Supporting Wraparound Implementation: Chapter 5g

Family Driven, Individualized, *and* Outcomes Based:

Improving Wraparound Teamwork and Outcomes Using the Managing and Adapting Practice (MAP) System

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The wraparound team process has established itself as a standard of care for children and youth with complex needs and their families who require coordination of care and for whom a single intervention is unlikely to suffice. The wraparound practice model operationalizes critical system of care principles such as family driven and youth guided, community based, and collaborative; it is extremely popular with families; and the process is locally adaptive in that it can be flexibly applied in a range of public service systems. Moreover, evidence continues to accumulate for its effectiveness (Bruns, et al., 2010; Suter & Bruns, 2009).

Research results indicate that wraparound's strongest evidence for positive effects are in the residential, family, and cost domains. In these areas, significant, medium-sized effects have been found across a range of studies. Positive clinical and youth functioning outcomes, on the other hand, have been less consistently found. Where significant, effects on these outcomes have been found to be small (Suter & Bruns, 2009).

It is perhaps not surprising that more positive results are found for residential, family, and cost outcomes. Wraparound's primary innovation is to focus on teamwork that yields individualized strategies to keep children in their home communities with their families. Wraparound teams actively consider the multiple levels of a child's social ecology (family, friends and neighbors, providers, systems, com-

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munity) and identify service and support strategies that fit within the family's contexts and culture (Bruns, et al., 2010; Walker & Matarese, 2011; Walker, Bruns, & Penn, 2008). The result is that youths are maintained in their homes—or in "home like" community settings—and are more likely to avoid costly out-of-home placements (Bruns, 2008; Bruns & Suter, 2010; Bruns, et al., 2010). As evidence, a recently completed 10-state Medicaid demonstration project found wraparound cost to be substantially less than institutional and other alternatives, with an average per capita saving of $20,000 to $40,000 (Urdapilleta, et al., 2011).

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This is highly encouraging news, but what about the clinical and functional outcomes? As described above, effects in these areas are smaller, and we often hear families, system partners, and researchers alike express concerns about whether wraparound can be as successful at reducing problematic behaviors and improving emotional functioning as it is at supporting families and stabilizing placements. Individual therapy (for children) and family therapy are the most common services included on wraparound plans, yet wraparound teams often find themselves frustrated by the lack of high quality clinical services available in their communities. In short, research and experience has inspired many wraparound and system of care advocates to ask how better clinical and functional progress in youths might be promoted through thoughtful application of evidence-based practices (EBPs) within wraparound.

Applying a Relevant EBP Paradigm to Wraparound

Communities have become aware of the fact that EBPs have the potential to produce better outcomes than treatment as usual (Weisz, et al., 2012; Weisz & Kazdin, 2010). However, manualized EBPs are not available for all child disorders, and, when a child has complex challenges that might suggest the use of multiple EBPs, there is usually no mechanism to ensure coordination. Moreover, many manualized EBPs are expensive to implement, requiring training and retraining by the treatment developer.

Finally, manualized EBPs often do not represent a good fit with either family's expressed needs or the philosophy embedded in the wraparound process. The service and support strategies provided through wraparound are intended to be highly flexible and individualized, so that they match family needs, preferences, and perceptions of utility as described above. In contrast, manualized EBPs usually emphasize strict adherence to specific protocols. Thus the wraparound team (and by extension, the family and youth) lose the power to individualize and optimize the treatment.

Recognizing the difficulties that have arisen in attempts to reconcile wraparound and EBP, researchers have been searching for a way to combine the strengths of the two approaches in a synergistic manner (Weisz, Sandler, Durlak, & Anton, 2006). On the surface, this would seem to be simple: Wraparound is flexible and individualized and has substantial "real-world" credibility and adaptability (but less evidence for clinical and functional effects). EBPs show extensive support for their clinical efficacy but less clarity regarding their "real world" effectiveness, feasibility, and cost/benefit ratio (Chorpita, et al., 2011). Thus, the complementary nature of the limitations of wraparound and EBPs seemingly points to an opportunity to leverage the strengths of both. The question is: How?

Applying a Knowledge Management Approach to EBP

Some applications of EBP have taken a more individualized approach that aligns with the wrap-

around philosophy. Instead of strict implementation of one or more manualized treatments, these applications are based on quality improvement models and flexible application of the evidence for "what works" in child and family treatments. Such *knowledge management approaches* to EBP flexibly inform practice by generating options based on research studies and tracking practice and progress for each youth (Daleiden & Chorpita, 2005). Thus, treatment is coordinated based on evidence for effects of psychosocial interventions while also being flexible, modularized, and capable of mid-course corrections when the youth needs demand a more individualized and tailored approach.

