# Spotlight on Caroline Families First Wraparound Program: Lessons for Advancing Collaborative Family-Centred Care for Complex Child and Youth Mental Health

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## ABSTRACT

The Caroline Families First Wraparound Program operationalizes cross-sectoral collaboration and planning, family peer support, and family-directed care consistent with strategic directions within the Mental Health Strategy for Canada. In this spotlight article, we present findings from a case study that describes what makes the program work, the barriers and facilitators to its success, and draw conclusions about the lessons learned. For example, while family-directed care is a core and essential value of the program, unless well understood, it can create tensions within teams. Similarly, structural factors such as provider reimbursement can inhibit physician involvement. Suggestions about these and other contextual factors can inform other efforts to mobilize the Mental Health Strategy.


**Keywords:** wraparound, child and youth mental health, family peer support, cross-sectoral collaboration, primary health care


## RÉSUMÉ

Le programme Caroline Families First est un bon exemple de projet mis en place pour favoriser l'intégration des soins de santé primaires et des soins de santé mentale. Il permet d'établir une collaboration et une planification intersectorielles pour ainsi offrir aux familles qui en ont besoin un soutien par les pairs et des soins axés sur la famille, ce qui est conforme aux orientations de la Stratégie en matière de santé mentale pour le Canada. Dans cette étude de cas de Caroline Families First, les auteurs examinent les facteurs qui contribuent au bon fonctionnement du programme, les éléments qui soutiennent son succès et les difficultés rencontrées dans sa mise en place; ils tirent ensuite des leçons utiles pour l'avenir. Par exemple, bien que les soins axés sur la famille constituent un élément essentiel du programme, quand ils ne sont pas bien compris, ils peuvent entraîner des tensions au sein des équipes. De la même façon, des facteurs structurels, comme les modalités de paiement des fournisseurs de soins, peuvent décourager des médecins à participer au programme. Les auteurs font des suggestions, sur ces facteurs structurels et sur d'autres éléments du programme, qui pourraient soutenir des efforts à venir en vue de promouvoir la Stratégie en matière de santé mentale.


**Mots clés :** prise en charge globale (*wraparound*), santé mentale des enfants et des adolescents, soutien des familles par les pairs, collaboration intersectorielle, soins de santé primaires.



The Mental Health Strategy for Canada (MHSC) calls upon planners and providers to develop services that deliver individualized care predicated on needs and strengths. It also suggests the need for greater involvement of primary care, integration of persons with lived experience in mental healthcare planning and delivery, and improved services for Canada's children and youth (Mental Health Commission of Canada, 2012). For example, the MHSC first Strategic Direction (SD), Priority 1.2 calls for enhancing "the capacity of families, caregivers, schools, post-secondary institutions and community organizations to promote the mental health of infants, children, and youth, prevent mental illness and suicide wherever possible and to intervene early when problems first emerge." (Mental Health Commission of Canada, 2012). Other SDs call for providing "Access to the right combination of services, treatments and supports, when and where people need them" (SD3); and to "Mobilize leadership, improve knowledge, and foster collaboration at all levels" (SD6).

Taken together these three SDs offer tremendous potential to assist children with complex mental health needs and their families, who often require services that are difficult to access and are not well co-ordinated amongst multiple providers and sectors (Reid & Belle Brown, 2008; Reid, Cunningham, Tobon et al., 2011; Schraeder, 2012). Physicians often spend time in care coordination rather than treatment for these children/youth, which can contribute to lengthy wait lists for accessing care (Caroline Families First Steering Committee, 2012). In some cases, parents have unrecognized mental health needs themselves, which can worsen child outcomes and increase the burden on health systems (Rose, Mallison & Gerson, 2006).

