Building on Practice-Based Evidence: Using Expert Perspectives to Define the Wraparound Process

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Objective: **In order to expand the research base on effective community-based mental health treatments, methods are needed to define and evaluate promising interventions that have not been systematically developed and tested. In this report, the authors describe the results of an effort to better define the wraparound process for children and adolescents with serious emotional and behavioral problems.** ***Methods:*** **A broad review of wraparound treatment manuals and model descriptions was conducted. With the help of a small group of experts, this review was synthesized into an initial description of the phases and activities of the wraparound process. This model was then presented to a multidisciplinary advisory panel of 31 experts on the wraparound process who provided structured and semistructured feedback.** ***Results:*** **Overall, respondents expressed a high level of agreement with the proposed set of activities. For 23 of the 31 activities presented, there was unanimous or near-unanimous agreement (that is, one dissenter) that the activity was an essential component of the wraparound process. For 20 of the 31 activities, there was unanimous agreement that the description was phrased acceptably. A final model was created on the basis of feedback from reviewers.** ***Conclusions:*** **Results indicate that using the experience of a wide base of stakeholders to operationalize a complex model such as wraparound is feasible and holds many potential benefits, including building consensus in the field, improving service quality, and accelerating the incorporation of evaluation results into real-world practice. (*Psychiatric Services* 57:1579–1585, 2006)**

Within children's mental health, the growing focus on promoting evidence-based practices (1,2) has raised awareness of the need to increase the number of such practices (3), particularly those that have demonstrated effectiveness for diverse populations in usual-care settings (4). For children with severe emotional and behavioral disorders there has been particular focus on developing community-based interventions as an alternative to institutional care. This is due to several factors, including the high cost of institutional care, the lack of evidence for its effectiveness, and the philosophical shift toward providing care in the most normalized settings possible (5).

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However, observers caution that relying on traditional models for validating new community interventions may limit the capacity of the field to respond efficiently to this growing demand for evidence-based practices. Traditional models are criticized for placing primary emphasis on demonstrating efficacy, largely ignoring the attributes of usual-practice contexts and populations. This may result in interventions which, despite evidence of efficacy, lack effectiveness because they are not readily transportable to usual-care settings with populations that are socioeconomically and ethnically diverse or whose problems are severe and heterogeneous (4,6,7). Furthermore, an intervention may be difficult to implement given available community resources, may not be attractive or acceptable to clinicians, or may fail to promote engagement or adherence among service recipients.

As a remedy, alternative models for developing and testing interventions have been proposed. Such models aim to accelerate the production of evidence by studying practices that are developed or refined in community practice settings (7,8). The intent is to enhance external validity and speed up the process of developing valid and effective services, yet still move in an orderly fashion from intervention design and manualization to studies of efficacy and then effectiveness.

A challenge to this orderly progression, however, is posed by interventions that have not been the ob-

ject of a coherent process of development and testing but are nevertheless widely practiced in community settings. Though some of these real-world services may be ineffective, others are regarded as promising but untested (8). Formal testing of such practices is often hampered because they are unstandardized, having evolved to fit within a variety of practice settings. At the same time, an intervention's survival and adaptation across contexts suggests that it is feasible to implement as well as attractive to both practitioners and recipients of services. Indeed, as a complement to the dissemination of existing evidence-based practices, there have been calls for a process of capitalizing on such accumulated practical experience and incorporating practice-based evidence into the process of developing and testing interventions (9,10).

One example of a widely implemented promising practice is the wraparound process, a team-based, collaborative process for developing and implementing individualized care plans for children with severe disorders and their families. Wraparound emerged in the 1980s as a value-driven approach to providing community-based care for children and youths who would otherwise likely be institutionalized. The values associated with wraparound specified that care was to be strengths based, culturally competent, and organized around family members' own perceptions of their needs and goals (11,12). The term wraparound came to be more and more widely used throughout the 1990s, and although wraparound programs shared features with one another, there existed no consensus about how wraparound could be defined or distinguished from other planning approaches. By the late 1990s a positive research base began to emerge (13); however, the studied programs differed substantially from one another, to the extent that it is not even clear that the same intervention was attempted (13).

