Implementing Evidence Based Practice within Wraparound and Systems of Care

(starting soon)

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*This webinar and the PowerPoint will be available on the NWI website.
http://www.nwi.pdx.edu/webinars.shtml

Hosted by the National Wraparound Initiative and the National TA Network for Children’s Behavioral Health
January 29, 2015
Implementing Evidence Based Practice within Wraparound and Systems of Care

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Hosted by the National Wraparound Initiative and the National TA Network for Children’s Behavioral Health
January 29, 2015
Overview of the webinar

• Evidence-based practices: A quick review
  – Misconceptions and realities
  – Alignment with systems of care and wraparound philosophies
• Role of EBPs in systems of care and wraparound
• Options for coordinating EBP with wraparound for youth with complex needs
• Examples from the field
  – Wraparound with modularized EBP
  – Integrating EBP procedures into wraparound practice
  – Building EBPs and wraparound into statewide system redesign
Main Points

• It is important that we use effective and cost-effective strategies in children’s behavioral health
• EBP movement is evolving and maturing
  – There are more of them
  – They work better in the “real world” than ever
• Although there are challenges, EBP can be thoughtfully integrated into family- and youth-driven, individualized systems of care
• There are options for integrating EBP at multiple levels:
  – The system level
  – The provider level
  – The youth, family, and team level
Child and Family Evidence Based Practice Consortium: Who we are & what we do

• Formed in 2004, reflects both national & international perspectives

• Participation from academia, administrators, policymakers, & purveyors

• Multiple forums for training, technical assistance & networking

  https://ebpconsortium2014.wordpress.com

• Goal: Expand dissemination & use of evidence-based practice & implementation frameworks
Consortium Research & Dissemination

• Survey of North American behavioral health care administrators & supervisors (Barwick, 2011)

• EBP integration in North American MSW programs (Bertram, Charnin, Kerns, & Long (in press))

• Survey of EBP in Marriage & Family Therapy programs (2015)

• Multi-method program implementation evaluation of 34 Kansas City MSW field sites (Bertram, King, Pederson, & Nutt, 2014)

• Topical webinars on implementation science & EBPs (Allison Metz, December 2014; Kimberly Hoagwood, February 2015, etc.)

Find these & more at

Child & Family Evidence Based Practice Consortium website:

https://ebpconsortium2014.wordpress.com/resources/articles-papers
Why Implement Proven Practices?

Youth & families should expect evidence informed behavioral health services just as they expect proven practices when visiting their medical service provider.
Why Implement Proven Practices?

- More likely to efficiently produce positive effects
- Improved behavioral health outcomes at less cost
- Practices are clearly defined = transparent accountability with clear selection, training, coaching, & fidelity criteria
- Aligns with Affordable Health Care Act by matching proven practices with specific client needs
Evidence Based Practice Misconceptions
Misconception

EBPs are a ‘cookbook’ approach to very complex issues

Realities

Practitioner experience, knowledge, & skills form the basis for:

1. Client engagement
2. Assessment of contributing factors to behaviors of concern
3. Delivery of interventions

EBPs provide a written framework & guidelines, but practitioner actions depend on their experience, judgment & skills.

When practitioner skillset is challenged by client actions or factors shaping behaviors of concern, EBPs provide a compass, not a detailed roadmap.
**Misconception**

EBPs don’t account for or engage practitioner expertise

**Realities**

Within EBPs steps & tools, goals, objectives & specific interventions are based on individualized assessment & planning facilitated & enhanced by practitioner expertise.

Precisely because of complexities of human interaction, it is impossible to fully predict a step by step approach.

Practitioners continuously adapt within the structure of the EBP.
**Misconception**

**EBPs ignore client values & preferences**

**Realities**

EBPs emphasize that *clients must be full partners* in defining the problem, determining goals, & evaluation of intervention effectiveness.

There are many client *choice points* regardless of the treatment approach.

EBPs support *informed decisions* by clients regarding the process, steps, & evidence for expected outcomes.

[Image of NWIC - National Wraparound Implementation Center]
**Misconception**

EBPs don’t take into account issues of client diversity

**Realities**

Many EBPs emphasize careful assessment of unique combinations of factors shaping behaviors of concern & client achievements.

