Integrating Common Elements of Evidence Based Practice into the Wraparound Process, Part 1

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California Wraparound Institute

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Overview of this session

- Is wraparound evidence based? What might be improved in the practice model?
- What about evidence based treatments? How is the field getting them into “real world” practices like Wraparound?
- Flexible approaches to promoting EBP: Managing and Adapting Practice (MAP)
- Integrating MAP and Wrap: Some options
- Reflection, Q & A and Discussion

Session 2 (330-5pm)

- More in-depth exploration of methods to incorporate “common elements and factors” of EBP into wraparound
  - MAP tools
  - Management feedback system for Wraparound
- Exercise – how can MAP tools be applied to families in wraparound?

Wraparound

- Is a system level intervention; however
- It has a complex and intensive practice component

What characterizes the practice of wraparound?

- Facilitator undertakes a defined engagement phase with documentation of youth/family strengths, needs, and culture
- Interdisciplinary team specific to the youth is convened and meets frequently
- Natural supports and informal, community supports are brought to the table and are part of the team/plan
- A plan is developed by the team, integrated across helpers, and updated frequently
- Intensive effort by facilitator and team to monitor progress and follow through on efforts of team members

Is Wraparound Evidence Based?

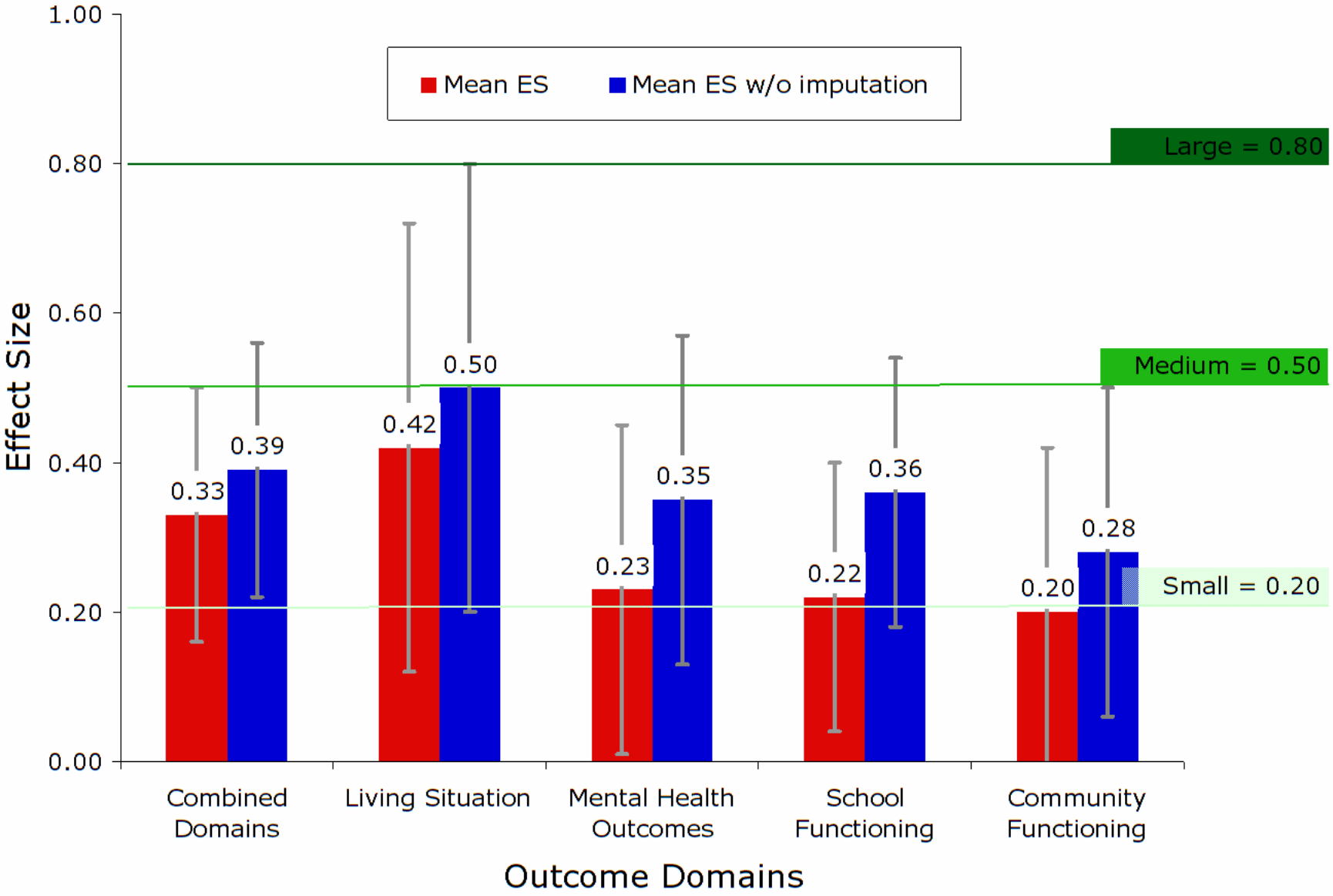
- Incorporates several common factors of evidence based treatment
  - Engagement strategies
  - Promoting social support
  - Ecological focus (holistic, full family focus) community-based)
  - Outcomes focus (frequent progress monitoring)
- Widespread support from providers and families
- 100,000 + children served nationwide
- But… what about the research?

What is the research base?
Nine Published Controlled Studies of Wraparound

Study	Target population	Control Group Design	N
1. Hyde et al. (1996)*	Mental health	Non-equivalent comparison	69
2. Clark et al. (1998)*	Child welfare	Randomized control	132
3. Evans et al. (1998)*	Mental health	Randomized control	42
4. Bickman et al. (2003)*	Mental health	Non-equivalent comparison	111
5. Carney et al. (2003)*	Juvenile justice	Randomized control	141
6. Pullman et al. (2006)*	Juvenile justice	Historical comparison	204
7. Rast et al. (2007)*	Child welfare	Matched comparison	67
8. Rauso et al. (2009)	Child welfare	Matched comparison	210
9. Mears et al. (2009)	MH/Child welfare	Matched comparison	121

*Included in 2009 meta-analysis (Suter & Bruns, 2009)

Mean Effect Sizes of Wraparound



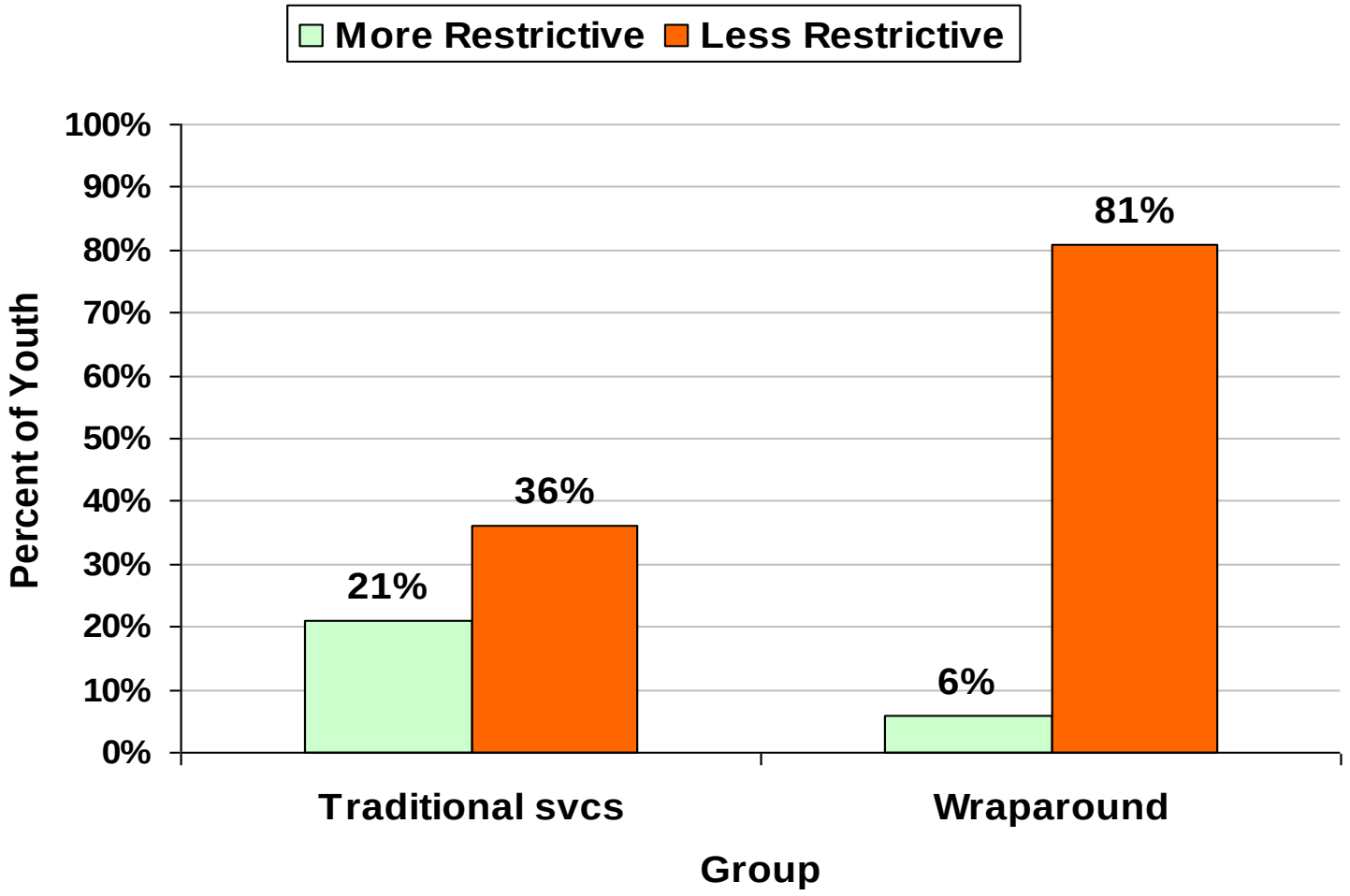
Research to Date on Wraparound

- 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
  - **But… Sometimes, outcomes are poorer than for cheaper, alternative conditions**

*Suter, J.C. & Bruns, E.J. (2009). Effectiveness of the Wraparound Process for Children with Emotional and Behavioral Disorders: A Meta-Analysis. *Clinical Child and Family Psychology Review, 12,* 336-351

Results from Nevada:

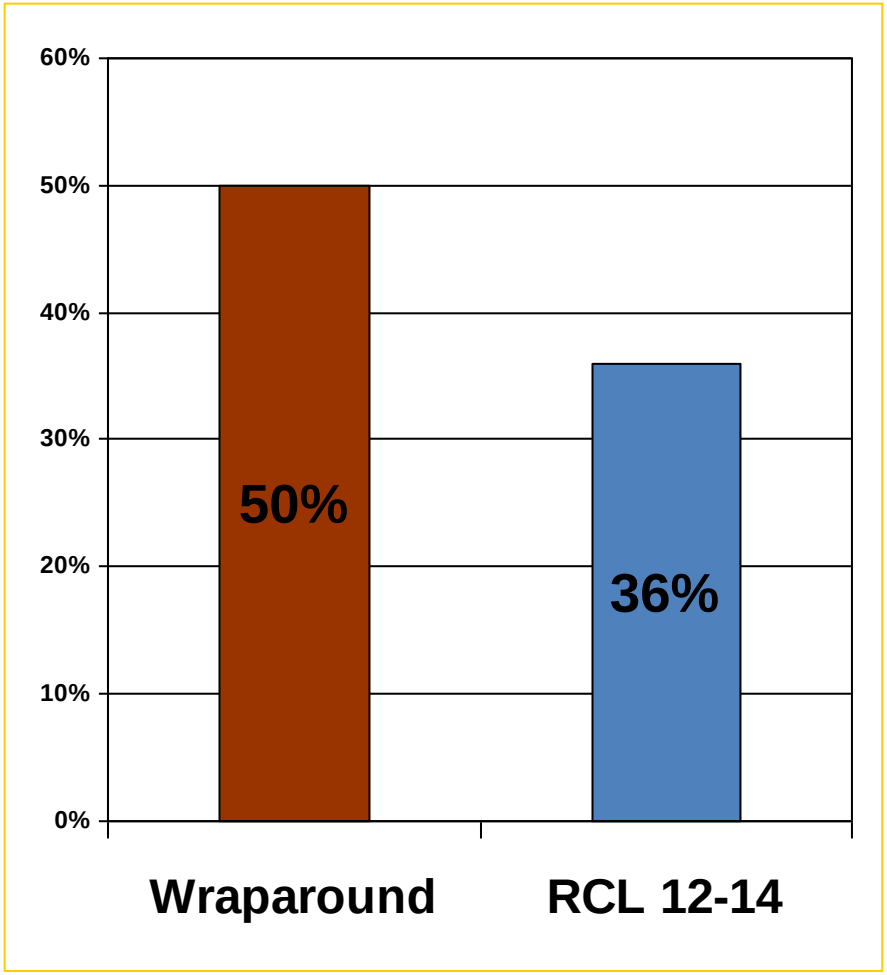
Impact on Residential Placement



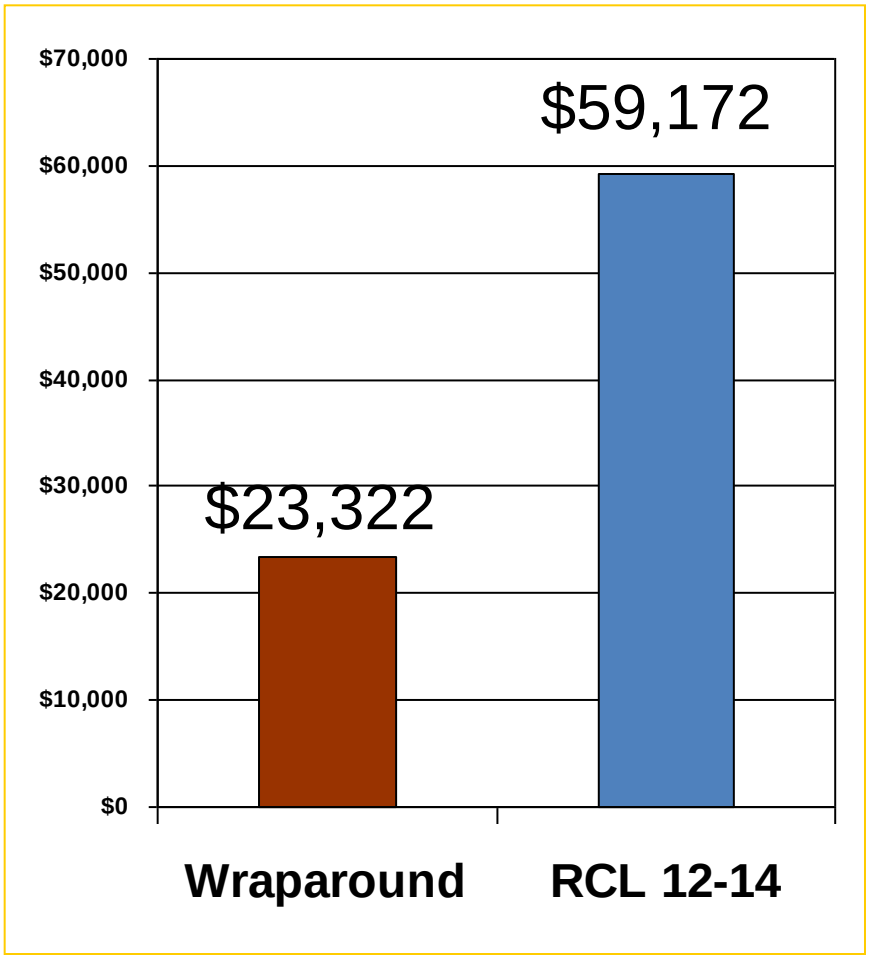
Bruns, E.J., Rast, J., Walker, J.S., Peterson, C.R., & Bosworth, J. (2006). Spreadsheets, service providers, and the statehouse: Using data and the wraparound process to reform systems for children and families. *American Journal of Community Psychology, 38,* 201-212.

Los Angeles County Research Study: Outcomes 18 months after wraparound or RCL 12-14

Percent of youths living at home



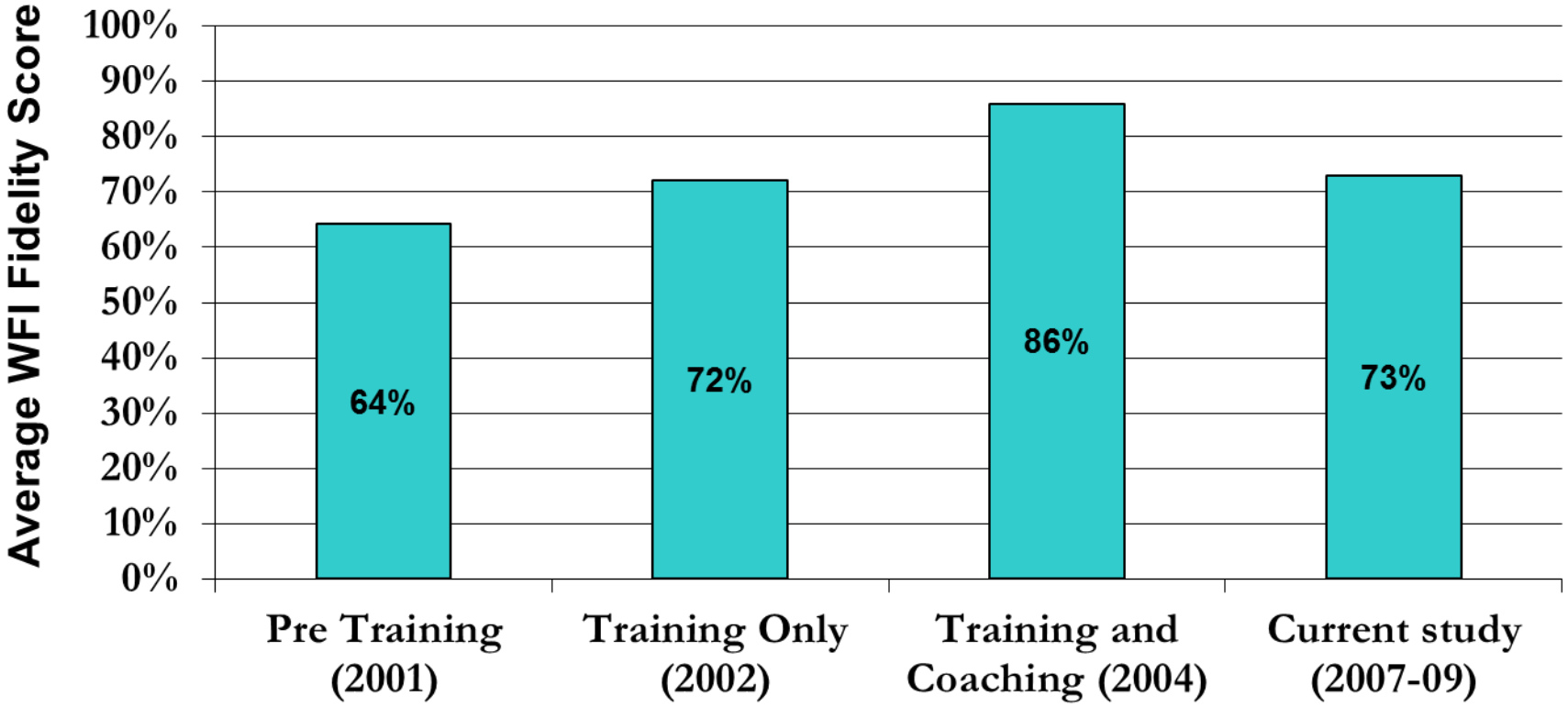
Average out of home placement cost per child



Summary of the research

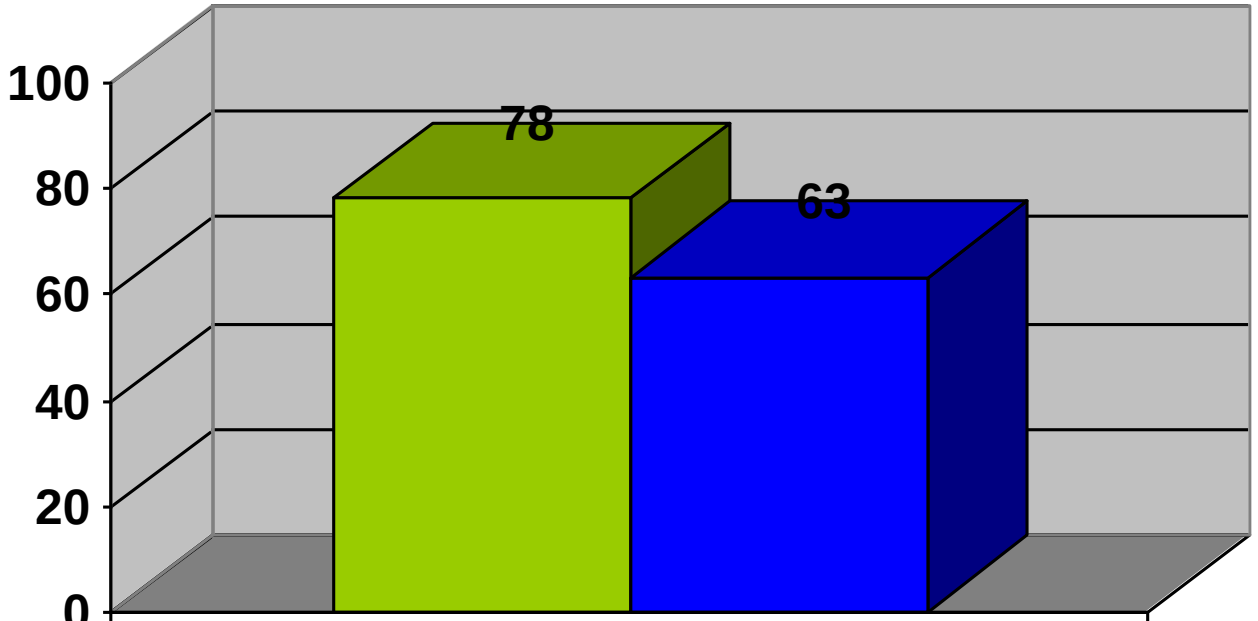
- The news is good overall for wraparound's effectiveness *when implemented as intended, and with connection to effective services*
- However, we have 2 big problems with wraparound:
  - The implementation / fidelity issue
  - Connections to effective clinical care

The Fidelity issue: Caregiver WFI Fidelity over time in NV



Bruns, Rast, Walker, Peterson, & Bosworth (2006).
American Journal of Community Psychology.