The **Managing and Adapting Practice (MAP)** system provides an approach and an array of tools to support coordinated knowledge management in services delivery and application of EBP resources (PracticeWise, 2010; see also CIMH, 2012). The most relevant and visible of these tools are the *PracticeWise Evidence Based Services (PWEBS) Database*, codified clinical supports called *Practitioner Guides*, and a feedback tool to monitor practices used and youth progress called the *Clinical Dashboard*. All these tools are supported by an online resource library and user interface maintained by PracticeWise (www.practicewise.com).

The PWEBS provides a method for a practitioner to use a database of treatment components, or elements, that have been found to be effective at addressing common child and youth problem areas. Among the many hundreds of *interventions* that exist for youth problems, there are a relatively small number of treatment *components*. These components—sometimes referred to as "common elements" of EBP (Barth, et al., 2011; Chorpita, Delaiden, & Weisz, 2005a)—are essentially the smaller pieces that make up interventions. Chorpita and Daleiden (2009) reviewed 322 randomized trials of treatments for the most common problem areas of youth, including depression, anxiety, and disruptive behaviors. Coding of the components of these studies found that 41 common practice elements could be "distilled" from the 615 manualized protocols reviewed.

PWEBS assists a practitioner to match a youth and his or her problem areas to the most relevant, research-supported, treatment elements.

After input of youth (e.g., age, race, gender) and treatment (e.g., setting, format) characteristics, PWEBS returns a review of treatment elements with evidence for effectiveness from controlled studies for that type of youth and setting. With tools to help review the applicability of the components to the youth, the clinician or wraparound team may select from among these components and implement them, while monitoring how the child responds. If desired outcomes are not being achieved, systematic adaptations may be attempted, such as implementing different components (Chorpita, Bernstein, Daleiden, & the Research Network on Youth Mental Health, 2008). Thus, in addition to a resource for clinicians, the PWEBS provides a potential tool for wraparound facilitators and teams to improve brainstorming of strategies and the effectiveness of strategies.

The Practitioner Guides present two-page reviews of the steps to implement the common treatment practices and processes, in a way that reflects the research literature. (See an example in Figure 1.) The Practitioner Guides can be used flexibly by a range of practitioners to enhance their skills (if they are well versed in the treatment) or structure the care they provide (if they are relatively unfamiliar). These guides may also be used to help a wraparound facilitator understand the nature of treatment that is expected from a clinician to whom the team has referred a youth, or to help a natural support, mentor, behavioral aide, or family member support a treatment (e.g., rehearse cognitive or behavioral strategies in the community).

Figure 1. Example of Practice Guide from the Managing and Adapting Practice (MAP) System

Practice Guide

Commands or Effective Instructions

Use This When:

To increase child's compliance with caregiver instructions.

For Caregiver

Objectives:

- to provide the caregiver with strategies to clearly and consistently communicate instructions to the child
- to provide the caregiver with strategies to demonstrate to the child that caregiver will see the task through to its completion
- to minimize discord between the child and caregiver regarding directives

Steps:

☐	Provide rationale	Increasing a child's compliance with instructions involves managing what happens before the command (antecedents), addressing the form and content of commands, and managing what happens after the command (consequences).
☐	Set the stage for success	Instruct the caregiver to optimize the likelihood of compliance by managing certain setting events, including: • minimizing distractions (e.g., turning off television), • getting the child's attention by saying the child's name, making eye contact, and standing near the child, and • providing a transition warning when appropriate (e.g., "In two minutes it will be time to put the toys away").
☐	Example: Tone of voice	Instruct the caregiver to use a firm, but calm, tone of voice. A critical tone or one that conveys frustration may increase the likelihood of noncompliance.
☐	Example: One at a time	• Instruct the caregiver to provide commands one at a time. • This helps increase compliance by minimizing the number of things the child has to remember to do and by providing caregiver with opportunities to praise compliance after each task is successfully completed. • Example: "Brush your teeth." [Wait for compliance.] "I like how you brushed your teeth when I asked. Now wash your face."
☐	Example: Simple is better	• Provide simple, clear instructions (e.g., "Put on your coat."). • Avoid vague requests (e.g., "Get ready to go."), or general criticisms (e.g., "We're leaving soon and you are not ready!").
☐	Example: Tell, don't ask	• Instruct the caregiver to provide commands in statement form ("Put away your toy truck") • Avoid question form (e.g., "Would you put away your truck?" "Would you do me a favor and put away your truck?) • Avoid using the word "Let's" if the caregiver does not intend to participate (e.g., "Let's put away the toys now.")
☐	Example: Tell child what to do	The caregiver should instruct the child about what to do (e.g., "Walk in the hallway"), rather than what to stop doing ("Don't run!"). Telling the child what to do is more positive and informative than telling the child to stop doing something.