Recognizing the need for greater clarification of the wraparound process, a group of stakeholders gathered for a three-day meeting in 1998 to specify essential elements and implementation requirements. The group produced a consensus document that provided a clear description of the philosophy that should guide wraparound practice (14). This description included ten essential elements that stipulated, for example, that the wraparound process should include families as "full and active partners in every level of the wraparound process" and that plans should be individualized, be based on strengths, and include a balance of formal and informal services and supports. This foundation document did not, however, provide a specific description of what providers or team members should do to ensure that the philosophical elements were translated into practice.

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The consensus document nonetheless marked an important milestone, and it allowed the development of two fidelity measures. One of these measures, the Wraparound Fidelity Index (15), uses interviews with team members to assess adherence to the philosophical elements. But because the measure assesses adherence to principles rather than practices, it provides little information about what specific activities are being implemented or how practice should be improved. The other measure, the Wraparound Observation Form (16,17), is also keyed to the essential elements but uses observations of team meetings to determine whether the philosophy is evident in teamwork. Although this measure assesses practice directly, it is clear that what happens during meetings represents only a small part of wraparound's activities and interactions.

Despite this progress, clear, comprehensive guidelines for carrying out wraparound are still lacking. Not surprisingly, practice continues to vary considerably, often failing to be consistent with the philosophy as expressed in the consensus document (18). For example, two recent multisite studies of wraparound found high variability in wraparound quality (19,20), with many teams failing to monitor outcomes, incorporate informal supports, or use family and community strengths to implement services.

At the same time, results from existing research and program evaluation indicate that planning approaches based on the wraparound principles can achieve positive outcomes in community settings and that such approaches tend to be viewed very positively by children and families from diverse populations (13,18,21, 22). For these and other reasons (23) wraparound implementation continues to increase (24). This trend may continue, given that prominent national reports have described wraparound as a "promising" (8) or "emerging" (2) best practice. However, it is unlikely that this enthusiasm will continue unless the wraparound practice can be more clearly defined. Such clarification would facilitate development of more comprehensive fidelity measures, support research on effectiveness, and assist states and jurisdictions that wish to specify their expectations of providers or to certify programs.

One possible solution to this difficulty is to wait for one community or

program's model to be standardized and studied, eventually emerging as the de facto standard for wraparound. However, though there have been several high-profile wraparound programs that have documented their success (21,22), waiting for the necessary momentum to gather behind a single program takes time. Furthermore, relying on only one program may sacrifice much of the collective wisdom that has grown out of efforts to implement wraparound within diverse communities and contexts. It is also quite possible that no single program would emerge as the model, setting the stage for rival models competing for legitimacy and evaluation resources.

In light of these difficulties, and recognizing that the increased focus on evidence-based practices demands efforts toward standardizing and testing wraparound, stakeholders from across the country came together in 2003 to work out a strategy for collaboratively defining the process. This advisory group, selected to include highly experienced practitioners, trainers, administrators, family members, and researchers, prioritized a need for wraparound to be described in terms of a standard set of constituent activities. The activities, in turn, would be defined in a manner that was sufficiently precise to permit measurement of process fidelity but that was also sufficiently flexible to allow for diversity in the manner in which a given activity might be accomplished. This article describes the methods used to define the wraparound process and the results of the advisory group's effort.

Methods

To begin the process, in early 2004 a core group of eight researchers, trainers, family advocates, and program administrators reviewed existing wraparound manuals and training materials to distill a first draft of a practice model. Manuals were requested from national-level trainers with experience at numerous sites and from well-regarded wraparound programs. Two methods were used to identify well-regarded wraparound programs: nomination by the national-level trainers or recognition by the Center for Mental Health Services for having implemented promising practices related to wraparound (25–27). Other manuals and training documents were provided by members of the advisory group. [An appendix showing the list of manuals reviewed is available as an online supplement at ps.psychiatryonline.org.]