The wraparound model is an evidence-based approach to improving services and outcomes for children/youth with complex mental health needs (Boydell, Bullock, & Goering, 2009; Burns, Schoenwald, Burchard, Faw & Santos, 2000; Walker, Bruns, & Penn, 2008). Wraparound can advance collaborative approaches across sectors as called for in the MHSC. In wraparound, the child/youth and family set health and well-being goals, and are supported in meeting them through an individualized care plan (wrap action plan). This plan specifies membership of the wraparound team of professionals, services, and agencies that work together in a coordinated way to support the child/youth and family. (Walker & Bruns, 2006 as cited in Sather & Bruns, 2016). Wraparound uses a measurable, community-based process that is child/youth and family directed, strengths-based, and culturally informed (Bruns, Walker, & The National Wraparound Initiative Advisory Group, 2008). The model has long been used in the US, but despite strong evidence of effectiveness, has not been widely applied in Canada.[1]

A novel take on the wraparound approach, the Caroline Families First Wraparound Program (CFF) was introduced in Halton, Ontario in 2014. The program better coordinates primary and community-based mental health care for children/youth with suspected or diagnosed mental health problems and illnesses[2] requiring multidisciplinary intervention. Families can be referred to the program when a partnered physician identifies that the caregiver(s) are struggling with capacity concerns or are feeling overwhelmed with their child's mental health needs. The program features co-leadership by a children's mental health organization and a family health team (an interdisciplinary model of primary health care); co-location of program staff in the family health team setting; and cross-sectoral funding, scope, and oversight by the Ministries of Health and Long-Term Care and Child and Youth Services.

At the heart of the CFF program is its family-centred approach. Program staff include two paid family support providers (FSPs) that provide peer support to the family member (typically a parent or guardian) by drawing on their own lived experience of raising or having raised a child with a mental health problem or illness, and two care coordinators (CCs) that span the boundaries of the systems and services involved. Together, an FSP and CC help the youth and family set their individualized care goals, identify wraparound team members,[3] manage team communication, and ensure family voice and choice are central. The CC and FSP guide wraparound team members in developing wrap action plans, and facilitate and monitor progress toward the goals at the wraparound meetings. They also work with families outside of wraparound meetings to provide support, mentoring, and advocacy to build family capacity and to facilitate access to other supports and associated funding. There are four pediatricians and eight family physicians who refer children/youth into the program, and at the time of the study 33 community organizations had participated in at least one wraparound team (See Table 1) with 99 families (136 children/youth) served and 317 wraparound meetings held between January 2014 and April 2016.

**Table 1**

**Program Productivity Statistics (January, 2014–April, 2016)**

| Program Activity | Count |
|---|---|
| Cases referred to program | 166 |
| Families served | 99 |
| Children/youth served (0–21 years) | 136 |
| Physicians making referrals (pediatrician, GP) | 4, 8 |
| Average length of program involvement (based on 74 closed cases) | 388 days |
| Total number of wraparound meetings | 317 |
| Adults served (22+) | 13 |

The CFF program aligns with all three priority areas of the MHSC identified above: It prioritizes the mental health of children and youth while focusing on developing family capacity (Priority 1.2); increases availability and coordination of mental health services in the community, including individualized treatment plans (Priority 3.2); expands the role of primary care in meeting mental health needs (Priority 3.1); provides family peer support as an essential component of mental health care (Priority 3.4); demonstrates intersectoral collaborative planning within government (Priority 6.1); and promotes leadership of individuals with lived experience in planning processes (Priority 6.4).

In this spotlight article, we examine the experience of the CFF program from the perspective of program participants (young people, family members, siblings, physicians, service providers, and natural supports) and draw lessons for other programs that aim to operationalize the MHSC strategic directions.

## METHODS

We used an exploratory qualitative case study approach to understand how the CFF wraparound program could advance MHSC directions. This approach was selected for its ability to elicit "lessons learned" that can be used to improve practice in other settings (Yin, 2013). The case was defined as "the implementation of the Caroline Families First program as a high-fidelity Primary Care Wraparound program in Halton, Ontario." We employed a purposive sampling approach to identify three subcases that represented a range of family experiences with the program in terms of reasons for program entry, types of challenges being faced and extent of success in applying processes consistent with the wraparound approach (see Table 2; Miles, Huberman, & Saldana, 2013; Yin, 2013). By selecting subcases where wraparound processes were seen to be highly successful, moderately successful, and less successful, the intent of this sampling strategy was to capture the full range of themes about what makes the program work (or not) in practice, and identify barriers and facilitators to success. We gathered data from three sources between October, 2015 and March, 2016: program data, 25 individual informant interviews, and one focus group. Note that among individual informants, the CCs, FSPs, and several referring physicians shared their insights based on experiences with numerous families beyond the selected subcases. Wherever possible, interviews were conducted with all