Many family centered EBPs were developed for specific ethnic minority populations & studied with ethnic minority clientele:

- Huey & Polo (2008), identify EBPs for ethnic minority youth
- EBPs that focus on family & ecology promote cultural sensitivity.
- They share a fundamental premise that to address behaviors of concern, client context must be fully appreciated & accessed
Misconception

EBPs disregard the importance of the therapeutic alliance

Realities

Client engagement is a central theme in EBPs & accountability for client engagement often rests with the clinician/practitioner.
Misconception

There is a big research-to-practice gap

Realities

Many EBP models have moved from *efficacy* studies (in research settings) to *effectiveness* studies in clinical settings

Some EBPs have studied the implementation & dissemination process.

They provide tools to support the model & to monitor fidelity
**Misconception**

EBPs are cost-cutting tools promoted by insurance companies

**Realities**

This misconception often assumes limiting costs restricts service access.

Support for EBPs directs funds to interventions with a greater likelihood of efficiently improving client outcomes.

Thus more clients may have access to proven service models.
Integrate or refer?
NIRN Implementation Drivers

Improved outcomes

Consistent program implementation

Performance assessment (fidelity)

Coaching

Systems level intervention

Facilitative administration

Decision support data system

Integrated and compensatory

Competency Drivers

Organization Drivers

Leadership Drivers

Technical

Adaptive

Selection

Training

© Fixsen & Blase, 2008-2012
Systematic data-informed coaching develops a culture of support & accountability
EBP and Systems of Care

- **EBP**
  - May be focused on addressing a specific symptom or problem
  - Defined and manualized
  - Skill-focused
  - Practitioner-directed
  - Often time limited

- **Systems of care/wrap**
  - Comprehensive plans, multiple components
  - Individualized, holistic, flexible
  - Family and youth directed
  - Engages community and natural supports
  - Support persists until needs are met
Potential barriers to integration

• EBPs do not address the complexity of youth needs
  – Many youth not eligible
  – Not flexible enough to change course – if youth does not respond, what next?
• Specification may leave little room for family choice
• Some EBPs are comprehensive and require cessation of other supports (e.g., wrap facilitators)
• Costs of EBP
  – Funding care coordinators, family and youth support, and other SOC features + EBP is challenging
• Attitudinal
  – Misconceptions about the underlying philosophies
  – Lack of understanding of how they can be coordinated
Benefits of coordinating EBP with SOC-wrap

- Families and youth have “informed choice” and can choose from proven practices
  - Systems of care principles dictate need for an array of effective service options
- Clinical providers can implement proven practices in a flexible, individualized, family-directed manner
- Peer support workers and natural supports can provide follow-on support for skill-building
- Evidence shows it can improve youth outcomes
“Getting better at getting them better”: Wrap+EBP in Hawaii led to greater improvement over time.

System-level: Options for coordination

- Analyze local EBP availability
- Invest in intensive, community-based EBPs that can meet youth and family needs
  - MST
  - FFT
  - Triple-P
  - Specific office-based models, e.g., TFCBT, AF-CBT
- Ensure a community team is regularly reviewing data on needs and outcomes of youth and families to direct investment in the service array
A few EBPs can go a long way...
and more than 2-3 may be overkill

“Coverage” of youth problem areas (by age, gender) provided by different numbers of EBPs

Matching need to options:
Example from one system of care

Request for intensive services:
Review of referral, CANS and family information

Eligible for intensive services through the SOC?

NO: Refer to outpatient/family support

MST appropriate and eligible?

Yes: Commence MST (4-5 mos)

Needs met?

Yes: Transition out of formal SOC

NO: Needs not met or need for follow-on support

Wrap appropriate and eligible?

Refer to wraparound
Youth Needs and Outcomes

*In a system with both MST and wrap*

Mean Scores for SDQ at Intake and Discharge of MST Services (N=32)

- **Emotional Symptoms Score***: 4.36 (Intake), 3.36 (Discharge)
- **Conduct Problems Score***: 5.36 (Intake), 2.88 (Discharge)
- **Hyperactivity Score**: 6.40 (Intake), 5.40 (Discharge)
- **Peer Problems Score**: 3.52 (Intake), 2.94 (Discharge)

MST only relevant for 25% of youth with complex needs

Mean Scores for SDQ at Baseline and Six Months for Wraparound Enrolled Youths (N=94)