The Clinical Dashboard monitors practices delivered and how the child is responding, so that strategies can be adjusted as needed by monitoring of youth progress and process. The MAP Dashboard presents progress (such as toward a goal or as assessed by a standardized measure) in one pane, and practice (e.g., the treatment components that were implemented) in another pane, both along the same axis of time. (See Figure 2.) In wraparound, the principle of *outcomes based* demands that needs be prioritized and progress toward meeting needs and achieving outcomes be measured and reviewed by the team so that service and supports can be adjusted as necessary. However, such efforts are often not undertaken by wraparound teams or staff (Bruns, Suter, Burchard, Leverentz-Brady, & Force, 2004; Bruns, et al., 2010). A standardized means for doing so, such as via a consistent yet individualized clinical dashboard, would be likely to promote positive teamwork and outcomes in wraparound.

Discussion

For all its strengths, application of wraparound practice in real world settings often does not provide explicit guidance for how best to incorporate evidence-based clinical content into plans of care. Though the research is not well-developed, this shortcoming may reduce wraparound's effectiveness, especially on symptom outcomes. An obvious alternative is to use and train on manualized EBPs instead of wraparound. The benefit of this approach is that EBPs have evidence for efficacy in addressing symptom-level outcomes. However, as discussed above, this option does not provide clear guidance on how to manage multi-component plans of care. Moreover, EBPs may be incompatible with family preferences and/or not provide the holistic support necessary to maintain a youth with complex needs in his or her community. Another potential solution to this problem would be to promote use of manualized EBPs along with wraparound in systems of care. However, installing multiple EBPs along with wraparound will likely result in a great deal of complexity, and differences in the practices and value systems of EBPs and wraparound may be hard to reconcile at a system and practice level.

The alternative, proposed in this article, is to introduce a clinical model that incorporates knowledge of all EBPs in an individualized manner and that does not just align with the wraparound principles but actually reinforces them. A weakness of this "Wrap and MAP" approach is that there is limited evidence from controlled research that it works: Only one randomized trial (Weisz, et al., 2012) and a statewide open trial (Daleiden, et al., 2006). The potential strengths of this option, however, are greater provider buy-in (Borntrager, et al., 2009), better fit with real world systems (Palinkas, et al., 2009), and greater likelihood of aligning with critical aspects of the wraparound process, such as team-based planning, creative brainstorming, and purposeful use of natural and community supports (Chorpita, et al., 2008; Chorpita, et al., 2011; Daleiden & Chorpita, 2005). Most important, a system may get the best of all worlds with respect to outcomes: youth symptoms and functioning as well as family resilience and maintenance in the community.

At this point, a range of options for how to combine the mutually reinforcing models of "Wrap and MAP" remain to be developed and tested. As one option, the MAP approach could simply be used by clinicians who will therefore become more effective at treating children and youth as well as more effective members of wraparound teams. Or, "Wrap PLUS MAP" could be administered in a coordinated way, whereby wraparound staff and teams are themselves trained to use the MAP concepts and tools to better use research evidence to generate more and better options for the plan of care. The PracticeWise system supports training, coaching, and certification of a range of roles, including therapists, agency supervisors, and professionals who can train others in their agency or system on use of the system (PracticeWise, 2010). Training, coaching, and certification on MAP for wraparound-specific roles is now being developed.

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Figure 2. Example of a Wraparound-Specific Dashboard from the MAP System

