The Wraparound Process

and its Current Place within the Research Base on Treatments for Children, Youth, and Families

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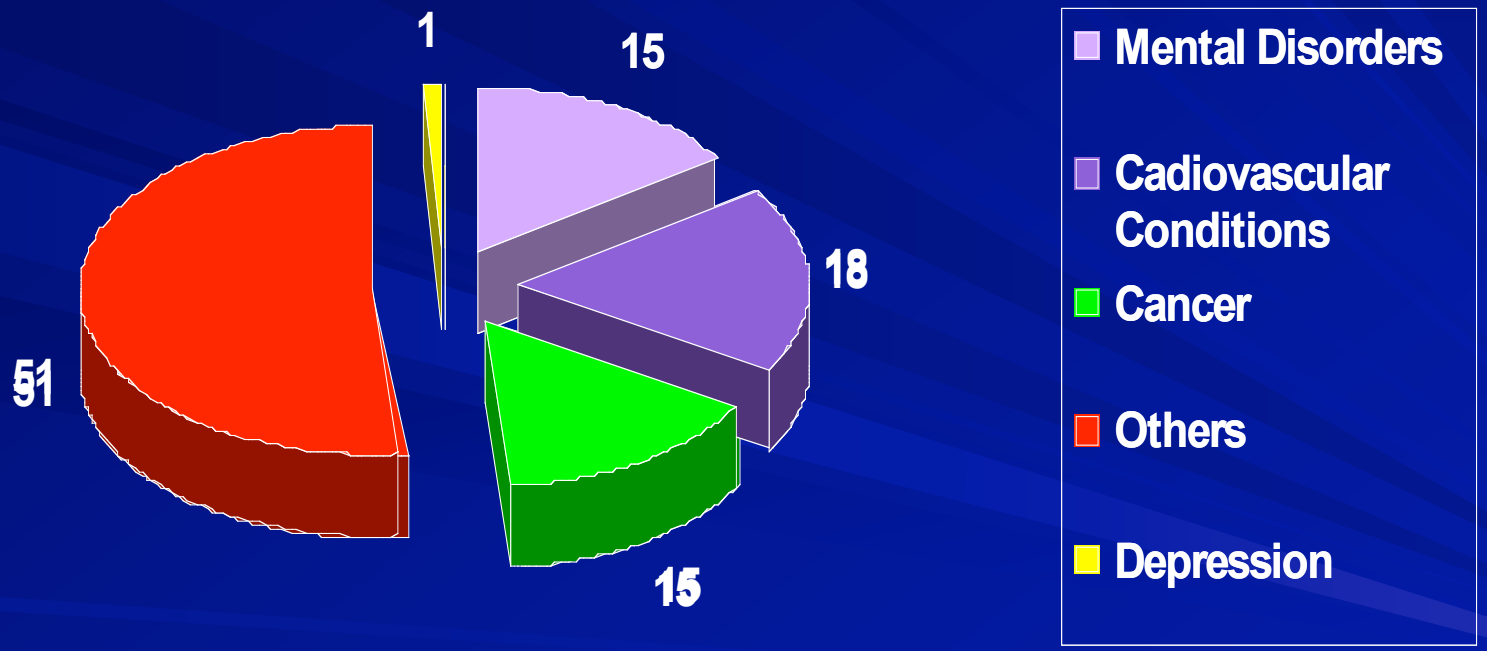
Presentation overview

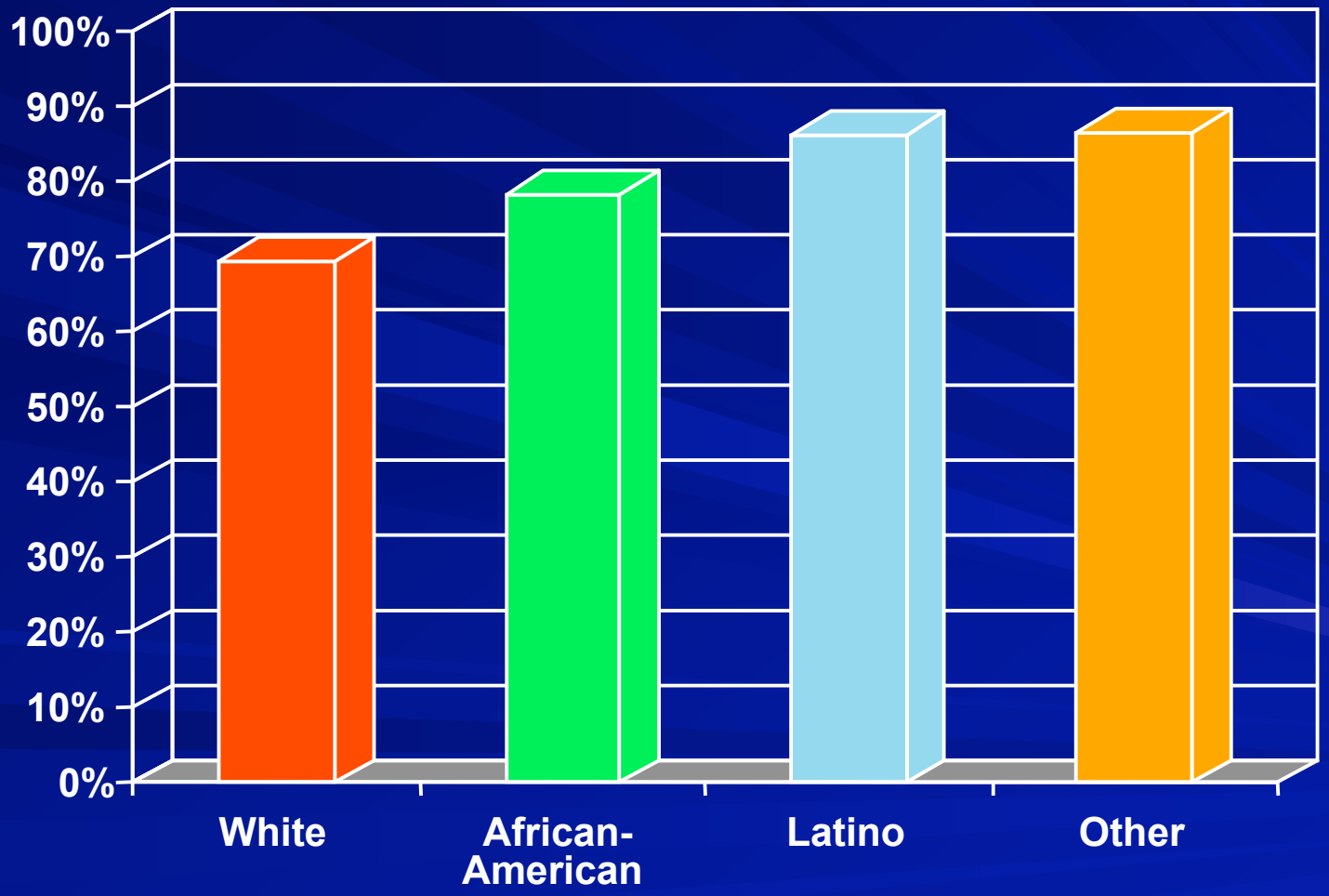
- Background: Treating youth with serious MH, emotional, and behavioral problems
- History, philosophy, and evolution of the wraparound process
- The evidence base for wraparound
- Research on wraparound implementation
- Current work: Model development and planned research directions

Global Burden of Mental Disorders



*Global Burden of Disease (Murray & Lopez, 1996)
** DALYS- Disability Adjusted Life Years

Challenge: % Unmet Need for Mental Health Services



Sturm et al., 2000 (from NHIS)

Estimates of MH problems in children and adolescents

- 20% Children experiencing a diagnosable disorder
- 4-8% Children experiencing severe emotional disturbance
- 16% Children who may benefit from help who actually receive a MH service

The costs of doing nothing

- Emotional and behavioral disorders in childhood/adolescence associated with:
  - School dropout
    - estimated cost to society: $243,000 - $388,000
  - Substance abuse
    - estimated cost to society: $370,000 - $970,000
  - Criminality
    - estimated costs to society of a ‘life of crime’: $1.3million - $1.5million

– Jones, Dodge, Foster, Nix, and the Conduct Problems Prevention Research Group (2002)

Positive trends in Children's MH

- Definition of a foundational value base for "systems of care" – a philosophy about how public systems should care for families with children with MH needs
  - Coordinated
  - Family centered
  - Community based
  - Culturally competent
- Emergence of treatments found to be effective

Treatment effectiveness:
How much do we know about what?

Well-established	**Growing**	**Long way to go**
ADHD	Eating Disorders	Child maltreatment
Oppositional problems (young children)	Depression	Attachment Disorders
Obsessive-Compulsive Do.	Anxiety	Substance Abuse/Comorbid Disorders
	Conduct problems	Sexual Aggression
	Autistic spectrum	Girls with any Disorder
	Schizophrenia/Psychotic Disorders	
	Traumatic Stress/PTSD	

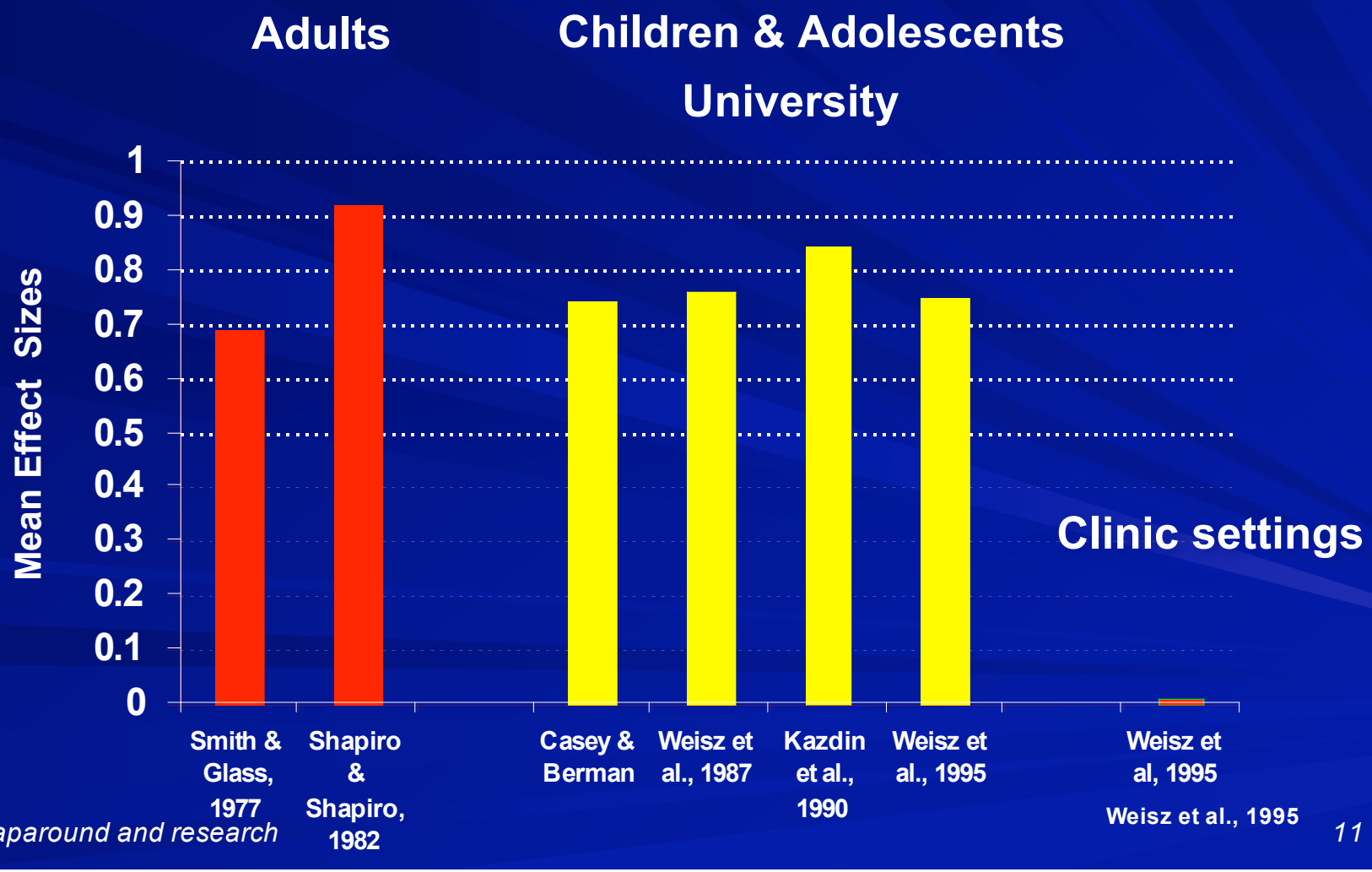
Child and adolescent treatments with best empirical support (selected)

- Cognitive-behavior therapy for childhood anxiety disorders
- Cognitive-behavioral coping skills therapy for depression (including school-based treatments)
- Parent management training for disruptive behaviors (including videos for parents)
- Problem-solving skills therapy for disruptive behaviors
- Social skills training for young children who are aggressive (including school-based treatments)
- Medication or multi-modal treatment for Attention Disorders
- Intensive home-based Applied Behavioral Analysis for autistic spectrum disorders

Child and adolescent treatments with moderate empirical support (selected)