Team Observation Results from Nevada



	Total TOM % Fidelity
Nat'l mean	78
Wrap in NV	63

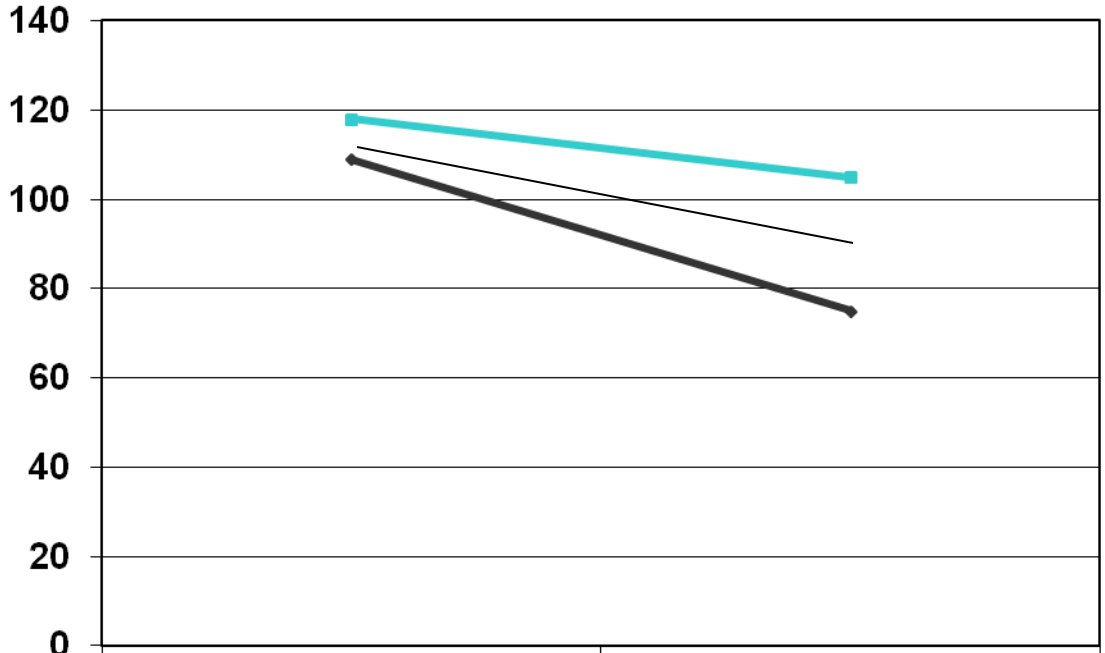
Mean over 3 waves of data collection

What was no longer happening?

- Families identifying team members
- Natural supports being meaningfully involved
- Effective crisis planning taking place
- Teams developing statements of mission, goals, or priority needs
- Teams finding creative, individualized ways to meet needs
- Youth involved in community activities
- Team members following through on tasks
- Effective transition planning

What happened to the outcomes?

Average functional impairment score from the CAFAS



	Baseline	6 mos
Wrap gone to scale (2008)	118	105
Wrap pilot (2005)	109	75

Bruns, Pullmann, Sather, Brinson, & Ramey, in submission

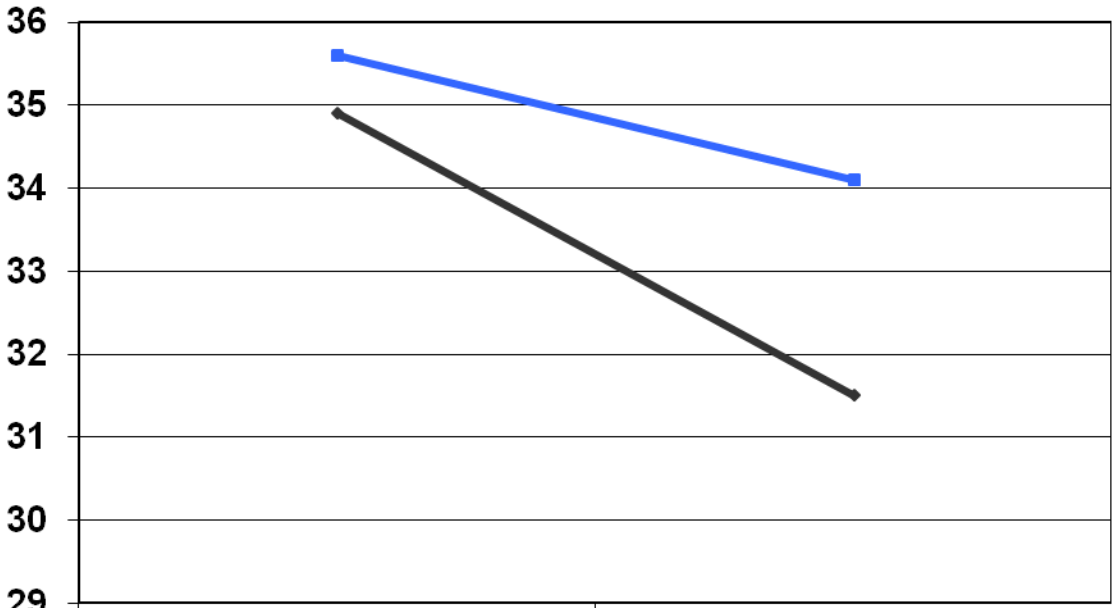
Clinical outcomes in an Evaluation in Washington State

	Baseline	6 Months
North Sound	21.3	19.9
Wrap Wash	23.7	20.9

Largest weaknesses as identified on CSWI by system stakeholders:
Adequacy of service array and teamwork by providers and systems

Emotional and Behavioral Problems
6 month outcomes from a randomized study of wrap vs. clinical case management

SDQ – Total EBD Problems

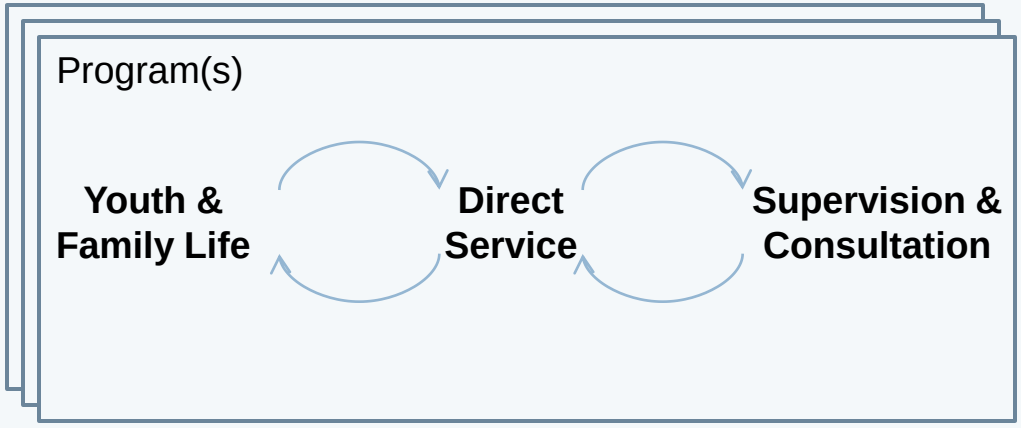


	Baseline	6 mos
Wrap (n=42)	35.6	34.1
ICM (n=34)	34.9	31.5

New directions

- The field would benefit from an enhancement to Wraparound that
  - Promotes more consistent implementation of elements of the practice model that drive ultimate outcomes
  - Supports the necessary support condition for wraparound that effective treatment is available and provided
    - NWI study (Walker et al, 2003) – 95% of teams studied had therapy
    - LA County providers – 75% - 90% receive therapy
- The question is: HOW? What is an approach to EBP that would work?

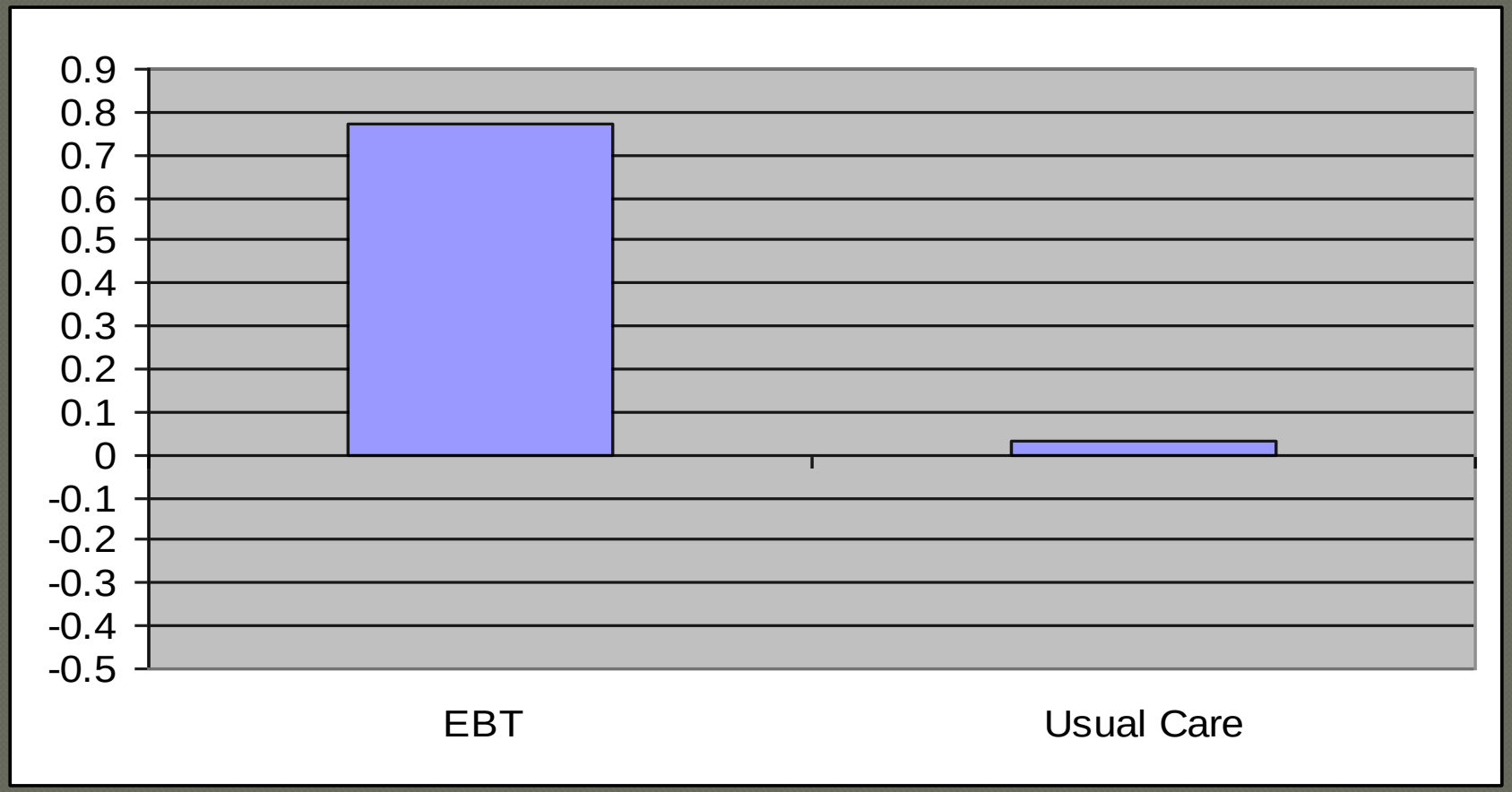
“The System”


Program(s)
Youth & Family Life
Direct Service
Supervision & Consultation

No Shortage of Evidence

- Chorpita et al. (2011) identified 395 evidence-based protocols in a recent review of over 750 non-pharmacological treatments tested in controlled clinical trials

Comparison with Usual Care



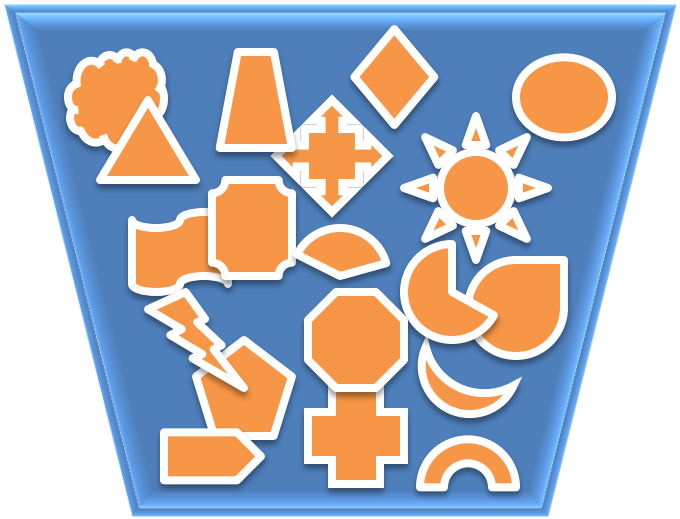
Weisz et al., (1995); see also Weisz et al., (2006)

Questions Raised

- "How can I learn enough EBTs?"
- "Aren't there other forms of evidence?"
- "What about what I was doing before?"
- "How will what I learn stay current?"
- "Are there EBTs for all the different kinds of kids I see?"
- "What do I do if there are not?"
- "What do I do if a child does not respond to an EBT?"

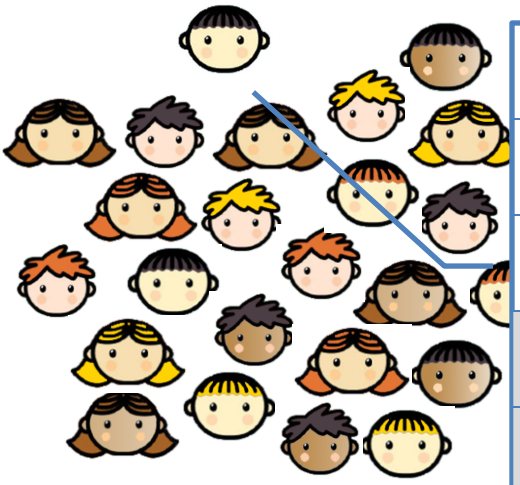
A Look at the Current Paradigm

- "Relevance Mapping"
  - Combine study data and client/student information to see how well the studies apply to the kids who you serve



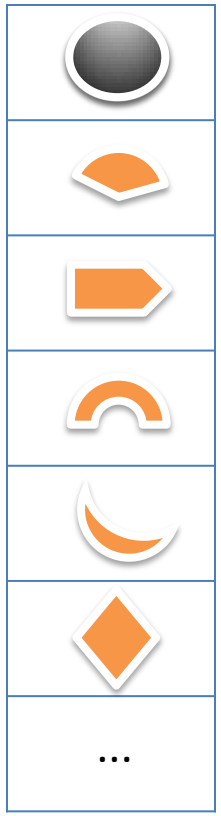
Treatments from the Literature

EBTs

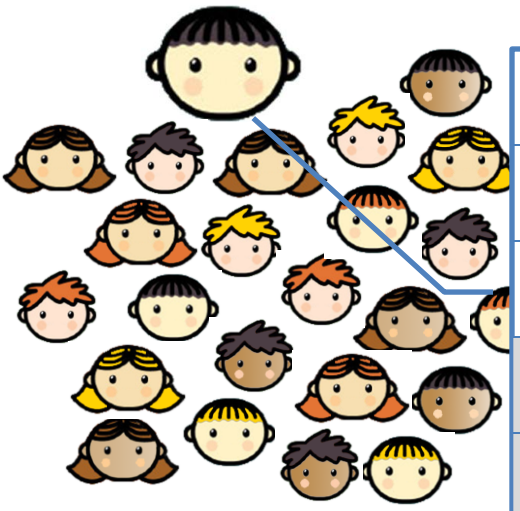


P	Anxiety
A	8 years old
G	Male
E	Hispanic
S	School

×	P	Depression
×	A	13-17
✓	G	F & M
	E	Caucasian
	S	Clinic



EBTs



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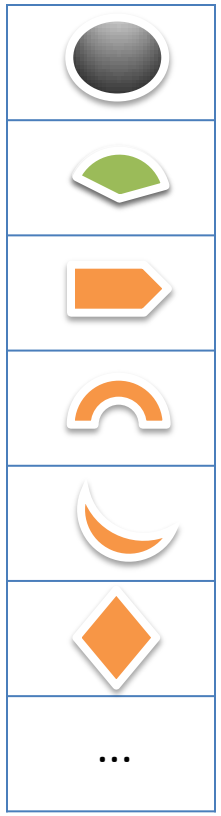
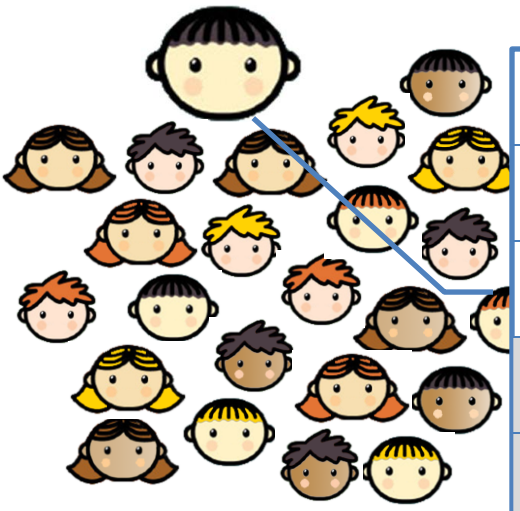


EBTs



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G	Male
E	Hispanic
S	School

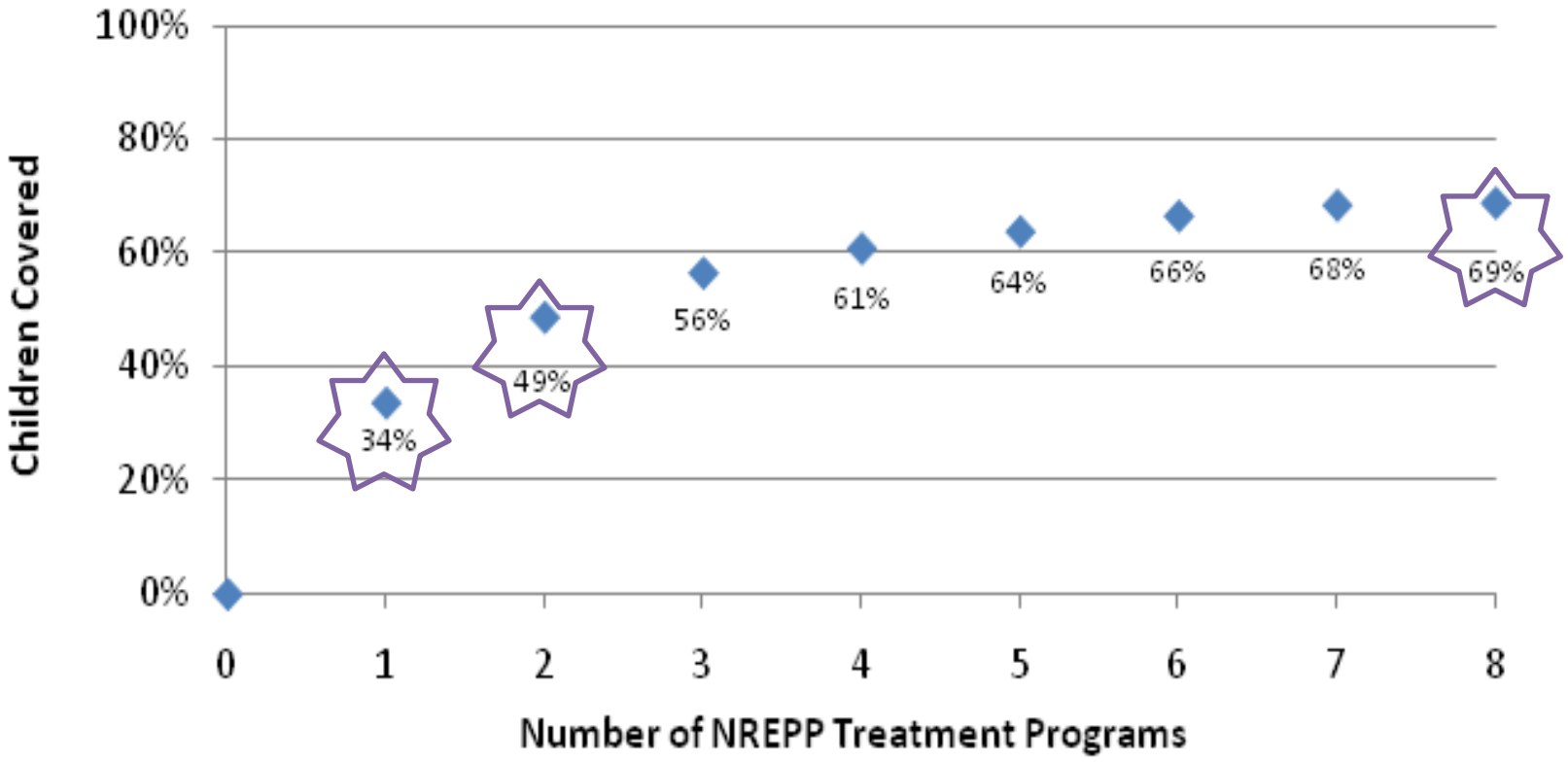
✓	P	Anxiety
✓	A	8-10
✓	G	F & M
	E	…
	S	…

