Wraparound Is Worth Doing Well: An Evidence-Based Statement

By Eric J. Bruns

"Anything worth doing is worth doing well." At some point, a parent, teacher, coach, or supervisor probably has given you this sage advice. Did you ever wonder whether there was evidence to support it?

In fact there is. Research tells us we should heed this guidance when delivering our children's behavioral health services. Meta-analyses of interventions delivered in "real world" systems have shown that "services as usual" are often no more effective than no service at all. Services based on evidence for effectiveness have a better chance of succeeding, but they must be delivered with quality and model fidelity if they are to produce positive effects.

Wraparound care coordination is no exception. Over 20 years, findings from controlled, peer-reviewed research articles (see Suter & Bruns, 2009; Bruns & Suter, 2010; Bruns, Walker, et al., 2014 for reviews) and federal evaluation reports (e.g., Urdapilleta et al., 2011) have consistently found Wraparound to be associated with positive residential, functioning, and cost outcomes. Most of these studies were small pilot projects, however, in which implementation was tightly overseen and staff were well-trained and supervised (e.g., Bruns, Rast, Walker, Peterson, & Bosworth, 2006; Pullmann et al., 2006).

In 2014, two studies were published that provide cautionary notes to policymakers and providers involved in the increasingly common enterprise of taking Wraparound programs to scale in real world public systems. The first study, funded by the National Institute of Mental Health, randomly assigned 93 youths with complex emotional and behavioral needs and involved in the Nevada child welfare system to Wraparound care coordination (N=47) versus more traditional intensive case management (N=46). The Wraparound group received more mean hours of care management and services and demonstrated initially better residential outcomes. By 12 months, however, there were no group differences in functioning or emotional and behavioral symptoms (Bruns, Pullmann, Sather, Brinson, & Ramey, 2014).

The second study evaluated whether the addition of a Wraparound facilitator to regular child protection services (CPS) in Ontario, Canada, improved child and family functioning over 20 months. While both groups improved significantly in child functioning, caregiver psychological

distress, and family resources, the addition of a facilitator did not improve outcomes above regular CPS (Browne, Puente-Dura, Shlonsky, Thabane, & Verticchio, 2014).

In addition to rigorously examining Wraparound outcomes at some level of scale in "real world" systems, these two studies also shared another thing in common – both found Wraparound implementation quality to be poor.[1] In the Ontario study, fidelity, as assessed by the Wraparound Fidelity Index (WFI), was found to be in the "below average" or "not Wraparound" ranges for six of the scale's 10 subscales, per standards disseminated by the NWI (Bruns, Leverentz-Brady, & Suter, 2008). The authors concluded that "some of the major components of Wraparound may not have been sufficiently provided in order to promote optimal support and care for families" and that "a little bit of Wraparound fidelity may not be enough for optimal treatment success."

In the Nevada study, fidelity as assessed by the WFI was worse than 80 percent of sites nationally for parent reports and worse than 90 percent of sites nationally per a team observation measure. Parents and caregiver responses on the WFI and observation of team meetings suggested that the program did not consistently do things associated with high-quality implementation, such as:

- Involve youth and family members in the development of the Wraparound team;
- Actively engage and integrate the family's natural supports;
- Develop proactive crisis plans based on functional assessments;
- Link caregivers to social supports;
- Involve youths in community activities;
- Develop statements of team mission or family priority needs;
- Brainstorming individualized strategies to meet needs;
- Ensure team members followed through on tasks; and
- Develop effective transition plans.

In contrast, earlier studies of smaller-scale Wraparound initiatives in the same system with only 4-5 WSM facilitators and extensive training and coaching showed high levels of fidelity and far better residential and functional outcomes for Wraparound than for a comparison group of similar youths (Bruns, Rast, et al., 2006; Mears, Yaffe, & Harris, 2009). To put the differences in perspective, youths enrolled in the pilot project improved by an average of 35 points on the

[1] Notably, both studies also applied wraparound facilitation to youth involved in child welfare. It is possible that this also played a factor in the finding of no significant effects over services as usual.

Child and Adolescent Functional Assessment Scale (CAFAS), compared to only 13 points in the study of Wraparound taken to scale.

Looking at the big picture, these two studies bring the total number of controlled (experimental or quasi-experimental) Wraparound studies in peer reviewed journals to 12. Among these, only one other study (Bickman, Smith, Lambert, & Andrade, 2003) found uniformly null effects for the Wraparound condition. Perhaps not surprisingly, this is also the one other study among the 12 that documented a lack of adherence to the prescribed Wraparound model. In this study, the authors concluded, "many elements of the practice model of Wraparound were not present" and that the Wraparound condition "was not meaningfully different from the comparison condition."