**Table 2**

**Interview Informants by Subcase and Type**

| Subcase | Interviews | | | | | Focus Group | Total |
|---|---|---|---|---|---|---|---|
| | CC | FSP | Youth | Parent | Doctor | Supports | |
| 1 | 2 | 1 | 1 | 1 | 1 | 3 | 9 |
| 2 | 2 | 1 | 3 | 1 | 1 | 1 | 9 |
| 3 | 1 | 0 | 1 | 1 | 3 | 1 | 7 |
| Total | 5* | 2* | 5 | 3 | 5 | 5 | 25 |

*Due to CCs and FSPs being involved with multiple cases, 3 separate CCs and 1 FSP were interviewed, spanning 3 and 1 interviews respectively.



members of the wraparound team (program staff, referring physicians, and formal and informal supports) and family (subject to family member approval). In the selected cases, "family member" refers to a parent.

The interviews varied considerably in length (from 10 minutes to two hours), with much shorter interviews for children/youth than for formal supports and program staff. BO primarily conducted interviews, with support from GM and two research assistants. Interviews were transcribed by professional transcriptionists, and managed using NVivo 11.1. An initial codebook reflected elements of the program's logic model as overarching codes.[4] During a pre-coding exercise, research team members met with program representatives and a parent peer consultant to discuss and resolve any coding discrepancies. The codebook was further expanded and refined based on emerging themes during subsequent coding of all the data. During the analysis phase, we reviewed coded data against the MHSC SDs and priorities. Families were offered the opportunity to review and comment on an overview of the findings, but none responded. Ethics approval was received from the Hamilton Integrated Research Ethics Board.

## FINDINGS

We review key themes that emerged with respect to what makes the program work in practice and alignment with the MHSC priority areas. We then discus contextual factors that may influence the program's success in meeting MHSC priorities.

### How the Program Works and MHSC Priorities

**Building family capacity.** All categories of interview informants (informants) emphasized the importance of the FSP role. Families value the FSP as someone who partners with them to listen, support, plan, strategize, and empower the parent(s) and family to meet their goals and "feel safe" in working with services. The FSP helps build families' capacities to promote the mental health of the children/youth in homes and schools as outlined in SD1, priority area 1.2 (Table 3, column 2).

> Honestly, sometimes it's just nice to have somebody who's been through it to sit there and talk to, and get an honest—not textbook—answer as to things that they've tried in their own home … or seen done in the community and had success with. (parent)

Informants also emphasized the importance of the CC role in building family member capacity.

> The other key piece that case management does not do [that a care coordinator does] is spend the time to build the capacity of the caregiver. We can build up a child, and we can give them tons of services, but if we never work on that parent, nothing's ever going to change. So, capacity building is also a huge part of what care coordination does. (care coordinator)

**Family-centred approach**. Informants described family-centred care as a fundamental value for successful wraparound processes. Informants indicated that while all other themes discussed below were important, the process would not be true to the CFF program vision if it were not family-centred. This is consistent with the overall direction of SD3.

> I think, that having people around a table, that could give [family member] strategies, that were all there for her, she really loved that. (family support provider)

Being family-centred also requires providing choice to family members and tailoring processes to the needs of individual families.

> [Family member] brought some school pictures of [the children] and some drawings that they did. We put them up on the wall in the room that we were in as a way to make it feel like these are the kids we're talking about. They're people. This is who they are, which was really a neat visual to have. (care coordinator)

This approach also means focusing on the strengths of individual families, so they come to identify and work from those strengths. This is key to preparing families to ultimately leave the program.

