of the services. As a result, numerous wraparound agencies failed accreditation which resulted in a dramatic decrease in service providers. Unaware of the changes occurring in BHRS, I began the process of selecting wraparound sites just two years after critical changes within the system were underway. These changes in part, I believe, impacted my research process. I will recount in detail my rationale for selecting certain wraparound agencies and what transpired during that selection process.

In March 2001, I contacted a School District of Philadelphia employee. That employee, Ms. Catherine Provenzano, was a district liaison in the Special Education division's "Support for Students with Disabilities." When I inquired about information pertaining to TSS, I learned as part of a mandatory requirement based on a legal settlement agreement (Kellner v. School District of Philadelphia), "the District must conduct surveys of its schools every year, one in October and one in February, to determine the number and

location of TSS workers" (SDP, 2001). Ms. Provenzano was responsible for managing data on TSS in schools. In a phone conversation in early March, I requested survey data on TSS. Ms. Provenzano sent me an email with the number of students receiving the TSS service and the number of students waiting for TSS. I emailed her back and asked if it were possible to get a breakdown of TSS by school site. A meeting was scheduled and Ms. Provenzano provided me with raw data so that I could analyze the database to get what I needed. I obtained hardcopies of spreadsheets containing the following information: type of setting where TSS served (general or special education classroom), school (elementary, middle or high school), TSS employment (name of agency providing services), and distinct categories of placement (students receiving TSS or waiting for TSS).

After compiling a list of each wraparound agency, I calculated frequencies of active TSS by agency. I then put together a list of those agencies with the highest TSS representation and calculated percentages and ranked them in order from most TSS to least TSS. I used a cutoff point to determine which agencies would be selected for this study. Of the 71 agencies identified in the database, 10 agencies plus the school district accounted for 60% of all TSS in schools. Each agency utilized at least 65 TSS. Initially, I had hoped to collect data from 10 wraparound agencies plus the school district. The 10 largest agencies with TSS representation in the School District of Philadelphia (and the district itself) were selected due to their dominance of the TSS service in public schools. It seemed these agencies represented the most "typical" providers using the TSS service. My sense was findings would reveal how "typical" monitoring/assessment practices are across agencies. It was assumed that the largest agencies have established, formal practices due to the large number of TSS they employ; hence, this suggests systematic efforts to monitor/assess

treatment integrity. In other words, I reasoned the more employees an agency has the more that agency must systematize its practices.

As I was preparing to submit my dissertation and IRB proposals, I learned the wraparound process I based the research on was not Pennsylvania's wraparound services as I had assumed. The absence of literature on wraparound services coupled with my limited knowledge of Pennsylvania's behavioral health system contributed to this mistake which resulted in me abandoning the proposals I was preparing to submit and starting from scratch. It took one year to learn more about Pennsylvania's wraparound services before I began to write another proposal.

I contacted Ms. Provenzano again in 2002. We met once more and she provided me with updated survey data. Following the same analysis procedures I had used the previous year, the outcome was nearly the same. I selected 10 agencies with the largest TSS presence in schools. At the time, I included the school district as well and followed the required route for getting access to schools. This process alone took one full year. My dissertation was approved in October 2002. I contacted the school district in December 2002. I was asked to submit six copies of an IRB proposal to its evaluation board. Honoring this request was a problem because I could not obtain IRB approval until I received "letters of support" from agencies. After waiting several months, in June 2003 I contacted one of the school district's evaluation board members, Dr. Robert Sebastian. I explained my situation to Dr. Sebastian and he then suggested I submit six copies of the IRB proposal. When the six copies were sent, in July I received a phone from Dr. Sebastian informing me the evaluation board was requesting that I submit six copies of the approved dissertation proposal. I sent the requested

material and in October 2003, I received permission to conduct the study in the School District of Philadelphia. This was the first official "letter of support" I received.

In the interim, I had been contacting potential wraparound agencies beginning as early as April 2002. I was getting names of appropriate contact persons as well as inquiring about agencies' procedures for permission to conduct research at their sites. In June 2002, I submitted my dissertation proposal to CPRC; it was approved in October 2002. In January 2003, I submitted my IRB proposal. One month later, I learned IRB approval was pending "letters of support" from proposed agencies. In March 2003, I then began submitting information to wraparound agencies. Beginning with 10 agencies, I submitted a cover letter as well as the IRB proposal. Out of that effort, only three agencies granted consent, three declined in writing, and four never responded. Those three agencies granting consent did so by returning a portion of a permission sheet. It was not an official "letter of support." And instead of me requesting consent on official stationery, I continued submitting letters to other agencies until every one of the 71 agencies was contacted. At the time I was attempting to use the largest 10 agencies as part of my sample but recognized the wise thing to do was to use whichever agencies consented to the study.

