Wraparound assessment & interventions: Unexamined factors affecting efficiency & outcomes

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Discussion topics

1. The nature of assessment & design of interventions
   Values vs. theory base(s) or Values supported by theory base(s) to guide implementation of key elements & activities

2. Insufficient attention to implementation frameworks & drivers

3. Distribution & adaptation → model drift toward “family friendly case management”

4. Comparison of options to improve fidelity, efficiency & effectiveness
In the beginning was the word...

Wraparound elements & activities (VanDenBerg & Grealish, 1996)

Parents included in every part of the wraparound process

Team based: Engage key players in lives of child & family

Non-judgmental, culturally competent, family centered approach

A strengths discovery conversation with child & family

“This does not mean that problems are ignored”

Needs assessment via 12 life domains → Individualized service & support plan

Create/arrange services & supports that do not presently exist

Services are unconditional & outcome-based

Prepare for transition
In the beginning was the word…..
Assessment & design of interventions 1996

Brainstorming unmet needs by life domain (12 identified)
Prioritize needs via voting, give the family more votes or veto power

Brainstorm solutions, strategies to meet unmet needs
Ideally should use informal supports
Voting (give family more votes or veto power)

Plan should include
Strengths, needs, outcomes desired, strategy to produce outcomes, & each intervention should have a matching child or family strength

Studying application of the word: 1997-2002
Participatory evaluations @ SAMHSA CMHI grant sites

Illinois & Kansas: Team Composition & Structure
- Limited family engagement...most often just mother & identified child.
- Few natural supports
- Teams lacked structure (goals, rules of operation)
- Crises or change of team facilitator ---> Collapse of team & plan

Illinois & Kansas: Assessment & Interventions
- Inconsistent definitions & increasing number of life domains
- Hesitance to use the word “behavior” or to focus on parenting
- Strengths identified as a personal attribute, not identified behaviorally
- Most common strength: “caring about child” or “desire to access service”
- Hence, strengths were not levers for change in design of interventions
- Plans resembled case management, were infrequently revised

(Bertram & Bertram, 2004; Malysiak-Bertram, 2000; Malysiak 1997, 1998; Malysiak, Sharma, et al, 1997)
Clarifying the word: 2004-2008
National Wraparound Initiative Monographs


Clarifying the word: 2004-2008

Principles:
Family voice/choice, Team-based, Strengths-based, Collaboration, Natural supports, Culturally competent, Individualized, Persistence Community-based, Outcome-based

Phases & Activities:
Phase 1A: Engagement & Support
Phase 1B: Team Preparation
Phase 2: Initial Plan Development
Phase 3: Plan Implementation
Phase 4: Transition
Not well examined or discussed implementation components

A National Wraparound Initiative (NWI) review of 21 years of wraparound literature used NIRN frameworks identified less-examined intervention & implementation components:

- Target population, theory base, & theory of change
- Staff selection, training, coaching, & use of purveyors
- Facilitative administration, decision support data systems

A recent wraparound theory of change (2011)

- Effective values-driven collaborative teamwork
- Assessment & planning process driven by “underlying needs”
- Assessment & planning “grounded in a strengths perspective”
- Interventions are brainstormed & focus on positively reframed needs identified by youth & family in a “whole youth & family focus”
- A focus on developing optimism & self-efficacy
- A focus on developing enduring social supports
- Assets & capacities mobilized & re-enforced to meet family needs, to promote well-being & to achieve family’s vision for a better life.

Texas wraparound implementation concerns: 2009-11

SAMHSA CMHI grant, Houston TX: Director, supervisors, family members & consultant \( (n=8) \) examined:

- Frequency & focus of family contact
- Timeliness of team composition & structure
- Depth & breadth of assessments
- Focus & means of interventions
- Frequency & nature of care plan revisions


Indiana wraparound implementation concerns 2012

SAMHSA CMHI grant participatory evaluation by clinical program managers & supervisors with consultant \( (n=10) \) engaged in similar exploration.
Texas & Indiana implementation findings & concerns

20-30% of cases = wraparound as described in NWI monographs.
• Teams were well-composed, engaging extended family, friends & other natural supports in contextual assessments & multi-system interventions.
• Teams achieved goals & revised interventions in a step-by-step, timely manner that addressed behaviors of concern.