> It's those strengths that help you achieve the goals that you want. Everybody has strengths; it's just about identifying those. And we identify those early on in our first couple of meetings with the family. (family support provider)

Finally, the program focuses on the whole family, rather than just the child/youth referred into the program. It is common to find that other children/youth and parent(s) need support. Interview informants described how attending to the needs of the whole family reduced overall family stress levels and resulted in marked improvement in behaviour for some children/youth.

**Collaboration of care delivery across sectors.** Program effectiveness also depends on collaboration of care and provider organizations across sectors, consistent with Priority 3.2. A wraparound team can bring together providers from health, social services, housing, and education (for example) to create an individualized team of experts to best serve a family. This was described as resulting in a more comprehensive and shared understanding of the family and a streamlined approach in working towards family goals.

> Having everybody kind of on the same page and working towards the same goals was huge … It was streamlining it. (formal support)

It also helped some formal supports to see the child/youth's behaviour and performance in a different light.

> And the information from the wraparound teams really helped me get a good global view. So I wasn't seeing [child/youth] just as a student from the school and marks on a piece of paper and that kind of stuff. I really got to see how important it is to know the whole picture…. (formal support)

**Involvement of primary care.** Informants also noted the importance of the partnership between children's mental health and primary care providers, consistent with Priority 3.1. Physicians explained that meetings provide an opportunity to educate service providers from other sectors, which can inform the services offered to children/youth and families.

> I think involving primary health care is really important… A lot of times schools have expressed that it's so difficult to have the pediatrician or the family physician sit down and discuss a diagnosis of the child's mental health need, so having that part involved makes a really big difference, and that also makes a difference in how the child is treated. I think that's pretty integral. (care coordinator)

Similarly, physicians reported gaining a more comprehensive understanding of their patients because of the input from other providers during wraparound meetings or by the CC between meetings.

> I can't think of any other time in a physician's practice that you can ever really get a sense of what is happening at one parent's house… And maybe even another parent's house… And maybe even an aunt's house… And maybe an after school program … So all of those things, it's actually pretty cool what happens there. (physician)

Physicians also reported that their respective scopes of practice had improved because they can refer patients with complex needs to the program.

> I kind of feel mentally at ease that yes, some of these families can really be helped, whereas earlier, you had nowhere to turn to … I do feel very supported and feel there's something that is more wholesome than just sitting in my office, seeing them, giving them a diagnosis, and doing a prescription for them … I cannot do everybody's job, and I cannot do [mine] well unless there's a whole team. (physician)

Another physician described the wraparound meeting as "honestly, the most powerful thing I've ever done in my practice to help kids with mental health and behaviour problems."

**Paid family peer support.** The FSP's lived experience and the ability to offer support to families after hours are critical to helping the family member build trust in the program (Priority 3.4). One informant spoke about accompanying a family member when her child needed to be admitted to hospital, to allay fears and assist with communication.

The FSP also has access to the home and other parenting spaces, which can provide additional information that can be brought forward to other supports to help address issues.

> It's beneficial for FSPs to visit right at the house, so they're getting a real understanding of the family and their needs, and they'll come back to us and say, so and so could use this, so and so could do that, and we find unique things that may not—[that] you don't normally. (care coordinator)

**Collaborative planning.** Informants viewed the intergovernmental coordination and joint funding (Priority 6.1) from Ontario's Ministries of Child and Youth Services and Health and Long-Term Care, and involvement of family members in planning (Priority 6.4) as being instrumental to collaboration between professionals in service delivery, improving their effectiveness.

