

Knowledge, Training and Supports For evidence-based treatments: *Differences between wraparound and non- wraparound providers*

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Evidence-based Treatment (EBT)

- 1) The treatment approach was developed using research.**
- 2) Studies were conducted that compared children who received the treatment to those who did not, and they found that the children who received the treatment had better outcomes.**
- 3) A manual or set of guidelines exist for delivering the treatment.**

Background

From the Literature

1. We often don't use the things that have been found to work

- We don't know what they are
- We don't know how to use them
- We don't have the resources to learn to use them

2. It is difficult to do “what works” in the real world, for a number of reasons

- Too difficult
- Too time consuming
- Too artificial

Questions to ask when Trying to Implement Effective Interventions

- What is the background and training of the providers?
- Are the providers aware of EBTs?
- Do the providers believe the EBTs work?
- How do the providers feel about using EBTs?
- What are the characteristics of the child and the family that might affect a providers decision to use an EBT?
- How does the provider's employer support their use of EBTs?

Question:

What evidence do you use?

What works for children and
families?

What does not work?

Part 1:
The Evidence Based Treatment
Survey

What treatments do providers believe work?
What treatments do providers actually use?
Are providers supported to implement EBTs?

Evidence-based Treatment Survey

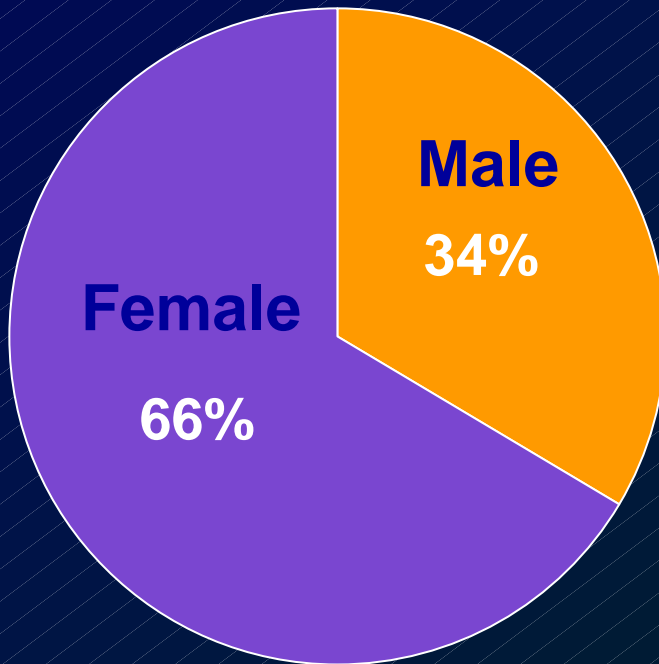
- A survey of mental health service providers for children with serious emotional disturbance
- Web-based (hard copies made available)
- 65 items (15-20 minute completion time)
 - Demographic characteristics of the provider
 - Training and experience of the provider
 - Provider knowledge of EBTs
 - Provider perception of effectiveness of EBTs
 - Provider Use of EBTs
 - Employer support of EBTs

Provider Response to Survey

- 1401 providers of service children with SED asked to participate
- 615 responded (43.9%)
- 547 of those reported they were direct children's mental health service providers (89%)

Provider Characteristics

Gender (n=416)