After a year of contacting agencies, I submitted the three permission sheets to IRB; these sheets were not on official letterhead so the second proposal was rejected. When I contacted the three agencies again to get the appropriate "letters of support," wraparound officials had reservations about me conducting the research; consequently, I was not able to obtain the letters. This led me to take another course of action. I met with Department of Public Welfare officials to get assistance for securing wraparound agency approval. I also contacted mental health professionals at the state level. State officials kept referring me to

local officials. Wraparound officials began to pass the buck citing the main reason for not agreeing to the study was because they "can't do this without approval from CBH." This statement was repeated consistently. So I contacted Community Behavioral Health, the umbrella agency for all mental health programs in Philadelphia. Three ranking officials requested the documents I submitted to wraparound agencies. The information was submitted, my proposal was reviewed, and CBH responded thusly:

> Our contractual language with our Providers stipulates that if they obtain data from us and subsequently it is to be used in publication, that they must receive our approval before they can publish. Your research does not fall under that contractual agreement and it is totally left up to the discretion of the Provider as to their participation in your study. (McLaulin, personal communication, 2004)

Ultimately, CBH was neutral in the matter. But at least I was armed with CBH documentation. Subsequently, I contacted all of the agencies again. All 71! Out of that effort, only three agencies responded favorably and sent official "letters of support." After three years of attempting to gain access to wraparound agencies (from February 2002 to April 2005), I made a decision to use these three agencies rather than the proposed 10 agencies. I resubmitted a third IRB proposal; it was approved in May 2005.

Four months after IRB approval, I began conducting interviews (from October 2005 through November 2006). Instead of collecting documents while simultaneously conducting interviews, wraparound officials informed me it would be less intrusive for them if I were to request the materials after all interviews were conducted because two of the three documents I requested were a part of clients' medical records. Officials wanted this to be a smooth process where I could collect the documents at one time as opposed to collecting them sporadically. There was also the matter of approval. Approval to use documents (students' medical records) was authorized solely by wraparound officials but it was a sensitive issue.

There was some concern regarding potential violation of HIPAA laws specifically client confidentiality. The Pennsylvania Department of Public Welfare's website has information posted regarding HIPAA privacy. Part of the posting reads thusly:

> DPW must follow new laws protecting the privacy of [clients'] protected health information. These new laws are known as the Health Insurance Portability and Accountability Act (HIPAA) privacy rules. When we do use or disclose protected health information, we will make every reasonable effort to limit its use or disclosure to the minimum necessary to accomplish the intended purpose…. There are different reasons why we may use or disclose your protected health information. The law says that we may use or disclose information without your consent or authorization for the reasons described [here]: [treatment, payment, operating our programs, law enforcement purposes, government programs, national security, public health and safety, and for research]. For research: We may disclose information for permitted research purposes and to develop reports. These reports do not identify specific people. (DPW, 2008)

When I was granted approval by wraparound agencies, the IRB consent forms clearly spelled out that treatment plans and progress notes were an integral part of the study. Prior to my conducting any interviews, I met with each agency's wraparound manager and we worked out the logistics of collecting those documents. Each wraparound agency official had decided early on that an agency designee would photocopy the requested documents. Designees would also be responsible for blacking out the names of students. They also requested that my research not "specify people [or agencies]." I agreed to those conditions. Once all interviews were completed and it was time to obtain the requested documents, wraparound managers did not want to release the documents. I later learned the lengthy time span between me conducting interviews and requesting the documents, several months after interviews began, was the reason for wraparound officials' initial decline. Ultimately, after numerous emails, phone calls, meetings (over a six month period) and with my advisor intervening, wraparound managers agreed to release the documents. That information was collected in late 2006. A designated staff member from each agency prepared the materials

for me. Two agencies mailed the documents to me; one agency prepared the documents and allowed me to pick them up.

APPENDIX F

BEHAVIOR SPECIALIST CONSULTANT INTERVIEW PROTOCOL

Treatment Integrity

1) What is your understanding of the term "treatment integrity"?
2) How does your agency define treatment integrity?
3) How does your agency operationally define treatment? In other words, what does the agency use as a standard for clearly defining how treatment should be administered?