70-80% of cases = wraparound as case management that constrained fidelity, effectiveness, & efficiency.
• Teams most often composed of female caregiver & youth, limiting assessment, design of interventions & use of strengths.
• When family conflict contributed to youth behavior, fathers, step-parents, grandparents & siblings often were not team participants, & those conflicts were seldom addressed in plans.
• Team goals were often “visions of pie in the sky” & teams often lacked guidelines for information sharing & decision-making.
Similar constraining implementation patterns in TX & IN

Assessments & interventions
- Addressed basic needs. Did not clearly address behaviors of concern.
- Goals & interventions often were not behaviorally specific & were not frequently revised.
- Care plans relied upon similar formal services.

Strengths-based approach
- Hesitance to use the word “behavior” = often not behaviorally focused.
- Can we focus on parenting?
- Assess/describe strengths as individual characteristics, or as a desire for a specific service as the basis for change.
Factors constraining effective, efficient assessment & interventions:
• Limited team composition, especially by family & natural supports
• Limited focus on behaviors of concern in goal development
• Undeveloped team structure (lwhat information is needed, how to share it, & how decisions are made amidst team disagreement)
• Value driven implementation unsupported by theory base(s)

Factors supporting effective, efficient assessment & interventions:
• Youth & families resilient & willing to focus on parenting & behavior
• More effective interventions have a short duration
Theory-based revisions to Houston TX implementation: Training, coaching, data support, use of consultant

Family story
• Timeline achievements, behaviors & events
• Clarify behavior of concern: Duration, frequency, intensity & context

Team composition & development
(Eno-Heineman, 1997; Bertram & Bertram 2004; Walker 2008; Bertram, 2008)
• Differentiate core & extended team
• Team agreements on behavioral goals & 4 supporting rules of operation

Ecological systems theory: Assessment & interventions (Henggeler, et al., 2009)
• Fit circle assessment of contributing factors to family accomplishments
• Fit circle assessment of contributing factors to problem/unmet needs
• Multi-systemic assessment (youth, family, peers, school, community)
• Behavioral strengths-based, step-by-step interventions to diminish or eliminate factors contributing to well-identified problem.
Results: Theory-base(s) supporting values

Improved team development, assessments & interventions
- Expanded & differentiated team composition
- More robust assessment when teams had behaviorally specific goals, team guidelines & used fit circles.
- Staff were surprised when families embrace use of timelines, fit circles, as well as focus on behaviors & parenting
- Behavioral strengths of 2 or more are basis for interventions
- Multi-systemic complexity in design of interventions (E.g., Parents use rewards/consequences integrated with similar school interventions)
- More effective interventions have duration of <6 weeks
Pre & post theory-based implementation

WFI-4 Scores by Principle

*Family Voice & Choice  | Team Based  | Natural Supports  | Collaboration  | Community Based

SOH 2010               | SOH 2011   | National Mean    | SOH 2011       | National Mean

*Family Voice & Choice: 83 (SOH 2010), 92 (SOH 2011), 83 (National Mean)
Team Based: 74 (SOH 2010), 83 (SOH 2011), 72 (National Mean)
Natural Supports: 67 (SOH 2010), 71 (SOH 2011), 64 (National Mean)
Collaboration: 78 (SOH 2010), 88 (SOH 2011), 85 (National Mean)
Community Based: 63 (SOH 2010), 82 (SOH 2011), 71 (National Mean)

*p ≤ 0.05
Pre & post theory-based implementation

WFI-4 Scores by Principle

* Culturally Competent
* Individualized
* Strengths Based
* Persistence
* Outcome Based