…

EBTs

Match Table:
Child x Treatment

Effect of Adding Programs



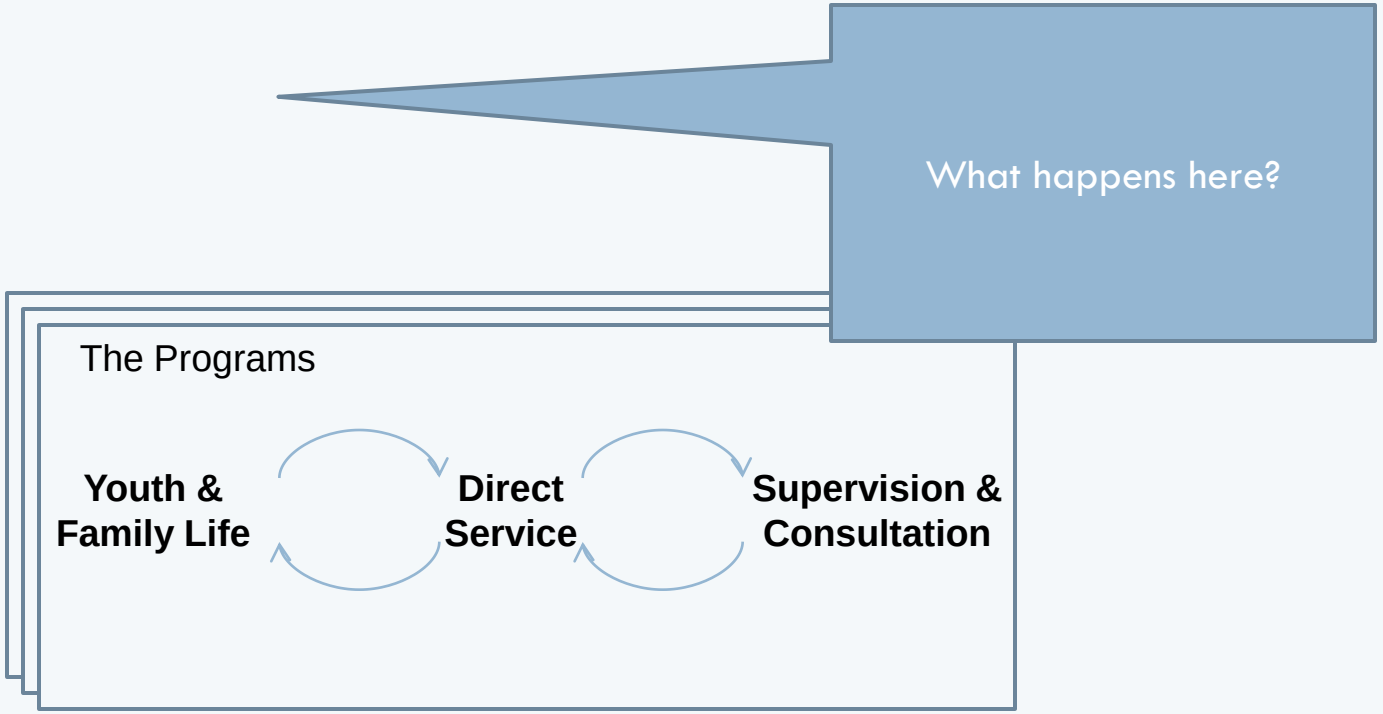
A Local Menu of Best Programs

	1 Treatment Program		4 Treatment Programs		8 Treatment Programs	
Percentage of Children Covered:	33.6%		60.7%		68.6%	
NREPP Program	**In best set?**	**Case Application**	**In best set?**	**Case Application**	**In best set?**	**Case Application**
Community Reinforcement Approach			☐	4.3%	☐	4.3%
Adolescent Coping W/ Depression			✓	15.0%	✓	15.0%
Brief Strategic Family Therapy			☐	4.3%	☐	4.3%
Children's Summer Treatment Prgrm					✓	1.9%
Coping Cat					✓	2.9%
Family Behavior Therapy			☐	4.3%	☐	4.3%
Incredible Years					✓	2.8%
Multidimensional Family Therapy			☐	4.3%	☐	4.3%
MST for Juvenile Offenders	✓	33.6%	✓	33.6%	✓	33.6%
Trauma Focused CBT			✓	7.8%	✓	7.8%
Triple P--Positive Parenting Prgrm					✓	0.5%

Summary

- Good news: Just a few EBT programs can go a long way (if chosen *carefully*)
- Bad news: Diminishing returns, and programs are not enough
  - Even if you knew 395 EBTs, you could have roughly 1/3 of youth and families receiving "usual care"

The System


What happens here?
The Programs
Youth & Family Life
Direct Service
Supervision & Consultation

But the idea was to build a better *system*…

- State of the art
- Self-correcting
- Prioritizes best ideas
- Locally relevant (culture, values)

A Knowledge Management Approach

- In addition to installing and arranging EBTs in a system…
- Improve the practices that are already there
- See the evidence base as *knowledge* and not simply *products*…

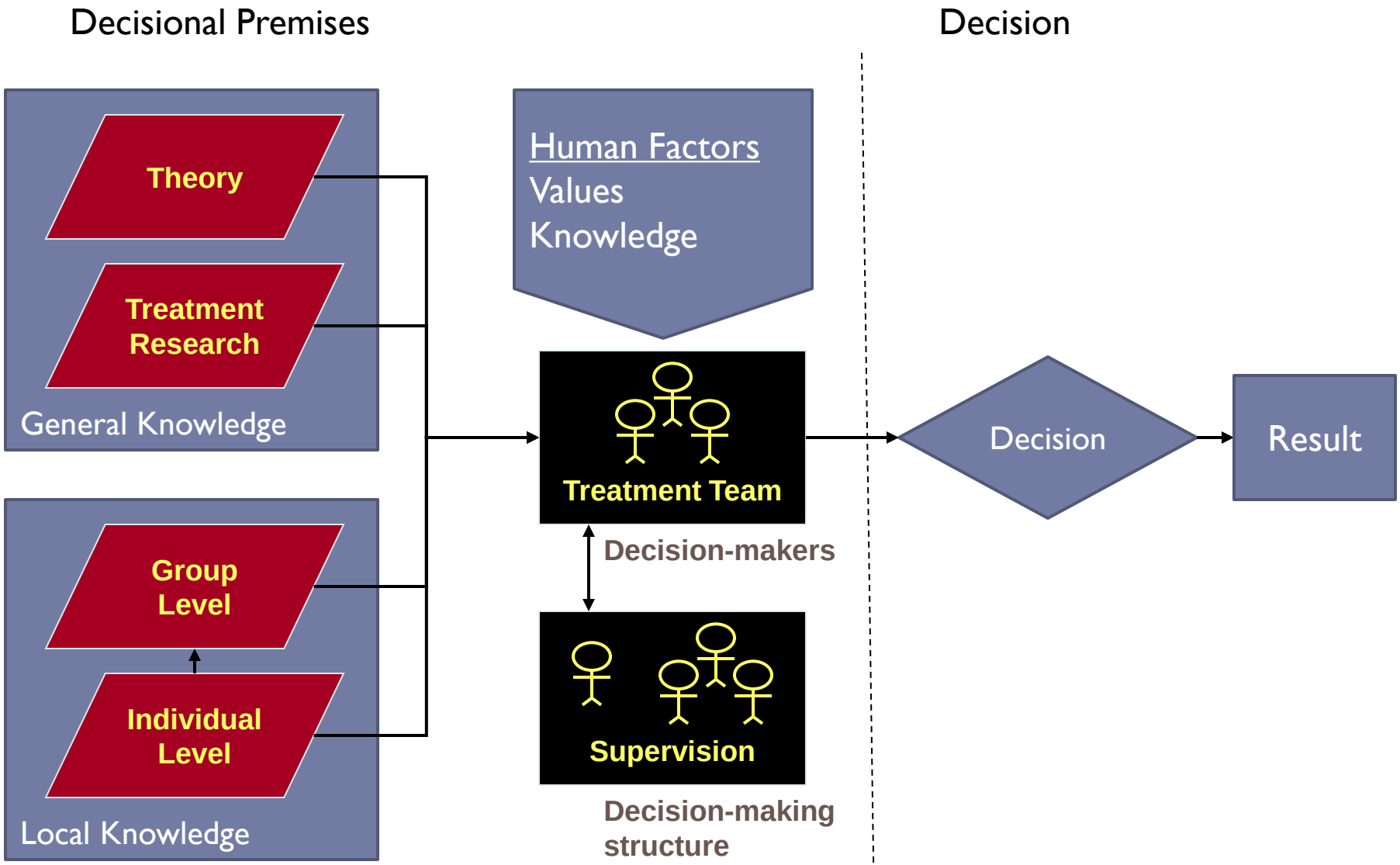
A Knowledge Management Approach

- Model the decisions in systems
- Deliver best information to guide those decisions
- Local control and adaption occurs in the field in real time
  - e.g., treatments are "collaboratively designed" by therapists, families, and treatment developers

Managing and Adapting Practice (MAP)

- Not really a treatment, but more of a framework for collaborative treatment design
- Its direct service model is not another treatment program, but a way to improve "usual care" in the rest of the system (or the entire system)

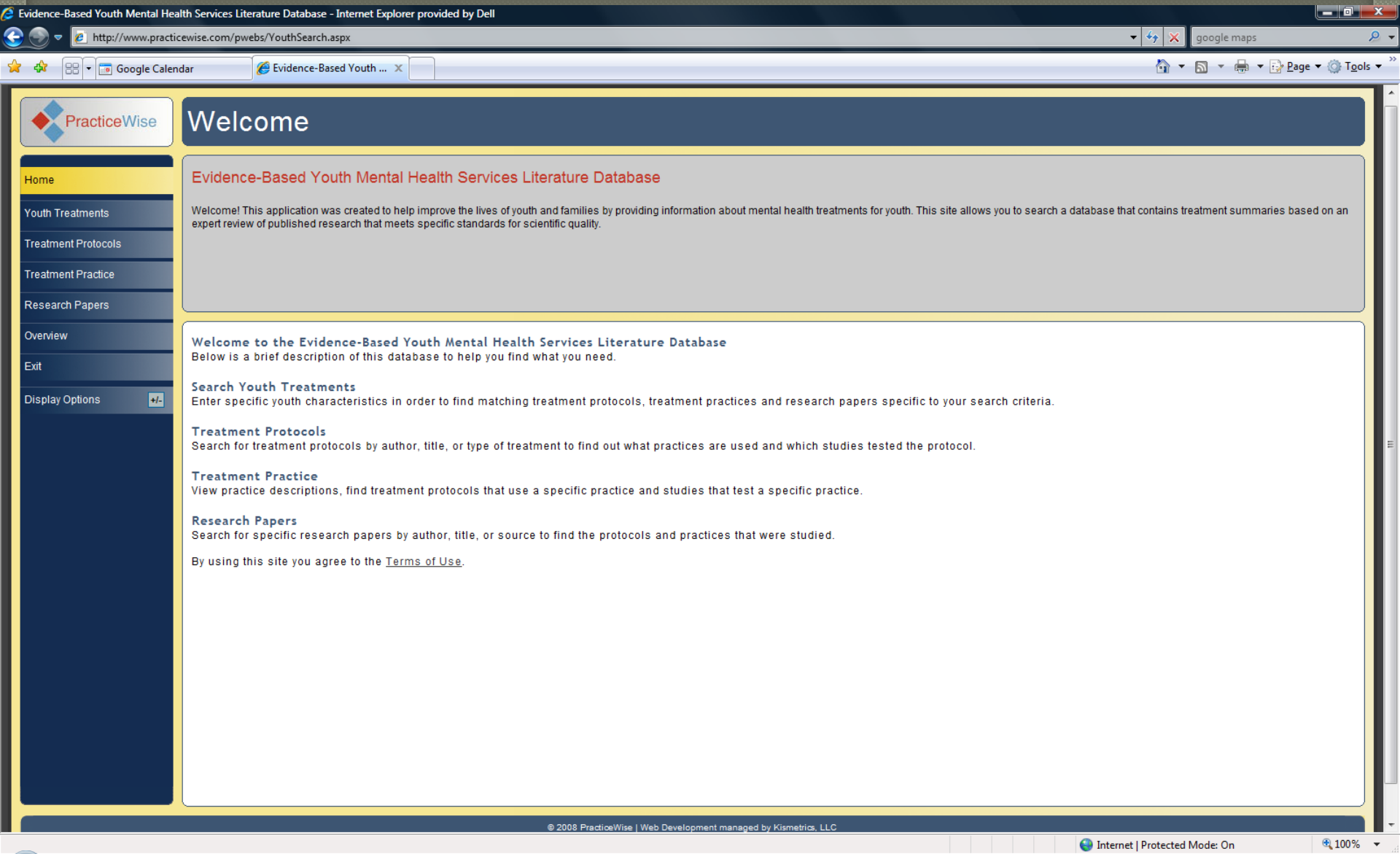
Let's Design for Collaboration



Example of a Knowledge Management Problem

"Good to see you, Maggie. As soon as I finish reading these research studies, we can start our session today."

PWEBS Database: Treatment Outcome Knowledge



How This Evidence Can Be Used

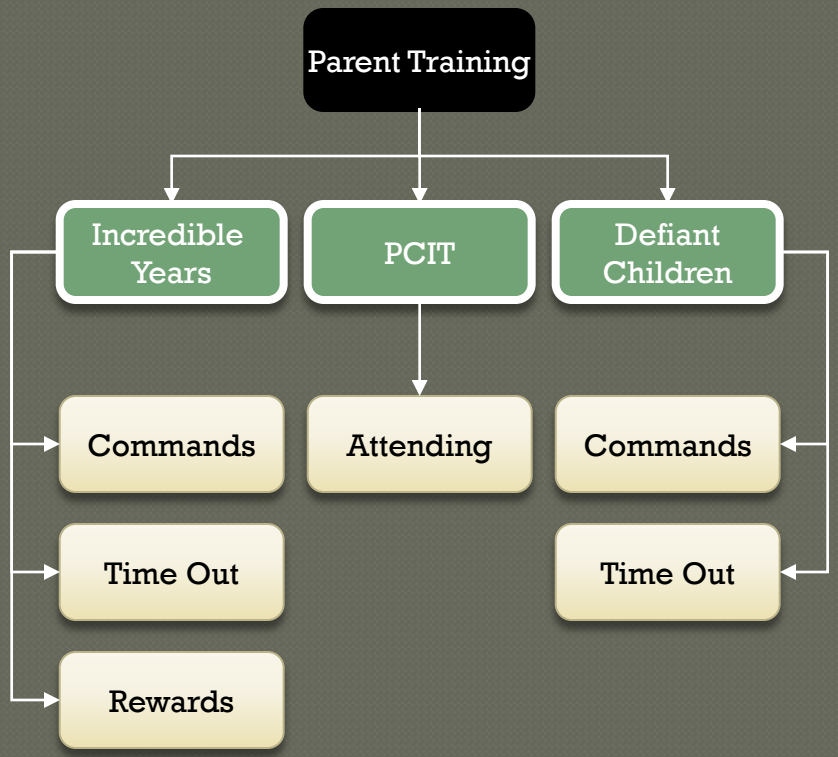
- Can point to programs
- Can point to components practice elements
- Can speak to fit with youth characteristics

Can We Get More from the Evidence Base?

Families

Protocols

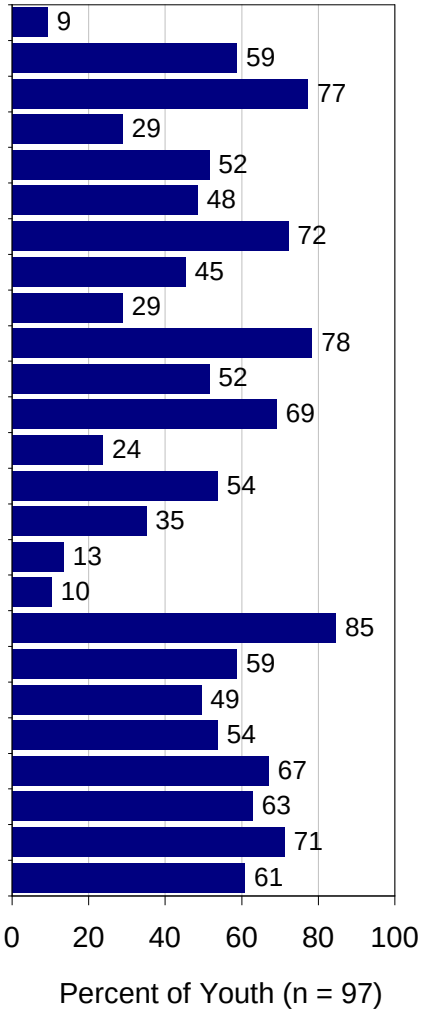
Practice Elements



How Evidence Based Is Usual Care?

Anxiety Disorders Example

Practice Element	EBS Study Groups (%, n = 36)	Actual Care Primary Anxiety Diagnosis
Exposure	97	9
Modeling	44	59
Cognitive/Coping	39	77
Relaxation	31	29
Psychoeducational-Child	25	52
Tangible Rewards	25	48
Therapist Praise/Rewards	22	72
Self-Monitoring	19	45
Self-Reward/Self-Praise	19	29
Problem Solving	17	78
Psychoeducational-Parent	14	52
Relationship/Rapport Building	11	69
Maintenance/Relapse Prevention	11	24
Parent Praise	8	54
Assertiveness Training	8	35
Ignoring or DRO	8	13
Guided Imagery	8	10
Supportive Listening/Client-Center	6	85
Parent Coping	6	59
Activity Scheduling	6	49
Skill Building/Behavioral Rehearsal	6	54
Insight Building	6	67
Family Therapy	3	63
Emotional Processing	3	71
Natural and Logical Consequences	3	61



We Need Recipes

- Not just ingredients…

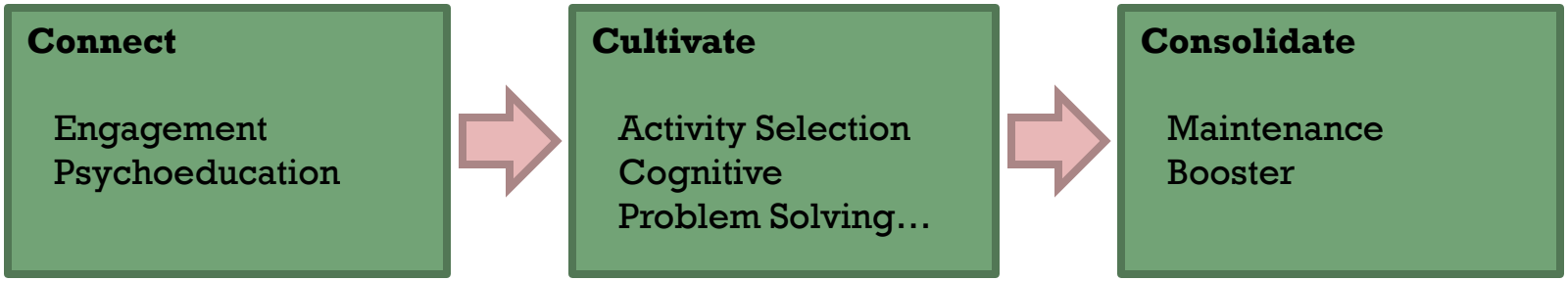
Putting Practices Together

Focus

Interference

Depression Example

Focus



Interference

Low Motivation: Rewards
Complaining and Irritability: Active Ignoring
Tantrums: Time Out…

From "What to Do" to "How to Do…"

We still have to know the basic steps…right?

Practitioner Guides (Another MAP Resource)

Practitioner Guide

Attending

Use This When:

To improve the quality of the caregiver-child relationship.

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.

One 2-sided page per practice

Other "Recipes"

- Session Planning
- Embracing Diversity

Process Guide

The Session Planner

(Clinical Event Structure)

Opening

- Check In
- Review Earlier Skills/Homework
- Set Agenda

Working

- Teach
- Rehearse
- Repeat

Closing

- Review
- Assign Homework
- Reward

Embracing Diversity

Adapt Process

- Style
- Communication
- Change Agent

Adapt Content

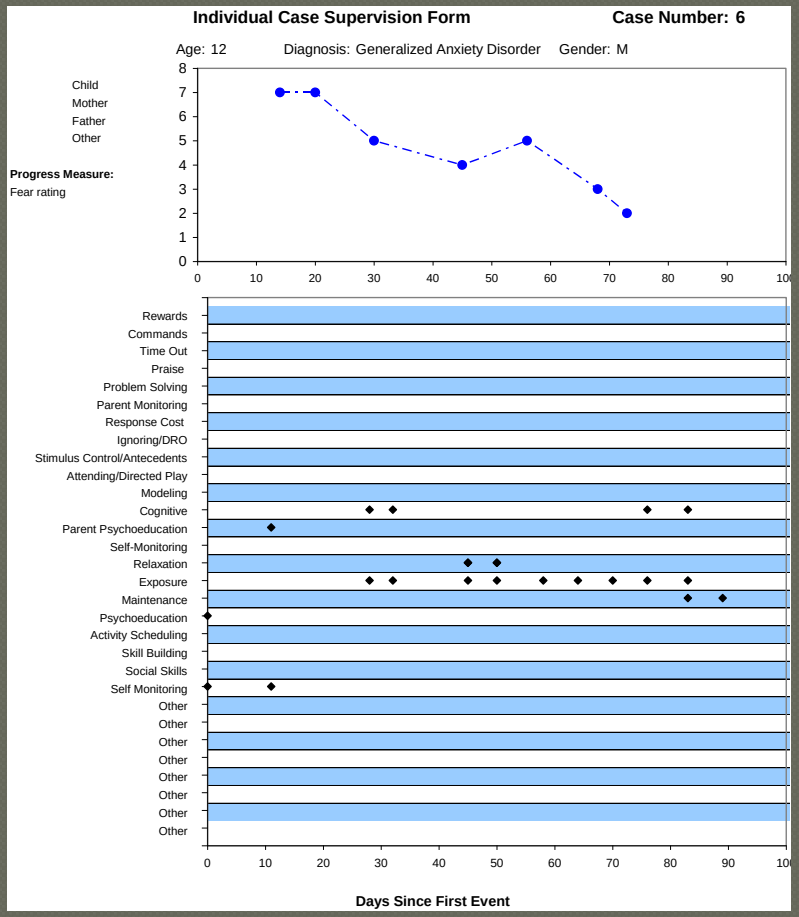
- Conceptualization
- Message
- Procedures

Other Questions

- How do I know if it is working?
- What do I do if it is not?