**Table 3**

**Alignment of Themes with Mental Health Strategy and Contextual Considerations**

| MHSC Alignment | How Operationalized | Contextual Considerations |
|---|---|---|
| SD1: Promote mental health across the lifespan in homes, schools, and workplaces, and prevent mental illness and suicide wherever possible. | | |
| Priority 1.2<br>Increase capacities of family, caregiver, schools, and community organizations | FSP and CC help to build family capacity | Child/youth and family member capacity to participate in the program.<br>"Where it's not working is that the parent … cannot do the work. This program requires the parent to be actively involved to change. You're going to help build their capacity, you're going to help them to advocate for their children. But eventually what we want to do is we want to build capacity for that parent, so that when we step out of our role, the family will be able to continue to do the good stuff that they're doing." (family support provider) |
| SD3: Provide access to the right combination of services, treatments and supports, when and where people need them. | | |
| Family-centred approach | Empowering family members by providing voice and choice<br>Focus on family strengths<br>Addressing needs of whole family | Understanding and accepting true meaning of family centredness<br>"… a really big challenge as a care coordinator sometimes, is having service providers understand you work for the family and not for them. And so sometimes you're not going to give service providers the information they may want and they may be used to getting … because you are working for the family and you are taking the family's direction." (care coordinator) |
| Priority 3.2<br>Collaboration across sectors | Bringing everyone together and having them on the same page through wraparound meetings<br>Seeing the child/youth in a different light because of collaboration across sectors | Differences in care philosophies<br>"The program is also trying to break down these barriers with the worlds of education and Children's Aid… There were a lot of barriers to getting into doors to those schools at the beginning, and now they're starting to get used to us and know who we are, and really working with us." (care coordinator)<br><br>Waiting lists and geopolitical boundaries for other services<br>"The only barrier I would say is the availability of services because even though the program is trying to do all this good to these families, there are still waiting lists." (referring physician) |

Continued…

**Table 3, continued**

| | | |
|---|---|---|
| Priority 3.1<br>Involvement of primary care | Other sectors gain access to physicians<br>Physicians can share knowledge about medical considerations to help inform other formal supports<br>Physicians gain better understanding of child/youth and family needs<br>Wraparound meetings seen as a very powerful tool to assist children and youth with mental health problems and illnesses | Co-location<br>"I think that we have our locations, being on-site, and that the doctors or physicians have been willing to open up their space to us for children's mental health services to be located in their buildings is huge." (care coordinator)<br><br>Physician involvement<br>"I think that when this model started, the intent was for the doctors to be a little bit more involved in the process, and I don't think they're as involved as sometimes what needs to be. Some doctors are really good, and there are other doctors that are not so good. But I think the doctors who make the referral, the person that makes the referral into the program, should make available time to come to wraparound meetings." (family support provider)<br><br>Payment<br>"Well, I definitely think the rate-limiting factor is me, because I'm fee for service. […] So you definitely can get paid. I think the difficulty is, you are going to get paid for 90 minutes what you are going to make seeing one patient in your office for 30 minutes. So it's not the best way to make money." (family physician) |
| Priority 3.4<br>Paid family peer support | FSP helps the family to gain confidence in the program<br>FSP offers after hours assistance<br>FSP provides insight from home environment | Individual traits<br>"I think that the FSP needs to be organized and needs to know when they're out of their depth, or when they need support themselves. I think that's key. […]. It's just being genuinely concerned for your people and really wanting to be helpful." (family support provider) |
| SD6: Mobilize leadership, improve knowledge and foster collaboration at all levels. | | |
| Priority 6.1 Intergovernmental and inter-sectoral coordination<br><br>Priority 6.4<br>Expanded leadership role for people with lived experience | Funding and collaboration across two Ontario ministries<br>Family members as members of program Steering Committee<br>Partnership with community organizations including Parents for Children's Mental Health | Partnerships with government, community, and family organizations.<br>"So, those are all really key community partnerships in a higher systems level that helped design this program, that have an invested interest in this program. … Any of the barriers that we might face, we talked about in that steering committee level, and those are champions in our community that are out there talking about our program, and I think that's a key thing. (care coordinator) |

> I think on a systems level, what are helpful things are the fact that we have this agreement with Ministry of Health and MCYS [Ministry of Child and Youth Services] to fund our program—that's huge. Another key piece, … is our partnerships. … we have a partnership for community pediatricians, we have a partnership with … Parents for Children's Mental Health. (care coordinator)



### Challenges to Achieving MHSC Priorities

Informants pointed to key contextual factors that influence the program's success in each of the above theme areas. We summarize and organize these by the SDs and priorities of the MHSC in Table 3, column 3.