Thus, many may initially interpret the results of these studies as evidence against the growing movement by states and large jurisdictions to invest in care coordination using the intensive procedures recommended by the National Wraparound Initiative (Walker & Bruns, 2006) for youths at risk for costly and disruptive out of community placement. Closer examination of the studies, however, suggests their findings may simply be an extension of hard lessons learned about implementation of evidence-based practices in general. Not only is it worth doing these practices well, outcomes for youth and families probably depend on it.

Doing Wraparound Well

So, what does it mean to "do Wraparound well"? Obviously, the research summarized above suggests that implementation with fidelity to the prescribed practice model is critical. As has been described in multiple research articles and program descriptions (e.g., Walker & Bruns, 2006; Walker & Matarese, 2011), these practice-level elements must be in place for Wraparound to live up to its theory of change and represent the well-coordinated, youth- and family-driven, multisystemic strategy that it is intended to be.

To achieve high-quality practice, system and program supports must be accounted for into the initiative. According to implementation science, the three big implementation drivers to keep in mind are **Leadership, Workforce Development, and Program and System Support.** Obviously, it would be ideal to do this from the beginning, but many Wraparound projects have also successfully developed these "implementation drivers" over time.

Training, Coaching and Supervision. Wraparound projects require a thoughtful and deliberate approach to building staff and personnel capacity. This includes effective training, coaching, and supervision, as well as other types of human resource decisions, such as appropriate job

descriptions, hiring practices, caseload sizes, performance systems, and staff support, including compensation.

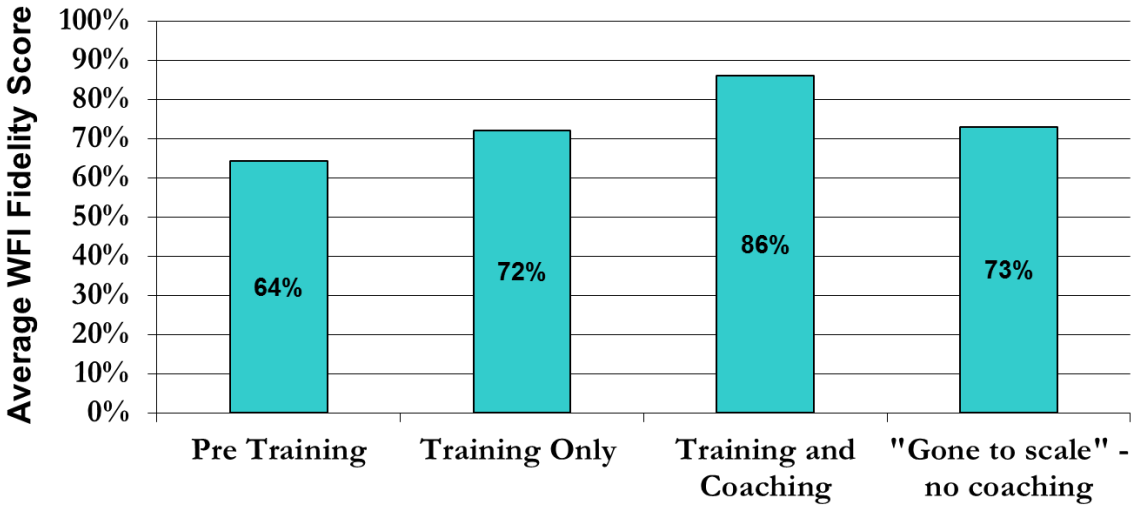

Figure 1. Wraparound fidelity in a system of care with variable workforce development over time

When it comes to training, coaching, and supervision, the evidence is growing crystal clear in human services that the "train and hope" model is destined to fail to achieve high-quality implementation. In the Nevada study cited above, for example, the drop-off in fidelity and outcomes coincided with the withdrawal of resources for staff training and coaching that accompanied the national recession of 2007 that hit that state particularly hard (see Figure 1).

To help ensure states and systems understand what is important to attend to in workforce development, the National Wraparound Initiative (NWI) worked with its community of practice to develop guidelines for training, coaching and supervision for Wraparound Facilitators. As shown in Figure 2 (next page), this guidance describes the types of content and practice activities to which facilitators should be exposed in initial training and orientation before they start to work with families. It goes on to describe the all-too-often neglected "apprentice" period, during which facilitators work in tandem with an experienced facilitator— a "coach" – who uses a structured process to help them gradually develop the ability to work independently with families. In a third phase of skill development, ongoing coaching and supervision should be provided to ensure that facilitators continually develop their skills and expertise. In each of the phases, the learning experience should be characterized by a "tell,

show, practice, feedback" process, whereby training and coaching shifts gradually from imitation of skillful performance to production of skillful performance.