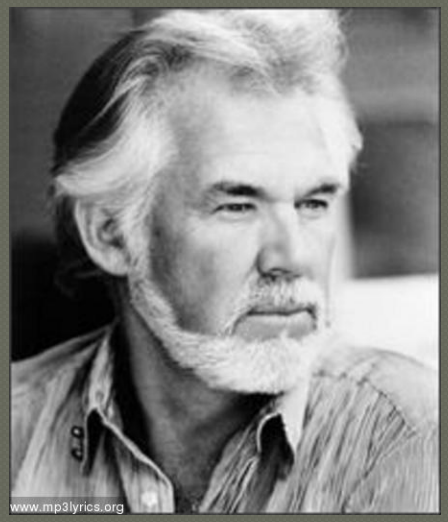
Individual Evidence (Local)

- Clinical Dashboard
  - Progress
  - Practices

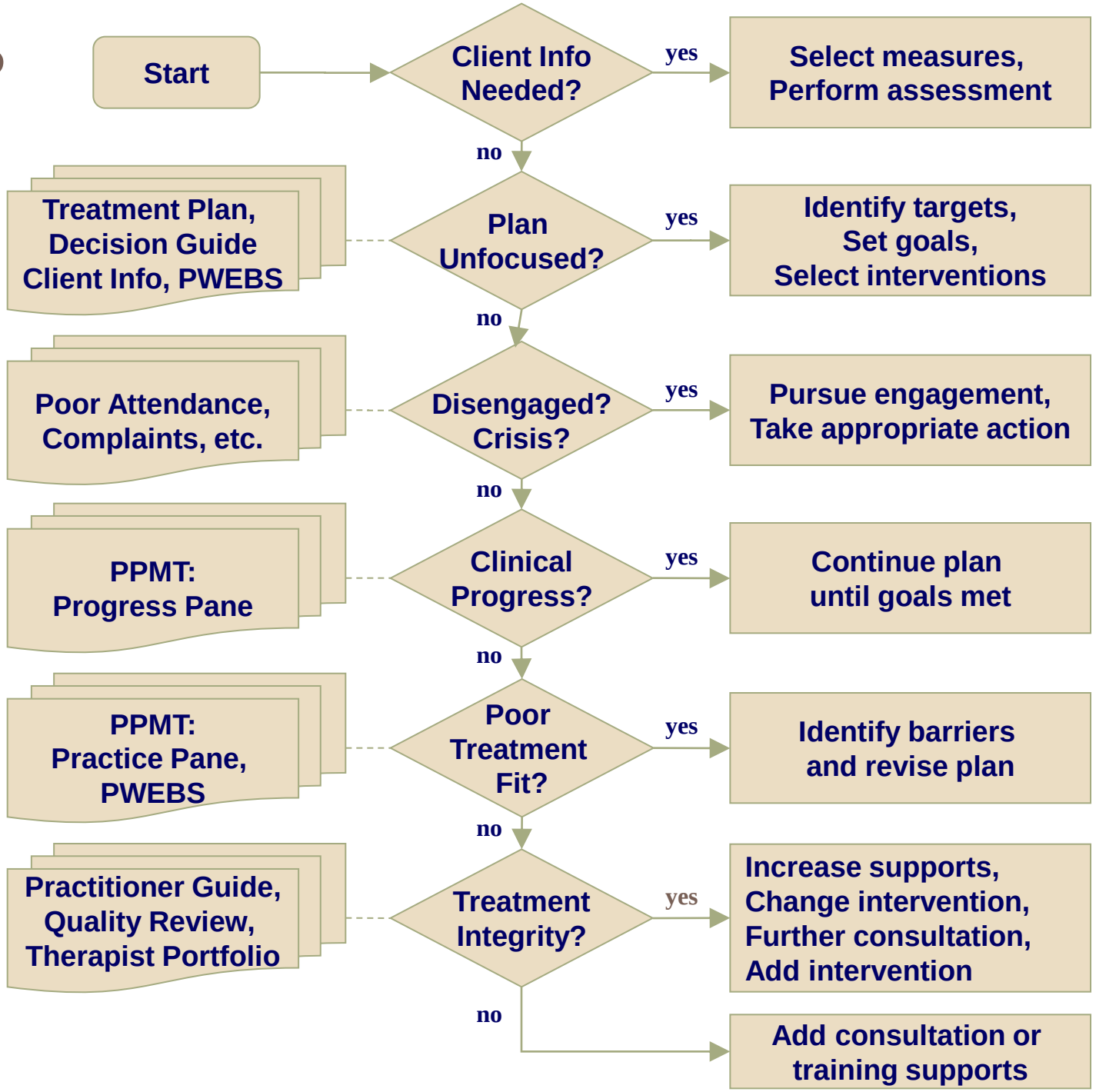


Example of a Knowledge Delivery Model: The "MAP"

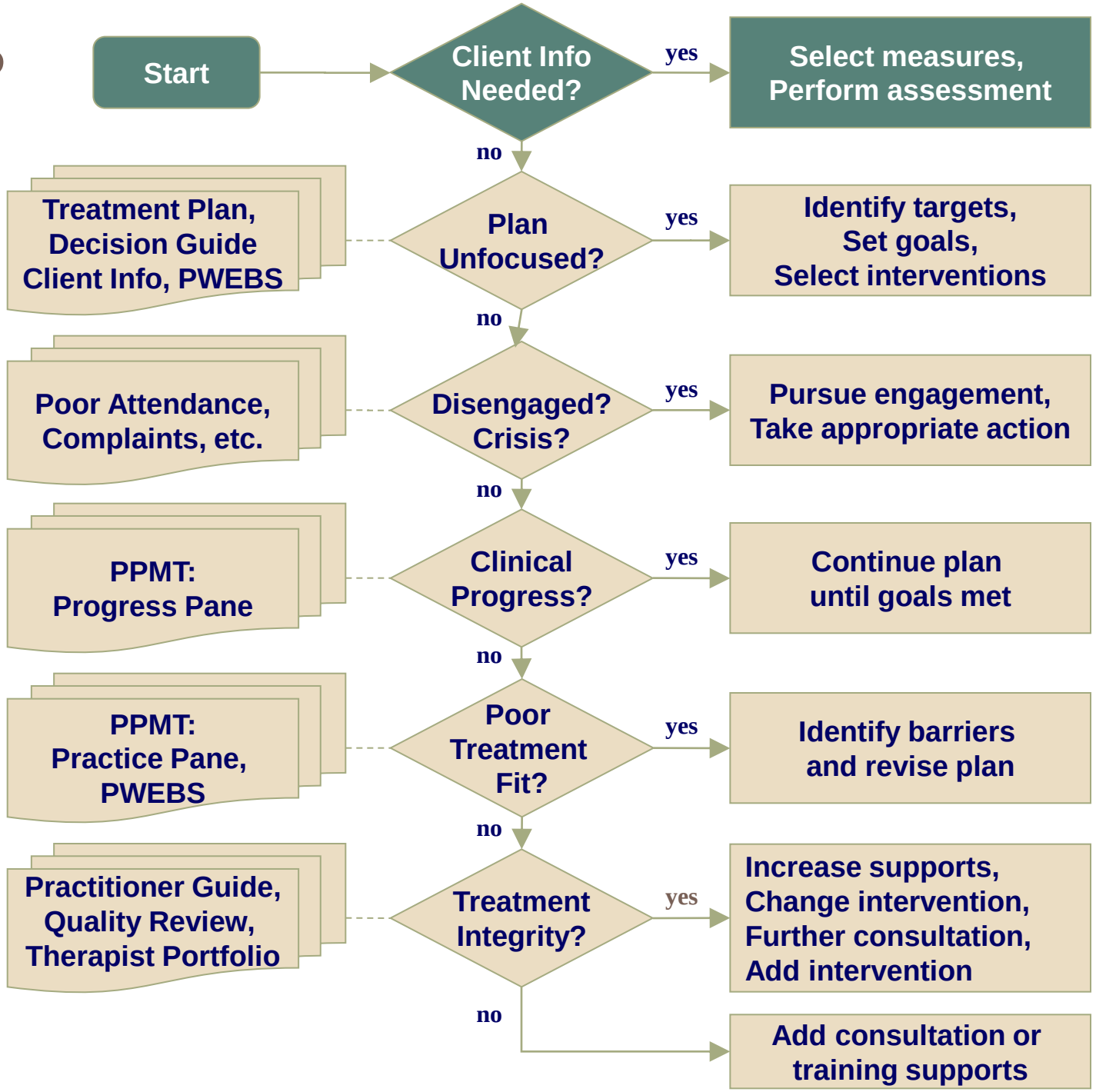
- Wisdom is knowing **when** to apply our knowledge and when not to (Speigler, 2000).
  - So….how do we know which of these tools to use when?



The MAP


Start
Client Info Needed?
yes
Select measures, Perform assessment
no
Treatment Plan, Decision Guide Client Info, PWEBS
Plan Unfocused?
yes
Identify targets, Set goals, Select interventions
no
Poor Attendance, Complaints, etc.
Disengaged? Crisis?
yes
Pursue engagement, Take appropriate action
no
PPMT: Progress Pane
Clinical Progress?
yes
Continue plan until goals met
no
PPMT: Practice Pane, PWEBS
Poor Treatment Fit?
yes
Identify barriers and revise plan
no
Practitioner Guide, Quality Review, Therapist Portfolio
Treatment Integrity?
yes
Increase supports, Change intervention, Further consultation, Add intervention
no
Add consultation or training supports

The MAP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Add consultation or training supports

The MAP

Start

Client Info Needed?

yes

Select measures, Perform assessment

no

Treatment Plan, Decision Guide Client Info, PWEBS

Plan Unfocused?

yes

Identify targets, Set goals, Select interventions

no

Poor Attendance, Complaints, etc.

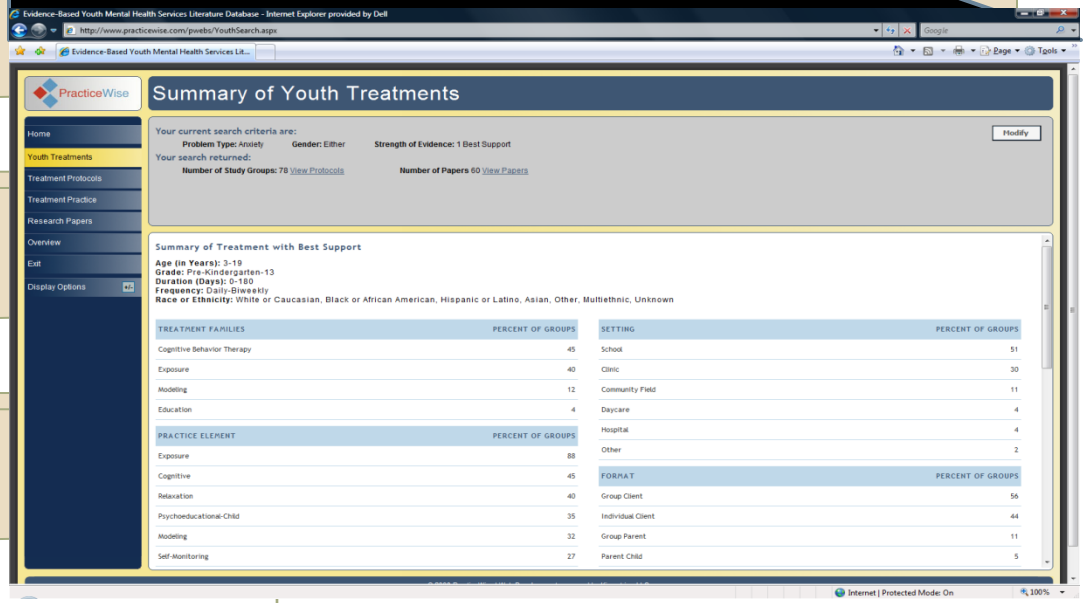
yes

Pursue engagement, Take appropriate action

PPMT: Progress Pane

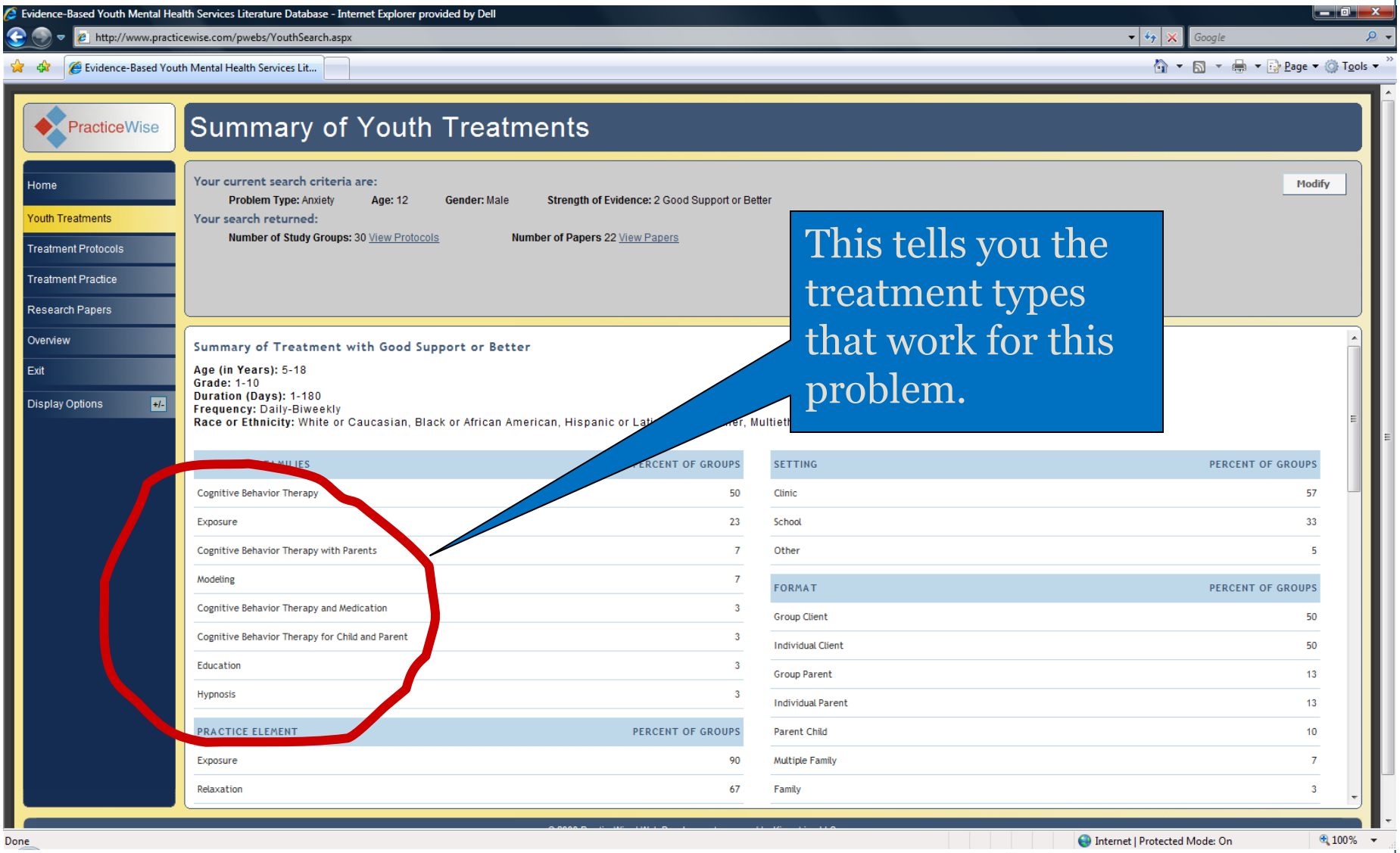
PPMT: Practice Pane, PWEBS

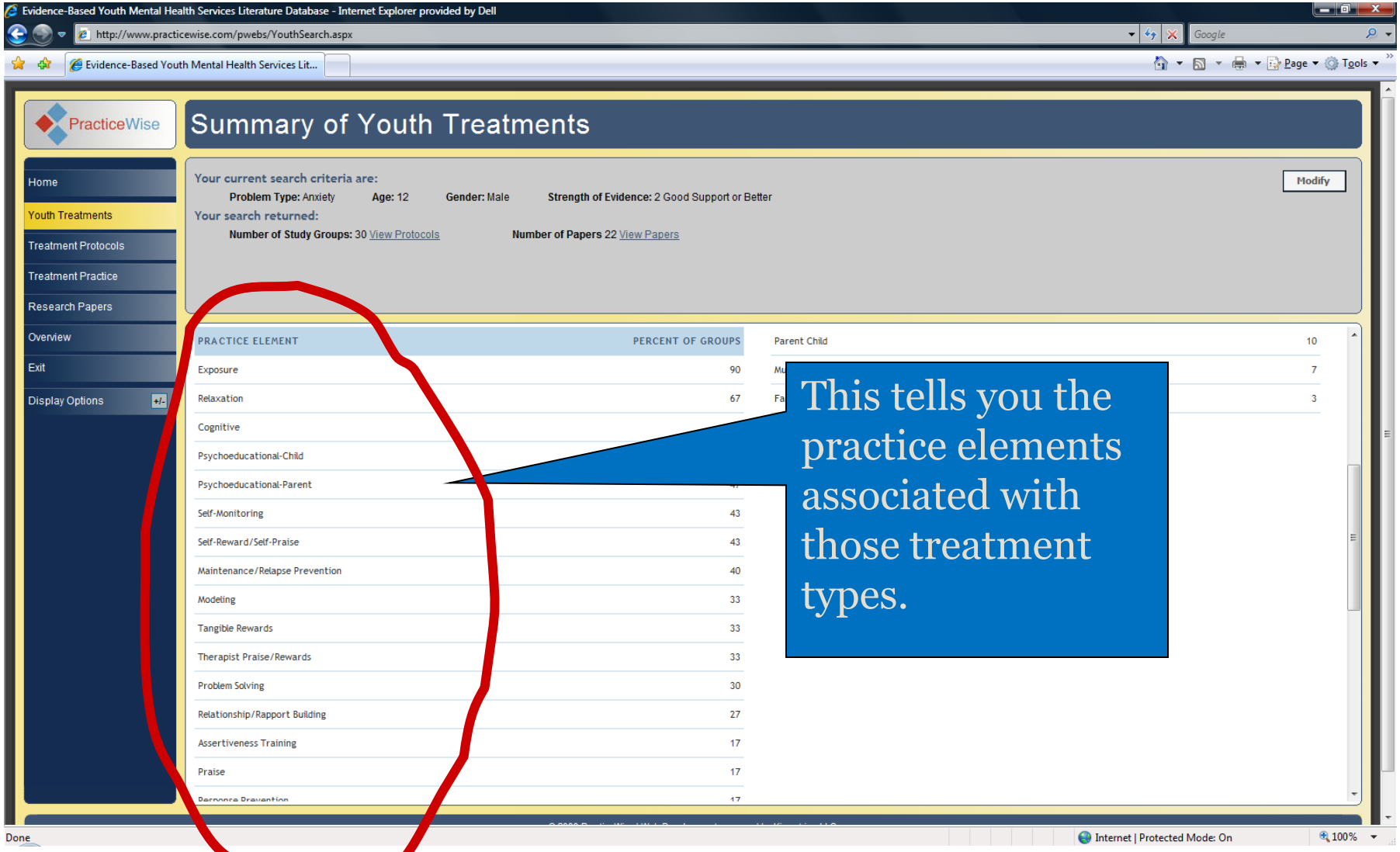
Practitioner Guide, Quality Review, Therapist Portfolio