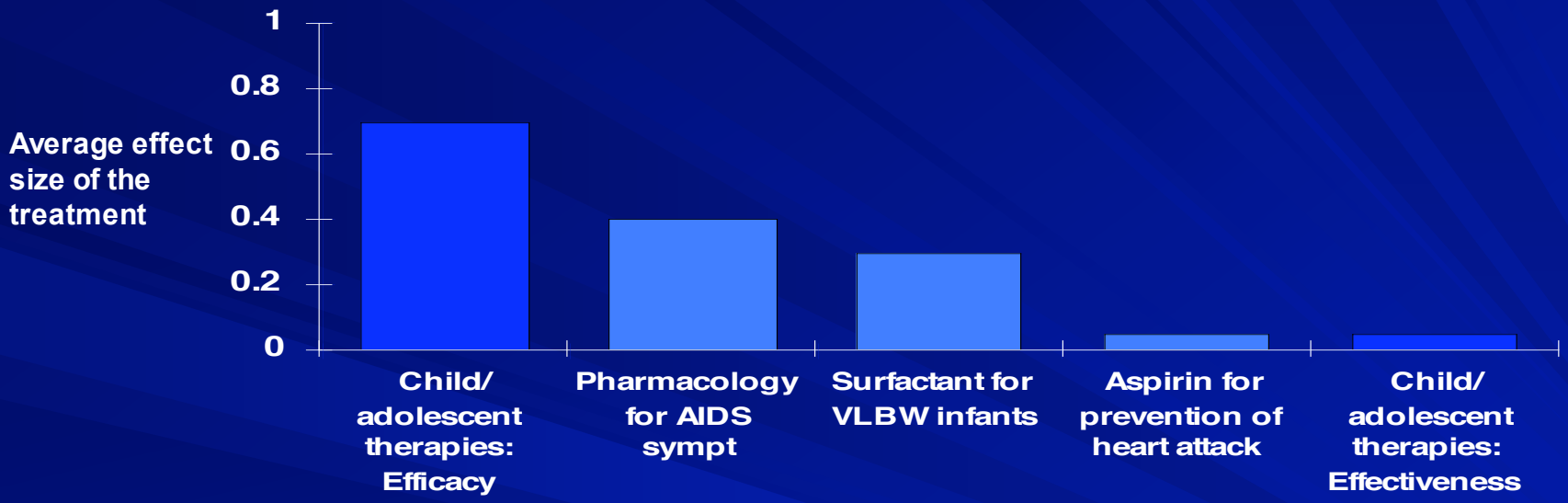
- Family therapy for parent-adolescent conflict
- Teacher consultation models for disruptive behaviors
  - (improvement in school outcomes found; clinical effects unclear)
- Assertive Community Treatment for Adolescents for Schizophrenia
- EMDR for traumatic stress disorders
- Psychotropic medication for a number of other symptoms (e.g., depression, anxiety, autistic behaviors)
- Several approaches to treating substance abuse

Challenge: Psychotherapies in Routine Clinic Settings Have Little to no Effect



Wraparound and research

Efficacy of child and adolescent therapies

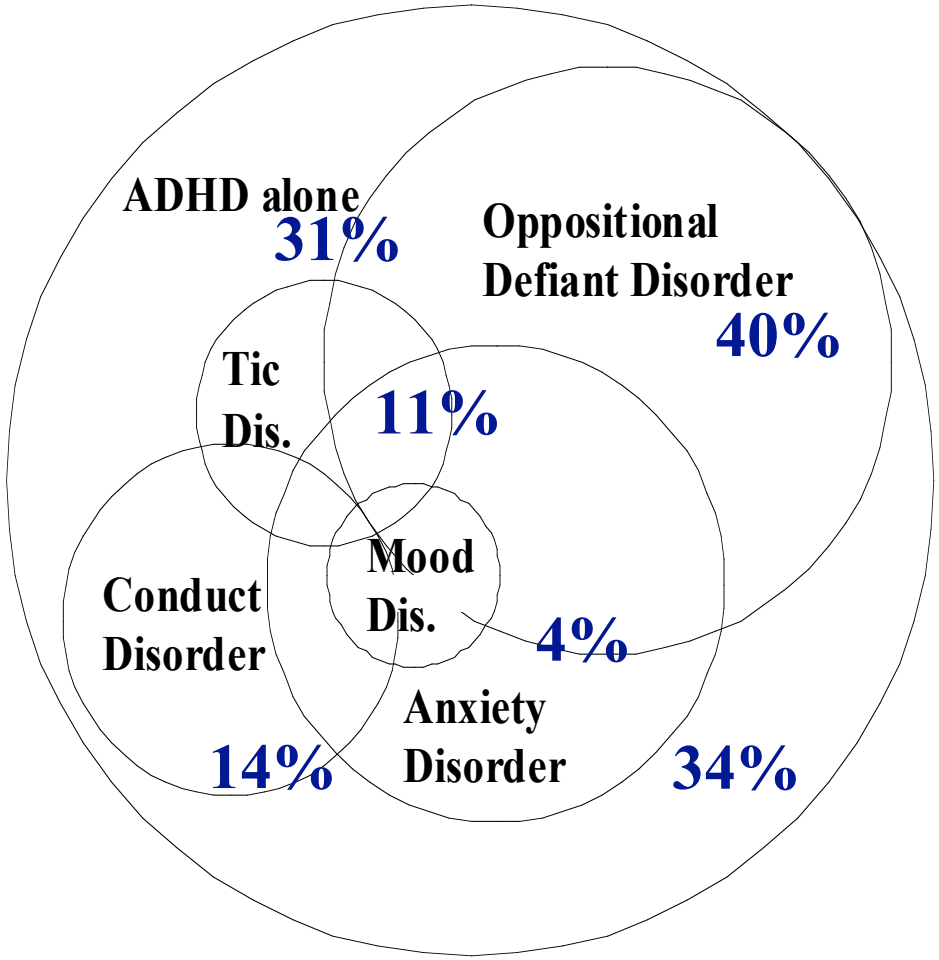


- Overall, controlled research on child and adolescent therapies for specific populations shows excellent efficacy, even in comparison to studies of effects of well-established medical treatments
- Unfortunately, results of research in "real-world" clinical settings have been far less positive – both because of study methodological issues as well as treatment implementation issues

Barriers to Positive Outcomes

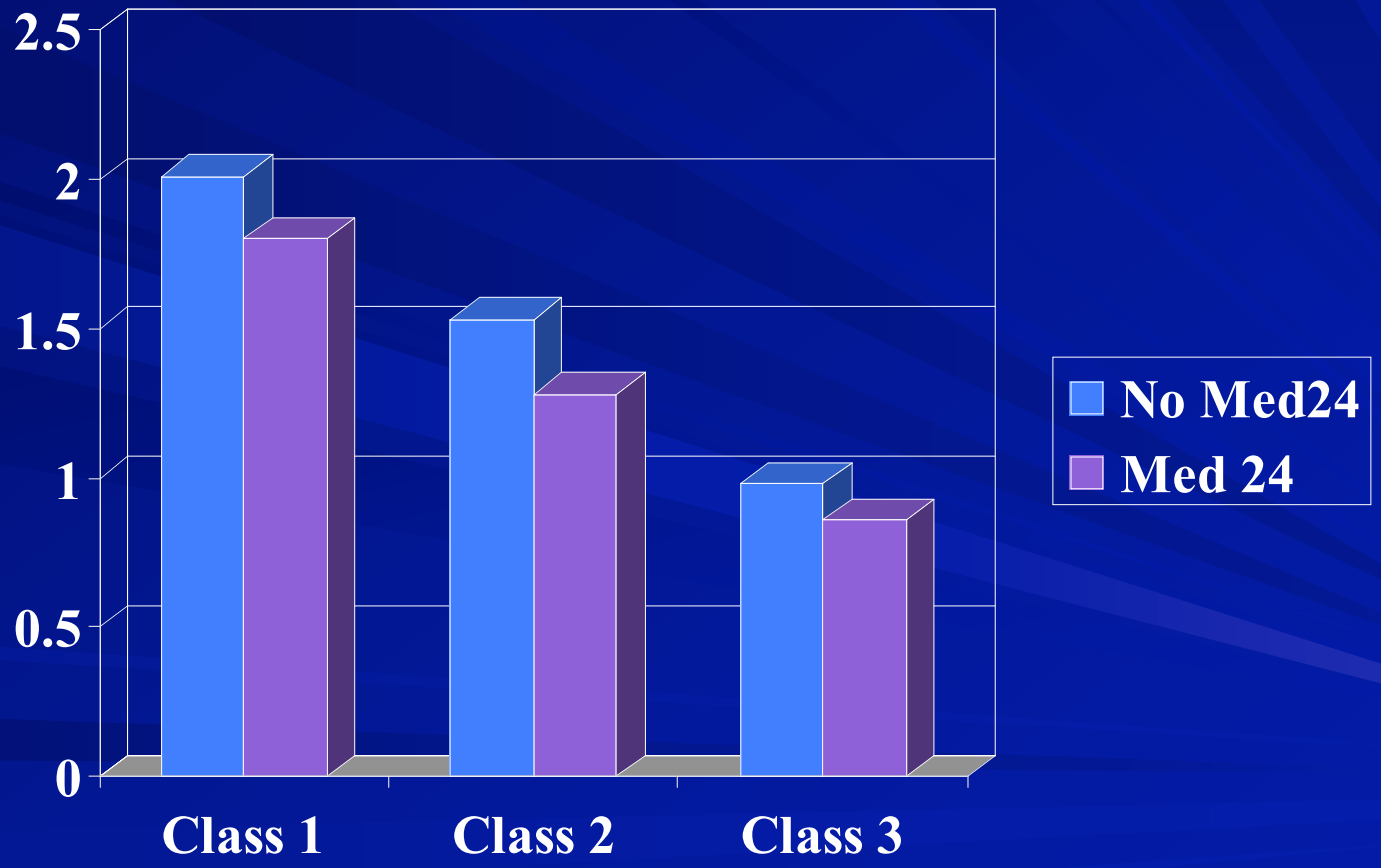
- Comorbidity and complexity of child and family needs
- Lack of full engagement of families
- Lack of adaptation and individualization of treatments
  - Including adaptation to the culture of the family
- Interagency coordination is not sufficient:
  - Attention to organizational and system context
  - Applying technologies that allow for high-quality implementation of effective practices

Co-Occurring Disorders in MTA Children (n=579) Jensen, 2003



Efficacy at 24 Months by Class and Medication Status at 24 Months

Latent Class Analysis from MTA Study, Jensen, 2003



Findings from MTA study

- Less impact of treatment for children with multiple problem areas (comorbidity) and families with complex needs (Jensen, 2004)
  - Lack of “fit” between families’ complex needs and services/supports provided
  - Lack of engagement of families

The Challenge of full family engagement

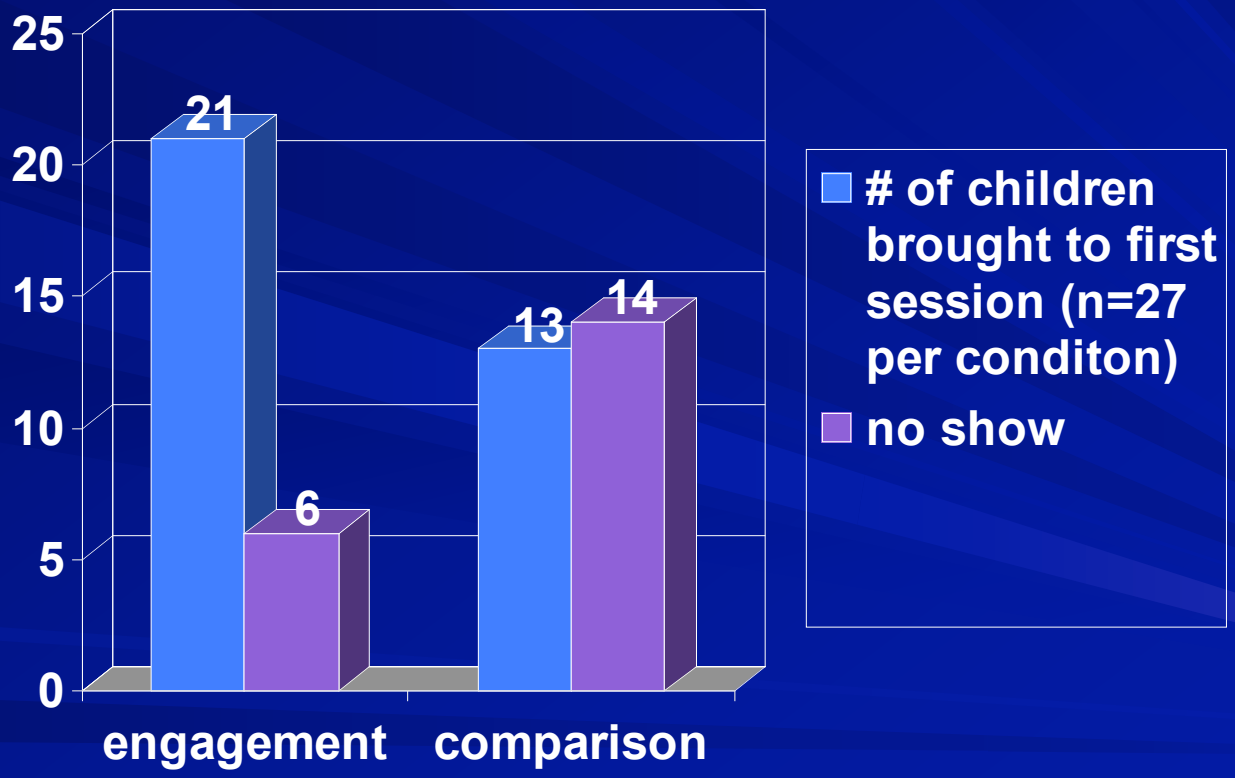
- 40-60% families may drop out of services before their formal completion (Kazdin et al., 1997)
- Children from vulnerable populations are less likely to stay in treatment past the 1st session (Kazdin, 1993)
- Factors related to drop-out
  - Stressors associated with treatment
  - Treatment irrelevance
  - Poor relationship with therapist (Kazdin et al., 1997)
  - Triple threat: poverty, single parent status and stress
  - Concrete obstacles: time, transportation, child care, competing priorities
  - Previous negative experiences with mental health or institutions