*SOH 2010
*SOH 2011
National Mean

*\( p \leq 0.05 \)
## School Disciplinary Actions 2011

<table>
<thead>
<tr>
<th>Actions</th>
<th>National (n = 134)</th>
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<th>SOH (n = 44)</th>
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<tbody>
<tr>
<td></td>
<td>Intake</td>
<td>6 Months</td>
<td>Intake</td>
<td>6 Months</td>
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<tr>
<td>Suspended</td>
<td>32.8%</td>
<td>26.1%</td>
<td>54.5%</td>
<td>31.8%</td>
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<tr>
<td>Expelled</td>
<td>0.0%</td>
<td>0.0%</td>
<td>4.5%</td>
<td>0.0%</td>
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<tr>
<td>Neither Suspended Nor Expelled</td>
<td>64.9%</td>
<td>69.4%</td>
<td>38.6%</td>
<td>63.6%</td>
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</table>
Research to Date on Wraparound

- There have been 9 controlled studies of wraparound published in peer review journals
- Results consistently indicate superior outcomes for wraparound compared to “services as usual”*
  - Moderate (ES = .50) effects for living situation and community (e.g., recidivism, school attendance) outcomes
  - Smaller (ES = .25 - .30) effects for behavioral, functional, and clinical outcomes
- However:
  - Evaluations have shown better outcomes for alternative conditions, when connected to effective clinical care (Bruns et al., in revision)
  - Study comparing Wrap to MST (Stambaugh et al., 2007) found:
    - Wrap addressed the needs of more youths in the system and similar functional outcomes, but
    - Better clinical outcomes for MST and shorter length of intervention for MST
- There is a lack of specificity about how to use evidence in wraparound.

A call to action

• “It is time to finally develop and test a model in which the community based strengths and potent delivery systems of wraparound are united with the empirical strength of evidence-based interventions, to promote and protect mental health in children and their families”
  
Big ideas

- Enhance wraparound in 4 ways
  1. Generate evidence based strategies that fit the youth and family’s needs during the wraparound planning process
  2. Ensure clinicians use effective therapies that connect to the youth and family’s priority needs
  3. Train family and youth partners, mentors, and other natural and community supports to use EBP appropriately
  4. Monitor progress and practice more consistently and change plans as needed

- The question is: HOW? What is an approach to EBP that would work for
Evidence based practice

• The good
  - We have hundreds of research studies that demonstrate what works
  - Lots of common problems are covered:
    • Anxiety, conduct, depression, trauma
  - Manuals help practitioners know what to do

• The bad
  - You can’t learn all the manuals
  - All kids aren’t covered
  - When kids have multiple issues, doesn’t tell you how to pick or move between them
  - Therapists don’t really like using manuals
  - Manualized EBPs don’t work well in the real world
The answer: Organize EBP into a Knowledge Management Approach

- See the evidence base as *knowledge* and not simply *products*...
- Train practitioners to flexibly use COMMON ELEMENTS of EBP: the components of EBP that work
- Consistently do other things that have been found to improve outcomes (COMMON FACTORS)
  - Engagement and alliance
  - Effective teamwork
  - Connect to natural supports
  - Monitoring & feedback
  - Holistic
  - Promote self-efficacy
Getting down to the building blocks of “what works” so we can use them in collaborative planning.
Managing and Adapting Practice (MAP)

- Three main innovations:
  - *PracticeWise Evidence Based Services (PWEBS) Database*
    - Method for a practitioner to use the database of common treatment elements
  - *Practitioner Guides*
    - Codified clinical supports
  - *Clinical Dashboard*
    - Feedback tool to monitor process and progress of treatment
  - Supported by an on-line resource library and user interface called *PracticeWise (www.practicewise.com)*
This tells you the practice elements associated with those treatment types.
Objectives:
• to increase the amount of positive attention provided to the child, even if the child has misbehaved at other times during the day
• to teach the caregiver to attend to positive behaviors
• to promote the child’s sense of self-worth

Steps:
☐ Provide rationale
  - Emphasize the importance of providing positive attention to the child.
  - Elicit the caregiver’s opinion about how attention affects behavior and people’s motivation to do a good job.
  - Have the caregiver describe his or her best and worst “managers” and the caregiver’s motivation to work for each.
  - Lead the caregiver to recognize that how he or she was treated affected the caregiver’s desire to work.
  - Discuss how the child’s behavior may be affected by the caregiver’s behavior towards the child and how the child’s desire to behave can be increased by improving the caregiver-child relationship.

☐ Set aside one-on-one time for caregiver and child
  Encourage the caregiver to set aside a block of time (e.g., 10 minutes) each day devoted to joining the child in an activity the child has chosen.