no

Add consultation or training supports


Evidence-Based Youth Mental Health Services Literature Database - Internet Explorer provided by Dell
http://www.practicewise.com/pwebs/YouthSearch.aspx
Evidence-Based Youth Mental Health Services Lit...
PracticeWise
Summary of Youth Treatments
Home
Youth Treatments
Treatment Protocols
Treatment Practice
Research Papers
Overview
Exit
Display Options
Your current search criteria are:
Problem Type: Anxiety
Age: 12
Gender: Male
Strength of Evidence: 2 Good Support or Better
Modify
Your search returned:
Number of Study Groups: 30 View Protocols
Number of Papers 22 View Papers
Summary of Treatment with Good Support or Better
Age (in Years): 5-18
Grade: 1-10
Duration (Days): 1-180
Frequency: Daily-Biweekly
Race or Ethnicity: White or Caucasian, Black or African American, Hispanic or Lati
PERCENT OF GROUPS
Cognitive Behavior Therapy 50
Exposure 23
Cognitive Behavior Therapy with Parents 7
Modeling 7
Cognitive Behavior Therapy and Medication 3
Cognitive Behavior Therapy for Child and Parent 3
Education 3
Hypnosis 3
PRACTICE ELEMENT
PERCENT OF GROUPS
Exposure 90
Relaxation 67
SETTING
PERCENT OF GROUPS
Clinic 57
School 33
Other 5
FORMAT
PERCENT OF GROUPS
Group Client 50
Individual Client 50
Group Parent 13
Individual Parent 13
Parent Child 10
Multiple Family 7
Family 3
This tells you the treatment types that work for this problem.
Done
Internet | Protected Mode: On
100%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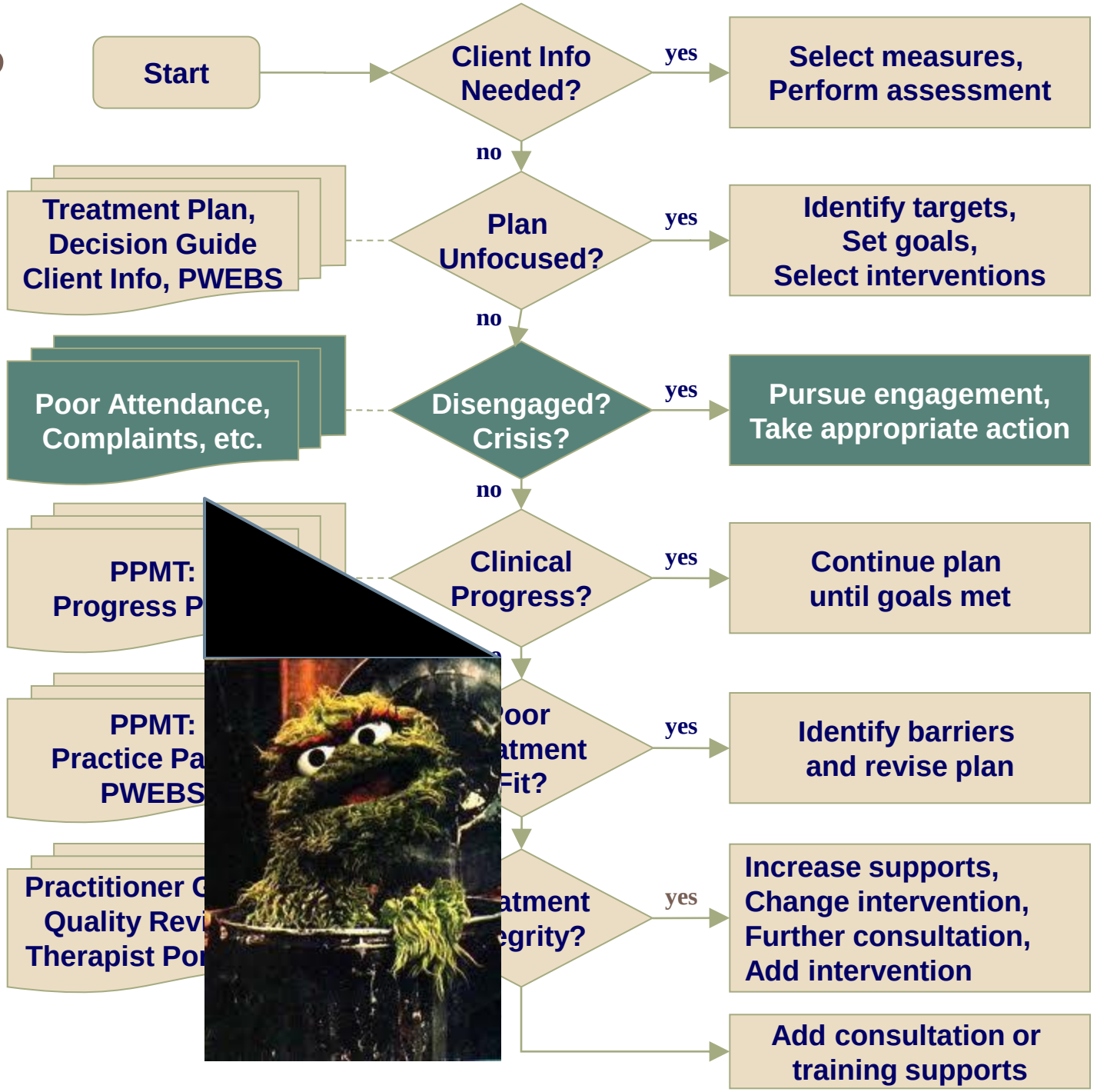
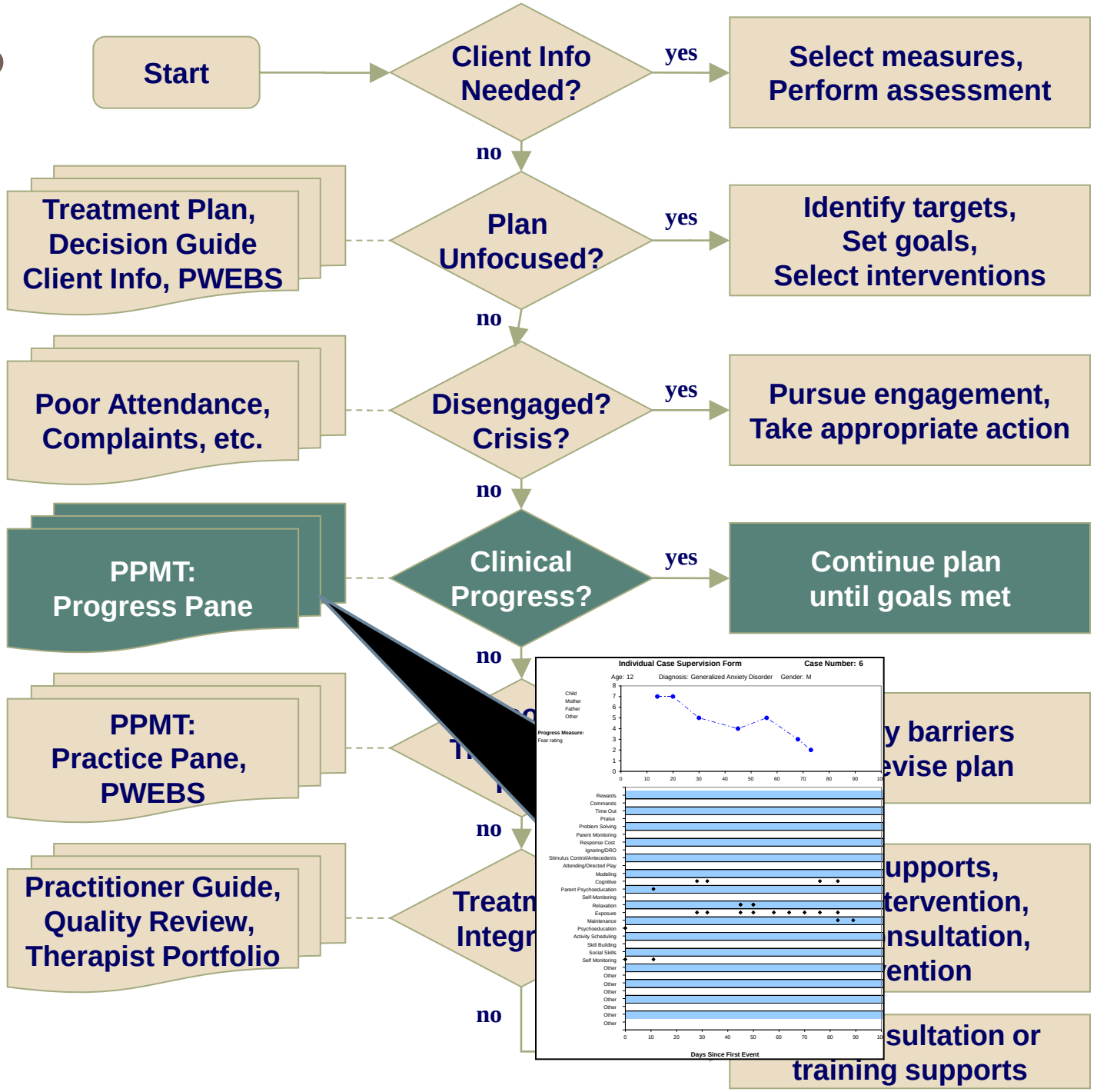
Exit
Display Options
Your current search criteria are:
Problem Type: Anxiety
Age: 12
Gender: Male
Strength of Evidence: 2 Good Support or Better
Modify
Your search returned:
Number of Study Groups: 30 View Protocols
Number of Papers 22 View Papers
PRACTICE ELEMENT
PERCENT OF GROUPS
Exposure 90
Relaxation 67
Cognitive
Psychoeducational-Child
Psychoeducational-Parent
Self-Monitoring 43
Self-Reward/Self-Praise 43
Maintenance/Relapse Prevention 40
Modeling 33
Tangible Rewards 33
Therapist Praise/Rewards 33
Problem Solving 30
Relationship/Rapport Building 27
Assertiveness Training 17
Praise 17
Parent Child 10
7
3
This tells you the practice elements associated with those treatment types.
Done
Internet | Protected Mode: On
100%

The MAP


Start
Client Info Needed?
yes
Select measures, Perform assessment
no
Treatment Plan, Decision Guide Client Info, PWEBS
Plan Unfocused?
yes
Identify targets, Set goals, Select interventions
no
Poor Attendance, Complaints, etc.
Disengaged? Crisis?
yes
Pursue engagement, Take appropriate action
no
PPMT:
Progress P
Clinical Progress?
yes
Continue plan until goals met
PPMT:
Practice Pa
PWEBS
oor
atment
Fit?
yes
Identify barriers and revise plan
Practitioner C
Quality Revi
Therapist Por
atment
egrity?
yes
Increase supports, Change intervention, Further consultation, Add intervention
Add consultation or training supports

The MAP

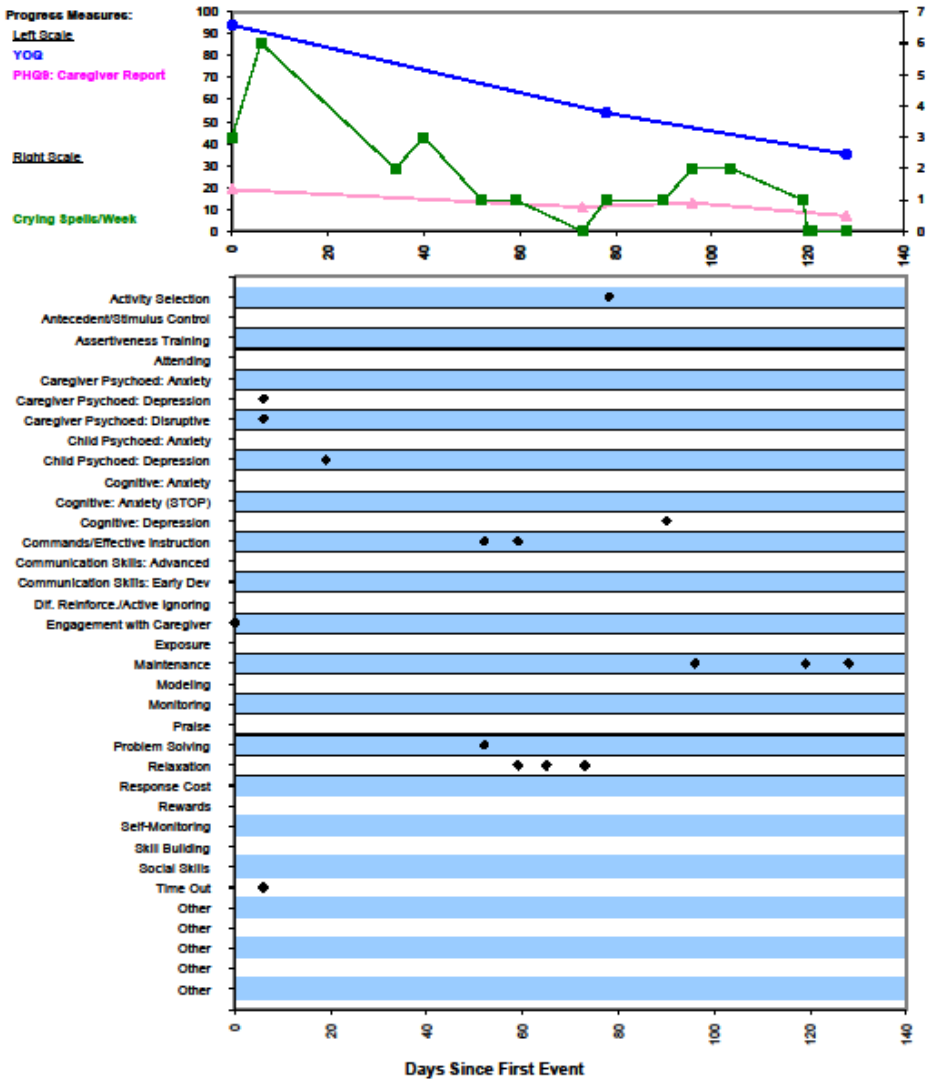

Start
Client Info Needed?
yes
Select measures, Perform assessment
no
Treatment Plan, Decision Guide Client Info, PWEBS
Plan Unfocused?
yes
Identify targets, Set goals, Select interventions
no
Poor Attendance, Complaints, etc.
Disengaged? Crisis?
yes
Pursue engagement, Take appropriate action
no
PPMT: Progress Pane
Clinical Progress?
yes
Continue plan until goals met
no
PPMT: Practice Pane, PWEBS
no
Practitioner Guide, Quality Review, Therapist Portfolio
no
Individual Case Supervision Form
Case Number: 6
Age: 12
Diagnosis: Generalized Anxiety Disorder
Gender: M
Progress Measure:
Fear rating
Days Since First Event

Progress and Practice Monitoring Tool

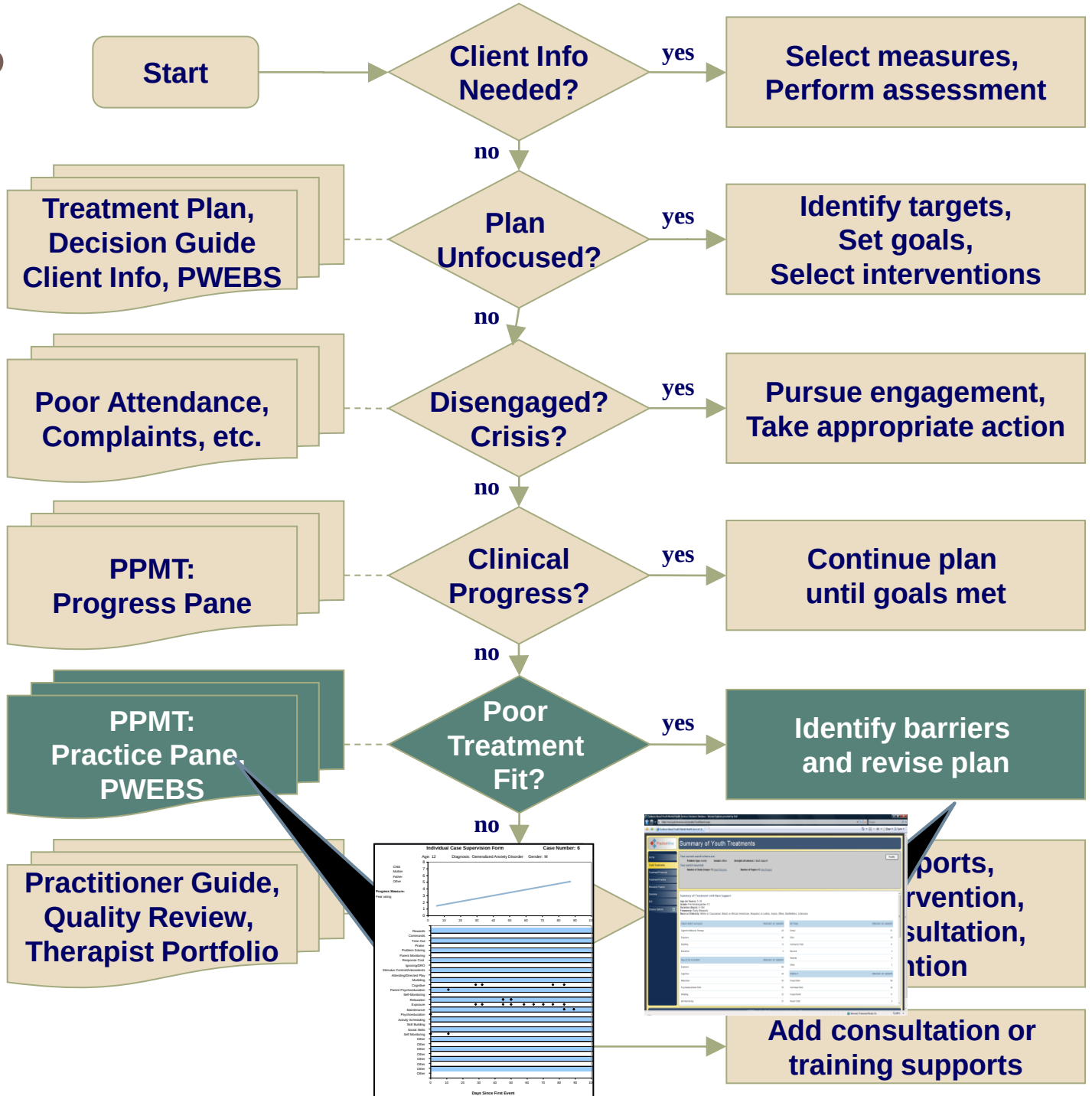
Case ID: Maggie

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

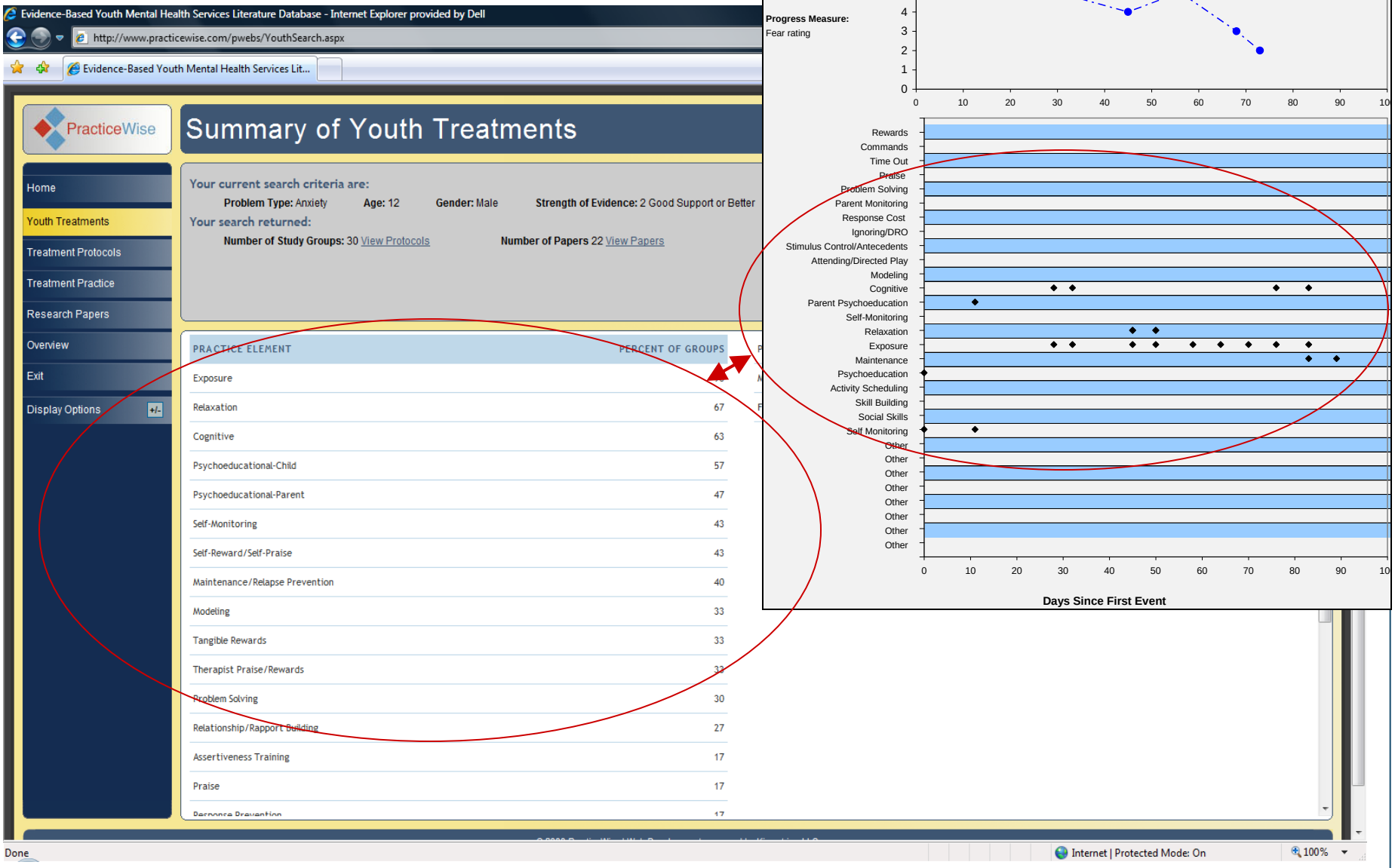
Gender: Female
Ethnicity: African American



The MAP


Start
Client Info Needed?
yes
Select measures, Perform assessment
no
Treatment Plan, Decision Guide Client Info, PWEBS
Plan Unfocused?
yes
Identify targets, Set goals, Select interventions
no
Poor Attendance, Complaints, etc.
Disengaged? Crisis?
yes
Pursue engagement, Take appropriate action
no
PPMT: Progress Pane
Clinical Progress?
yes
Continue plan until goals met
no
PPMT: Practice Pane, PWEBS
Poor Treatment Fit?
yes
Identify barriers and revise plan
no
Practitioner Guide, Quality Review, Therapist Portfolio
Add consultation or training supports

Do the practices fit the problem?



The MAP

Start

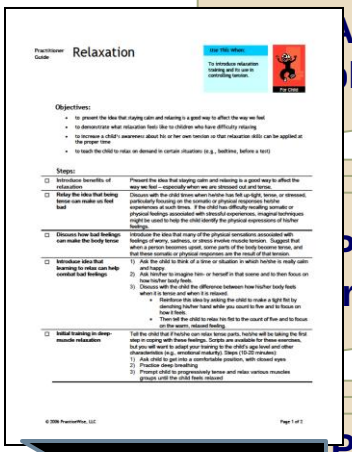
Client Info Needed?
yes → Select measures, Perform assessment
no ↓

Treatment Plan, Decision Guide Client Info, PWEBS

Plan Unfocused?
yes → Identify targets, Set goals, Select interventions
no ↓

ttendance, laints, etc.