The first draft of the practice model organized wraparound activities into four phases: engagement, initial plan development, plan implementation, and transition. The resulting practice model was sent out for review and comment by ten additional reviewers, primarily administrators of wraparound programs widely recognized as exemplars of high-quality practice and including five from the well-regarded programs previously identified. These stakeholders provided feedback in written form or through verbal debriefing, and their feedback was synthesized by the coordinators and incorporated into a new draft. This draft was reviewed by the core group and approved by consensus.

Although the practice model that emerged from this process included no activities that were completely novel, the overall model was nonetheless quite distinct from those described in any existing manual or program description. For example, the proposed model defined four phases for wraparound and placed a far greater emphasis than existing models on engagement and transition activities. The proposed model was also more precise regarding the sequencing and timelines for the various activities and contained greater detail in describing key activities for developing a plan, including prioritizing needs and goals; for defining outcomes and indicators; and for selecting strategies.

In order to maximize the inclusiveness of the process for defining the practice model, the core group decided to solicit both structured and semistructured feedback from the entire membership of the larger advisory group. At least two published studies used a broadly similar approach to clarify practice and program ingredients for mental health practices that were already widely implemented in diverse community settings. McGrew and Bond (28) asked expert judges to provide ratings and open-ended feedback regarding essential program elements for assertive community treatment, a community-based practice used with adults. Similarly, McFarlane (29) sought structured and semistructured feedback from an international group of experts as part a process to define critical elements of family psychoeducation.

By the time this version of the practice model was prepared in mid-2004, the advisory group had grown to include 50 members and had come to be known as the National Wraparound Initiative. The group included representatives from each of the well-regarded programs mentioned earlier, as well as researchers and national-level trainers. Existing members had been asked to provide names of others whom they considered expert, with a special emphasis placed on increasing the number of family members in the group who were wraparound experts.

Advisors were asked to rate each activity in the model in two ways: first, to indicate whether an activity like the one described was essential, optional, or inadvisable for wraparound; second, whether, as written, the description of the activity was fine, acceptable with minor revisions, or unacceptable. Reviewers were given the opportunity to provide a rationale for their ratings or general comments about each activity. The task also requested feedback on each phase overall and its constituent procedures, including whether all necessary activities had been covered.

Results

During late 2004 a total of 31 of the 50 advisors responded to the task via e-mail and fax, although two provided only overall commentary without ratings. Respondents were from 18 states and the District of Columbia. Twenty-four respondents (77 percent) identified themselves as Caucasian, four (13 percent) as African American, two (6 percent) as His-

panic, and one (3 percent) as "mixed nonwhite." The group included 13 people (42 percent) with experience on their own child's team, eight people (26 percent) with experience as a family advocate on wraparound teams (mean±SD experience of 6.8±3.4 years), 13 people (42 percent) who had conducted research on wraparound, 25 people (81 percent) with experience in wraparound training (mean of 6.1±3.0 years), 17 (55 percent) with experience in facilitation (mean of 6.5±3.5 years), and 18 (58 percent) with experience in wraparound program administration (mean of 5.6±2.5 years). Most advisors had experience in two or more of these capacities.

As shown in Table 1, overall, the 29 respondents expressed a very high level of agreement with the proposed set of activities. For 23 of the 31 activities presented, there was unanimous or near-unanimous (that is, one dissenter) agreement that the activity was essential. The two activities that received the highest number of "optional" ratings were transition activities intended to mark the "graduation" of a family from wraparound.

Respondents also found proposed descriptions of the activities generally acceptable; in fact, all respondents rated the description acceptable for 20 of the 31 activities. Seven activities had one unacceptable rating and three had two (Table 1). A single item, describe and prioritize needs and goals, had three unacceptable ratings. Advisors commented that this activity, as well as the subsequent one, select strategies and assign action steps, actually contained multiple activities and described a confusing process for moving from an overarching goal (the team mission) to specific action steps. Nevertheless, advisors saw these activities as essential, with unanimous agreement for one activity and near-unanimity for the other. These two activities were subdivided into four activities in the final version of the model.