- **Emotional Symptoms Score***: 6.54 (Baseline), 5.12 (6M)
- **Conduct Problems Score***: 5.90 (Baseline), 5.09 (6M)
- **Hyperactivity Score**: 6.99 (Baseline), 6.72 (6M)
- **Peer Problems Score**: 4.38 (Baseline), 3.94 (6M)

Wraparound enrolled youth show substantially greater overall clinical needs as per the SDQ

MST youth show greater improvement in conduct problems

Wraparound youth show greater improvement in emotional symptoms
Provider options for applying EBPs to wraparound populations

• Train clinicians in the SOC on relevant manualized EBPs
• Train clinicians on modularized EBP approaches
  – *To flexibly* meet the needs of youth and families engaged in team-based wraparound care coordination
• Train and supervise care coordinators to understand how to build plans of care that include EBPs
  – While also adhering to wraparound model and a strength and need orientation
• Train and supervise family and youth support partners to understand how to be effective care extenders for EBP elements that are in plans of care
Informed Collaboration

- PracticeWise EBS (PWEBS) Database
  - Approx 700 trials that represent specific strategies for addressing particular youth and family needs
This tells you the practice elements that match the youth characteristics entered.
Dedicated Resources for Decisions and Action

**Process Guides**

- **Elicit a commitment**
- **Tell a success story**
- **Identify a small change**
- **Explore behavior change context of behavior**
- **Discuss life goals in the context of behavior**
- **Have the child state specific goals for 5, 10, and 20 years. Then, ask:**
  - **What is the behavior?**
  - **What does the target behavior have a place in the child's life in the long run?**
  - **What did it take for you to achieve your goals in the past?**
  - **Ask: “How will (the behavior) help you achieve your goals?” “How will it interfere with confidence?**

**Practice Guides**

- **Objectives:**
  - To highlight the discrepancy between values and life goals and current behavior
  - To increase self-efficacy
  - To increase reflection on behavior

- **Steps:**
  - **Adopt a collaborative, reflective style**
  - **Identify a small goal**
  - **Explain rationale**
  - **Reinforce change to behavior**
  - **Elicit benefits of a specific behavior**

**Helpful Tips:**

- **Before asking about behavior change, ask questions such as:**
  - **What is the behavior?**
  - **What does the target behavior have a place in the child's life in the long run?**
  - **What did it take for you to achieve your goals in the past?**
  - **Ask: “How will (the behavior) help you achieve your goals?” “How will it interfere with confidence?**

**Practice Guides**

- **Objectives:**
  - To increase reflection, efficacy, and commitment about behavior change.
  - To increase self-efficacy.

- **Steps:**
  - **Adopt a collaborative, reflective style**
  - **Identify a small goal**
  - **Explain rationale**
  - **Reinforce change to behavior**
  - **Elicit benefits of a specific behavior**

**Helpful Tips:**

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Problem Solving

Objectives:
- To teach a method of problem solving that involves clearly defining the problem, generating possible solutions, examining the solutions, implementing a solution and evaluating its effectiveness.

Use This When:
- To provide children with a systematic way to negotiate problems and to consider alternative solutions to situations.

Steps:
- Normalize problems
  - Discuss the fact that we all have problems, every day.
  - Note that solving them can make us feel good, and not solving them can make us feel bad.
- Discuss with the child the types of problems that people in general experience daily, and more specifically, those problems that the child might be dealing with. Appropriate self-disclosure may be useful.
- Ask the child to begin thinking about a particular problem he/she has experienced lately.
Facilitators Rate Usefulness of MAP Tools Almost as Highly as Therapists

- Therapist (n=5)
- Facilitators (n=4)
Wrap+MAP Idea 1: Generate Research Based Options in Planning and Implementation

- Use PWEBS searches at strategic points in planning process
  - When youth has a need that could be met through clinical services
  - When team is “stuck” and looking for options

- Use Practice Guides to help family and team members understand options
  - Increases transparency and clarity of purpose of clinical service
  - Moving from professional driven care to inclusion of natural helpers with training and support
Wrap+MAP Idea 2: Collective Team Focus & Integrated Support Planning