Disengaged? Crisis?
yes → Pursue engagement, Take appropriate action
no ↓


Relaxation

PPMT: ress Pane

Clinical Progress?
yes → Continue plan until goals met
no ↓

PPMT: ctice Pane, PWEBS

Poor Treatment Fit?
yes →
no ↓

Practitioner Guide, Quality Review, Therapist Portfolio

Treatment Integrity?
yes → Increase supports, Change intervention, Further consultation, Add intervention
no → Add consultation or training supports

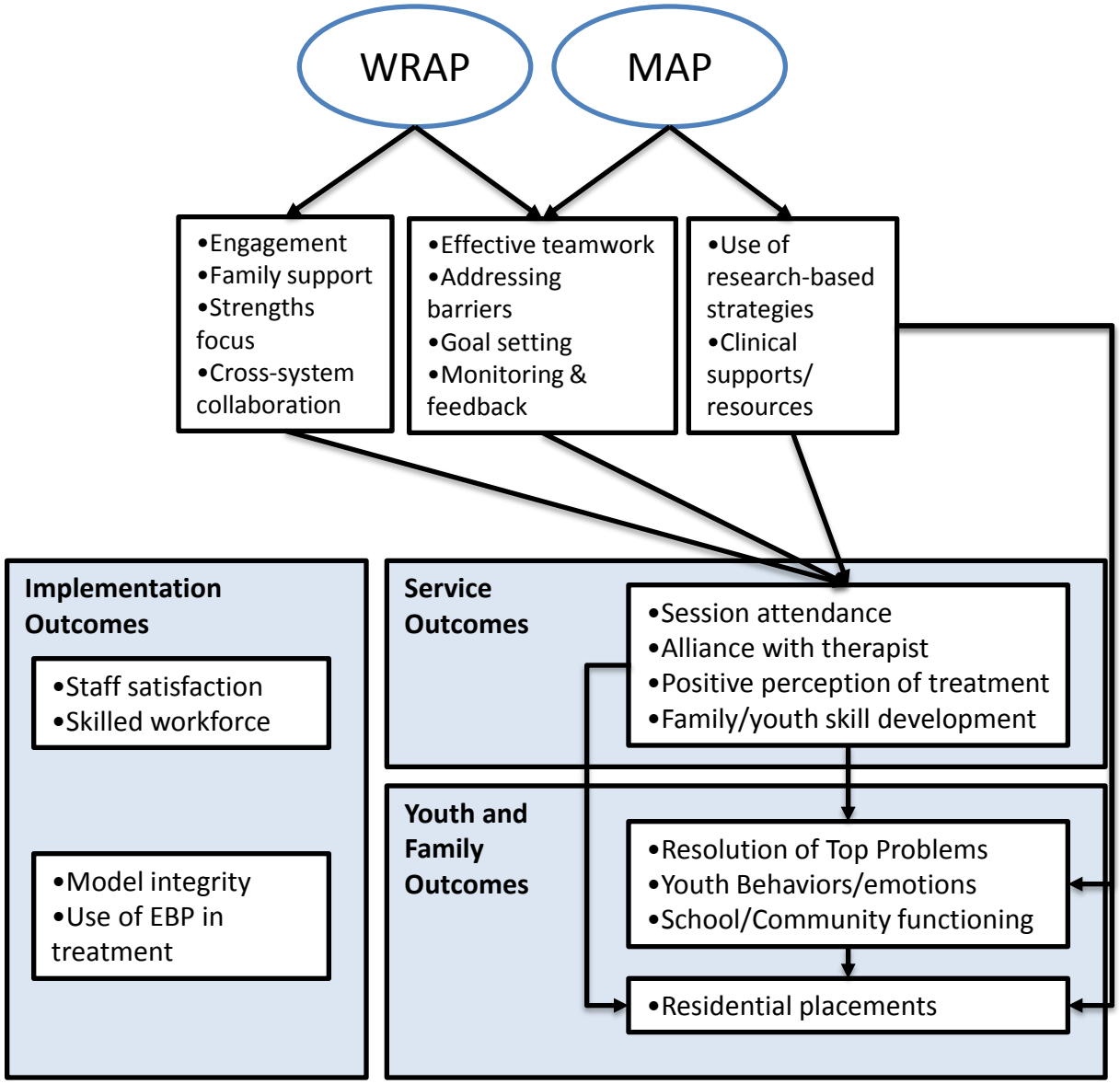
Why do we think WRAP+MAP would work?

- Both approaches share a philosophy
- It makes sense in theory
- People who serve in Wraparound roles would benefit from this enhanced resource
- MAP has good evidence behind it
- 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!

A shared philosophy

- **"The best options possible"**
  - Common elements of EBP
  - Common factors of effective care:
    - Engagement, use of knowledge, continual monitoring and adapting
- **"WHATEVER IT TAKES"**
  - i.e., Flexible, individualized, family-driven, outcomes-based care

Makes sense in theory



Fit with Wraparound Roles

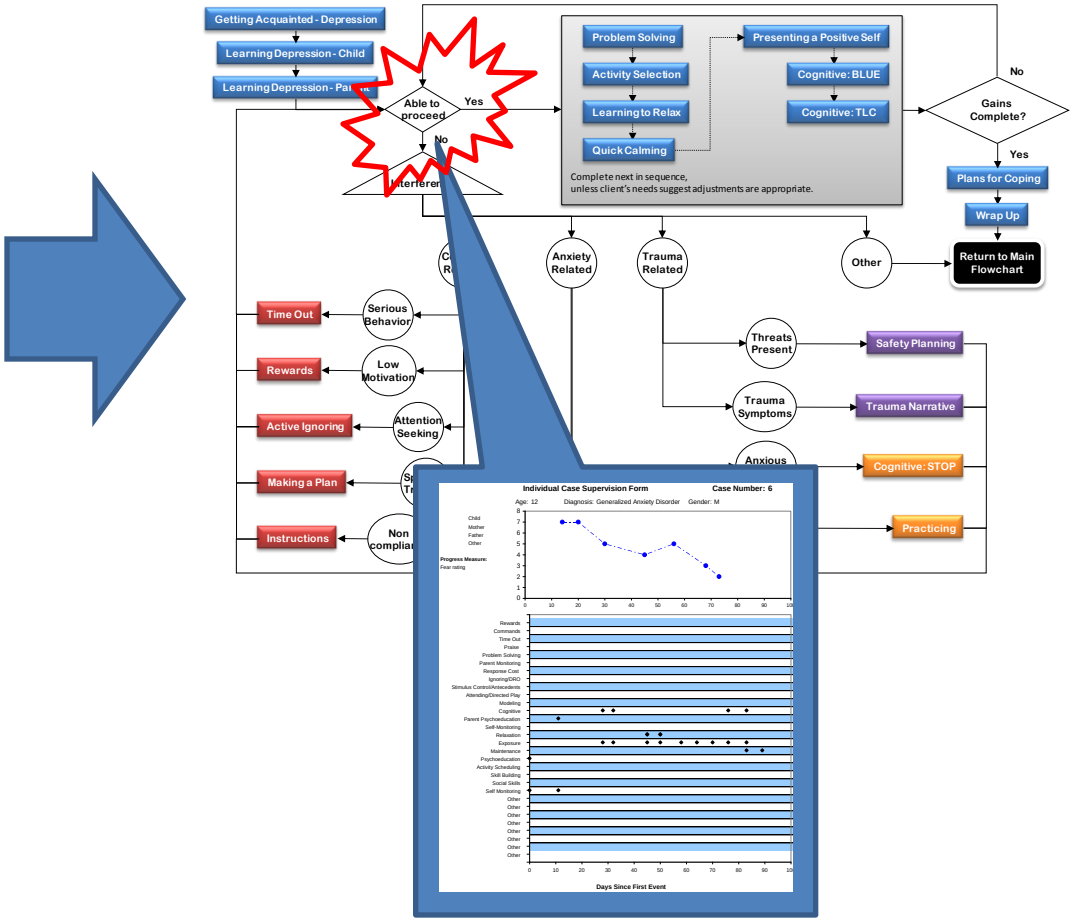
- Facilitator
- Parent partners
- Youth specialists/mentors/helpers
- Clinicians
- Natural supports

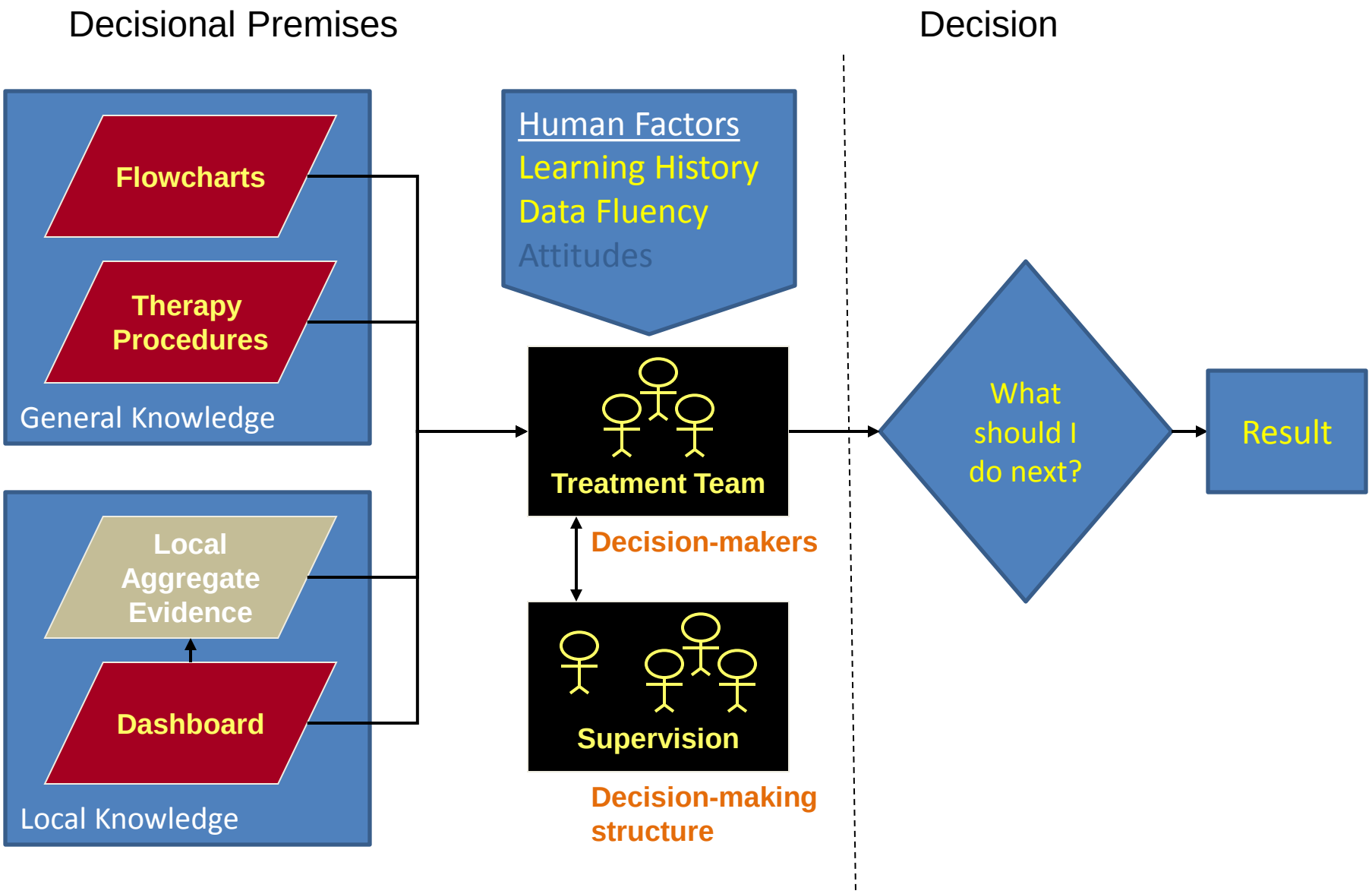
MAP Has good evidence behind it: Child STEPs Treatment Project

Child STEPs Treatment Project

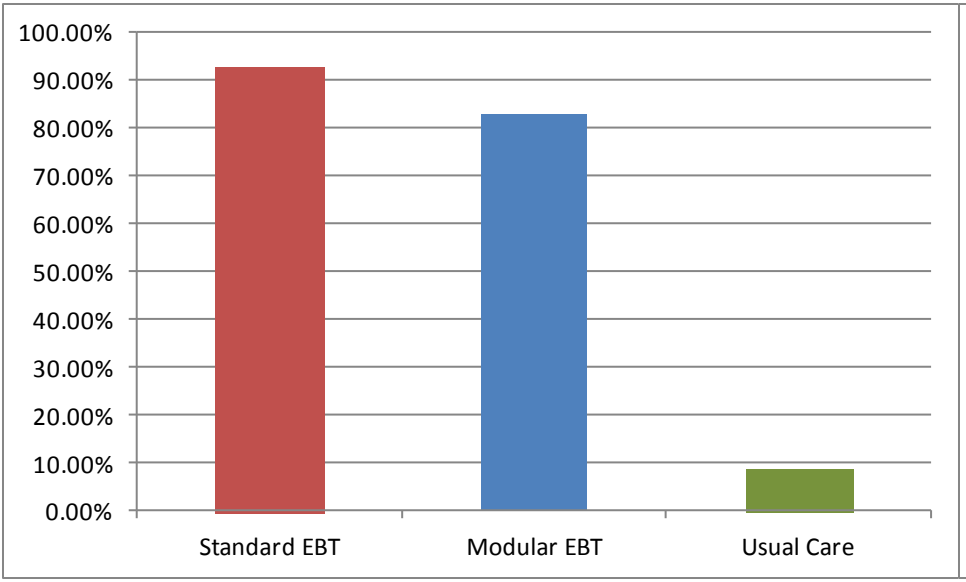
- Research Network on Youth Mental Health
- 5-Year, multisite randomized trial
  - Boston, Honolulu
- Anxiety, Depression, Conduct Problems
- Community therapists
- Standard Manuals, MATCH, Usual Care
- N = 174 children ages 7-13
- Funded by John D. and Catherine T. MacArthur Foundation

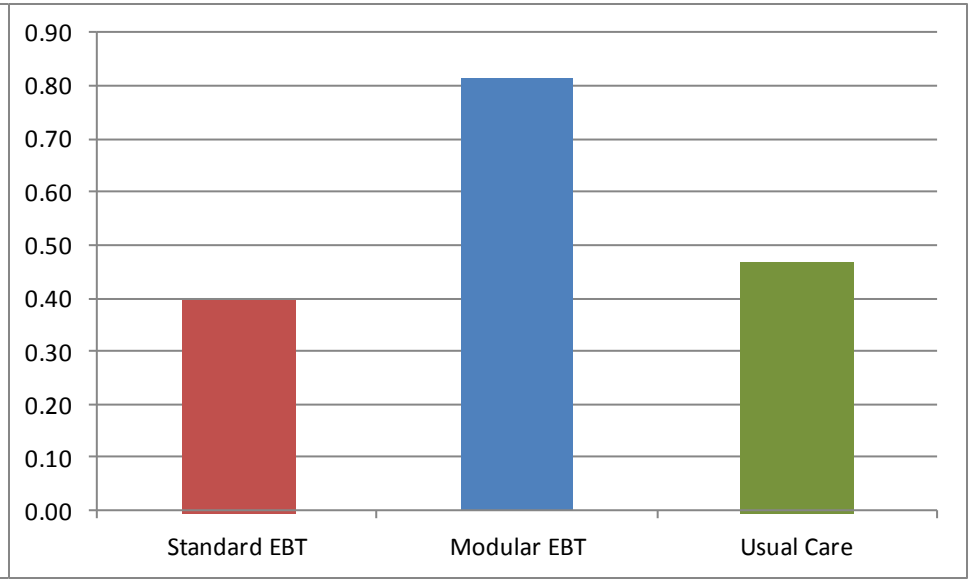
Toward Architectures for Collaboration and Coordination




Decisional Premises
Decision
Flowcharts
Therapy Procedures
General Knowledge
Local Aggregate Evidence
Dashboard
Local Knowledge
Human Factors
Learning History
Data Fluency
Attitudes
Treatment Team
Decision-makers
Supervision
Decision-making structure
What should I do next?
Result

Collaborative Design in Action





Fidelity

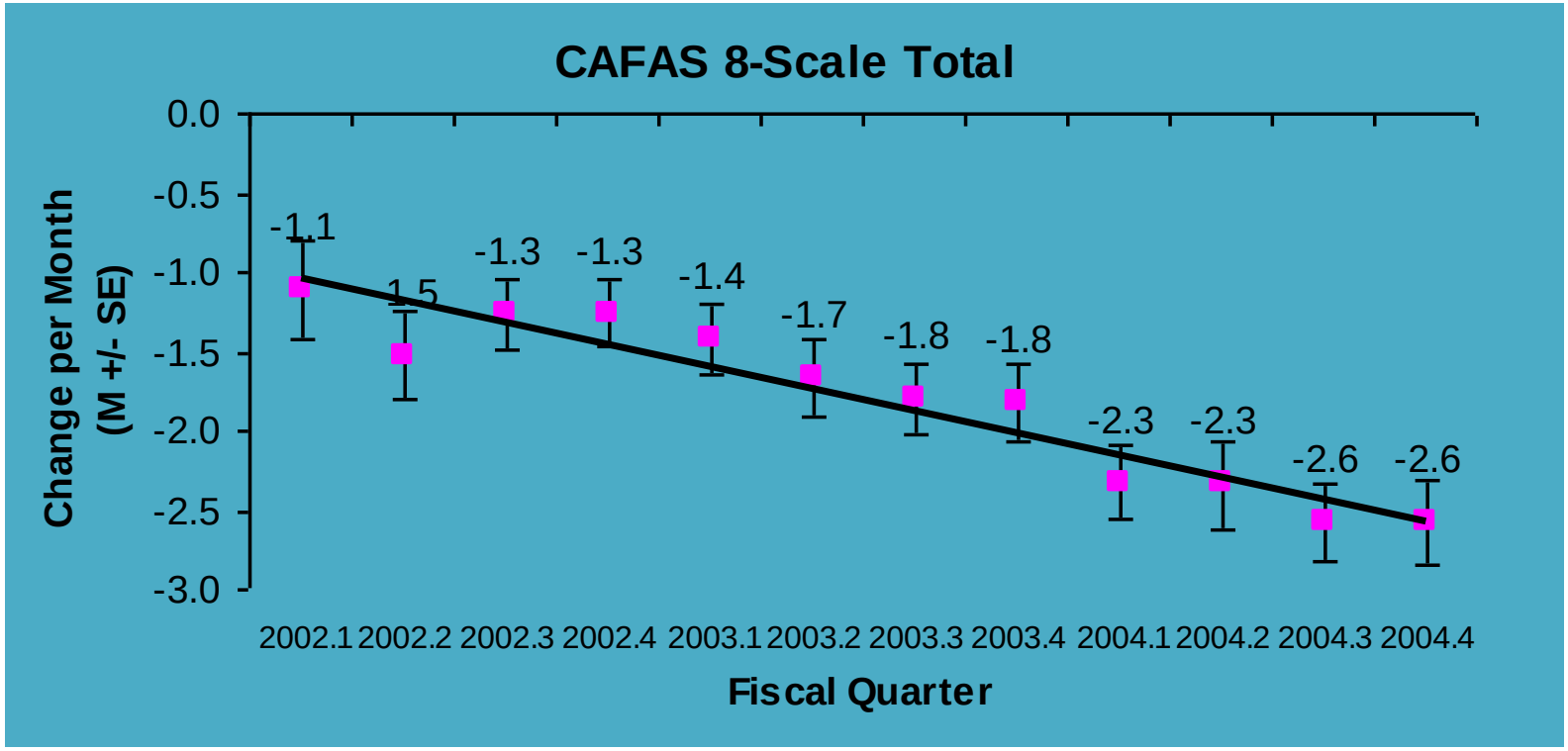
Percent "Investigator Designed"

Outcomes

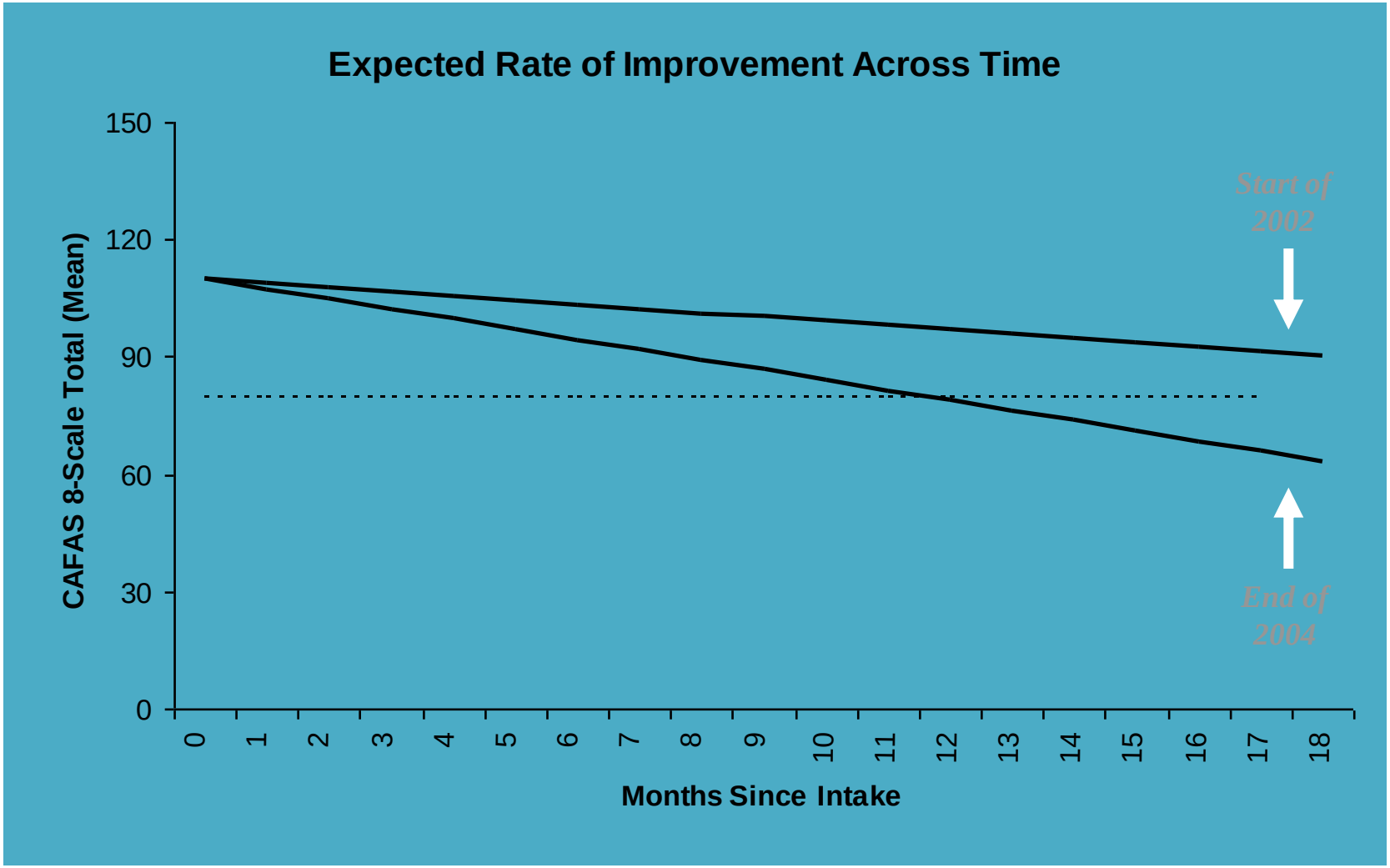
Modular EBT > Usual Care, Standard EBTs ($p < .05$)

Weisz, J.R., Chorpita, B.F., Palinkas, L.A., Schoenwald, S.K., Miranda, J., Bearman, S.K., Daleiden, E.L., Ugueto, A.M., Ho, A., Martin, J., Gray, J., Alleyne, A., Langer, D.A., Southam-Gerow, M.A., Gibbons, R.D., and the Research Network on Youth Mental Health. (2012). Testing standard and modular designs for psychotherapy with youth depression, anxiety, and conduct problems: A randomized effectiveness trial. *Archives of General Psychiatry*.