All reviewer comments and ratings were aggregated and made available publicly on the Internet (30). Incorporating this feedback, the coordinators (who were also the authors of this article) prepared a document that described the phases and activities more completely, along with notes about particular challenges and other considerations that might be associated with a given activity. These notes were derived from the commentaries provided by respondents and focused on how to accomplish difficult yet crucial activities, such as defining and prioritizing needs and eliciting and linking services and supports to the strengths of the child, family, and team member. This document was reviewed by the core group and accepted by consensus. It is publicly available in print and on the Internet (31). A summary of the resulting description of the phases and activities of the wraparound process is provided in Table 1.

The definition of wraparound in this article provides a critical starting point for measuring fidelity and evaluating impact.

Discussion and conclusions

Models for coordinating services and supports for individuals with complex needs have a long history of underspecification and poor monitoring (19). Long histories of implementation efforts can, however, yield substantial practical experience about what is feasible and effective in real-world community settings. The challenge for the field is to determine how to harness and apply this practice-based evidence. In 1995, McGrew and Bond (28) surveyed experts to identify the critical ingredients of assertive community treatment, now recognized as an evidence-based practice. Ten years later, the National Wraparound Initiative had similar goals and has employed similar methods to explore expert consensus about wraparound practice.

In the study presented here, consensus on the model was not absolute, of course, even among the advisors who responded. Many advisors chose not to respond, and the advisory group certainly does not include every wraparound expert or representation from every excellent program. Thus an important limitation of the study is that the participants cannot be said to be representative of all wraparound experts or programs. In addition, although adaptations were made to the model on the basis of advisors' comments, it is not certain that advisors would be satisfied with these changes. What is more, in some cases, reviewers gave ratings that indicated dissatisfaction but did not provide a rationale. The final model thus cannot be said to express a definitive consensus even among the participating advisors.

Nevertheless, the results of our consensus-building process seem to indicate a high level of preexisting agreement regarding the essential activities of wraparound, and the consensus expressed by advisors compares favorably with that obtained by McGrew and Bond (28). However, the resulting description of the model differed from previous descriptions in both content and format. The model summarized in Table 1 includes more details on the specific procedures of the wraparound care planning and management process than have typically been presented in training manuals or descriptions of the model in the literature.

It also appears that the feedback process itself has contributed to building the consensus that was expressed in reviewers' ratings. Soon after the initial Web publication of the document on the phases and activities, examples emerged of states,

Table 1

Ratings of proposed wraparound activities by 29 advisory group members

Major task activity	Rating[a]					
	Essential		Optional		Inadvisable	
	N	%	N	%	N	%
Phase 1: engagement and team preparation						
Orient the family and youth						
Orient the family and youth to wraparound	29	100	0	—	0	—
Address legal and ethical issues	26	96	1	4	0	—
Stabilize crises						
Ask the family and youth about immediate crisis concerns	28	97	1	3	0	—
Elicit information from agency representatives and potential team members about potential crises	25	89	3	11	0	—
If immediate response is necessary, formulate a response for immediate intervention or stabilization	29	100	0	—	0	—
Facilitate conversations with the family and youth or child						
Explore strengths, needs, culture, and vision[b]	28	100	0	—	0	—
Facilitator prepares a summary document[b]	22	85	4	15	0	—
Engage other team members	25	96	1	4	0	—
Make necessary meeting arrangements[b]	26	96	1	4	0	—
Phase 2: initial plan development						
Develop an initial plan of care						
Determine ground rules	27	100	0	—	0	—
Describe and document strengths	26	96	1	4	0	—
Create team mission[c]	26	96	0	—	1	4
Describe and prioritize needs and goals[c]	26	96	0	—	1	4
Determine goals and associated outcomes and indicators for each goal[d]	—		—		—	
Select strategies[c]	26	100	0	—	0	—
Assign action steps[d]	—		—		—	
Develop crisis and safety plan						
Determine potential serious risks	24	92	1	4	1	4
Create plan	27	100	0	—	0	—
Complete documentation and logistics	27	100	0	—	0	—
Phase 3: plan implementation						
Implement the plan						
Implement action steps for each strategy[c]	26	96	1	4	0	—
Track progress on action steps	28	100	0	—	0	—
Evaluate success of strategies	28	100	0	—	0	—
Celebrate successes	27	96	1	4	0	—
Revisit and update the plan: consider new strategies as necessary	28	100	0	—	0	—
Maintain and build team cohesiveness and trust						
Maintain awareness of team members' satisfaction and "buy-in"	24	89	3	11	0	—
Address issues of team cohesiveness and trust[b]	26	100	0	—	0	—
Complete necessary documentation and logistics	26	100	0	—	0	—
Phase 4: transition						
Plan for cessation of formal wraparound						
Create a transition plan[b]	26	100	0	—	0	—
Create a posttransition crisis management plan	26	100	0	—	0	—
Modify wraparound process to reflect transition[b]	14	93	1	7	0	—
Create a "commencement"						
Document the team's work[b]	23	85	4	15	0	—
Celebrate success	17	71	7	29	0	—
Follow up with family: conduct regular check-ins with family	20	83	4	17	0	—