Research on Engagement

- Participation rates can be increased by intensive engagement interventions that are tailored to the family
- Collaboration, active problem solving are key

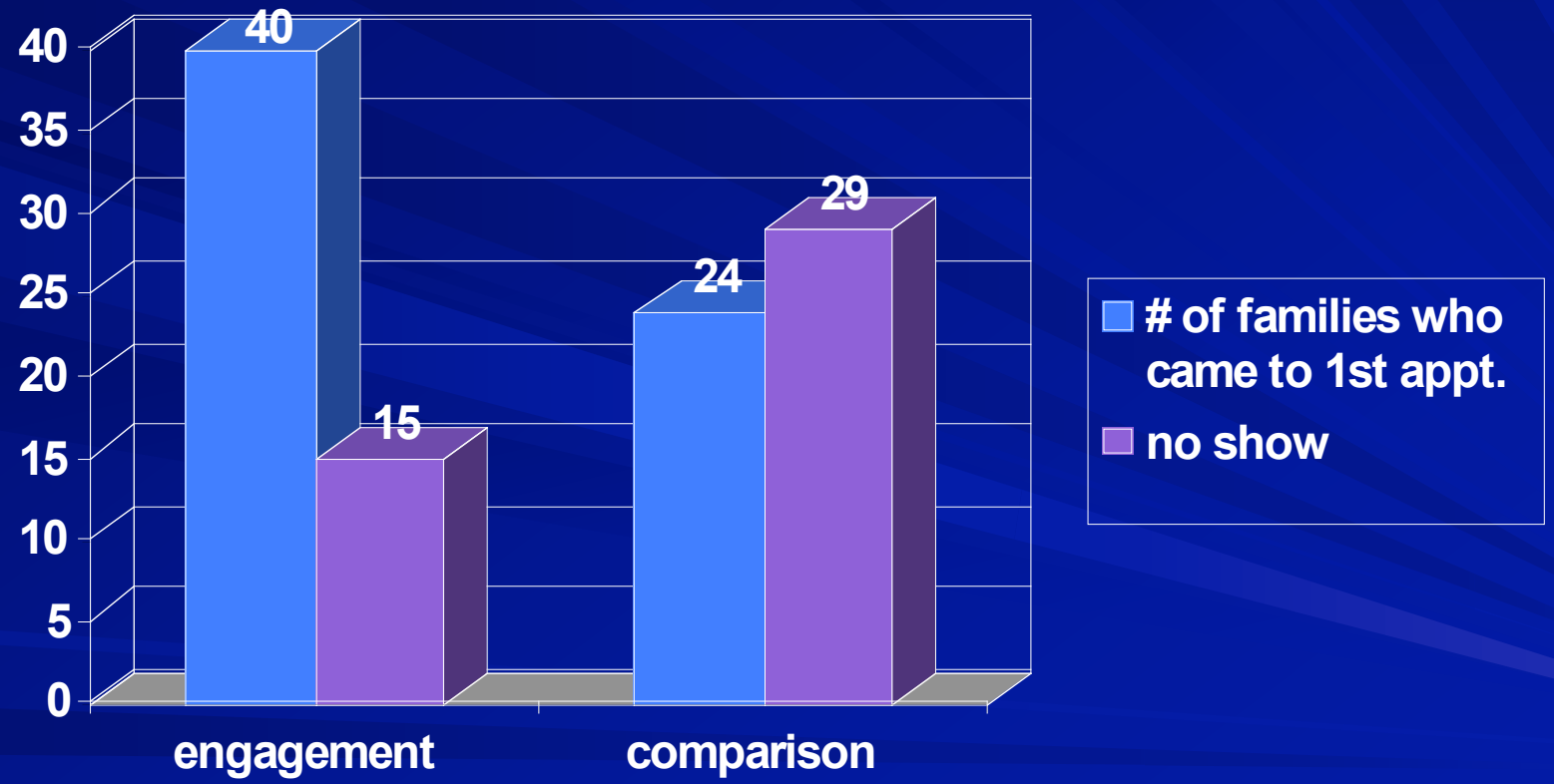
M. McKay, 1999

Results: Study One



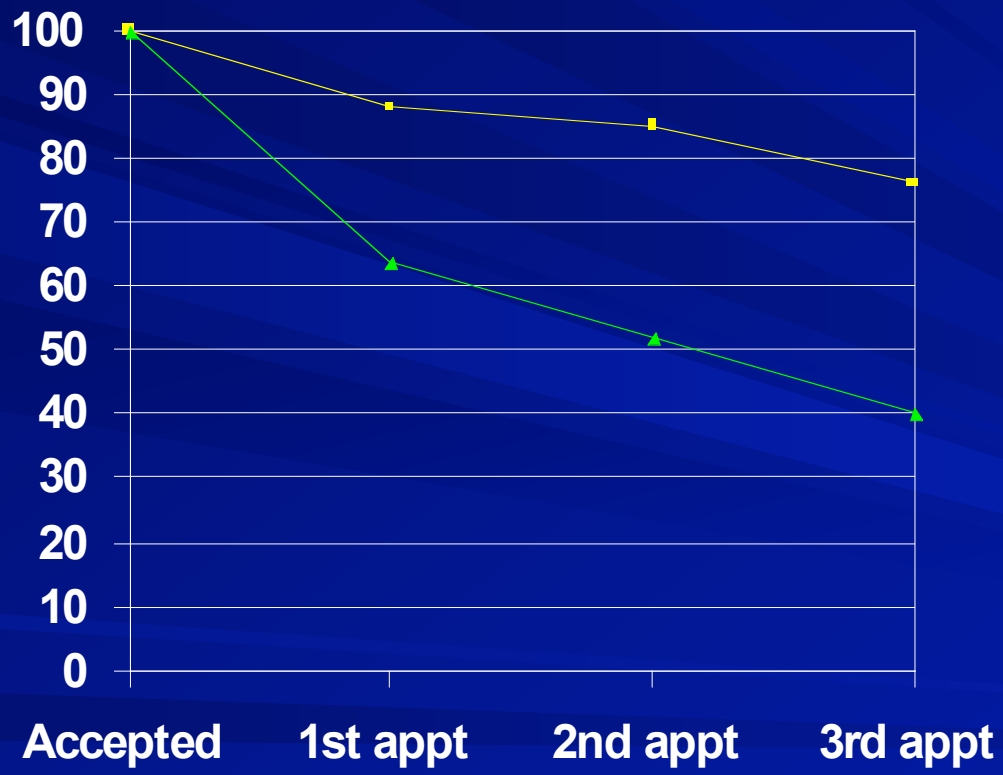
M. McKay, 1999

Results: Study Two



M. McKay, 1999

Results: Study Three



M. McKay, 1999

Results from MST mechanisms of change research

- High levels of fidelity to MST found to be *negatively* associated with outcomes in the absence of full engagement of the family
  - "therapist attempted to try to change how family members interact with others…"
  - "therapist recommendations required family members to work on their problems every day"
- Implication = adherence to protocols in absence of full engagement detrimental

Another challenge: Access to coordinated continuum of care alone insufficient

- Continuum of Care studies of integrated service systems
  - Children with Serious MH problems: Fort Bragg
  - Adults with SMI: ACCESS study
- General Findings
  - Increased access to services
  - Increased client satisfaction
  - Fewer placements in restrictive settings
- But also:
  - Increased costs
  - No differences in clinical improvement

(Bickman, 1996; Bickman et al., 1999; Randolph, Blasinsky, Morrissey, et al., 2002)

Yet another challenge: Keeping youth in the community

- No research base on effectiveness of residential treatment/psychiatric hospitalization
  - but these options consume 60% - 80% of our resources
- Best predictor of future out-of-home placement utilization is past utilization (Pfeiffer et al, 1990)
- 33% of youth in RTCs back in restrictive placement wi. one year; 75% back wi 6 yrs (NACTS study)
- Both placement stability and youth perception of placement stability predict future clinical outcomes (Dubovitz et al., 1993, Horvitz et al., 1994)
- Lots of evidence of superior outcomes of community-based treatment (e.g., MST, TFC, Berrick, Courteney et al, 1994)

Synthesis

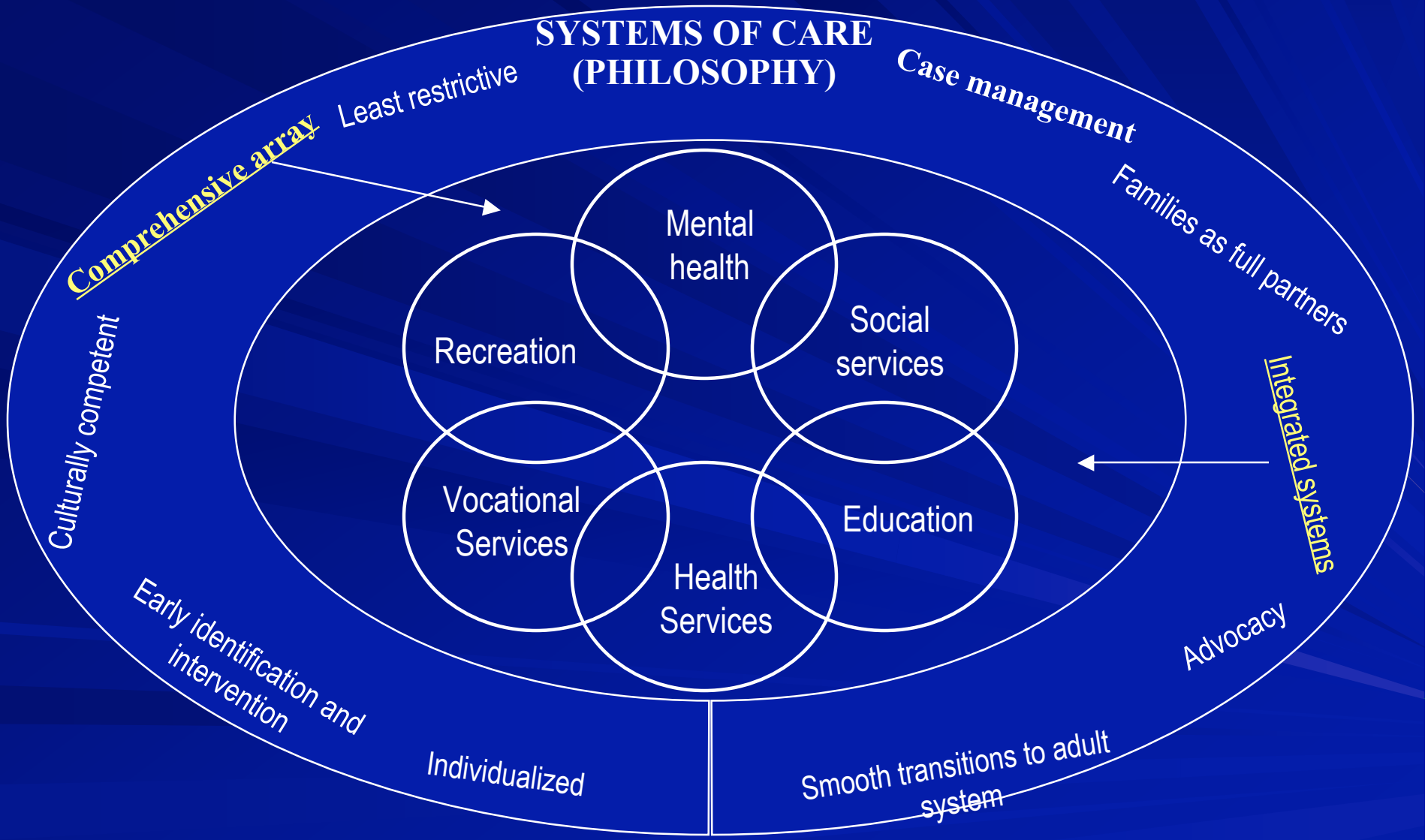
- The evidence base is difficult to apply to families with multiple, complex needs
  - Focal EBPs inadequate
  - Important to achieve individualized “fit” bw family needs and actual services/supports provided
  - Need to fully engage families in process, encourage full partnership
    - Families typically have had multiple prior negative experiences with “the system”
  - Need to overcome history of ineffective approaches
    - Overreliance on restrictive service settings
    - Better engineering of organizational and system structures than merely providing a “comprehensive array”