Progress and Practice Monitoring Tool
Case ID: Wraparound Practice Illustration
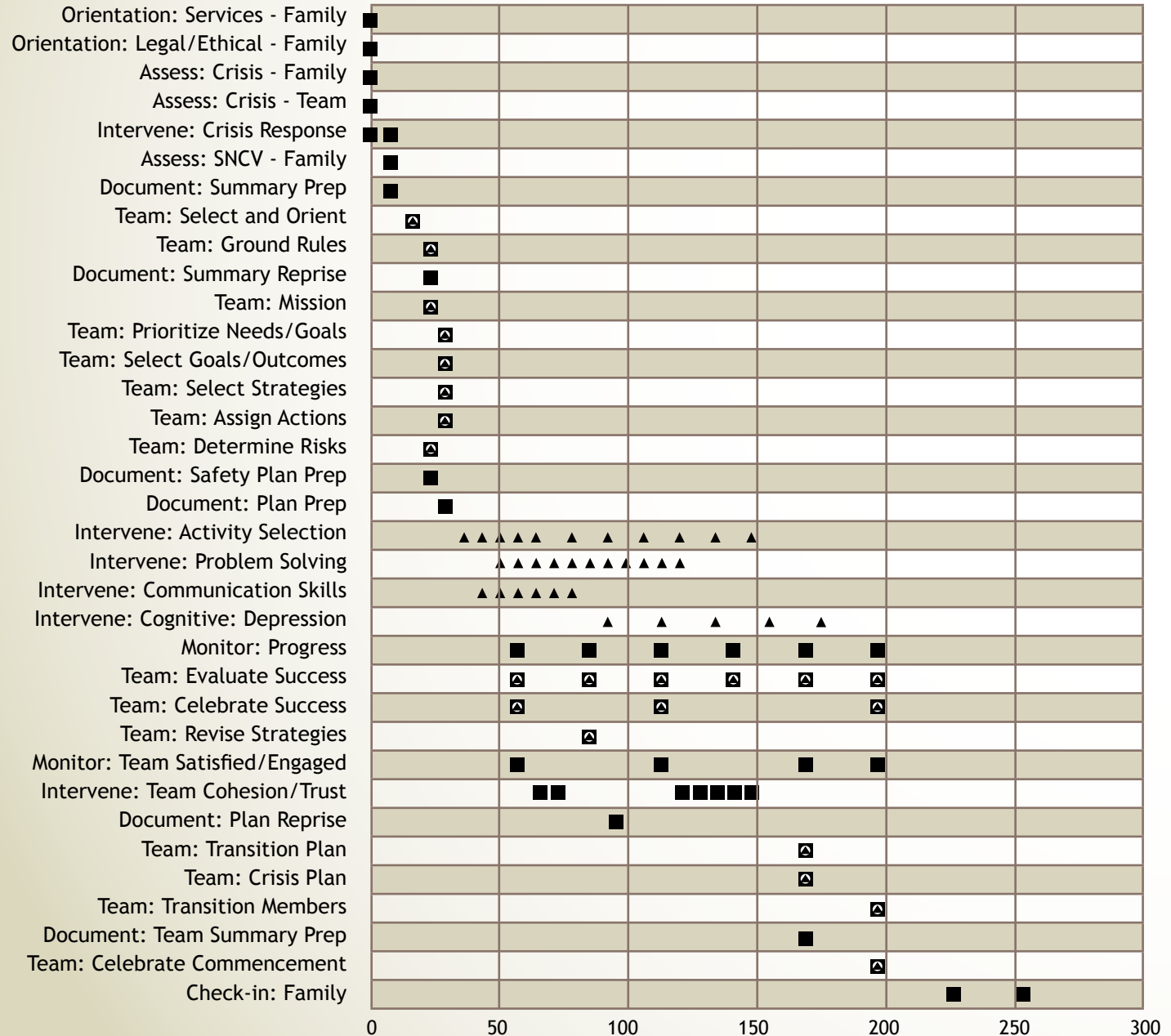
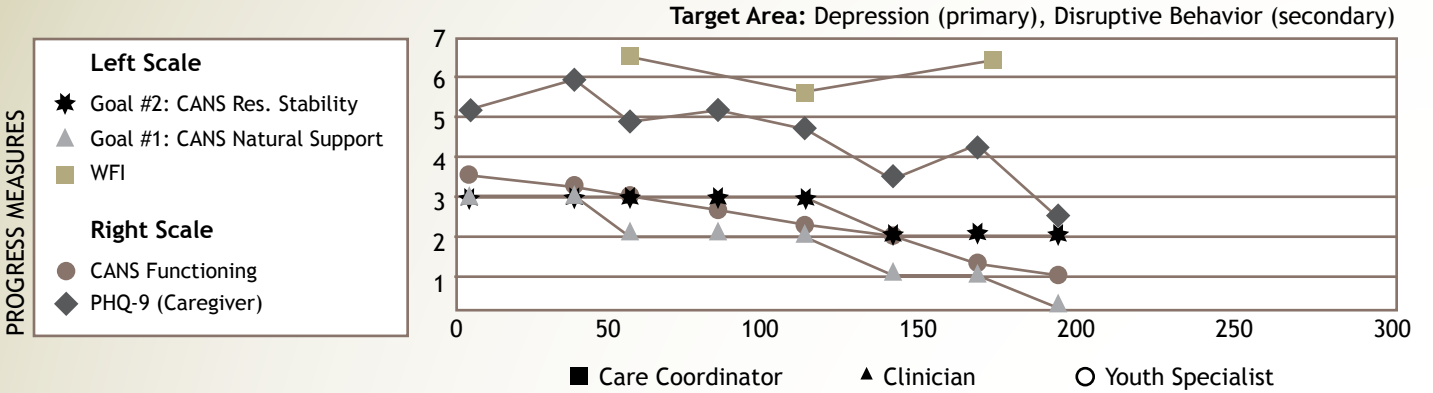**Gender:** Female
Ethnicity: Asian
Age (in years): 10.7
Target Area: Depression (primary), Disruptive Behavior (secondary)

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