A version of this has worked before:
A Statewide Open Trial
in a Care Coordination Context



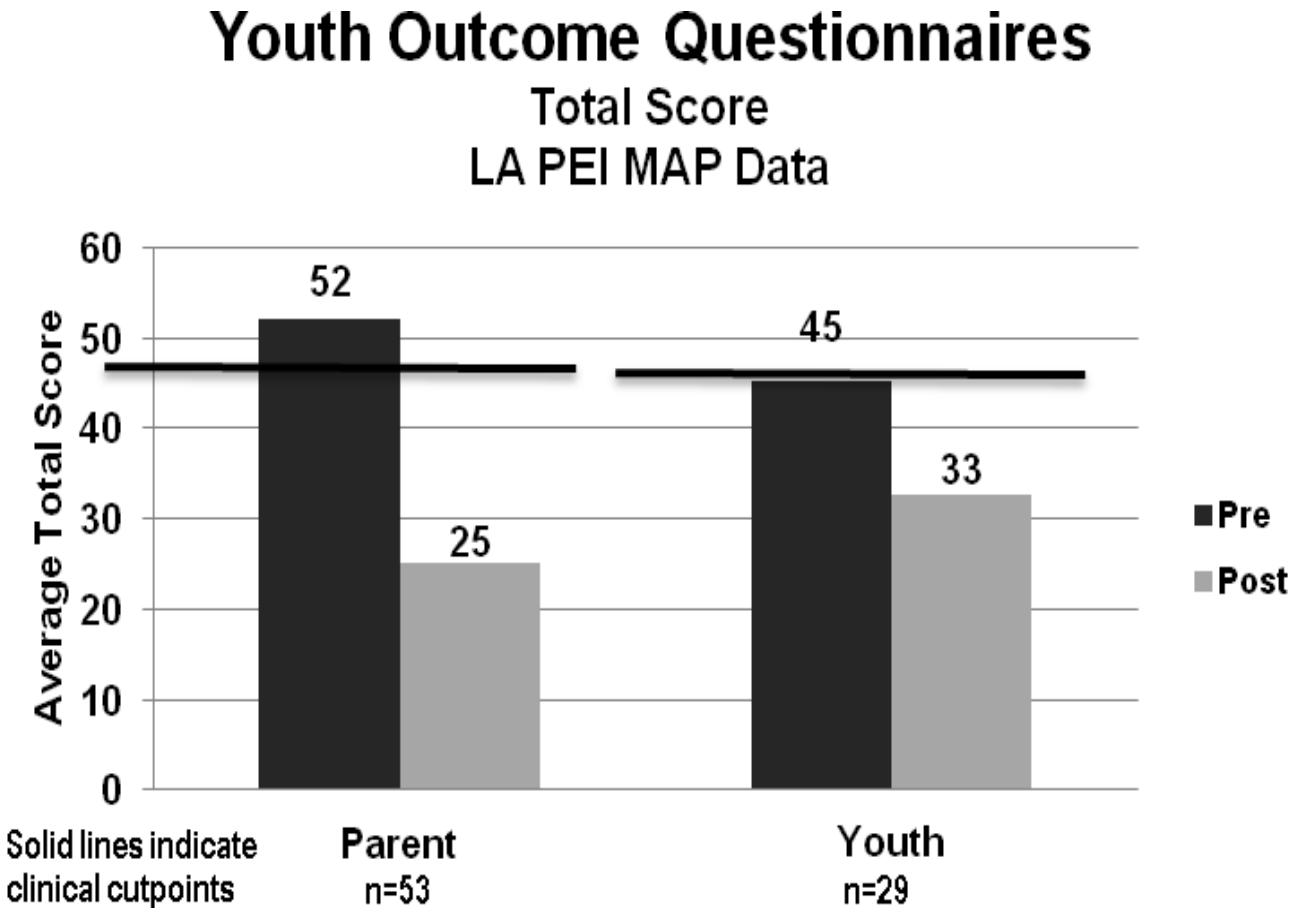
A version of this has worked before: Getting Better at Getting Them Better



The Practices fit Wraparound

- Compared 838 youths in wrap with 3,104 youths in other services
- Coverability is comparable
  - 59% of wrap youth vs 65% of non-wrap youth)
- Practices mostly the same
  - 24 practice elements relevant to both groups
    - Psychoeducation, problem solving, insight building, relaxation, exposure, cognitive, social skills, rewards, relationship building…

Average YOQ Scores Show Improvements from Pre- to Post-MAP



People think it will work

- Surveys of MAP clinicians and discussions with wraparound providers
- Major children's MH figures:
  - ***"It is time to finally 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"*** -- Weisz et al., *American Psychologist,* 2006 (p.645)

Wrap+MAP
HOW WOULD IT BE DONE?

Approach to Coordination

Wrap-specific dashboards

Training Curricula

Integrity monitoring

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

Fully coordinated process

Wrap Facilitator

…as well as…

Parent Partner

Youth Specialist

Service Literature (PWEBS)

Codified Procedures (PG)

Family/Collateral Communication

Direct Communication

Team Meeting

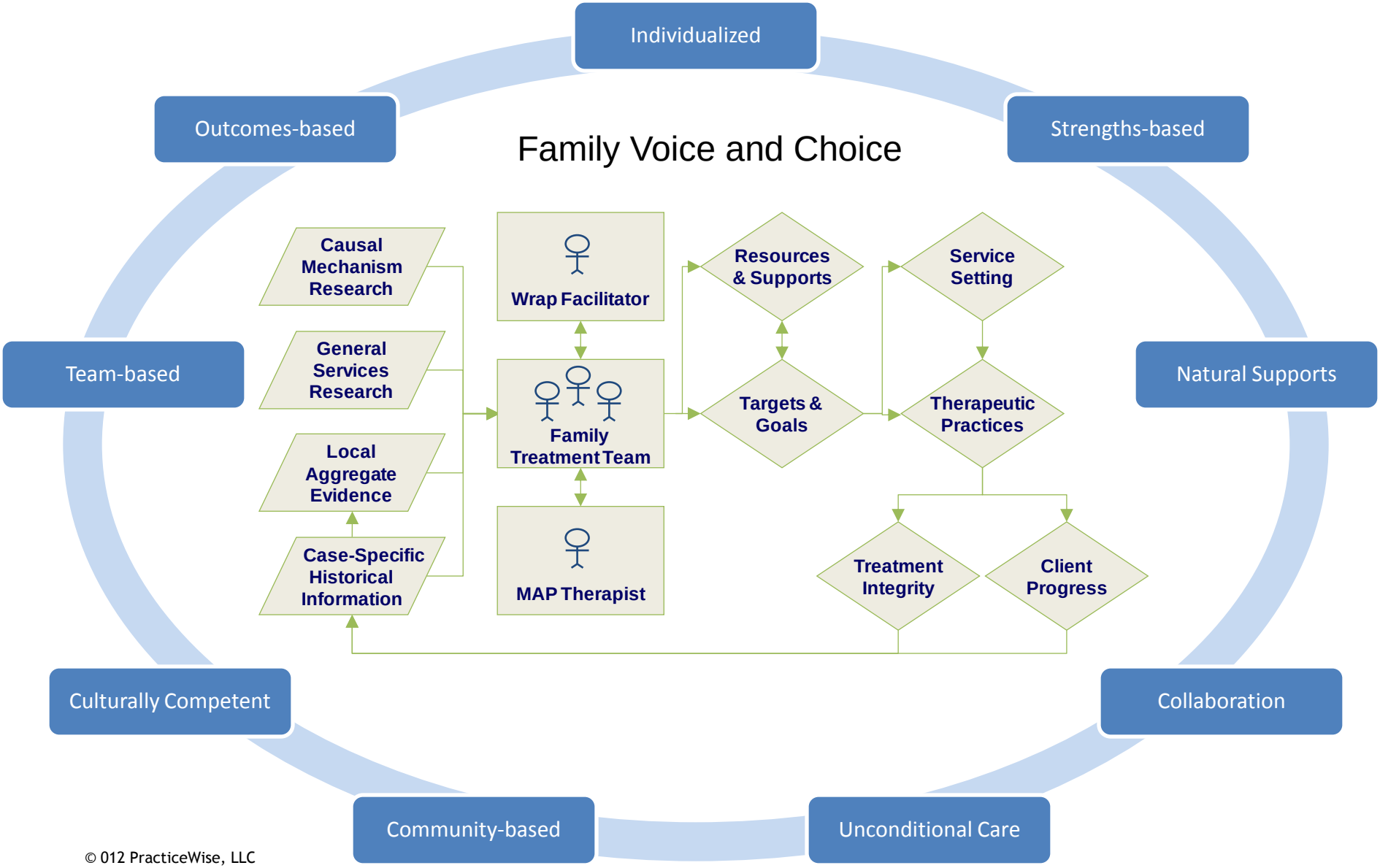
Plan of Care

Clinical Dashboard

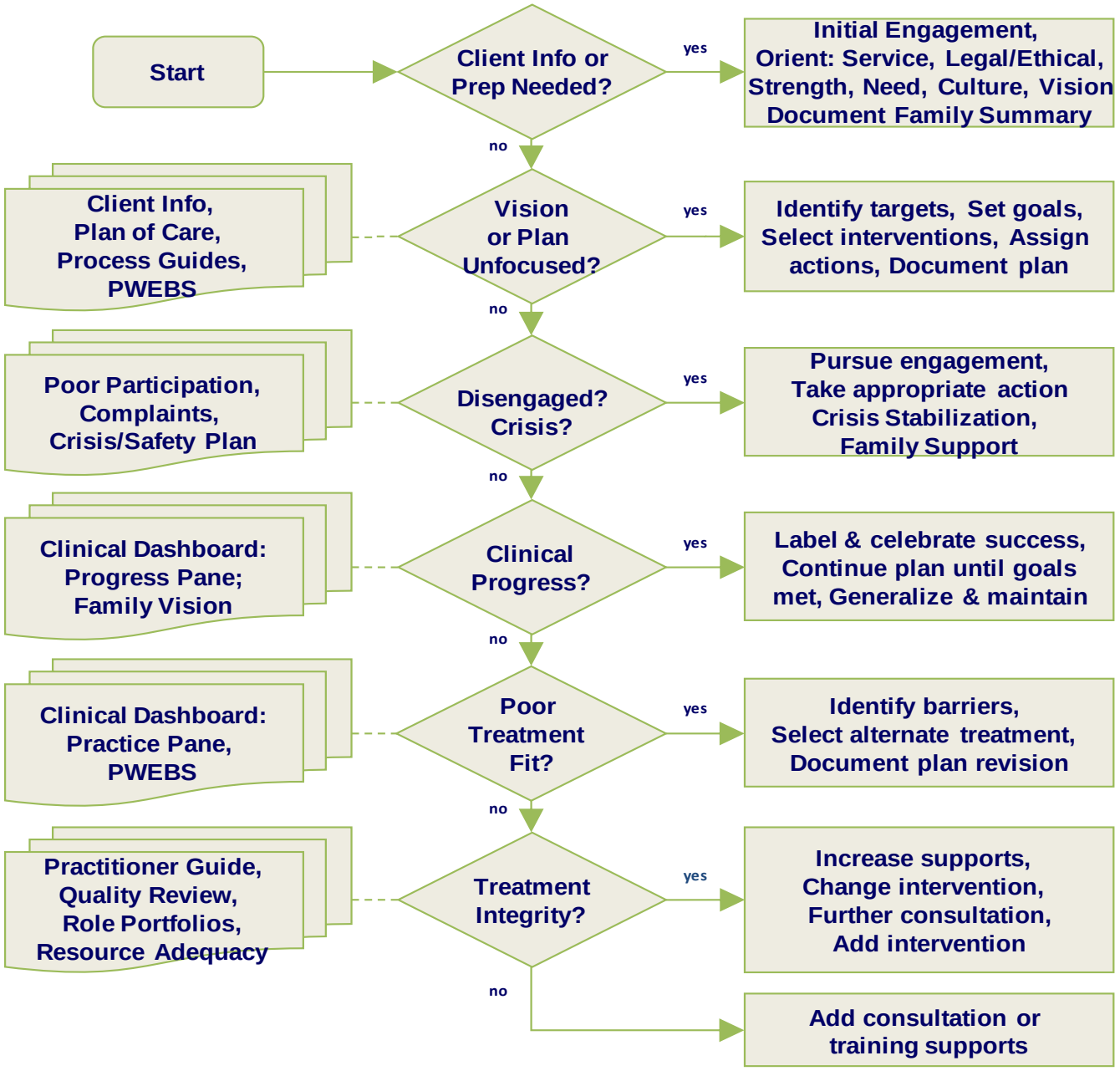
MAP Therapist

Process Guide

The Evidence-Based Services System Model: MAParound with Principles



The MAP: MAParound Family



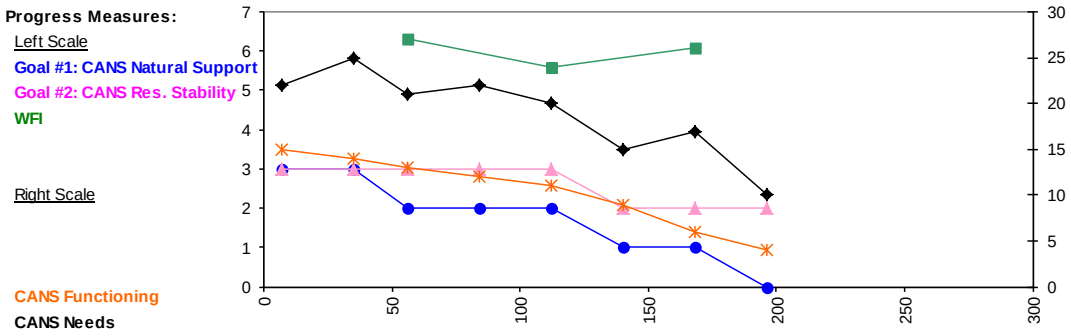
Progress and Practice Monitoring Tool **Case ID: Wraparound Practice Illustration**

Clear All D

Redact File

Age (in years): 10.7

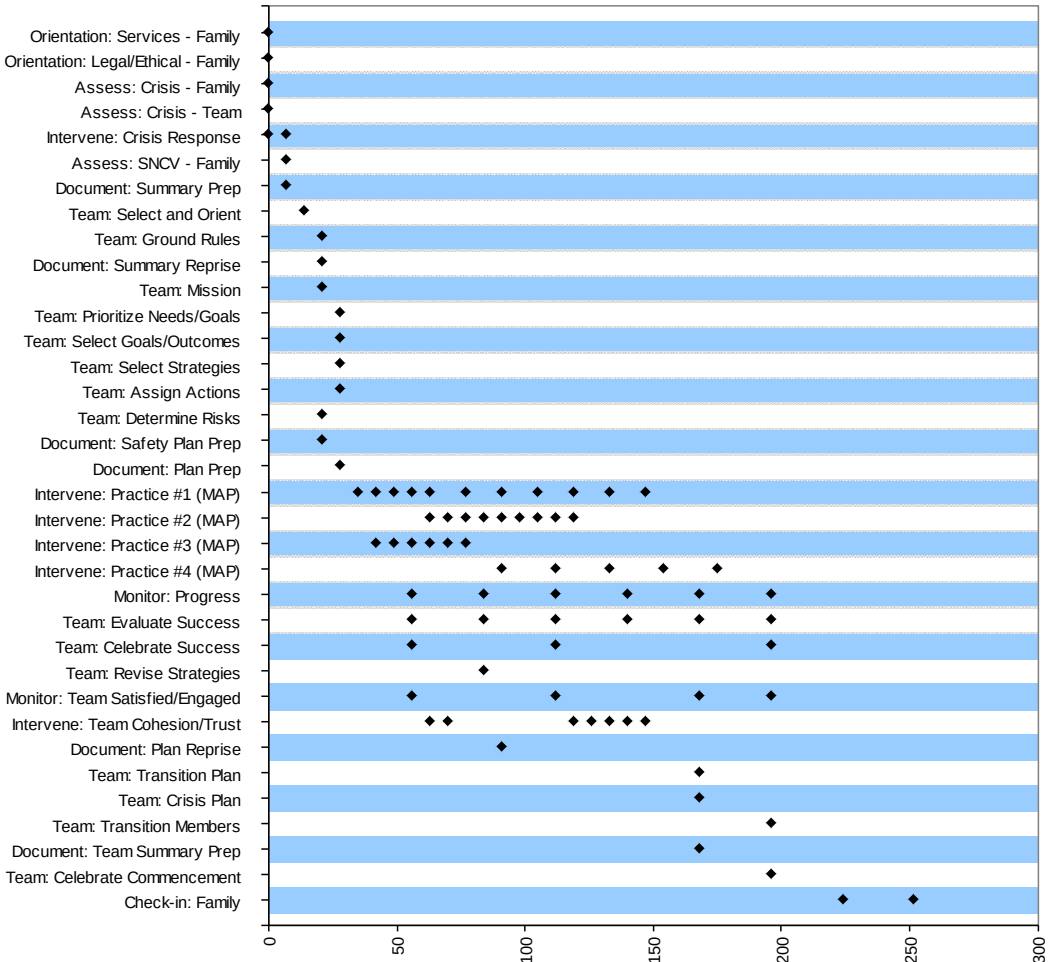
Gender: Female
Ethnicity: Asian



Display Measure:

Yes	Goal #1: CA
Yes	Goal #2: CA
Yes	WFI
Yes	CANS Funct
Yes	CANS Needs

Display Time:
To Last Event



Possible Wrap+MAP Curricula

for both MAP Clinician and Fully Coordinated MAPAround

Domain	MAP Direct Services (PracticeWise)	MAParound
Wraparound Content		
Values and Culture	As Typically Available	All Staff[1]
System Processes	As Typically Available	All Staff
Service Processes	As Typically Available	All Staff[2]
Roles & Responsibilities	As Typically Available	All Staff
Family Orientation	As Typically Available	All Staff[3]
Strength Discovery	As Typically Available	All Staff[4]
Needs Assessment	As Typically Available	All Staff[5]
Vision and Mission	As Typically Available	All Staff[6]
Supports and Resources	As Typically Available	All Staff[7]
Team Facilitation	As Typically Available	Facilitator[8]
Safety and Crisis Plan	As Typically Available	Facilitator, Clinician[9]
Plan of Care	As Typically Available	All Staff[10]
Transition Plan	As Typically Available	Facilitator, Clinician[11]
Monitoring/Evaluation	As Typically Available	All Staff[12]
MAP Content		
EBS System Overview	Clinician	Facilitator, Clinician
Supported Decision-Making	Clinician	Facilitator, Clinician
Episode Management	Clinician	Facilitator, Clinician[2]
Event Management	Clinician	Facilitator, Clinician[2, 8]
Embracing Diversity	Clinician	All Staff[1]
EBS Database	Clinician	Facilitator, Clinician
Practitioner Guides	Clinician	All Staff
Dashboards	Clinician	All Staff[12]
Treatment Pathways	Clinician	Facilitator, Clinician[2]
Assessment	Clinician	All Staff[4, 5]
Planning	Clinician	All Staff*, [10] Facilitator, Clinician[9, 10, 11]
Monitoring	Clinician	All Staff[12]
Practice Delivery	Clinician	All Staff*, [3, 4, 5, 6, 7]

Practitioner Portfolio: Promotion Review Forms

MAPAROUND

The MAParound Professional Development Program uses an achievement-based portfolio system for tracking and evaluating the continually evolving experience and expertise of individuals working with the MAParound system. You are responsible for documenting your experiences and achievements with the MAParound system and assembling your records into a defined portfolio format for promotion review consideration. To achieve MAParound Practitioner status for the first time, you will need to complete and submit a MAParound Practitioner Portfolio: Promotion Review packet. The next three pages of this document contain the MAParound Practitioner Portfolio: Promotion Review forms, and the remaining pages outline the instructions for completing a MAParound Practitioner Portfolio: Promotion Review submission, which includes both forms and case materials.