☐ Teach caregiver to provide positive and descriptive commentary
  - Show the caregiver how to demonstrate sincere interest in the child’s activities while they are playing.
  - Instruct the caregiver to provide enthusiastic descriptive (e.g., “You are drawing a tree”) and/or positive (e.g., “I like the way you stacked the blocks”) commentary and praise regarding the child’s behavior.

☐ Encourage caregiver to engage in child’s activity
  Suggest that the caregiver become actively involved in the play activity by imitating the child’s behavior in order to demonstrate approval.

☐ Restrict criticism, questions, and commands
  - It is important that the child lead the activity; that is, the caregiver should refrain from making suggestions, asking questions, and criticizing the child.
  - Allow the child to use his or her imagination (e.g., coloring the green or making up new rules to a game) without caregiver input about the “correct” way to do things.

☐ Anticipate difficulties
  When the procedure is initially implemented, the child may engage in negative behavior that characterizes the usual caregiver-child interaction. When this occurs, the caregiver should:
  - consistently ignore negative behavior by looking away;
  - refrain from scolding the child so as to avoid providing negative attention for misbehavior;
  - end one-to-one time if disruptive behavior continues or is dangerous.
  Over time, however, it is expected that consistent positive attending will result in decreased negative behavior and increased positive caregiver-child interactions.
Progress and Practice Monitoring Tool

Case ID: Maggie

Age (in years): 7.3
Primary Diagnosis: Depression (w/comorbid Disruptive Behavior, Anxiety, Trauma)

Gender: Female
Ethnicity: African American

<table>
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<tr>
<th>Progress Measures</th>
<th>Days Since First Event</th>
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<tbody>
<tr>
<td>Left Scale</td>
<td>120</td>
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<tr>
<td>TOCS</td>
<td>80</td>
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<tr>
<td>PHQ8: Caregiver Report</td>
<td>40</td>
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<tr>
<td>Right Scale</td>
<td>10</td>
</tr>
<tr>
<td>Crying Spells/Week</td>
<td>0</td>
</tr>
</tbody>
</table>

Activity Selection
Antecedent/Stimulus Control
Assertiveness Training
Attending
Caregiver Psychoed: Anxiety
Caregiver Psychoed: Depression
Caregiver Psychoed: Disruptive
Child Psychoed: Anxiety
Child Psychoed: Depression
Cognitive: Anxiety
Cognitive: Anxiety (STOP)
Cognitive: Depression
Communication/Effective Instruction
Communication Skills: Advanced
Communication Skills: Early Dev
Diff. Reinforc./Active Ignoring
Engagement with Caregiver
Exposure
Maintenance
Modeling
Monitoring
Praise
Problem Solving
Relaxation
Response Cost
Rewards
Self-Monitoring
Skill Building
Social Skills
Time Out
Other
Other
Other
Other
Other

Days Since First Event
Why do we think WRAP+MAP would work?

- Both approaches share a philosophy
- MAP has good evidence behind it
- People who serve in Wraparound roles would benefit from this enhanced resource
  - Family partners would like to be trained on specific skills they could use with youths/families
- A state that tried a version of this showed better outcomes
- The MAP practices will fit wraparound youths
- People say it’s time to try it!
One Idea = Ensure connection to a MAP Therapist

Wrap Facilitator
...as well as...
Parent Partner
Youth Specialist

MAP Therapist

Service Literature (PWEBS)
Codified Clinical Procedures (PG)
Clinical Dashboard
Bigger idea: Fully coordinated process

Wrap Facilitator

...as well as...