Monitoring Treatment Integrity

4) Can you tell me some of the ways your agency monitors treatment integrity?
5) In your opinion, what is the most common method of monitoring treatment integrity?
6) Do you think this method clearly captures TI or are there other ways that this type of monitoring can be strengthened?

Assessing Treatment Integrity

7) Does your agency measure treatment integrity?
8) What measures do you use to assess treatment?
9) What type of information do you expect to capture from these assessment measures?
10) Which method(s) do you find most useful?
11) What other methods, if any, could be used to strengthen current treatment integrity assessment practices?
12) What is treatment integrity assessment data used for?

Daily Treatment Notes

13) Explain the significance of the daily treatment notes?
14) When daily treatment notes are reviewed, what information do you look for to determine whether or not the treatment is being administered as intended?
15) Do you feel the information contained on the daily treatment notes comprehensively reflects proper treatment administration?
16) How is the daily treatment notes used?
17) What training, if any, did TSS receive for completing daily treatment notes?

Treatment Violations

18) What is your understanding of treatment violations?
19) What, in your opinion, appears to be the major reason(s) for TSS altering treatment (if applicable)?
20) Have you found, in your experience, there are times when it is necessary to alter treatment?
21) In your experience, when you have changed treatment, what effect has this had on subsequent treatment planning?
22) How important is it to follow the treatment plan as designed?
23) What type of training did you receive in applying behavior modification techniques?
24) Is it realistic to believe that one can follow a treatment plan exactly as it was designed on a long-term basis?

APPENDIX G

THERAPEUTIC STAFF SUPPORT INTERVIEW PROTOCOL

Treatment Integrity

1) What is your understanding of the term "treatment integrity"?
2) How does your agency define treatment integrity?
3) How does your agency operationally define treatment? In other words, what does the agency use as a standard for clearly defining how treatment should be administered?

Monitoring Treatment Integrity

4) Can you tell me some of the ways you are monitored?
5) In your opinion, what is the most common method in which the BSC monitors you?
6) Do you think this method clearly captures treatment integrity or are there other ways that this type of monitoring can be strengthened?

Assessing Treatment Integrity

7) How is your work performance assessed?

Definition of Interventions

7) What are some interventions you employ?
8) Is each intervention contained on the treatment plan?
9) Can you explain how the interventions are described on the treatment plan?

Treatment Violations

10) What is your understanding of treatment violations?
11) How closely do you adhere to the treatment plan?
12) What, in your opinion, appears to be the major reason(s) for TSS altering treatment (if applicable)?
13) Have you found, in your experience, there are times when it is necessary to alter treatment?
14) In your experience, when you have changed treatment, what effect has this had on subsequent treatment planning?
15) How important is it to follow the treatment plan as designed?
16) Do you feel the description of the intervention is comprehensive enough? That is, is there a step-by-step approach you must follow to administer treatment?
17) What type of training did you receive in applying behavior modification techniques?
18) Is it realistic to believe that one can follow a treatment plan exactly as it was designed on a long-term basis?
19) Do you generally discuss with the BSC why it might be necessary to alter treatment?

Supplemental Questions

1. What is your role as a TSS? (What do you do?)
2. What do you like most about your job?
3. What are some of the frustrations in carrying out your work?
4. What are some of the challenges a TSS, in general, faces?
5. What is the most difficult aspect of being a TSS?
6. How valuable is the TSS service?
7. What is the most significant contribution a TSS makes?

APPENDIX H

TREATMENT PLAN DESIGN MATRIX

Description of Items Contained on XPLAN	WRAP1	WRAP2	WRAP3
Diagnosis	○	○	○
(Axis I, II, III, IV	○	○	○
Client's Strengths	○	○	○
(Areas: Personal, Family, Educational, etc.)		○	○
Problem Statement	○	○	○
Elements of the Diagnosis		○	
GOAL	○	○	○
OBJECTIVE	○	○	○
Progress Declined Same			○
Problem Behavior		○	
Observable Alternative/Rep. Behavior		○	○
*Condition in Environment (Triggers)		○	
Criterian Achievement		○	
Current Baseline		○	○
Strengths Utilized		○	
INTERVENTION	○	○	○
(Services e.g., BSC, MT, TSS)	○	○	○
TSS Interventions	○	○	○
Progress/Discussion	○		
Opportunities for treatment		○	
Barriers to treatment			○
Description of treatment used	○	○	○
De-escalation Plan	○	○	
Crisis Plan	○		○
*Intervention Program		○	
Behavioral Health Conceptualization of Case		○	
Suggested Interventions Section			○