History and evolution of the wraparound process

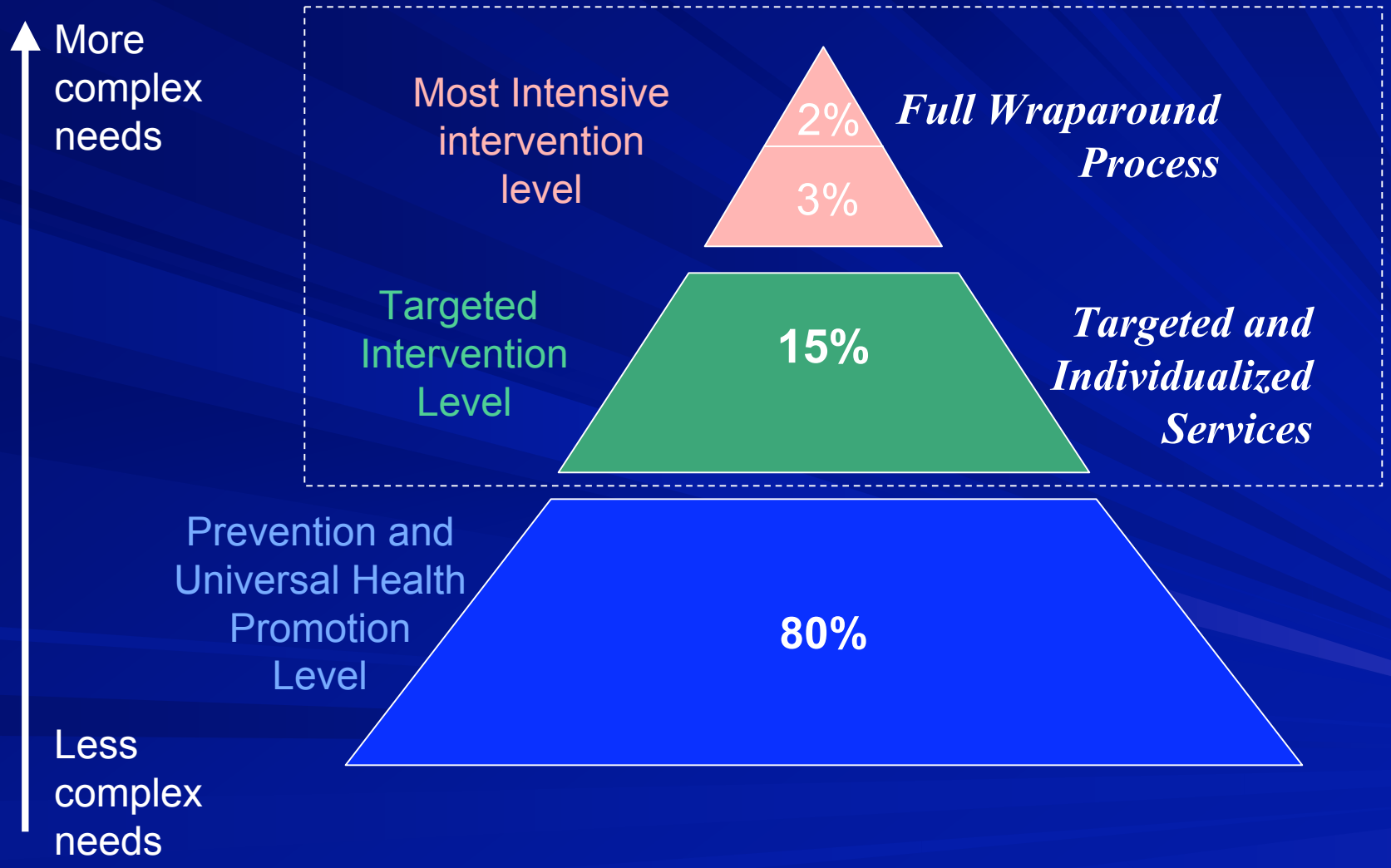
"Wraparound"

- Emerged in the mid-1980s as an attempt to address fragmented, overly professionalized, and overly restrictive treatments
- Co-evolved with systems of care values
  - Child-centered and family focused
  - Community-based
  - Culturally competent
    - (From Stroul & Friedman, 1986)

Systems of care



Levels of Behavioral Health Service Needs



Wraparound Process

System of Care values applied to families who need individualized, intensive care management

- Engaging the family in treatment
- Learning about the family's strengths, needs, and culture
- Engaging and leveraging community-based and natural supports
- Convening/running an interdisciplinary team
- Planning and implementing a set of services specific to the strengths & needs of the family

Wraparound Process

System of Care values applied to families who need individualized, intensive care management

- Setting goals and brainstorming strategies to meet them
- Determining indicators and measuring outcomes
- Continually revising care plans based on evidence for their effectiveness
- Celebrating successful transitions

Origins of Wraparound

- Kaleidoscope, Chicago – Karl Dennis
- Alaska Youth Initiative – John VanDenBerg
- Project Wraparound, Vermont – John Burchard/Richard Clarke

- Wraparound Milwaukee
  - Most widely cited example currently, serving over 700 kids referred and supported by all major child serving agencies

Wraparound Value Base

- Build on strengths to meet needs
- One family-One plan
- Increased parent choice
- Increased family independence
- Care for Children in context of families
- Care for families in context of community
- Never give up

Wraparound
Definition

- Through the wraparound process, a family and their team develop, implement, and fine-tune an plan of care that is individualized to achieve positive outcomes for the family.
- A set of 10 statements known as the *wraparound principles* defines the philosophical base for wraparound and guides the activities of the wraparound process

Wraparound Process

Principles

- Family voice and choice
- Team-based
- Natural supports
- Collaboration
- Community-based
- Culturally competent
- Individualized
- Strengths based
- Persistence
- Outcome-based

Walker, Bruns, Adams, Miles, Osher et al., 2004

Wraparound Principles

From the National Wraparound Initiative

- **Family voice and choice.** Family and youth/child perspectives are intentionally elicited and prioritized during all phases of the wraparound process. Planning is grounded in family members' perspectives, and the team strives to provide options and choices such that the plan reflects family values and preferences.
- **Team based.** The wraparound team consists of individuals agreed upon by the family and committed to them through informal, formal, and community support and service relationships.
- **Natural supports.** The team actively seeks out and encourages the full participation of team members drawn from family members' networks of interpersonal and community relationships. The wraparound plan reflects activities and interventions that draw on sources of natural support.
- **Collaboration.** Team members work cooperatively and share responsibility for developing, implementing, monitoring, and evaluating a single wraparound plan. The plan reflects a blending of team members' perspectives, mandates, and resources. The plan guides and coordinates each team member's work towards meeting the team's goals.

Wraparound principles (cont'd)

- **Community-based.** The wraparound team implements service and support strategies that take place in the most inclusive, most responsive, most accessible, and least restrictive settings possible; and that safely promote child and family integration into home and community life.
- **Culturally competent.** The wraparound process demonstrates respect for and builds on the values, preferences, beliefs, culture, and identity of the child/youth and family, and their community.
- **Individualized.** To achieve the goals laid out in the wraparound plan, the team develops and implements a customized set of strategies, supports, and services.

Wraparound principles (cont'd)

- **Strengths based.** The wraparound process and the wraparound plan identify, build on, and enhance the capabilities, knowledge, skills, and assets of the child and family, their community, and other team members.
- **Persistence.** Despite challenges, the team persists in working toward the goals included in the wraparound plan until the team reaches agreement that a formal wraparound process is no longer required.
- **Outcome based.** The team ties the goals and strategies of the wraparound plan to observable or measurable indicators of success, monitors progress in terms of these indicators, and revises the plan accordingly.

Walker, Bruns, Adams, Miles, Osher et al., 2004

www.rtc.pdx.edu/nwi

What Wraparound is Not: Common misapplications of the term

- Wraparound is a “service”
- Wraparound = Case management
- Wraparound occurs with the availability of flexible dollars or a new funding source
- Wraparound is any service that is not typically reimbursable
  - E.g., respite care, karate lessons, or transportation

What Wraparound is Not: A Categorical Approach

- Assess Problems, assign a diagnosis
- Look at Services that are Available…
- Plug Services into the Family
  - Services reflect what's available and reimbursable rather than what's really needed

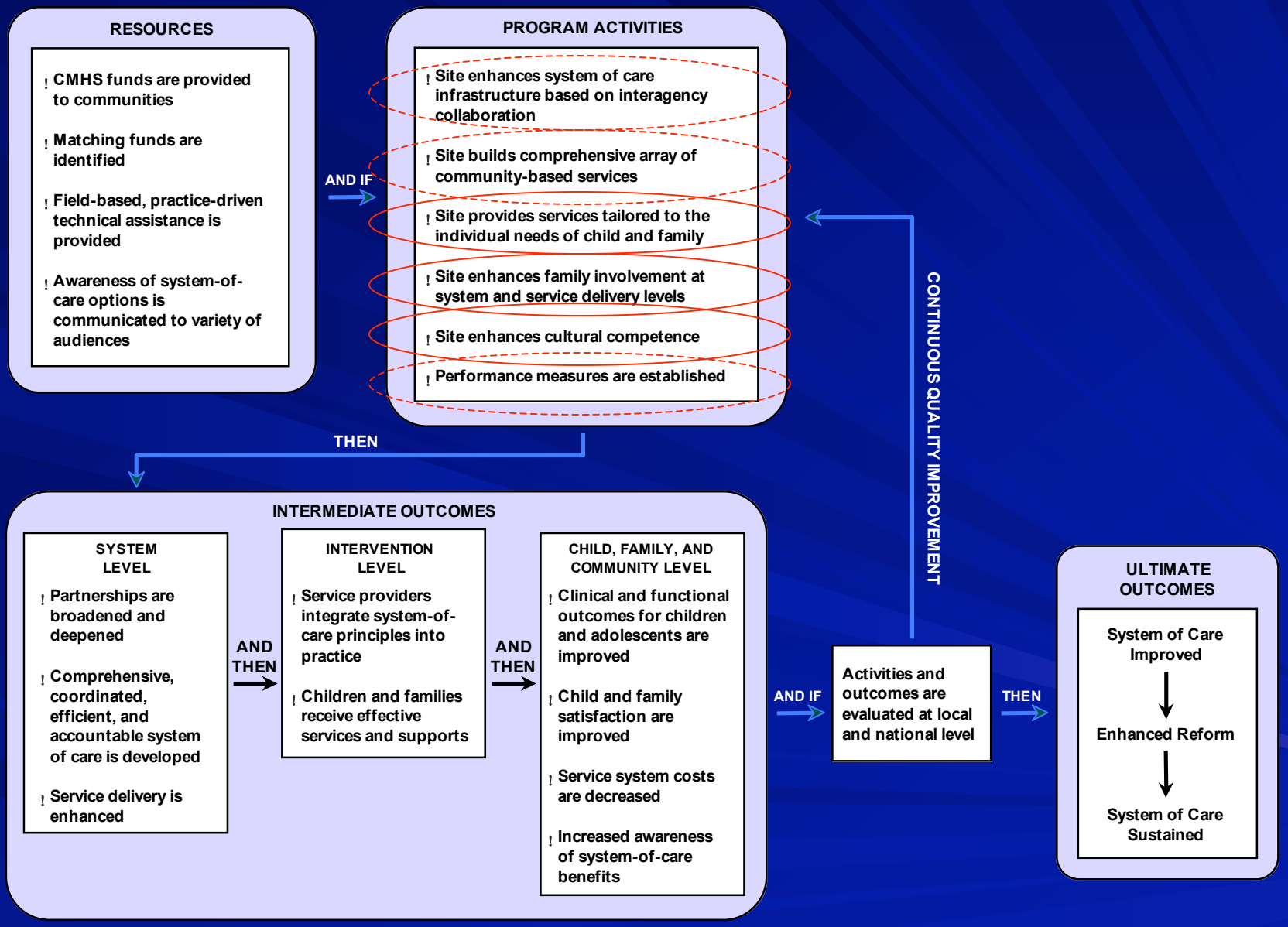
Prevalence of "Wraparound"

- Estimated 200,000 youth engaged in services delivered via Wraparound process (Faw, 1999)
- Recent survey found 38 of 42 State Mental Health liaisons report Wraparound process being used in their state (Burchard, 2002)
- Majority of CMHS-funded Systems of Care sites report utilizing Wraparound process