Your MAP Practitioner Portfolio: Promotion Review submission must include the following items:

Your Materials

- Submission Page (with Supervisor Certification Signature if required)
- MAParound Learning Record
- MAParound Case Record (with Practitioner Certification Signature)

Materials from Case 1

- Plan of Care
- PWEBS Summary of Youth Treatment
- Clinical Dashboard (De-identified)

Materials from Case 2

- Plan of Care
- PWEBS Summary of Youth Treatment
- Clinical Dashboard (De-identified)

Once all of the materials are assembled for your portfolio and you believe that you have met all of the relevant promotion criteria, please submit your completed portfolio via email to review@practicewise.com or via mail to:

PracticeWise, LLC
285 Wilson Avenue
Satellite Beach, FL 32937

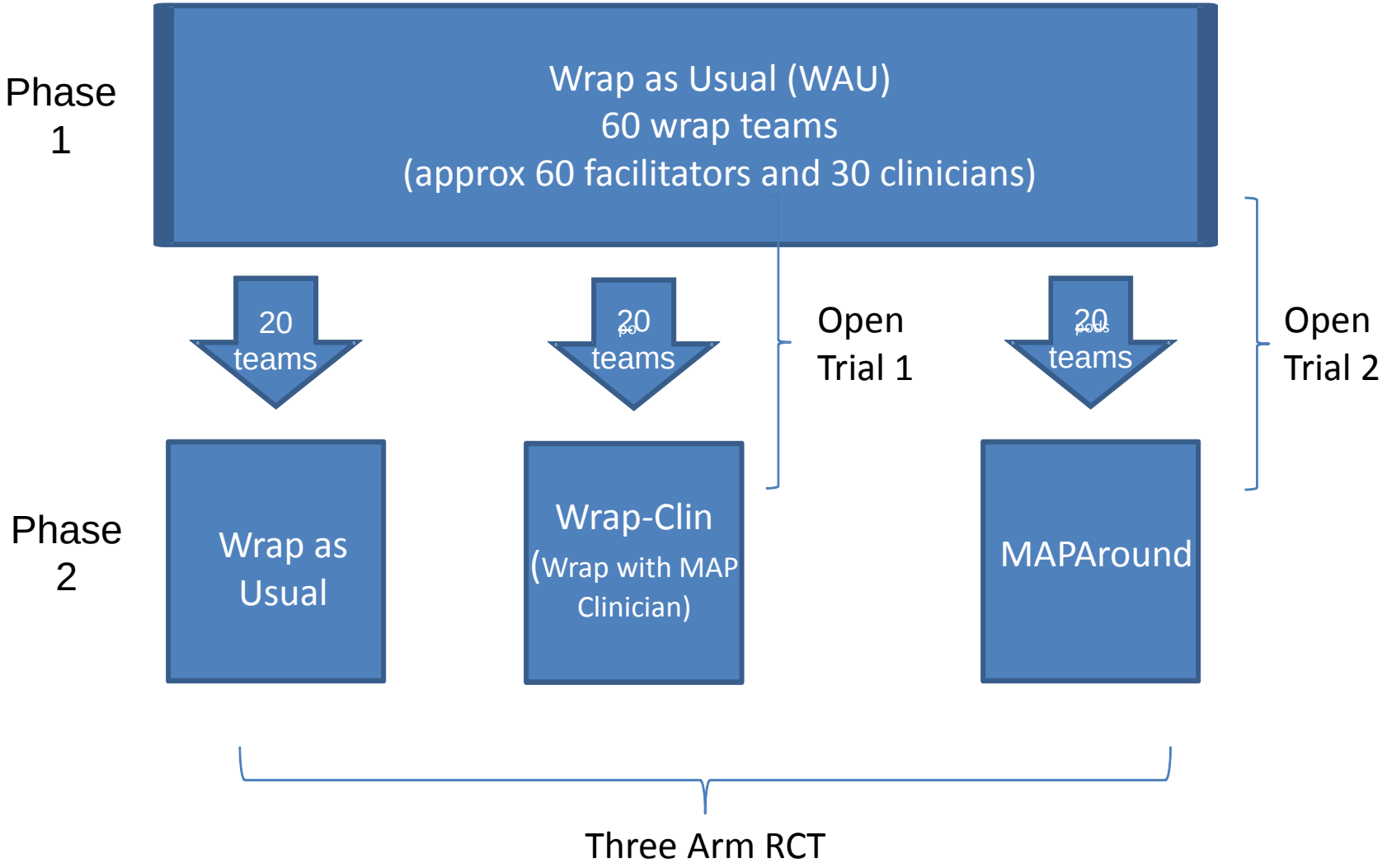
MAParound LEARNING RECORD

CONCEPTS	Experience		Expertise Achieved			
	Reviewed	Rehearsed	Knowledge	Production	Skill	Habit
System Values and Principles	☐	☐	☐	☐	☐	☐
Resources and Supports	☐	☐	☐	☐	☐	☐
EBS System Model	☐	☐	☐	☐	☐	☐
CARE Process	☐	☐	☐	☐	☐	☐
The MAP	☐	☐	☐	☐	☐	☐
Phases of Service	☐	☐	☐	☐	☐	☐
Focus-Interference	☐	☐	☐	☐	☐	☐
Life Domains	☐	☐	☐	☐	☐	☐
Clinical Event Structure	☐	☐	☐	☐	☐	☐
Embracing Diversity	☐	☐	☐	☐	☐	☐
RESOURCES	**Experience**		**Expertise Achieved**			
	Reviewed	Rehearsed	Knowledge	Production	Skill	Habit
Plan Guides	☐	☐	☐	☐	☐	☐
PWEBS	☐	☐	☐	☐	☐	☐
Practitioner Guides	☐	☐	☐	☐	☐	☐
Clinical Dashboard	☐	☐	☐	☐	☐	☐
Treatment Pathways						
Wraparound	☐	☐	☐	☐	☐	☐
Focus Domain 1: _____	☐	☐	☐	☐	☐	☐
APPLICATIONS	**Experience**		**Expertise Achieved**			
	Reviewed	Rehearsed	Knowledge	Production	Skill	Habit
Assessment						
Strengths	☐	☐	☐	☐	☐	☐
Needs	☐	☐	☐	☐	☐	☐
Culture and Values	☐	☐	☐	☐	☐	☐
Engagement	☐	☐	☐	☐	☐	☐
Planning						
Vision and Mission	☐	☐	☐	☐	☐	☐
Target Selection	☐	☐	☐	☐	☐	☐
Practice Selection	☐	☐	☐	☐	☐	☐
Plan of Care	☐	☐	☐	☐	☐	☐
Crisis and Safety Plan	☐	☐	☐	☐	☐	☐
Transition Plan	☐	☐	☐	☐	☐	☐
Monitoring						
Child and Family	☐	☐	☐	☐	☐	☐
Team	☐	☐	☐	☐	☐	☐

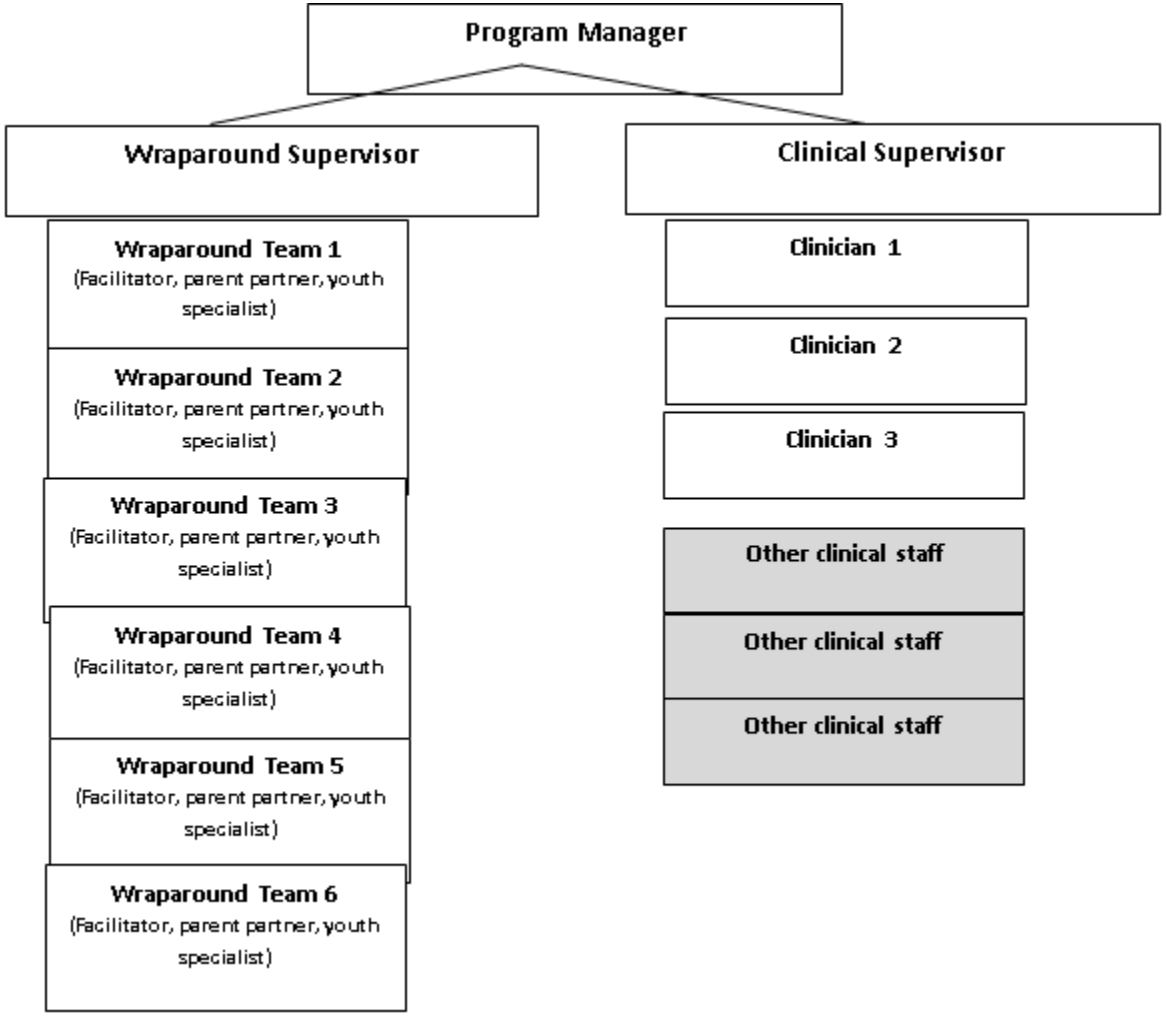
MAParound CASE RECORD

Client ID	1:	2:	3:	4:	5:	Criteria
Number of Clinical Event(s)						≥ 20 events
Number of Team Meeting(s)						
Document Complete						≥ 2 plans
Family Vision	☐	☐	☐	☐	☐	
Team Mission	☐	☐	☐	☐	☐	
Plan of Care	☐	☐	☐	☐	☐	
Crisis and Safety	☐	☐	☐	☐	☐	
Transition Plan	☐	☐	☐	☐	☐	
Measurement						≥ 2 clients
Child and Family	☐	☐	☐	☐	☐	
Progress	☐	☐	☐	☐	☐	
Practice	☐	☐	☐	☐	☐	
Team	☐	☐	☐	☐	☐	
Progress	☐	☐	☐	☐	☐	
Practice	☐	☐	☐	☐	☐	
EBS Knowledge Integration						
Planning	☐	☐	☐	☐	☐	
Review	☐	☐	☐	☐	☐	
Adaptation	☐	☐	☐	☐	☐	
MAParound Resources Used						
Plan Template	☐	☐	☐	☐	☐	
PWEBS	☐	☐	☐	☐	☐	
Practitioner Guide	☐	☐	☐	☐	☐	
Clinical Dashboard	☐	☐	☐	☐	☐	
Treatment Pathway	☐	☐	☐	☐	☐	
Session Plan	☐	☐	☐	☐	☐	
Outcome Achieved						
Family	☐	☐	☐	☐	☐	
Team	☐	☐	☐	☐	☐	

A Proposed Research Study to test Wrap+MAP



Structure in L.A. County for a clinical unit ("Pod") with 6 wrap teams



In the Next Session (3:30 – 5:00)

- Demonstration of the Managing and Adapting Practice system in action
  - PracticeWise Evidence Based Services database
  - Practice Guides
  - Progress and Process Dashboard
- Exercise: Testing these ideas in action with actual wraparound-enrolled youth

Integrating Common Elements of Evidence Based Practice into the Wraparound Process, Part 2

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Garden Grove, California

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Session 1

- Is wraparound evidence based? What might be improved in the practice model?
- What about evidence based treatments? How is the field getting them into “real world” practices like Wraparound?
- Flexible approaches to promoting EBP: Managing and Adapting Practice (MAP)
- Integrating MAP and Wrap: Some options

Session 2

- Demonstration of the Managing and Adapting Practice system in action
  - PracticeWise Evidence Based Services database
  - Practice Guides
  - Progress and Process Dashboard
- Exercise: Testing these ideas in action with actual wraparound-enrolled youth

Small Group Exercise

- Two vignettes of wraparound referred youths
  - Robert Smith
  - Oliver Post
- As a group, (quickly) identify/develop:
  - Functional strengths
  - Family vision statement
  - Underlying Needs
  - Team members
- For one priority need, develop:
  - An outcome statement
  - Up to 10 possible strategies
- **Then we will see what the MAP contributes to the ideas**

Smith Family

- Robert Smith is a 14 year old Caucasian male starting the 9th grade at High School. He was referred to wraparound when his parents requested a crisis placement after he ran away for 3 days with another youth. Mr. and Ms. Smith stated they had had enough and could no longer control Robert. They reported being tired and not knowing what to do. Robert's current diagnoses are:
- Axis: I Major Depressive Disorder, Recurrent, Unspecified;
- Axis I: Bipolar Disorder NOS;
- Axis: II: Deferred.
- Axis: III Asthma; Allergies.
- Axis: IV Primary Support; School Problems.
- Axis: V 50.

- Robert is currently prescribed Depakote 500 mg. and Wellbutrin 150mg. He began receiving mental health services at the age of 5 when he was diagnosed with ADHD. He has continued in treatment, with some breaks, with several different agencies, but currently does not see a therapist regularly. Services in the past have included out-patient mental health treatment, partial hospitalization, two acute hospitalizations and a two year stay at Residential Treatment Center (RTC). Behaviors contributing to the recent RTC placement include telling his parents he didn't want to live anymore, cutting himself, and running away. He was discharged from the RTC 2 months ago. Since then he has seen a therapist at the RTC twice but says he does not want to see him anymore because he feels like all he does is talk and he doesn't do anything to help. His mother and stepfather are concerned that Robert does not have a therapist but is not opposed to his ceasing therapy because it takes over an hour to get to the RTC and they are not sure what the goals of treatment are.

Smith Family, continued

- Robert was voluntarily placed with his maternal grandmother, Ms. Rogers, shortly after birth. At that time, Ms. Smith, age 18, was feeling overwhelmed and felt she was unable to provide a stable home environment for Robert. Robert describes his time with his grandmother as abusive. He states that she would hit him frequently. The abuse was reported when Robert disclosed this information to his care coordinator when he was referred for wraparound. The abuse was unsubstantiated.

- Ms. Smith describes Robert as a caring, sensitive individual. She states he would give anyone anything he had if they needed it. Some of her concerns include Robert being extremely socially anxious and trying so hard to fit in that he sometimes makes dangerous decisions to impress his peers. She sees him as a follower and believes he would be very capable of being a leader if he could be "less nervous about meeting friends" and if his self-esteem improved. However, when things do not go well with peers he can become extremely depressed and not want to leave the house or go to school. She finds this to be very sad because Robert has a good sense of humor and loves to be around others.

Smith Family

- Robert currently resides with his mother, age 32, and Mr. Smith, age 41. He does not have any contact with his biological father. Mr. and Ms. Smith have been married since Robert was 5 and shortly after getting married, took Robert back in to their home. At the same time, Robert was adopted by his step-father and has lived with Mr. and Ms. Smith since. Robert feels Mr. Smith is his father. Both Ms. and Mr. Smith work in the food industry and are concerned about the amount of free time Robert has due to their work schedule. “Too much time allows Robert to get in trouble.” Robert has an older sister who lives nearby, Jane, who likes doing going out and doing things with Robert. However, Jane works two jobs and often cannot find time. Ms. Smith’s oldest daughter, Sarah, is 16 and lives with her biological father in another state where she has resided since birth. Ms. Smith has little contact with Sarah. Sarah and Robert have different fathers. Ms. Smith states she grew up in a strict household. Her father worked offshore and was gone for long periods of time. She is one of three children, but has little contact with her mother or siblings.

Smith Family

- The family enjoys doing activities together like going swimming at the neighborhood pool and watching DVDs together. They eat together whenever possible and treasure the time they can spend together. Decisions within the family are shared with secrets being avoided. Both Mr. and Ms. Smith discuss all issues relating to Robert and try to agree prior to acting. There is not always agreement according to both parents, yet they try hard to be a united front.
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- According to Robert his strengths include playing video games and football. His goal for the future is to create new video games. He smiles often and is easy to engage in conversation. When discussing some of his difficulties he states other kids used to pick on him but not any longer. He claims he has no problem fighting back any more.
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- The family strengths include the affection each member has for each other, the ability of the adults to be honest about past and present difficulties and the current willingness to ask for help when it is needed. In addition, each family member enjoys laughing and has seemed to learn how to use their sense of humor to help alleviate stressors and concerns.

Post family vignette

- Oliver Post is an 11 year old male referred to wraparound by the local hospital upon discharge from the psychiatric unit. He was recommended for a Residential Treatment Center as a result of fighting and aggressive behaviors associated with past trauma events. At the time of the referral Oliver had injured a peer in school who subsequently had to be hospitalized. Oliver is currently in the custody of his grandmother and has resided with her the last eight months. He was removed from his mother's home at the age of 8 by Child Protective Services in another state where there was a history of severe sexual and physical abuse by his mother's boyfriend and a great uncle. He then resided with his father and again was removed by Child Protective Services after allegations of severe abuse and neglect were substantiated.
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- Ms. Post's biggest concerns are about her grandson's disrespect as well as stealing behaviors. Oliver has been removed from after school activities as a result of his behaviors. Ms. Post reports Oliver is disrespectful at home. He refuses to follow Ms. Post's requests and often has angry outbursts. Though she will not say it in front of Oliver, Ms Post confides to professionals that she will have to seek voluntary custody if the behavior continues or worsens. Oliver feels everyone is making fun of him and talking about him and says it makes him angry. Oliver is diagnosed with Post Traumatic Stress Disorder and Bi-Polar Disorder. He is prescribed Abilify, Trazadone and Triliptal.

Post family part 2

- Ms. Post is Oliver's paternal grandmother and guardian. Ms. Post was married at age 18 soon after her husband joined the military. When Mr. Post returned from the military he began work as an air traffic controller. Ms. and Mr. Post had 3 children. Oliver's father was the 3rd child born to Mr. and Ms. Post. Ms. Post began working as an assistant in a legal office just before her kids graduated high school. Mr. Post passed away as a result of cancer just a few years before Oliver was born.

- Oliver's abuse history includes being shocked by a stun gun and he sustained an injury to the head after being hit with a baseball bat by his mother's boyfriend. While living with his mother, Oliver was hospitalized three times as a result of the injuries sustained. He suffers from short-term memory loss. With his father, he experienced severe neglect including being humiliated and refused basic needs like food. Oliver was recently evaluated and deemed eligible for special education services. Oliver repeated kindergarten due to a speech impediment. He named mathematics and science as his favorite subject whereas history is his least favorite.

Post family

- Ms. Post feels her grandson is being well-supported in school. Oliver indicated having difficulty with other children in school earlier but he said this is no longer the case. According to other reports from the school Oliver has difficulty with peers and wants to fit in but has a very difficult time. He has engaged in many school fights with peers as a result of his perception of them talking about him or making fun of him. If a youth brushes past him, he will engage the youth in a confrontation. The school personnel have instituted personal supports such as walking Oliver to and from class and watching for physical signs of aggression before Oliver hits anyone. These incidents are related to past trauma and current manifestations including flashbacks associated with his past trauma experiences.
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- Oliver's relationship with the other members of the household is reportedly fair. Admittedly he gets along better with his grandmother's roommate. His responsibilities at home include taking out the trash, making the bed, helping with the yard work and taking his medications. His grandmother said he receives an allowance for doing his chores. Oliver is interested in playing basketball, boxing and sports in general. He also enjoys painting and drawing. He is very smart and creative. He talks about being an expert on his feelings, wants and needs.

Post family, part 4

- Oliver's most significant accomplishment is being a good person. His grandmother indicated working very hard, strong, and taking custody of her grandson as her most valued accomplishments. She supports Oliver by making sure he has food, clothes and takes him to his appointments. The family's strength is their diligence, consistency, organization and big hearts. Oliver, in particular, likes everything in its place. Oliver's individual strengths include his problem solving skills and his love of math, in particular algebra and science. He also likes to play with animals. Ms. Post is willing to try new things, have fun with her friends. When he is angry or upset, Oliver will either yell or walk away from a situation in order to calm down. Ms. Post will cook, clean or pull weeds in order to calm down when she is angry or upset. Oliver named his grandmother and Aunt and Uncle as his closest supports within the immediate family. Ms. Post named her sister and brother-in-law as her closest support within the family. Ms. Post stated throughout the interview she loves Oliver.
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- Oliver's goal one year from now is to become a successful person who loves everyone. He would also like to be a chess champion. Ms. Post wants her grandson to be successful. Five years from now Oliver hopes to be driving and starting college. He would like to do something in the field of computer science. Ms. Post's goal five years from now is to maintain her home. Oliver's long term goals involve working with computers.