**Increasing family capacity.** One key consideration for program success is the capacity of the family to benefit. While all of the families referred to the program are facing very difficult and complex circumstances, it is crucial that they not be facing acute crises that preclude follow through with appointments, attending wraparound meetings, or doing the work that success in the program demands. They must also have a willingness, desire, and capacity for change.

**Family-centred approach.** Informants indicated that getting buy-in to the family-centred approach across all wraparound team members or partner organizations can be difficult. Working from the family's direction requires a radical shift from "business as usual" that can be hard for service providers to understand. For example, the family's preference may be that some information is not shared among all members of the wraparound team.

**Collaboration of care delivery across sectors.** A key challenge to collaboration across sectors is managing differences in care philosophies while remaining true to program values. For example, educators may place greater emphasis on the learning needs of the child/youth, and Children's Aid organizations may prioritize child welfare over the family member's view of what is in the family's best interest. Other challenges to cross-sectoral collaboration can arise because of wait-lists for different services or inconsistencies in the geopolitical boundaries demarcating service areas.

**Involvement of primary care.** Program staff and formal supports described how co-location of CFF staff and primary care providers helped to facilitate involvement of primary care, which was difficult prior to the program. Physicians noted that co-location provided easy access to CFF staff and other providers involved in the child/youth's care.

At the same time, non-physicians noted that individual physicians differed in their approach to participating in the program. Some formal supports and program staff expected greater involvement of physicians in wraparound meetings and were concerned that physicians did not value the program. One physician pointed to payment schemes for specialists (fee-for-service based on the provincial health plan) as hampering participation at wraparound meetings, because they are reimbursed less for attending a family meeting than for providing direct patient care. Consequently, physicians may elect to selectively attend meetings where their presence is expected to be most impactful, and rely more on CCs to keep them informed between meetings. The resulting perceptions by other wraparound team members of limited program involvement by physicians were seen as adversely affecting the program potential.

**Family peer support.** In hiring an FSP, and in assigning an FSP to a family, individual capacities and traits must be considered. Informants explained that a good FSP needs more than just lived experience. He

or she must be relatable, compatible with program families, be able to engage in caring work, demonstrate genuine concern, and recognize personal limits and support needs. Some parent informants described disengaging if they could not relate to the FSP, or if they thought the FSP would be leaving the program. This points to the need to offer stable and well-supported FSP positions to help sustain rapport with families.

**Collaborative planning.** Although the collaboration between the health and children's ministries was well regarded by program staff and formal supports, some informants suggested that the Ministry of Education should also be a governmental partner for more effective collaborative planning. Early and ongoing involvement of people with lived experience in CFF program planning, development, and implementation has not only provided important insights, but also provided champions for the program in the greater community.

## DISCUSSION

The CFF program is an innovative program for child and youth mental health care that operationalizes a number of priority areas from the MHSC to improve mental health service delivery in Canada. Lessons learned from this case study may be instructive to others seeking to operationalize these MHSC elements in similar collaborative inter-organizational models.

For Priority 1.2, the findings suggest that achieving the goal of enhancing family capacity may depend on the readiness of program participants. It is essential that the child/youth and family members be able to fully engage in the wraparound process, including setting and following through on goals. This may be challenging if a parent or guardian is struggling with a mental health problem or illness, developmental issue, or overwhelming life circumstances.

For operationalizing SD3 (family-centredness), tailoring services to individual families and their objectives is a revolutionary program value to put into practice, when compared to traditional, more paternalistic approaches. This study shows that moving away from such traditional approaches is difficult because they have often become enshrined in existing philosophies, structures, and processes (Mulvale, Abelson, & Goering, 2007). Other challenges to family-centredness can arise with respect to information-sharing, and when professionals' views of what is best for the family clash with family preferences. Program leads will therefore need to educate and strategize about how to address such issues, while maintaining effective collaboration in meeting family needs.