- Train and coach wraparound-affiliated clinicians on MAP system and treatment elements
- Certify clinicians in MAP
- Train facilitators in the integration of EPT elements and eliciting expertise from team members
- Develop mechanism for training and integration across team members, settings, and strategy implementation
Wrap+MAP Idea 3: Parent Partners and Community Supports Serve as EBP “Care Extenders”

- Modify selected MAP treatment elements to “care extension” strategies appropriate to peer support and paraprofessional roles
- Orient/train team members in care extender model
- Facilitator to insure the team considers how to actively integrate this type of follow-on support into wraparound plans
Wrap+MAP Idea 4: Monitor More Consistently and Change Plans as Needed

- Facilitators trained to use team-level dashboard
- Clinicians trained to use MAP clinical dashboard
- Supervisors trained to use dashboards in supervision
Other options for wraparound providers

• Incorporate elements of evidence based models directly into the wraparound process
Integrating EBP elements: Houston example

Engagement phase:

Family organization & development (Solution Based Casework)
- Clarify behavior of concern: Duration, frequency, intensity & context
- Timeline events affecting family composition (learning the family story)

Planning Phase:

Team composition & development (Family Group Conferencing; TDM)
- Differentiate core & extended team
- Team structure via agreements on behavioral goals & guidelines

Planning and Implementation Phase:

Ecological systems theory: Assessment & interventions (MST)
- Fit circle assessment: Identifying functional strengths that promote outcomes
- Fit circle assessment: Contributing factors to Priority needs
- Specific, strengths-based, step-by-step interventions that build skills and diminish or eliminate factors contributing to well-identified problem.
Achievement Fit Circle: What are Functional Strengths?

Better school behavior & grades; No suspensions

- Youth engaged in church music group
- Improved social skills with mentor & developed pro-social friends.
- Family caregivers are more consistent in monitor, guidance & discipline.
- Mom works 2 jobs but use of chore chart & school chart has improved quality of family time

- Mom & grandma develop chore chart for each boy. Rewards & consequences are clear & consistent
- Teacher & youth agree on signal if he feels unfairly treated. Rewards if no outburst.
- Mom has new boyfriend but chore chart & teacher chart of behavior & homework help her monitor
- Mom has new boyfriend but chore chart & teacher chart of behavior & homework help her monitor
Strengths Assessment Data Form

- Interactions support family achievements = ID strengths & natural supports
- Strengths are behaviors, not personality characteristics, hopes or desires
- Develop achievement fit circles frequently with family & team
- Transfer identified strengths to this form
- Identify when team uses them as basis for interventions.

<table>
<thead>
<tr>
<th>Date Identified</th>
<th>Strengths</th>
<th>Date Applied in Intervention</th>
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<tbody>
<tr>
<td></td>
<td>Youth</td>
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<td></td>
<td>Family</td>
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<td>Peers</td>
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<td>School</td>
<td></td>
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<tr>
<td></td>
<td>Community</td>
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</table>
Fit Circle: What maintains the need?

Priority need: Youth needs to feel like school is a safe and welcoming place.

Outcomes: Better school behavior & grades; No suspensions.

- Explosive when he feels teacher treats him unfairly.
- Talks back when grandma tries to help mom by directing him to clean his twin brother’s messes.
- Mom has new boyfriend she met at work. This draws her attention away from youth performance.
- Mom works 2 jobs = little time or patience for monitoring, guiding behavior & academic performance.
- Poor social skills, has few pro-social friends.
- Family conflicts spill into school setting. Mom favors him. Grandmother favors twin brother.
- Peers pick on him daily, talk about his family.
Constraints Assessment Data Form

- Patterns of interaction in family or between family members & others often contribute to behaviors of concern
- We eliminate or diminish a contributing factor with strengths-based interventions designed by the family & team
- Regularly develop problem fit circles with family & team & transfer contributing factors as they are identified & targeted to this form.