APPENDIX I

PROGRESS NOTES DESIGN MATRIX

Description of Progress Notes	Wrap1	Wrap2	Wrap3
Definition of Behavior	□	□	□
Target Behavior	□		□
Replacement Behavior	□		□
Inappropriate		□	
Appropriate		□	
Treatment	□	□	□
Goal	□	□	□
Objective	□	□	□
Triggers		□	
Interventions Used	□	□	□
Client's Response	□	□	□
Progress		□	
Boxes for marking behavior (1 hour increments)	□	□	□
Total # of Replacement Behaviors	□		□
TSS Involvement with Interventions	□		□
Comments	□	□	□
Reflections (Was today different from yesterday? How so?)		□	
Forward Thinking (What will you do tomorrow?)		□	

APPENDIX J

TREATMENT PLAN RAW DATA

The following chart represents selected descriptions of interventions from treatment plans in this study. Information in the last five columns reflect the standard assessment criteria.

Description of Interventions	WO	WH	WN	HW	CLR
W1Xplan1					
TSS role not mentioned on Xplan	n/a	n/a	n/a	n/a	n/a
W1Xplan2					
TSS will prompt [client] to follow through with directives given by authority.	Yes	Yes	No	No	No
TSS will encourage [client] to cope effectively when upset by isolating him for about 5-20 min. depending on the intensity of the situation & encouraging problem-solving skills.	Yes	Yes	Yes	Yes	No
W1Xplan3					
Wrong X plan Submitted	n/a	n/a	n/a	n/a	n/a
W2Xplan1					
Have [client] verbally repeat all steps of the task before starting it.	Yes	Yes	Yes	Yes	No
Use of Premack Principle: Pair the low frequency behavior w/a high frequency behavior. Example. Points should serve the function of promoting compliance w/adult directives & encouraging healthy alternative behaviors to tantrums. Points shouldn't serve as punishers, because by doing so, they will lose their reinforcing effect on positive behaviors.	Yes	Yes	No	No	No
Will directly instruct [client] w/alternative methods to resolve conflict or communicate effectively.	Yes	Yes	No	No	No
W2Xplan2					
Will train, practice, & review daily anger management & conflict resolution skills with [client].	Yes	Yes	No	No	No
Use timeout as established in the classroom.	Yes	Yes	No	No	No
W2Xplan3					
The TSS will use verbal prompting for desired behavior & verbal redirection for undesired behavior.	Yes	Yes	No	No	No
W3Xplan1					
TSS – Verbal prompt. Verbal prompting/redirection will be used to signal [client] to eliminate undesired behaviors & demonstrate replacement behaviors.	Yes	Yes	No	No	No
W3Xplan2					
TSS – Proximity Control – Will utilize to empower client to comply with directive given.	Yes	Yes	No	No	No
TSS – Verbal Prompting/Visual Cueing – Verbal prompting/redirection will be used to signal [client] to eliminate undesired behaviors & demonstrate replacement behaviors.	Yes	Yes	No	No	No
W3Xplan3					
TSS – Redirection/verbal prompts, time out, verbal praise, non-verbal praise, reward system. TSS…will implement a reward system (praise when [client] meets objectives. TSS…will issue [client] verbal prompts/redirect…when [client] is impulsive. TSS… will continue to identify appropriate reinforcers for positive behavior.	Yes	Yes	No	No	No

APPENDIX K

MONITORING MATRIX

Most frequently reported monitoring practices.

	Notes	Obser.	Supv.	Trng	Fdbck	Tchrs	Prnts	Forms	Calls
W1CC	▪	▪	▪	▪					
W1BSC1	▪	▪	▪			▪	▪		▪
W1BSC2	▪	▪				▪			
W1BSC3	▪		▪	▪	▪	▪	▪	▪	
W1TSS1		▪	▪						▪
W1TSS2		▪	▪	▪			▪		▪
W1TSS3	▪	▪	▪						
W2CC	▪	▪	▪	▪	▪				
W2BSC1	▪		▪						▪
W2BSC2	▪	▪		▪	▪	▪	▪		▪
W2BSC3	▪	▪	▪						
W2TSS1	▪	▪	▪						
W2TSS2	▪	▪	▪	▪	▪				
W2TSS3	▪	▪	▪						
W2TSSx								▪	
W3BSC1	▪	▪	▪						
W3BSC2	▪	▪							
W3BSC3	▪	▪			▪	▪	▪	▪	▪
W3TSS1	▪	▪	▪						
W3TSS2		▪	▪		▪		▪	▪	
W3TSS3									▪