When it comes to improving collaboration across sectors (Priorities 3.2 and 6.1), the findings suggest that it will be important to have a governance structure that is joint across organizations; committed organizational leadership to address philosophical differences; and support at the regional or public policy level to enable flexibility in light of waitlists, geographic boundaries, and eligibility criteria. Strategies such as interprofessional education (Hall, 2005; van Amsterdam & Bruijnzeels, 2012), and engaging in team-building activities may assist in developing cross-organizational team work (Mulvale & Bourgeault, 2007).

There are also important lessons about greater involvement of primary care (Priority 3.1), which can be hampered by structural considerations such as physician remuneration levels within public payment schemes (Mulvale & Bourgeault, 2007; Mulvale, Danner, & Pasic, 2008). Here, the issue arose for specialist physicians paid on a fee-for-service basis, but not for family physicians paid through blended capitation (mix of base rate per patient and partial fee-for-service). Provincial ministries of health can encourage specialists

to participate in collaborative meetings with families by offering compensation commensurate with what is earned in direct patient care. Without such a policy response, it is important to be clear about the extent of physician involvement with program activities and to designate one individual, such as the CC in this model, as the touch point for information-sharing with physicians. Program evaluation is also needed to encourage physician engagement by demonstrating positive impacts on physician practices.

Education and role clarity for program staff and wraparound team members can assist in intersectoral care delivery. This is especially true for the FSP role, which is often not well understood as being distinct from the CC role. The universal emphasis on the benefits of both the CC and the FSP roles among informants suggests that both need to be offered as stable elements of any program. The CC provides coordination, and communication across agencies in the wraparound process and the FSP assists in establishing trust, developing family capacity and providing insight beyond what is gained in traditional practice (Mulvale, 2008; Soloman, 2004).

FSPs must also be well matched to family needs to build rapport, have adequate support for their own mental health, and sufficient remuneration and benefits to encourage stability in their positions (Priority 3.4).

Finally, careful intersectoral planning can help to avoid long wait-lists for services and misunderstandings about each service's role in jointly meeting family needs. Involving people with lived experience as leaders in intersectoral program planning (Priority 6.4) can provide important insight and enable them to be program ambassadors within the larger community.

**Limitations**

While this case study suggests many important lessons for operationalizing key elements of the MHSC, there are several limitations to consider. First, we chose to focus in-depth on as many wraparound team member perspectives as possible from a limited number of families for whom wraparound processes had marked variation in success. This enabled us to gain a deeper understanding of varied experiences with the program from multiple perspectives than could be obtained from conducting interviews with one or two members of a larger number of wraparound teams. Nonetheless, the findings may not be fully representative of the range of experiences with the program. Second, it is too early to conduct a full evaluation of the program in terms of impact on health of youth and families and overall system costs, which is planned as future work. This will be essential to demonstrate whether the higher upfront cost is justified by expected long run savings through early and comprehensive intervention among children/youth and families with complex needs. Finally, this research adopted a participatory approach and so program staff were involved throughout the research. While some may see this as a limitation, from our perspective the in-depth knowledge of the program staff was essential in selecting a diverse range of families in terms of program experiences, in providing access to families and related programs, and in conducting interviews in settings that were convenient to the families. Throughout the research, program staff demonstrated a genuine interest in identifying aspects of the program that are, and are not, working well in order to lead to program improvement.

## CONCLUSIONS

Achieving the kind of system-wide health reform called for in the MHSC is a complex process. However, this examination of the CFF program demonstrates how core elements of the strategy's vision, such as a family-centred approach, enhanced collaboration across sectors, involvement of primary care, paid family peer support and intersectoral planning can be operationalized. The findings suggest a number of lessons about how to create a context that is more conducive to operationalizing key MHSC strategic directions and priorities for intersectoral, collaborative, person-centred care delivery, and planning.

## ENDNOTES

1 To our knowledge there are currently 10 applications of the wraparound model for children and youth with mental disorders in Canada.
2 We adopt the language of mental health problem or illness, consistent with the Mental Health Strategy for Canada.
3 May include referring physicians and counsellors, formal supports (e.g., teacher) and natural supports (e.g., extended family member).
4 The program logic model was developed by Dr. Soo Chan Carusone and Dr. Gillian Mulvale of McMaster University with input from the CFF Steering Committee during 2014.

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