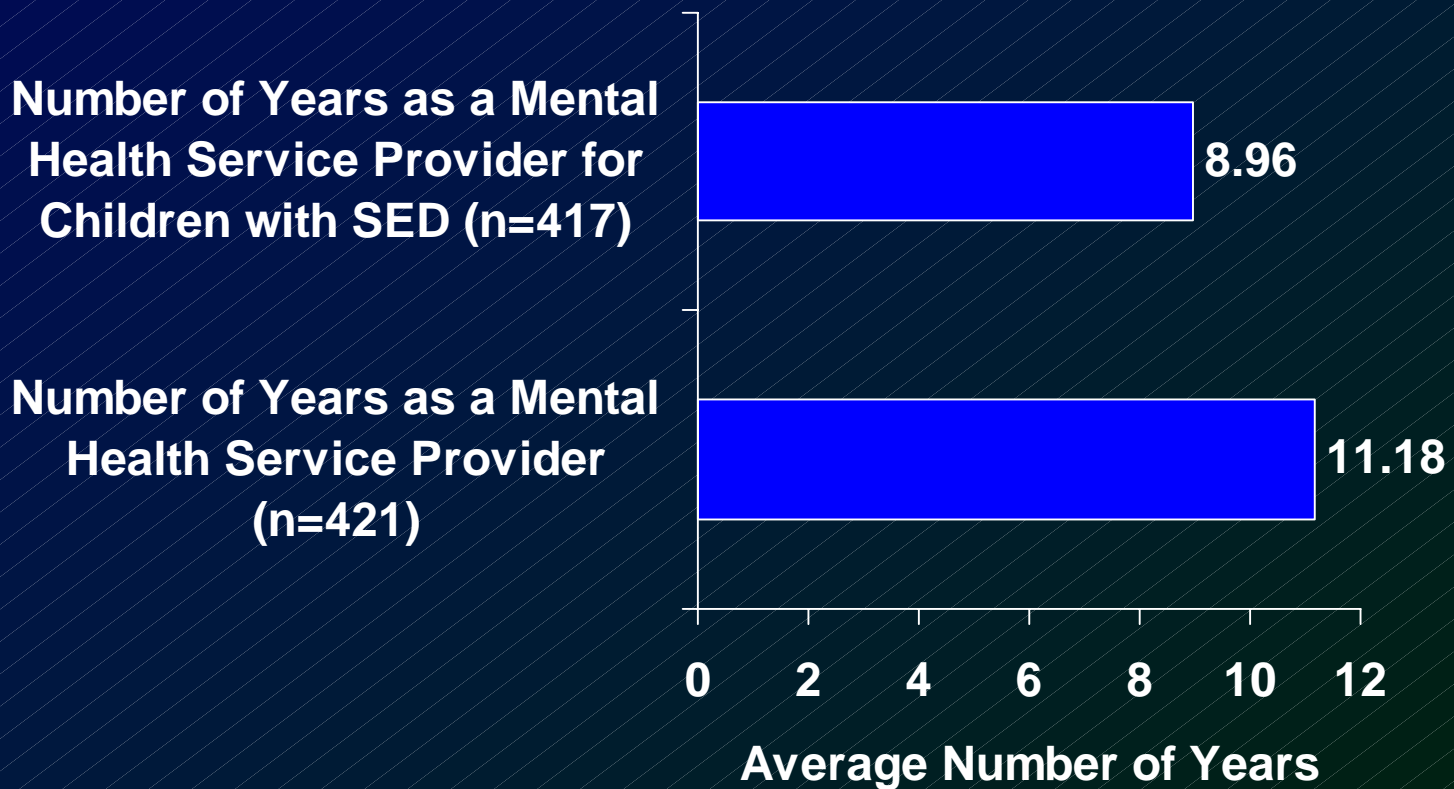
Race/Ethnicity (n=410)

White	89.0%
African-American	5.1%
Native American/Alaskan	2.9%
Hispanic	4.4%
Asian	0.2%
Hawaiian/Pacific Islander	0.5%
Other	3.9%