Parent Partner

Youth Specialist

MAP Therapist

Service Literature (PWEBS)

Codified Procedures (PG)

Family/Collateral Communication

Direct Communication

Team Meeting

Plan of Care

Clinical Dashboard
<table>
<thead>
<tr>
<th>Problem with WAU</th>
<th>Proposed enhancement</th>
<th>Mechanisms for achieving</th>
<th>Hypothesized effects</th>
</tr>
</thead>
</table>
| Knowledge base is limited to local and youth/family specific knowledge         | Use MAP tools to generate a broader array of research-based options that fit the youth and family’s needs | • Use PWEBS searches at strategic points in planning process  
• Use Practice Guides to help family and team members understand options | • Greater range of options for family/team  
• Options are based on evidence for effectiveness  
• Family/team better engaged, more hopeful, more satisfied |
| Therapy provided is unlikely to be based on evidence for effectiveness          | When therapeutic needs are identified, ensure clinicians use effective treatment elements that connect to the youth and family’s strengths and preferences | • Train and coach wraparound-affiliated clinicians on MAP system and treatment elements  
• Certify clinicians in MAP | • Treatments better fit youth clinical needs  
• Better communication with wraparound team about purpose of therapy  
• Treatments more focused  
• Treatments more effective |
| Individuals serving in peer, community, natural support roles have poorly defined roles or are not engaged at all | Parent and youth partners, mentors, behavioral specialists, and others serve as “care extenders,” provide appropriate follow-on support to treatment strategies | • Modify select MAP treatment elements to “care extension” strategies  
• Orient/train support staff in care extender model  
• Clinicians/team include follow-on support strategies in wraparound plans | • Better role definition for persons in support roles  
• More effective teamwork  
• Treatment strategies more effective  
• Support staff more satisfied and show greater self-efficacy |
| Progress monitoring is inconsistent and/or not                                | Use a structured tool to monitor progress and practices                                | • Facilitators trained to use team-level dashboard  
• Clinicians trained to use MAP clinical dashboard | • More frequent review of progress  
• Better teamwork and problem solving |
The Center for Effective Interventions
Promoting Evidence-Based Therapeutic Services for Families, Children and Youth
<table>
<thead>
<tr>
<th></th>
<th>Wraparound</th>
<th>MST</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Focus</strong></td>
<td>Service system/System of Care focused</td>
<td>Clinical treatment focused</td>
</tr>
<tr>
<td><strong>Provider</strong></td>
<td>Multi-agency/family/community team</td>
<td>Therapist as supported by generalist team</td>
</tr>
<tr>
<td><strong>Provider Role</strong></td>
<td>Broker of services and clinical treatments</td>
<td>Provider of clinical treatments</td>
</tr>
<tr>
<td><strong>Outcome</strong></td>
<td>Responsibility of team</td>
<td>Responsibility of therapist and agency</td>
</tr>
<tr>
<td><strong>Accountability</strong></td>
<td></td>
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<tr>
<td><strong>Clinical Staff:</strong></td>
<td>1: 10-20 (commonly)</td>
<td>1: 4-6</td>
</tr>
<tr>
<td><strong>Patients</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Wraparound</td>
<td>MST</td>
</tr>
<tr>
<td>----------------------</td>
<td>---------------------------------------------------</td>
<td>--------------------------------------------------</td>
</tr>
<tr>
<td><strong>Duration</strong></td>
<td>No limit in most programs</td>
<td>3 to 5 month treatment</td>
</tr>
<tr>
<td><strong>Expectation of Outcome</strong></td>
<td>Gradual change</td>
<td>Immediate, maximum effort by family &amp; staff to attain goals</td>
</tr>
<tr>
<td><strong>Supervision</strong></td>
<td>No standard practices established</td>
<td>Stringent supervision protocols for both team supervision and adherence to the model</td>
</tr>
<tr>
<td><strong>Prior Training</strong></td>
<td>B.A. level process facilitators</td>
<td>Ph.D. level supervision, Masters level therapists</td>
</tr>
<tr>
<td><strong>Certification</strong></td>
<td>None available or in development</td>
<td>In development</td>
</tr>
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</table>
MST theory-based principles

1. Finding the fit: Primary purpose of assessment is to understand the fit between identified problem & broader systemic context.

2. Positive & strengths-focused: Therapeutic contacts emphasize the positive & use strengths as levers for change.

3. Increasing responsibility: Interventions are designed to promote responsible behavior & decrease irresponsible behavior among family members.

4. Present-focused, action-oriented interventions target specific well-defined problems.

5. Interventions target sequences of behavior within & between multiple systems that maintain identified problems.
MST theory-based principles

6. Interventions are developmentally appropriate & fit developmental needs of youth

7. Continuous effort: Interventions require daily or weekly effort by family members.

8. Evaluation & accountability: Interventions evaluated continuously from multiple perspectives with providers assuming accountability for overcoming barriers to successful outcomes.