<table>
<thead>
<tr>
<th>Date Identified</th>
<th>Constraints</th>
<th>Date Targeted in Intervention</th>
</tr>
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<tr>
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<td>Youth</td>
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<td></td>
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<td></td>
<td>Community</td>
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# Smart Interventions Data Form

<table>
<thead>
<tr>
<th>Date___</th>
<th>Family/Youth_______</th>
<th>Care Coordinator ____</th>
<th>Parent Partner ____</th>
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<tbody>
<tr>
<td><strong>Underlying need and outcome of interest</strong></td>
<td><strong>Targeted contributing factors</strong></td>
<td><strong>Specific strengths used in intervention</strong></td>
<td><strong>Intervention</strong></td>
</tr>
<tr>
<td>Center of “Need/problem” fit circle</td>
<td>Surround problem fit circles &amp; in constraints data form</td>
<td>From strengths fit circles &amp; in strengths data form</td>
<td>Who does what with whom, when, &amp; in what manner?</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Who evaluates intervention &amp; how frequently?</td>
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Systematic data-informed coaching

Wraparound Implementation

Coaching: Staff development

Implementation consultation

Model pertinent case data
Improvements after 12-18 months

- Expanded & differentiated team composition
- With behaviorally specific goals, related rules of operation, & use of fit circles, team assessment and brainstorming became more robust.

Behavioral fit circle assessment ---> improved interventions

- More complex multi-system interventions (school & home interventions that complement each other)
- Effective step-by-step interventions last < 6 weeks
- Contrary to staff concerns, families embraced use of fit circles & a behavioral focus on parenting
Pre and Post Implementation

WFI-4 Scores by Principle

*\( p \leq 0.05 \)

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<th>Principle</th>
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<th>SOH 2011</th>
<th>National Mean</th>
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<tbody>
<tr>
<td>Family Voice &amp; Choice</td>
<td>83</td>
<td>92</td>
<td>83</td>
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<td>83</td>
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<td>Natural Supports</td>
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<td>88</td>
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<tr>
<td>Community Based</td>
<td>63</td>
<td>82</td>
<td>71</td>
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Fidelity Percentage

SOH 2010 | SOH 2011 | National Mean

*Family Voice & Choice*

*Team Based*

*Natural Supports*

*Collaboration*

*Community Based*
Pre and Post Implementation

WFI-4 Scores by Principle

* $p \leq 0.05$

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<th>SOH 2011</th>
<th>National Mean</th>
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<td>Persistence Based</td>
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<tr>
<td>Outcome Based</td>
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<td>77</td>
<td>67</td>
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<td>Actions</td>
<td>National (n = 134)</td>
<td>SOH (n = 44)</td>
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<td></td>
</tr>
<tr>
<td></td>
<td>Intake</td>
<td>6 Months</td>
<td>Intake</td>
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<tr>
<td>Suspended</td>
<td>32.8%</td>
<td>26.1%</td>
<td>54.5%</td>
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<tr>
<td>Expelled</td>
<td>0.0%</td>
<td>0.0%</td>
<td>4.5%</td>
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<tr>
<td>Neither Suspended Nor Expelled</td>
<td>64.9%</td>
<td>69.4%</td>
<td>38.6%</td>
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</tbody>
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School Disciplinary Actions 2011
System Re-design: The Texas landscape

- Priority—Evidence-Based Practices, Fidelity
- Selection of EBPs—Process
  - Appropriate/effective for population
  - Delivered by bachelor’s level staff (skills training)
  - Affordable
- EBPs Selected
  - Skills Training/Rehab: Aggression Replacement Training (ART), Seeking Safety, Nurturing Parenting, Skillstreaming,
  - Counseling: CBT, TF-CBT, PCIT
  - Intensive Needs: Wraparound
Integrating EBPs into a statewide system

- Texas Administrative Code
  - Intensive Case Management = Wraparound
  - Skills Training & Development = Department approved EBP

- Contract
  - Training/Competency Requirements

- Implementation Support
  - Billing Guidelines for ICM
    - Aligning activities of wraparound with intensive case management
  - Training Infrastructure
Lessons Learned

• State
  – Fidelity
  – Competency
  – Coaching/Support

• Organization
  – Organization-wide buy-in
  – Workforce development
  – Recruitment & Retention
Summary of Main Points

• It is important that we use effective and cost-effective strategies in children’s behavioral health
• Although there are challenges, EBP can be thoughtfully integrated into family- and youth-driven, individualized systems of care
  – System:
    • Include intensive EBPs as alternatives to wraparound
    • Include office-based EBPs as components of wrap plans
  – The provider level:
    • Train clinicians in the SOC on EBPs and use of evidence
    • Train facilitators and peer partners on how to use/support strategies with evidence for success
  – The youth, family, and team level
    • Work as a team to select and implement strategies that meet needs and are based on evidence