[a] Not all advisors rated each activity.

[b] The original wording of these activities received one rating of "unacceptable."

[c] The original wording of these activities received more than one rating of "unacceptable." One activity received three such ratings, and three activities received two. The remaining activities received zero or one rating of "unacceptable" for wording.

[d] In the rated version, each of these activities was combined with the activity immediately prior. Reviewers commented that they should be separate.

counties, and prominent wraparound trainers that had realigned policy and procedure manuals, practice expectations, and training and coaching curricula to reflect the document (32–34). Many of the people responsible for these products were members of the advisory group, and the group has continued to grow and take on new tasks, with advisors maintaining contact through the Internet and periodic meetings. The National Wraparound Initiative has also built an extensive Web site, www.rtc.pdx.edu/nwi, to provide current and detailed information about activities and products of the initiative. A central feature of the Web site is the extensive electronic repository of wraparound tools, exemplars, and other resources that members of the National Wraparound Initiative and others have made available to the public. Essentially, the National Wraparound Initiative has become a collaborative community of practice (35) that serves simultaneously as a vehicle for producing and disseminating practice-based evidence.

In addition to providing greater consensus on the core phases and activities of the model, the definition of wraparound in this article provides a critical starting point for measuring fidelity and evaluating impact. Though measures of adherence to the wraparound principles had been created and widely implemented, new measures (such as a revised version of the Wraparound Fidelity Index) are now available that assess implementation of the specific activities included in the National Wraparound Initiative model. Research using such measures will be more likely to determine which components of the process are critical to achieving outcomes.

Moreover, programs using these measures will be able to apply the results more readily to quality improvement efforts. For example, previous versions of the Wraparound Fidelity Index ask for respondents' perceptions about use of strengths as a basis for planning and implementing services. By using the model presented here, the revised Wraparound Fidelity Index assesses more specifically whether, for example, strengths were explored during engagement and whether the facilitator prepared a summary document before the first team meeting. In addition to the revised Wraparound Fidelity Index interviews, fidelity measures are also now being piloted that incorporate other methods to evaluate model adherence—for example, interviews, record reviews, and observation.

Finally, the National Wraparound Initiative model provides a basis for effectiveness trials, several of which are now under way. Though results from two previous randomized studies of intensive family-centered case management have provided evidence for wraparound's potential effectiveness (36,37), these studies did not use fidelity measures and they did not provide an adequately operationalized model that would allow for replication. Given the compatibility of the National Wraparound Initiative model with approaches already being implemented by trainers and programs, there is potential to accelerate the production of evidence and the incorporation of research results into real-world practice. More generally, this larger process provides a test case for the use of practice-based evidence and the benefits of building treatment models based on the accumulated experience of stakeholders.

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