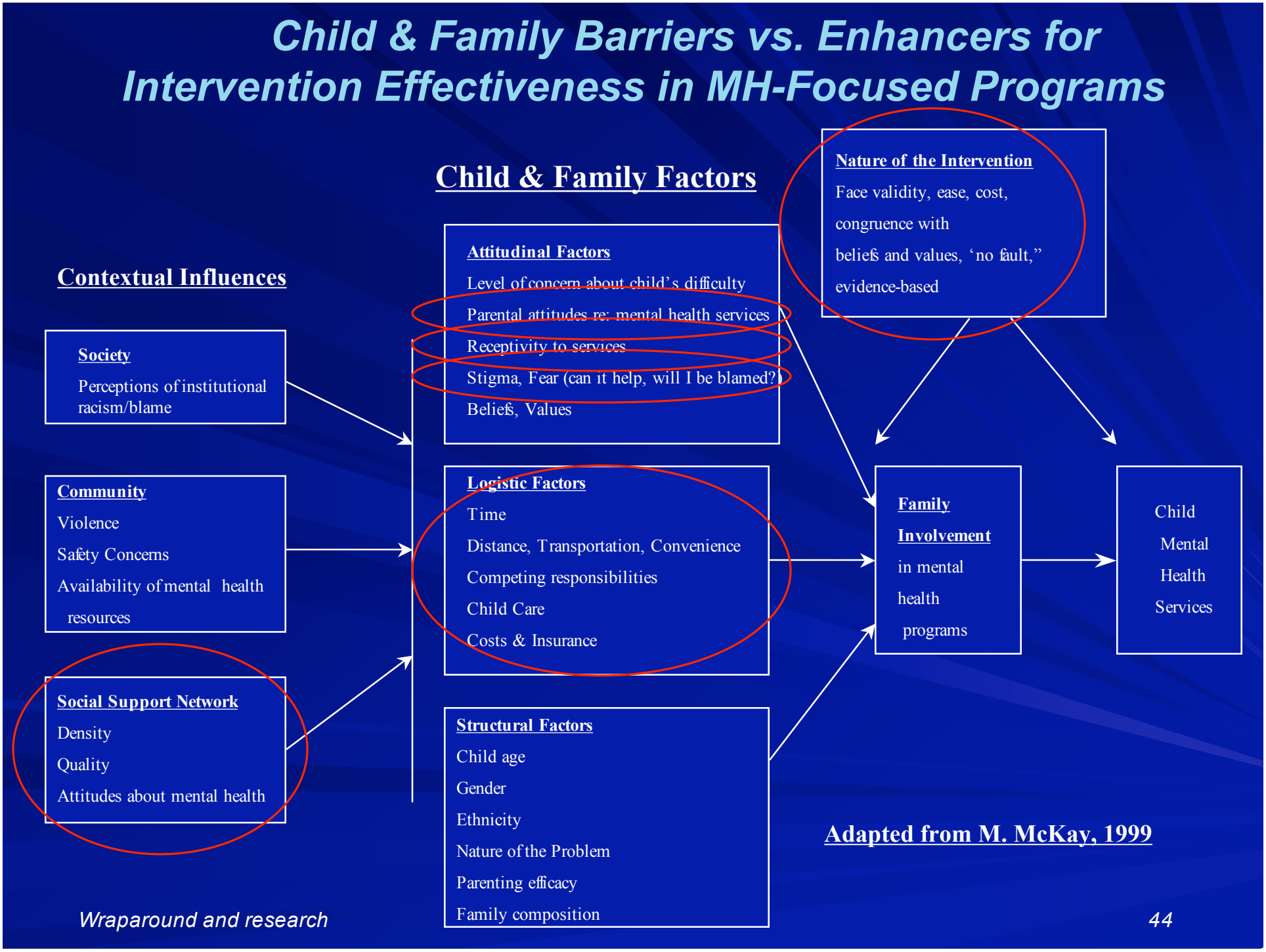
“Generic Theory Base” for wraparound

- Opportunity to shorten the logic chain between systems of care values and actual practice with families
- Opportunity to achieve appropriate, individualized fit between family needs and services/supports
- Full engagement of the family through strengths, needs, and culture discovery process
- Development of family members’ self-efficacy
- Enhancements to cultural competence
- Well-implemented wraparound program provides for high-quality teamwork, and organizational characteristics conducive to high-quality service delivery

System-of-Care Program Theory Model



Child & Family Barriers vs. Enhancers for Intervention Effectiveness in MH-Focused Programs



Integrated treatment approaches[1]

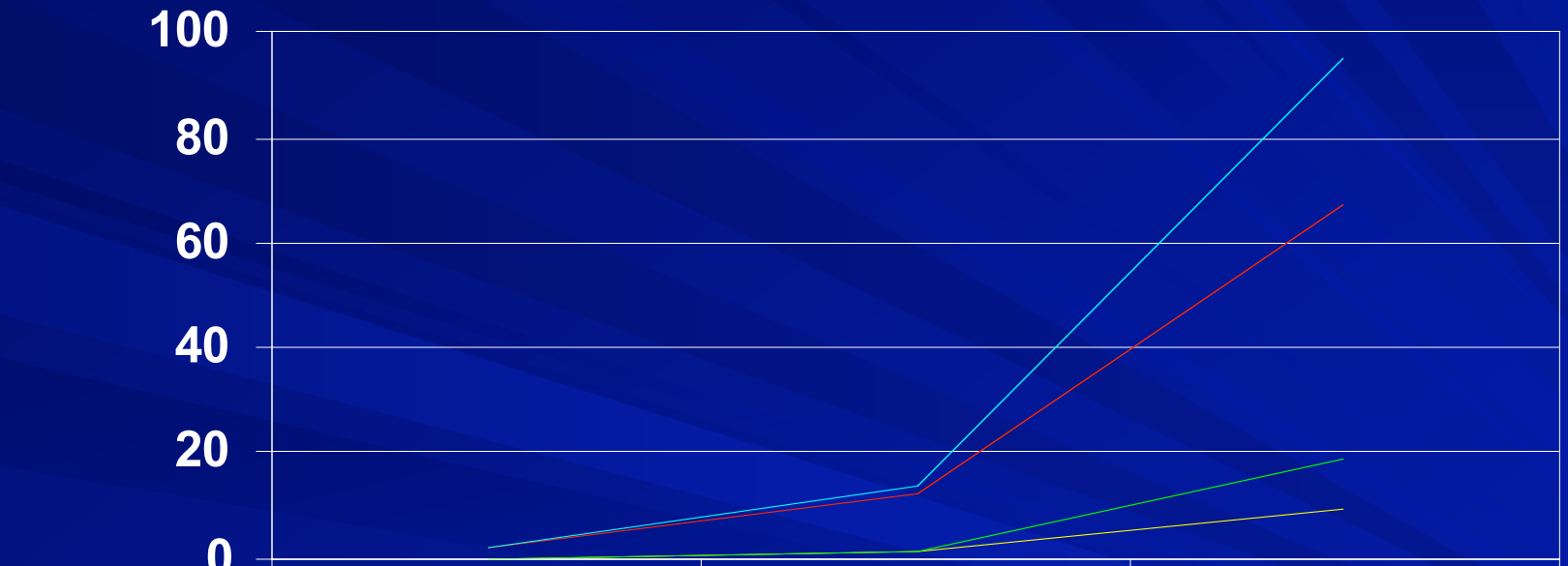
For youth with SEBD/complex needs

- Multi-systemic Therapy (MST)
- Treatment Foster Care
- Functional Family Therapy
- Wraparound process
  - ***From Burns, Hoagwood, & Maultsby, 1998***

[1]***In order of development of the research base***

Growth of Wraparound Literature Base

Number of citations, by database



	<1990	91-95	96-2002
PsychInfo	2	12	67
SocWkAb	0	1	9
ERIC	0	1	19
TOTAL	2	14	95

Wraparound Outcome Studies

- In peer reviewed publications
  - Nine pre-post studies
  - Three quasi-experimental studies
    - Two longitudinal studies comparing comparable groups
    - One within-subjects multiple baseline study
  - Two randomized clinical trials
- Results
  - Pre-post studies positive
  - 2 quasi-experimental studies positive, 1 no difference
  - Randomized trials: One positive, one mixed
- No implementation or fidelity measures employed in any of the exp or quasi-exp studies
- High levels of uncertainty about the model used

Implementation Measures

- Wraparound Observation Form (WOF; Epstein et al., 1998)
  - Structured observations of team process
- Wraparound Fidelity Index (WFI; Burchard et al., 2002; Bruns et al., 2004)
  - Administrator, care manager, caregiver and youth interviews
- Program and system assessments (Walker, Koroloff et al., 2003)
- Numerous program-specific approaches

Intervention Development

Typical progression

Theoretical framework

Based on problems/ proposed solutions

Intervention components

Defined and specified at multiple levels

Pilot studies; Fidelity measurement

Small intervention studies, fidelity measure based on specified practices

Clinical trials

Of well-defined and operationalized intervention

The Fidelity Problem in Wraparound

- "Values speak" substitutes for concrete practice steps
- Many things are referred to as Wraparound
- Model is not manualized or operationalized
  - Lack of implementation measures aligned with specific model
- Results in
  - Confusion for families, staff, communities
  - Many programs achieving poor outcomes
  - A poorly developed research base overall

A National Review of Wraparound Teams Showed

(Walker, Koroloff, & Schutte, 2003)

- Less than 1/3 of teams maintained a plan with team goals
- Less than 20% of teams considered >1 way to meet a need
- Only 12% of interventions were individualized or created just for that family
- All plans (out of more than 100) had psychotherapy
- Natural supports were represented minimally
  - 0 natural supports 60%
  - 1 natural support 32%
  - 2 or more natural support 8%
- No meetings included observer/supervisor/other QA mechanisms

Synthesis (no.2)

- The *wraparound process* has a compelling theory and philosophical base
  - Cited in *Surgeon General's* reports on mental health and youth violence
- Potential to account for variance in child and family outcomes
- The challenge:
  - To bring rigor to a widespread practice that has spawned multiple innovations but little standardization or replicability
  - To conduct research that informs us about its potential as a treatment process and about providing care to this population

Research on Wraparound Implementation

-implications for model development
-implications for serving youth with SEBD

Importance of Measuring Intervention Fidelity

- Program Development
  - Ensuring appropriate replication of evidence-based models
- Training
- Feedback to providers with respect to work with a specific family
  - Defining roles on a team
  - Positive feedback / Mid-course corrections
- Program evaluation
  - Interpretation of findings
    - Focusing on outcomes alone often yields null results and few lessons learned
  - Assessment of effects of service variation
  - Synthesizing knowledge from across studies

Goals for the *Wraparound Fidelity Index*

- Assess fidelity to principles of the wraparound process through opinions of multiple informants
- Allow for comparability between methods and across sites
- Feature psychometrics that permit summary scores across families or sites
  - Internal consistency (for Total WFI scores), test-retest, and construct validity
  - Fidelity scores found to be associated with outcomes

Wraparound Fidelity Index 3.0
Respondent Scheme, by element

	Number of items		
Element	Resource Facilitator	Parent	Youth
Parent/Youth Voice and Choice	4	4	4
Youth and Family Team	4	4	4
Community-based Svs/Suppts	4	4	4
Cultural Competence	4	4	4
Individualized Svs/Suppts	4	4	4
Strength-based Svs/Suppts	4	4	4
Natural Supports	4	4	4
Continuation of Care	4	4	4
Collaboration	4	4	
Flexible Resources/Funding	4	4	
Outcome-based Svs/Suppts	4	4	
Total Items	**44**	**44**	**32**
0-2 scale = Element Scores Range	**0-8**	**0-8**	**0-8**

National practice in Wraparound

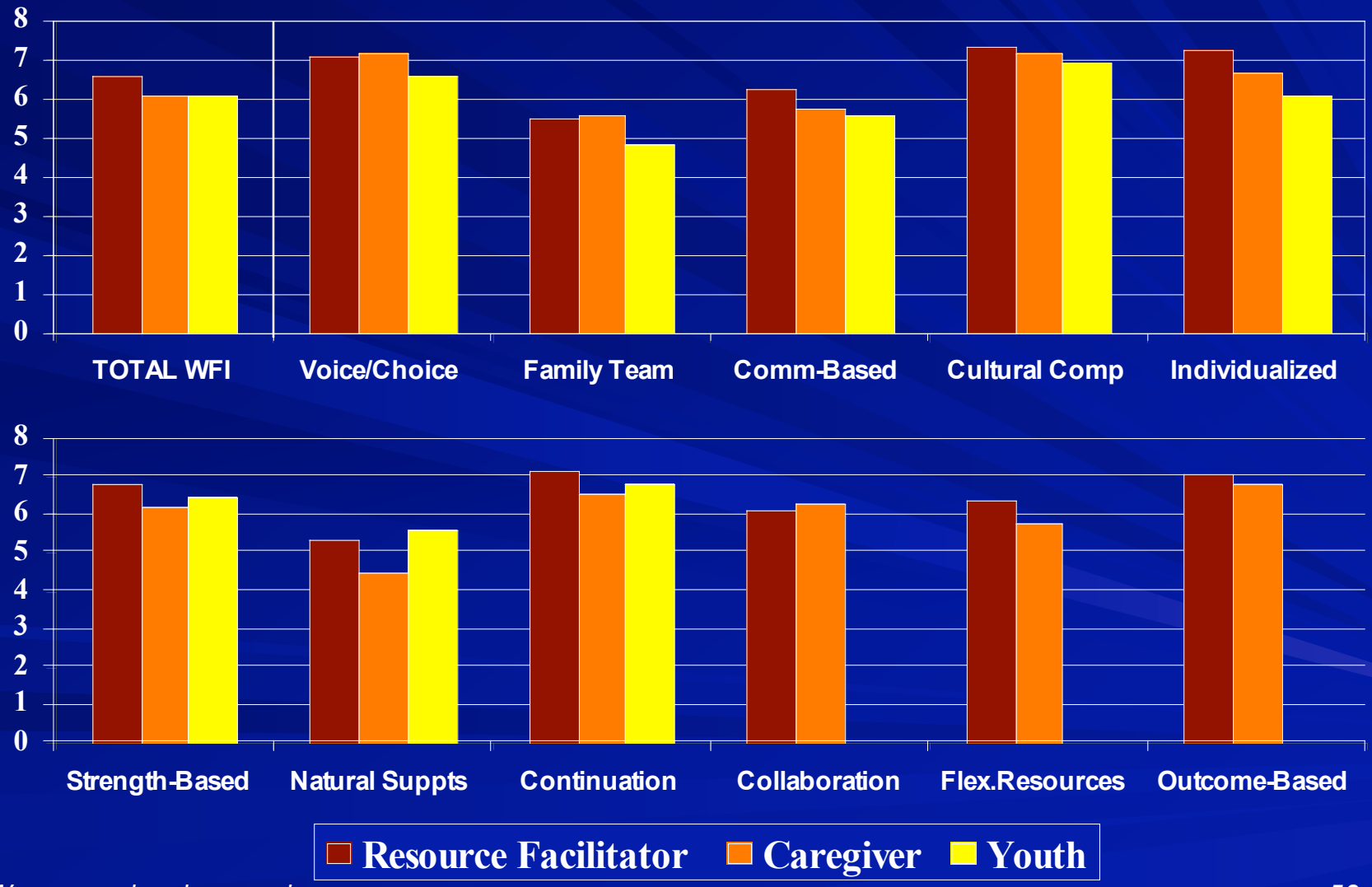
National pilot sample

Site	N Families	Number of WFI forms collected		
		WFI-RF	WFI-CG	WFI-Y
Alaska site 1	14	13	12	6
Alaska site 2	3	1	3	2
Arizona	34	26	22	24
California site 1	1	1	0	0
California site 2	20	20	12	19
California site 3	25	24	23	11
California site 4	44	32	26	31
Indiana site 1	11	11	11	6
Indiana site 2	17	17	16	6
Kentucky	32	27	31	20
Missouri site 1	40	40	30	19
Missouri site 2	46	46	37	25
Nebraska	43	18	32	0
North Carolina	55	0	43	40
Vermont site 1	5	3	3	0
Vermont site 2	14	14	12	10
Total WFIs	404	293	313	219