9. Generalization: Interventions are designed to promote treatment generalization & long term maintenance of change by empowering caregivers to address family members’ needs across multiple systemic contexts

Finding the Fit:
The primary purpose of assessment is to understand the “fit” between the identified problems and their broader systemic context.

Kim’s Substance Abuse

- Low monitoring by mother
- Drug using Peers
- Access to marijuana
- Modeling of use in community (peers and adults)
- Kim can buy drugs with cash given to her by relatives
- Boredom, doesn’t have other things to do
- Uses after conflicts with mother
- Lack of consequences for use
Evidence-based Wraparound Care Coordination Model?

- **Causal Mechanism Research**
  - **Wraparound Facilitator**
    - Engagement
    - Teamwork
    - Goal Setting
    - Integrated Plan of Care
    - Collateral Communication
    - Social Support
  - **Peer Support Worker**
    - Service Literature
    - Searchable Database
    - Codified Procedures
    - Clinical Dashboard
- **General Services Research**
  - **Wraparound Team/Process**
- **Local and Community Evidence**
- **Family Story and Timeline**
- **MAP Therapist**
- **Resources & Supports**
- **Service Setting**
  - **Priority Needs & Goals**
  - **Strategies, Supports, and Treatments**
  - **Satisfaction and Wrap Fidelity**
  - **Treatment Integrity**
  - **Client Progress**
MST Analytical Process

- Referral Behavior
- Desired Outcomes of Family and Other Key Participants
- Overarching Goals
- Environment of Alignment and Engagement of Family and Key Participants
- MST Conceptualization of “Fit”
- Re-evaluate
- Measurement of Advances & Barriers to Intervention Effectiveness
- Do
- Intervention Implementation
- Prioritize
- Intermediary Goals
- Intervention Development
- Overarching Goals

- MST Conceptualization of “Fit”
Social Ecological Model

Community
Provider Agency
School
Neighborhood
Peers
Extended Family
Caregiver

Family Members
CHILD
Siblings

Multisystemic Therapy (MST)
Overview
MST Theory of Change

MST

Improved Family Functioning

Peers
School
Community

Reduced Antisocial Behavior and Improved Functioning
Wraparound Focus on Distribution

“We recognize every community implements wraparound differently based on unique conditions. This means that, while we need to promote systems & organizations that support wraparound across a defined set of domains, application of overly rigid standards runs the risk of constraining local individualization, adaptation, and innovation.”

“What’s more, with too many rigid standards in place, many communities might decide that adopting the wraparound principles in practice is too costly or not worth the effort, de-railing the movement toward more collaborative, individualized, family-and youth-driven service systems.”

MST rigorous focus on dissemination with fidelity: Organizational supports, training, & consultation

Training resources & materials in organizational practices
- Program Developer Training
- Organizational Manual

Implement organizational practices needed to support MST delivery
- MST Program Development Method
- Ongoing problem solving of organizational & stakeholder barriers to implementation

Training & supports for therapists, supervisors & consultants
- 5-day orientation, Supervisor orientation, Training boosters, Consultation, Group supervision, & additional supervision & feedback for all staff as needed
- Training materials (MST text, 5-day training materials, Supervisory manual, Supervisor orientation materials, & Consultation manual
MST quality assurance:
Integrated data support, training, coaching, & consultation

Measure adherence to model & client outcomes
- Adherence measures entered & monitored via the MSTI enhanced website (TAM-R, SAM, CAM, Program Review Form)
- Work sample review (e.g. session recordings & field visits, group supervision recordings)
- Discharge Review Form data entered & monitored via the MSTI Enhanced Website

Coaching guided by adherence & outcomes, staff strengths & needs
- Group supervision & consultation
- Additional supervision & feedback as needed
- Program implementation review
- Professional development planning

Ongoing cycle of utilizing trainings & materials to guide implementation, then measuring & improving implementation
“People cannot benefit from interventions they do not receive”

Dean Fixsen, National Implementation Research Network