Program and System Supports. Critical though it may be, training and coaching alone is unlikely to ensure skillful practice and successful implementation. Over a decade ago, Walker, Koroloff, & Schutte (2003) showed that "doing Wraparound well" is a complex undertaking that requires a focus on an array of systems-level structures, policies, and supports necessary to ensure quality practice-level implementation and positive outcomes. These "necessary support conditions" have since been codified by the NWI in the form of six themes, shown in Table 1 (see end of article).

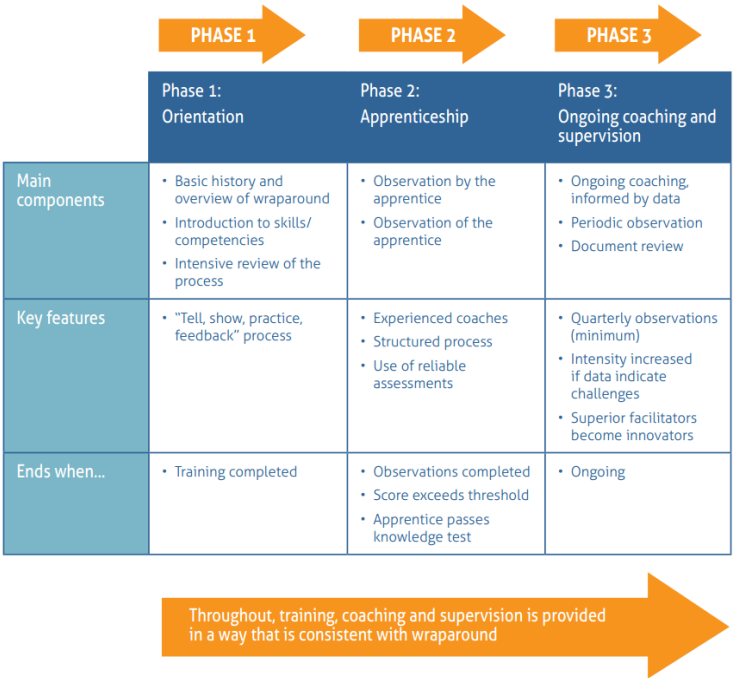

Figure 2. Workforce development in wraparound, from orientation to innovation.

Subsequent research has shown that these conditions can be measured and that they are associated with positive implementation on the ground level (Bruns, Leverentz-Brady, & Suter, 2006; Walker & Sanders, 2011). In the "real world" of Wraparound implementation, the following are examples of topics that will require careful attention:

- *System structures for governance and management*, including consideration of options such as care management entities and health homes;
- Investment in *quality assurance and accountability structures;*
- *Sustainable financing* of high quality Wraparound, including the use of Medicaid and other federal financing mechanisms;
- Developing *centers of excellence* for ongoing implementation, quality assurance, policy, financing, and evaluation support;

- Building, enhancing, and/or implementing *workforce development initiatives* outside of the Wraparound practice model, including shifting providers from residential services to quality home- and-community-based services; and
- Implementation of Wraparound in the context of other systems of care efforts, including developing and implementing other *evidence-based and promising practices*.

Conclusion

In the late 1990s and early 2000s, many feared that the exciting innovations in family- and youth-driven, team based "Wraparound" care would become a passing fad. Instead, Wraparound has become a touchstone for children's mental health, recommended as a strategy in federal guidance documents[2], and available in nearly every state in the U.S. While it is encouraging that Wraparound has gone to scale in this way, Wraparound applied inappropriately or implemented "in name only" may represent a waste of our increasingly scarce behavioral health dollars.

Though it is no longer radical, Wraparound has the potential to be quite powerful. To make the most of their investment in Wraparound, however, states and communities must heed the lessons learned from recent research, lest they be doomed to repeat the mistakes.

Eric J. Bruns is co-director of the National Wraparound Initiative and Associate Professor at the University of Washington School of Medicine in Seattle. Follow him on Twitter @ericjbruns / https://twitter.com/ericjbruns.

[2] (see http://medicaid.gov/Federal-Policy-Guidance/Downloads/CIB-05-07-2013.pdf

References

Bickman, L., Smith, C. M., Lambert, E. W., & Andrade, A. R. (2003). Evaluation of a Congressionally Mandated Wraparound Demonstration. *Journal of Child and Family Studies, 12*(2), 135-156. doi: 10.1023/A:1022854614689

Browne, D. T., Puente-Duran, S., Shlonsky, A., Thabane, L., & Verticchio, D. (2014). A randomized trial of Wraparound facilitation versus usual child protection services. *Research on Social Work Practice,* 1-14. doi: 10.1177/1049731514549630

Bruns, E.J., Leverentz-Brady, K.M., & Suter, J.C. (2008). Is it Wraparound yet? Setting fidelity standards for the Wraparound process. Journal of Behavioral Health Services and Research, 35, 240-252.