NOTE: WFI = Wraparound Fidelity Index; RF = Resource Facilitator; CG = Caregiver; Y= Youth

National practice in Wraparound

WFI Scores across Elements and Respondents



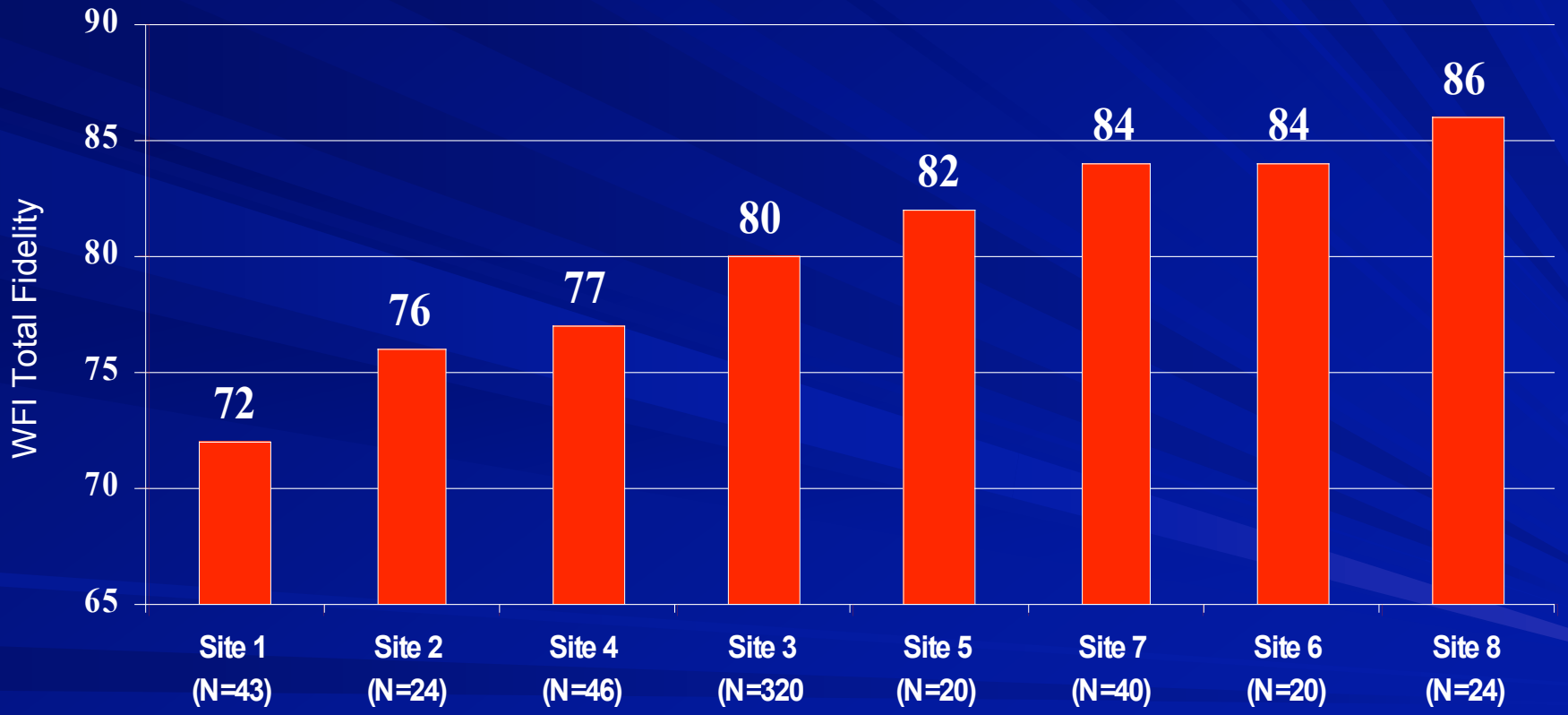
Common shortcomings in services

From analysis of WFI element and item scores

- Failing to incorporate full complement of important individuals on the individualized services team
- Failing to engage the youth in community activities, activities the youth does well, or activities that will allow him or her to develop appropriate friendships
- Failing to use family and community strengths to plan and implement services
- Failing to use natural supports, such as extended family members and community members
- Lack of flexible funds to help implement innovative ideas that emerge from the ongoing team planning process
- Inconsistent outcome & satisfaction assessment

Variation across Wraparound sites

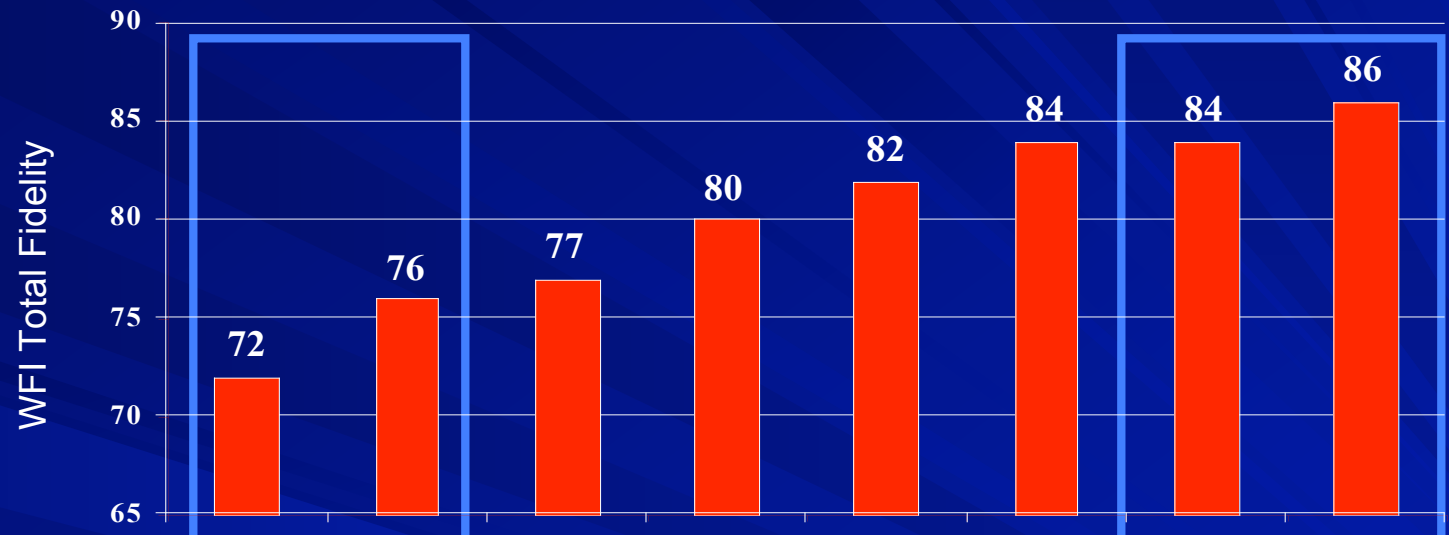
Total Fidelity Scores



Assessing program/system characteristics
Domains of the WFI-Program Administrator form

- General Site infrastructure
  - **Number of years the program has served families via Wraparound**
  - **Number of families served**
  - **Caseload of Resource Facilitators**
  - **Staff turnover**
- Program- & system-level adherence to Wraparound principles
  - **Interagency collaboration**
  - **Pooled funding**
  - **Natural supports**
  - **Family-centered policies**
  - **Flexible funding and supports**
  - **Outcome measurement**

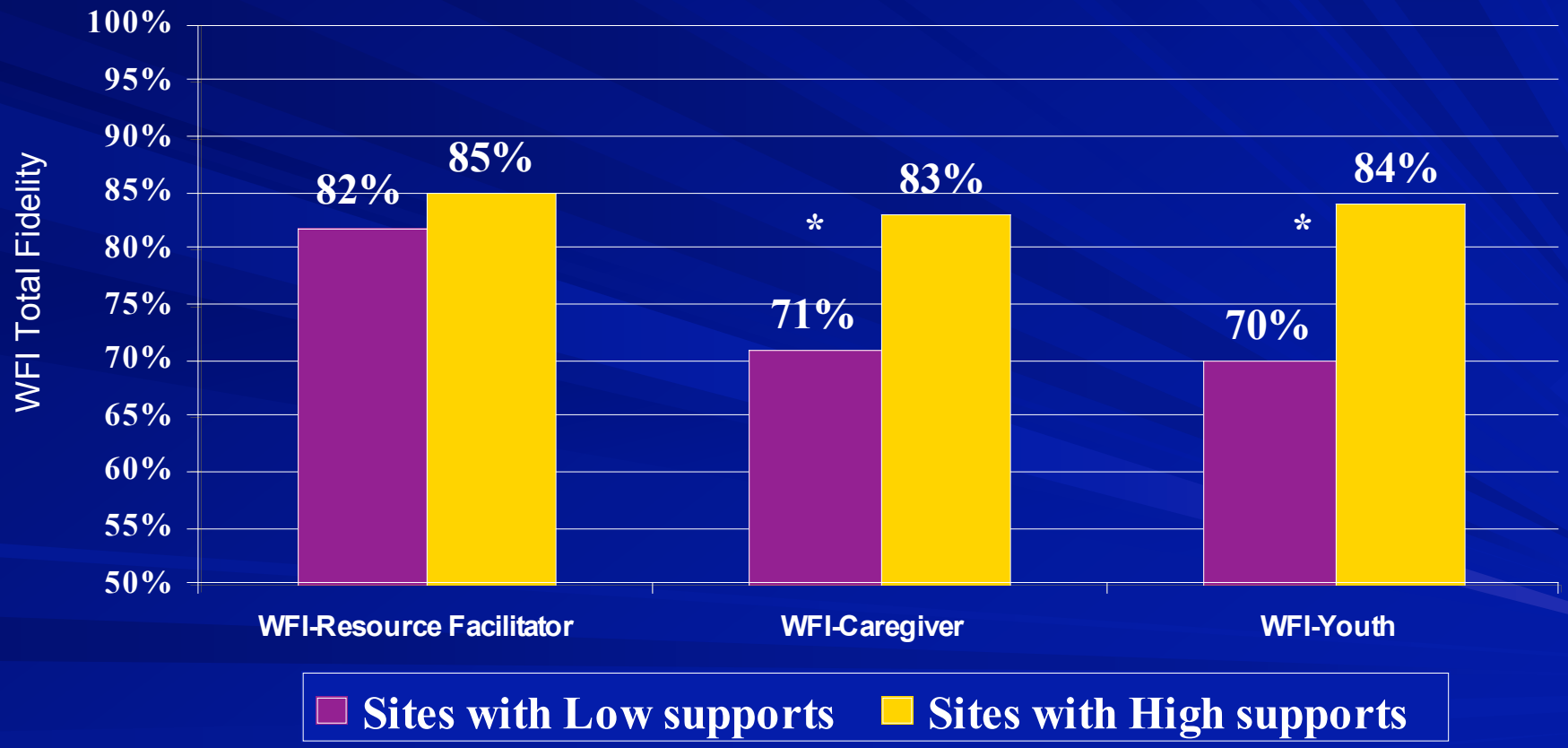
Number of system and program supports predicts wraparound fidelity



WFI-PA domains	Site 1	Site 2	Site 4	Site 3	Site 5	Site 7	Site 6	Site 8
Program Longevity	Y				Y	Y	Y	Y
Low Caseload Size		Y	Y	Y	Y			Y
Low Staff turnover			Y	Y		Y		
Interagency collab.	Y		Y	Y			Y	Y
Pooled funding					Y		Y	
Natural supports	Y			Y	Y	Y	Y	Y
Family centeredness		Y		Y		Y	Y	Y
Fund/Serv.Flexibility					Y	Y	Y	Y
Outcomes assessed					Y	Y	Y	Y
TOTAL WFI-PA	3	2	3	5	6	6	7	7

National study of wraparound supports

Greater level of system and program supports leads to higher fidelity scores



*p<.01

Predictors of higher-quality WA

Predicting Total WFI scores from system/program characteristics

Step		Beta	t	Sig	R-sq
1	Program N years	.214	2.76	.006***	
	N families served	.003	.496	.620	
	Average caseload	-.09.1	-3.29	.001***	
	Staff turnover rate	1.171	1.09	.310	**.08****
2	Program N years	.236	1.74	.084*	
	Currently serving	.003	1.37	.171	
	Average caseload	-.122	-3.09	.002***	
	Staff turnover rate	.720	.339	.735	
	Pooled funding?	-.012	-.045	.964	
	Fam centered?	-.546	-1.11	.267	
	Flex funding?	.414	1.89	.060*	
	Outcome-Based?	.623	1.94	.054**	**.10****

***p<.001; **p<.01; *p<.1;

Wraparound Fidelity and Outcomes Study

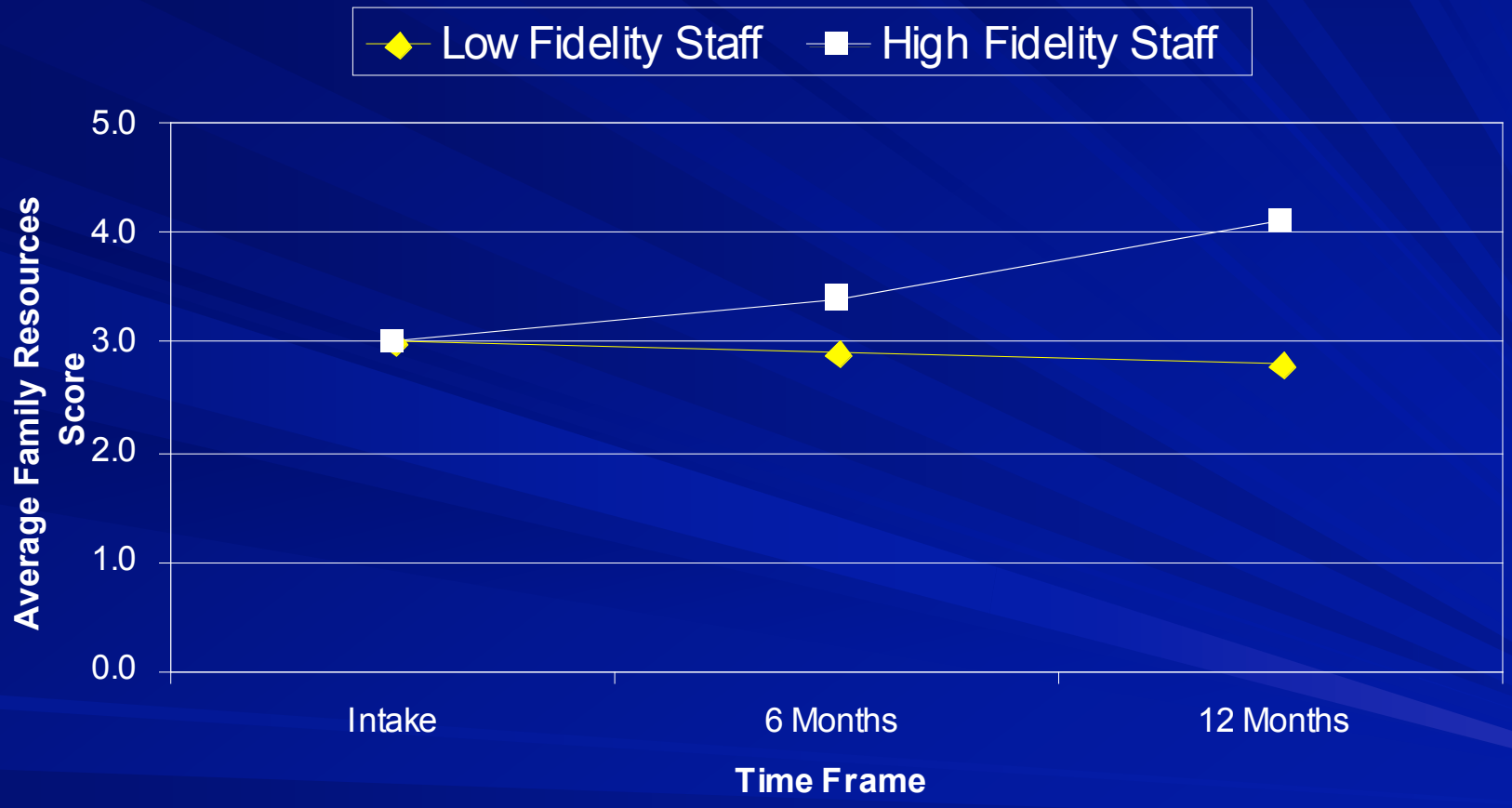
Wraparound Fidelity and Outcomes Study

Did Wraparound Fidelity Predict Outcomes?

Behavior (CBCL)	***yes***
Functioning (CAFAS)	**no**
Restrictiveness	***yes***
Overall satisfaction	***yes****
Satisfaction with child's progress	***yes***

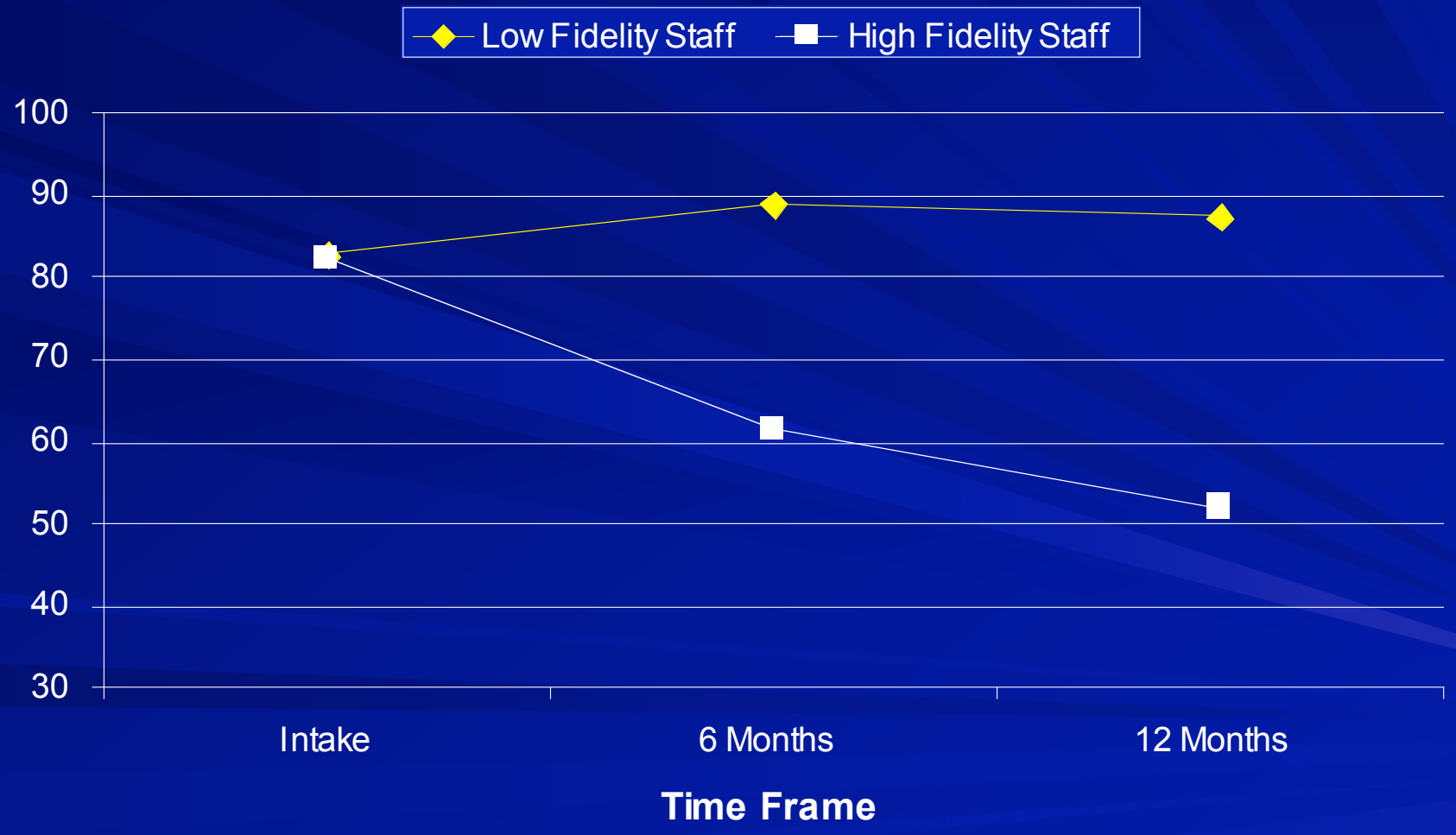
***p<.05; *p<.1*

Low- vs. high-fidelity wraparound in AZ: Family resources

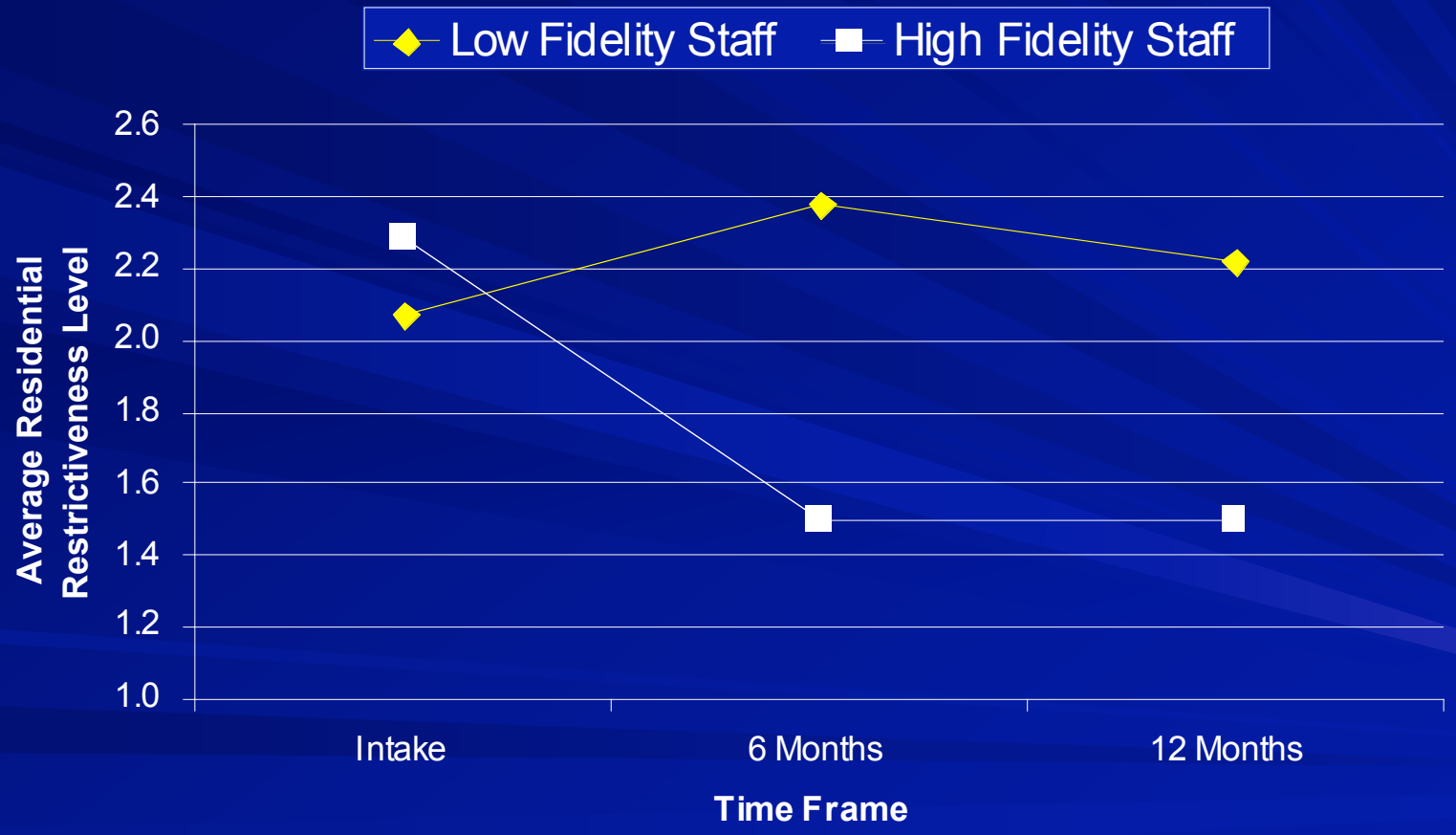


FRS measures a caregiver's report on the adequacy of a variety of resources (time, money, energy, etc.) needed to meet the needs of the family as a whole, as well as the needs of individual family members. Group average on the scale of 1 – 5 1 = Not at all adequate5 = Almost always adequate