Bruns, E. J., Pullmann, M. D., Sather, A., Brinson, R. D., & Ramey, M. (2014). Effectiveness of Wraparound versus case management for children and adolescents: Results of a randomized study. *Administration and Policy in Mental Health and Mental Health Services Research*.

Bruns, E. J., Rast, J., Peterson, C., Walker, J., & 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*(3-4), 201-212.

Bruns, E. J., & Suter, J. C. (2010). Summary of the Wraparound evidence base. In E. J. Bruns & J. S. Walker (Eds.), *The resouce guide to Wraparound*. Portland, OR: National Wraparound Initiative.

Bruns, E. J., Suter, J. C., & Leverentz-Brady, K. M. (2006). Relations between program and system variables and fidelity to the Wraparound process for children and families. *Psychiatric Services, 57*(11), 1586-1593.

Bruns, E. J., Walker, J. S., & NWI Advisory Group (2008). Ten principles of the Wraparound process. In E. J. Bruns & J. S. Walker (Eds.), *Resource guide to Wraparound*. Portland, OR: National Wraparound Initiative, Research and Training Center for Family Support and Children's Mental Health.

Bruns, E. J., Walker, J. S., Bernstein, A., Daleiden, E., Pullmann, M. D., & Chorpita, B. F. (2014). Family voice with informed choice: Coordinating Wraparound with research-based treatment for children and adolescents. *Journal of Clinical Child and Adolescent Psychology, 43*(2), 256-269.

Mears, S. L., Yaffe, J., & Harris, N. J. (2009). Evaluation of Wraparound services for severely emotionally disturbed youths. *Research on Social Work Practice, 19*(6), 678-685. doi: 10.1177/1049731508329385

Pullmann, M. D., Kerbs, J., Koroloff, N., Veach-White, E., Gaylor, R., & Sieler, D. D. (2006). Juvenile offenders with mental health needs: Reducing recidivism using Wraparound. *Crime & Delinquency, 52*(3), 375-397. doi: Doi 10.1177/0011128705278632

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*(4), 336-351.

Urdapilleta, O., Wang, Y., Varghese, R., Kim, G., Busam, S., & Palmisano, C. (2011). National Evaluation of the Medicaid Demonstration Home and Community Based Alternatives to Psychiatric Residential Treatment Facilitites (pp. 1-166): IMPAQ International, LLC.

Walker, J.S. & Bruns, E.J. (2006). Building on practice-based evidence: Using expert perspectives to define the Wraparound process. *Psychiatric Services, 57,* 1579-1585.

Walker, J. S., Koroloff, N., & Schutte, K. (2003). *Implementing high-quality collaborative Individualized Service/Support Planning: Necessary conditions.* Portland, OR: Portland State University Research and Training Center for Children's Mental Health.

Walker, J. S., & Matarese, M. (2011). Using a Theory of Change to Drive Human Resource Development for Wraparound. *Journal of Child and Family Studies, 20*(6), 791-803. doi: 10.1007/s10826-011-9532-6

Walker, J. S., & Sanders, B. (2011). The Community Supports for Wraparound Inventory: An assessment of the implementation context for Wraparound. *Journal of Child and Family Studies, 20*(6), 747-757. doi: 10.1007/s10826-010-9432-1

Table 1. Necessary support conditions for Wraparound

Theme	Description
Theme 1: Community Partnership.	Collective community ownership of and responsibility for Wraparound is built through collaborations among key stakeholder groups.
Theme 2: Collaborative Action.	Stakeholders involved in the Wraparound effort translate the Wraparound philosophy into concrete policies, practices and achievements.
Theme 3: Fiscal Policies and Sustainability.	The community has developed fiscal strategies to meet the needs of children participating in Wraparound and methods to collect and use data on expenditures for Wraparound-eligible youth.
Theme 4: Access to Needed Supports and Services.	The community has developed mechanisms for ensuring access to the Wraparound process and the services and supports that teams need to fully implement their plans, including evidence-based practices.
Theme 5: Human Resource Development & Support.	Wraparound and partner agency staff support practitioners to work in a manner that allows full implementation of the Wraparound model, including provision of high-quality training, coaching, and supervision.
Theme 6: Accountability.	The community has implemented mechanisms to monitor Wraparound fidelity, service quality, and outcomes, and to assess the quality and development of the overall Wraparound effort.