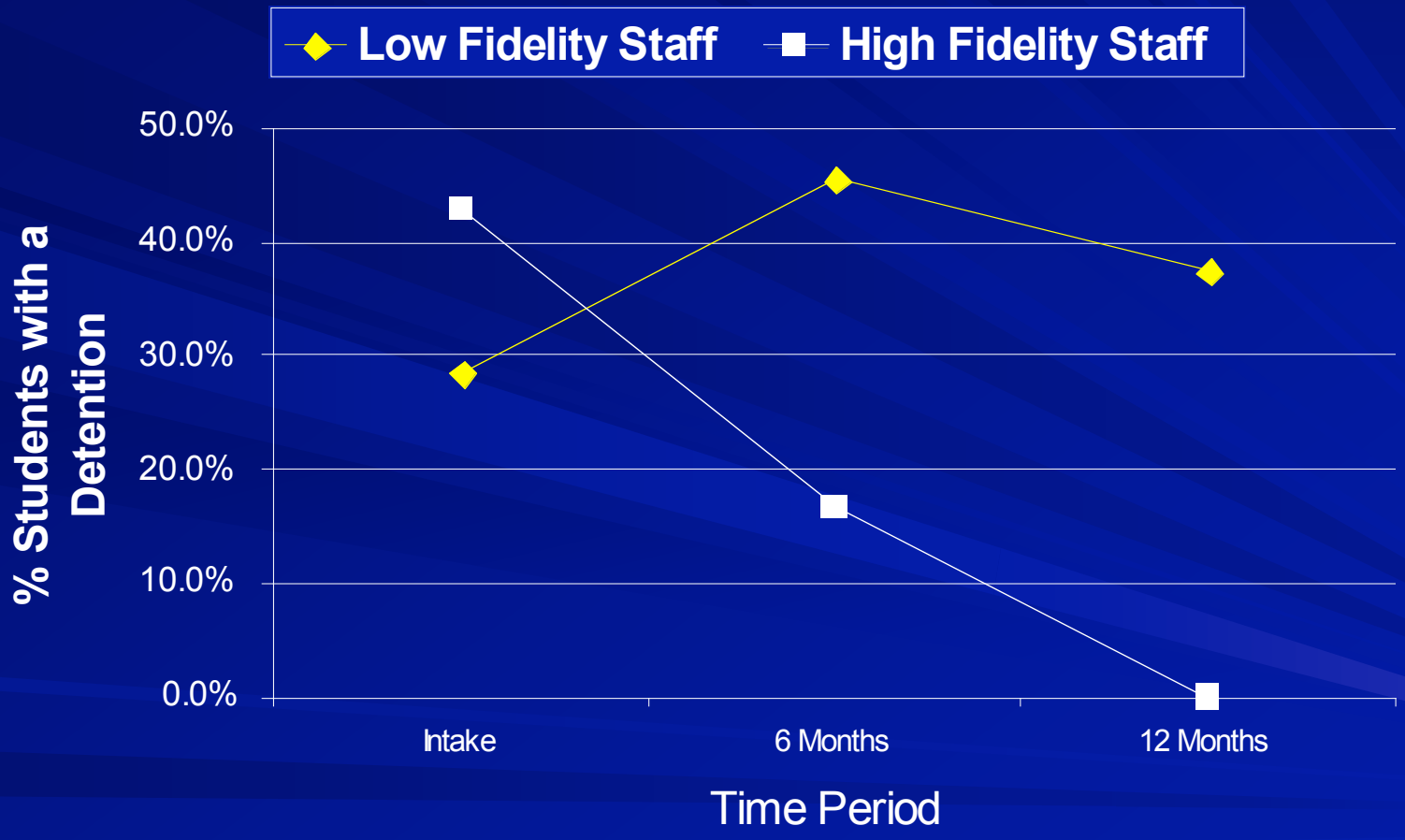
Low- vs. high-fidelity wraparound in AZ:
Child Behavior



Low- vs. high-fidelity wraparound in AZ: Residential Restrictiveness



Low- vs. high-fidelity wraparound in AZ: Educational Outcomes



Synthesis (no.3)

- Theory and observational research point to need for specifying methods to achieve high-quality implementation
- Even among self-selecting sites, adherence to philosophical principles is low for many domains and varies significantly
- Program and system characteristics seem to predict adherence to Wraparound principles
- Adherence to wraparound principles may be associated with improved outcomes

Emerging evidence

Surfacing factors that lead to outcomes

Program Administrative and System Characteristics → **Adherence to WA Principles in service delivery** → **Improved Child and Family Outcomes**

- Regulating caseload size, providing support for teams and staff
- Ensuring interagency coordination, blended funding, team training, availability of flexible funding
- Mandating specific policies; e.g., presence of natural supports, regular outcome and fidelity assessment

- Specialized roles for teams and providers
- Empowering flexible & creative service planning/implementation
- Training in specific provider behaviors
- Regular supervision tied to a specified model
- Training in effective team functioning
- Feedback of fidelity data in QA activities

- Meeting youth- and family-identified goals
- Maintenance in normalized school and community settings
- Improved functioning

Model definition for the wraparound process

“National Wraparound Initiative”

- Goals
  - To provide the field with a better understanding of the wraparound process and what is required to do implement the process in keeping with its principles
  - To facilitate implementation and evaluation research
    - Design of implementation tools
    - Design of logic models
  - To allow for replication of wraparound models found to have positive impact
  - To bring providers, trainers, researchers, parents/ advocates together into a learning and sharing community

“National Wraparound Initiative”

- Supported by:
  - Maryland Dept of Juvenile Services
  - Maryland Mental Hygiene Administration
  - US DHHS Center for Medical and Medicaid Services
  - Technical Assistance Partnership, American Institutes for Research
  - SAMHSA Center for Mental Health Services Research, Child, Adolescent and Family Branch

National Wraparound Initiative, phase 1

- Products
  - Agreed upon definitions and terms
  - Agreed upon description of the wraparound principles, specified for a team and family
  - Clear description of the phases and activities in a wraparound process
  - Required system and organizational conditions
  - Family member, youth, and team member Guides
- Methods
  - Existing elements and practice principles
  - Compiling of existing manuals, training materials, and literature
  - Small coordinating group
  - National Advisory Group (75 members)
  - Consensus-building research protocol (web-enabled *Delphi* process)

Findings from phase 1

- Method: *Delphi* process on revised principles and wraparound phases and activities
  1. Coordinators of the Delphi process consider the issue in an in-depth and open-ended manner.
  2. Coordinators synthesize the information and develop a questionnaire based on that synthesis for circulation to a chosen group of experts.
  3. The experts provide their responses to the questionnaire anonymously.
  4. Results from the questionnaire are aggregated by the coordinators, who circulate the results back to the experts in the form of a new questionnaire.
- Total N respondents = 53

Revised principles of wraparound

- Round 1: Agreement on overall acceptability of principles averaged 93%
  - Agreement across principles ranged from 87% (Youth and Family Team) to 100% (Outcome based)
- Round 2 (post-revision): Overall agreement 95% (Range = 85% - 100%)

Specifying phases and activities of wraparound

- National experts (trainers, program administrators, family advocates) worked together to surface common and/or critical procedures of a wraparound process
- Delphi process
  - Respondents (N=30) expressed a high level of agreement with the proposed set of activities.
    - For 23 of the 31 activities, there was unanimous or near-unanimous (i.e., one dissenter out of 30) agreement that the activity was essential.
    - For 20 of the 31 activities, all respondents rated the specific description of the activity acceptable
    - Only three activity definitions that were found unacceptable by two or more respondents.

Wraparound Process Implementation Facilitator Duties

Phase One: Engagement and Preparation

- ✓ Meets with family & stakeholders
- ✓ Gathers perspectives on strengths & needs
- ✓ Assess for safety & rest
- ✓ Provides or arranges stabilization response if safety is compromised
- ✓ Explains the wraparound process
- ✓ Identifies, invites & orients Child & Family Team members
- ✓ Completes strengths summaries & inventories
- ✓ Arranges initial Wraparound planning meeting

Phase Two: Plan Development

- ✓ Holds an initial Plan of care Meeting
- ✓ Introduces process & team members
- ✓ Presents strengths & distributes strength summary
- ✓ Solicits additional strength information from gathered group
- ✓ Leads team in creating a mission
- ✓ Introduces needs statements & solicits additional perspectives on needs from team
- ✓ Creates a way for team to prioritize needs
- ✓ Leads the team in generating brainstormed methods to meet needs
- ✓ Solicits or assigns volunteers

Wraparound Process Implementation Facilitator Duties

Phase Three: Plan Implementation & Refinement

- ✓ Sponsors & holds regular team meetings
- ✓ Solicits team feedback on accomplishments & documents
- ✓ Leads team members in assessing the plan
  - For Follow Through
  - For Impact
- ✓ Creates an opportunity for modification
  - Adjust services or interventions currently provided
  - Stop services or interventions currently provided
  - Maintain services or interventions currently provided
- ✓ Solicits volunteers to make changes in current plan array
- ✓ Documents & distributes team meetings

Phase Four: Transition

- ✓ Holds meetings
  - Solicits all team members sense of progress
  - Charts sense of met need
  - Has team discuss what life would like after Wraparound
- ✓ Reviews underlying context/conditions that brought family to the system in the first place to determine if situation has changed
- ✓ Identifies who else can be involved
- ✓ Facilitates approach of "post-system" Wraparound resource people
- ✓ Creates or assigns rehearsals or drills with a "what if" approach

Implications of Delphi results

- Testify to a high level of pre-existing--though not previously explicit--agreement regarding the guiding philosophy for wraparound and the overall structure of a practice model.
- Highlight areas of concern
  - Situations that challenge the spirit of the principles
  - Particular activities that are viewed as critical to the wraparound process
- Taken together, these documents provide a sense of the structure or framework within which the actual practice of wraparound occurs

Three Levels Of Necessary Conditions For Wraparound

Hospitable System (Policy and Funding Context)

Supportive Organization

(lead and partner agencies)

Effective Team

Five Categories Of Necessary Conditions For Wraparound

- **Wraparound practice–** *Do we understand wraparound and do it in keeping with the wraparound principles?*

2. **Collaboration/Partnerships**- *Do we work together flexibly and cooperatively?*
3. **Capacity building/Staffing**- *Do we have the right jobs and working conditions?*
4. **Acquiring services and supports-** *Do we provide the services and supports teams need?*
5. **Accountability-** *Do we have tools to make sure we're doing a good job?*

– *SOURCE: Portland State Research and Training Center on Family Support and Children's Mental Health www.rtc.pdx.edu*

TEAM LEVEL	ORGANIZATIONAL LEVEL	SYSTEM LEVEL
Practice model i. Team adheres to a practice model that promotes effective planning *and* the value base of WA. •Sub-conditions of practice model 1-7	**Practice model** i. Lead agency provides training, supervision and support for a clearly defined practice model. ii. Lead agency demonstrates its commitment to the values of WA. ii i. Partner agencies support the core values underlying the team WA process.	**Practice model** i. Leaders in the policy and funding context actively support the WA practice model.
Collaboration/partnerships i. Appropriate people, prepared to make decisions and commitments, attend meetings/participate collaboratively	**Collaboration/partnerships** i. Lead and partner agencies collaborate around the plan and the team. ii. Lead agency supports team efforts to get necessary members to attend meetings and participate collaboratively. ii i. Partner agencies support their workers as team members and empower them to make decisions.	**Collaboration/partnerships** i. Policy and funding context encourages interagency cooperation around the team and the plan. ii. Leaders in the policy and funding context play a problem-solving role across service boundaries.
Capacity building/staffing i. Team members capably perform their roles on the team.	**Capacity building/staffing** i. Lead and partner agencies provide working conditions that enable high quality work and reduce burnout.	**Capacity building/staffing** i. Policy and funding context supports development of the special skills needed for key roles on WA teams.
Acquiring services/supports i. Team is aware of a wide array of services and supports and their effectiveness. ii. Team identifies and develops family-specific natural supports. ii i. Team designs and tailor services based on families' expressed needs.	**Acquiring services/supports** i. Lead agency has clear policies and makes timely decisions regarding funding for costs required to meet families' unique needs. ii. Lead agency encourages teams to develop plans based on child/family needs and strengths, rather than service fads or financial pressures. ii i. Lead agency demonstrates its commitment to developing culturally competent community and natural services and supports. v. Lead agency demonstrates its commitment to developing an array of effective providers.	**Acquiring services/supports** i. Policy and funding context grants autonomy and incentives to develop effective services and supports consistent with WA practice model. ii. Policy and funding context supports fiscal policies that allow the flexibility needed by WA teams. ii i. Policy and funding context actively supports family and youth involvement in decision making.
Accountability i. Team maintains documentation for continuous improvement and mutual accountability.	**Accountability** i. Lead agency monitors adherence to practice model, implementation of plans, and cost and effectiveness.	**Accountability** i. Documentation requirements meet the needs of policy makers, funders, and other stakeholders.

National Initiative, phase 2

- Compilation of tools/protocols to aid implementation of the phases & activities
- Revision of Wraparound Fidelity Index to ensure comprehensiveness and alignment with NWI
- Creation of full theory of change for wraparound
- Comprehensive *Wraparound Implementation Guide* that compiles the full set of implementation tools

Ongoing research projects

Clinic/community Intervention Development and Deployment Model

Step 1	Theoretically and clinically informed construction, refinement, and manualizing of the protocol
Step 2	Initial efficacy trial under controlled conditions
Step 3	Single-case applications in practice setting with progressive adaptations to the protocol
Step 4	Initial effectiveness test, modest in scope and cost
Step 5	Full test of the effectiveness under everyday practice conditions, including cost effectiveness
Step 6	Effectiveness of treatment variations, effective ingredients, moderators, mediators, and costs
Step 7	Assessment of goodness-of-fit within the host organization, practice setting, or community
Step 8	Dissemination, quality, and sustainability within new organizations, settings, & communities

Ongoing research

- Comparison of outcomes for three matched CMHS-funded system of care sites achieving different levels of wraparound fidelity
  - Service outcomes
  - Clinical/functional outcomes
- Impact on fidelity of different types/intensities of training and coaching models
- Attitudes and practices of wraparound vs. non-wraparound providers around implementing evidence-based treatments
- Bootstrapping of fidelity benchmarks using national WFI sample (N=800 families in 16 sites)

Planned projects and protocols under review

- Randomized trial of wraparound process vs. traditional case management
- Randomized trial of wraparound process as implemented by MH facilitators vs. CPS case workers vs. treatment as usual
- Single-subject case design research in multiple sites nationally using consistent research protocol

Resources and Websites

- National Wraparound Initiative: www.rtc.pdx.edu/nwi
- Wraparound Fidelity Index: www.uvm.edu/~wrapvt
- Walker, Koroloff, Schutte monograph on Necessary supports for ISP/wraparound: www.rtc.pdx.edu
- Vroon VanDenBerg, LLC: www.vroonvdb.com
- Focal Point issue on Quality and Fidelity in Wraparound: http://www.rtc.pdx.edu/pgFocalPoint.shtml
- CMHS monographs on wraparound (2001, vol 1; 1998, vol 4): http://mentalhealth.samhsa.gov/cmhs/ChildrensCampaign/practices.asp