Providers were able to report more than one race/ethnicity

**Providers ranged in age from 23 to 66 years old.
The average age of providers was 42 years. (n=414)**

Provider Education and Experience

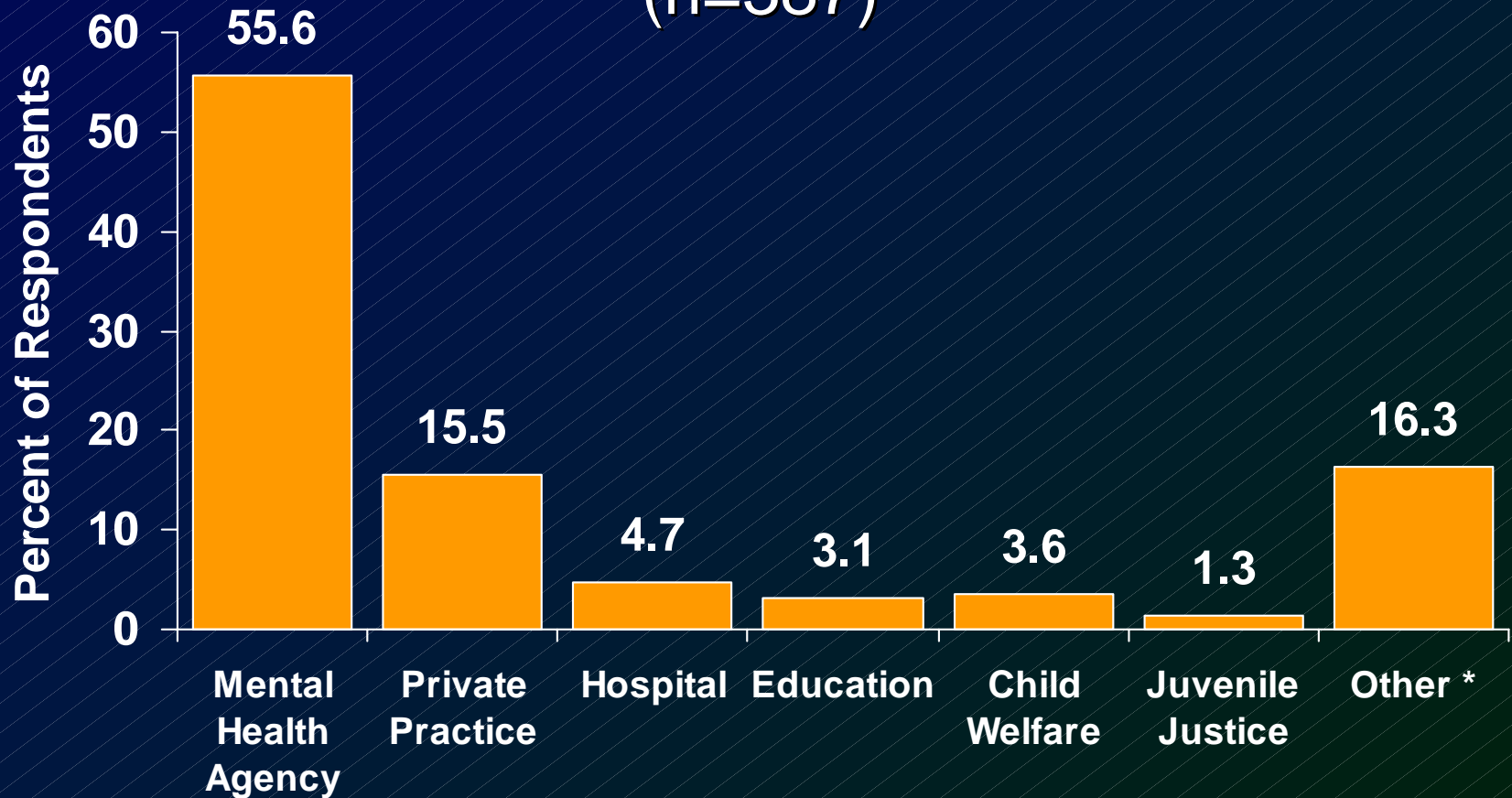


Provider Education and Experience (cont.)

- 86% of the providers had a master's degree or higher (n=425)
- 73% of providers were licensed (n=425)
- 61% were clinicians/therapists
- 10% were case managers/care coordinators

Where Were the Providers Employed?

(n=387)

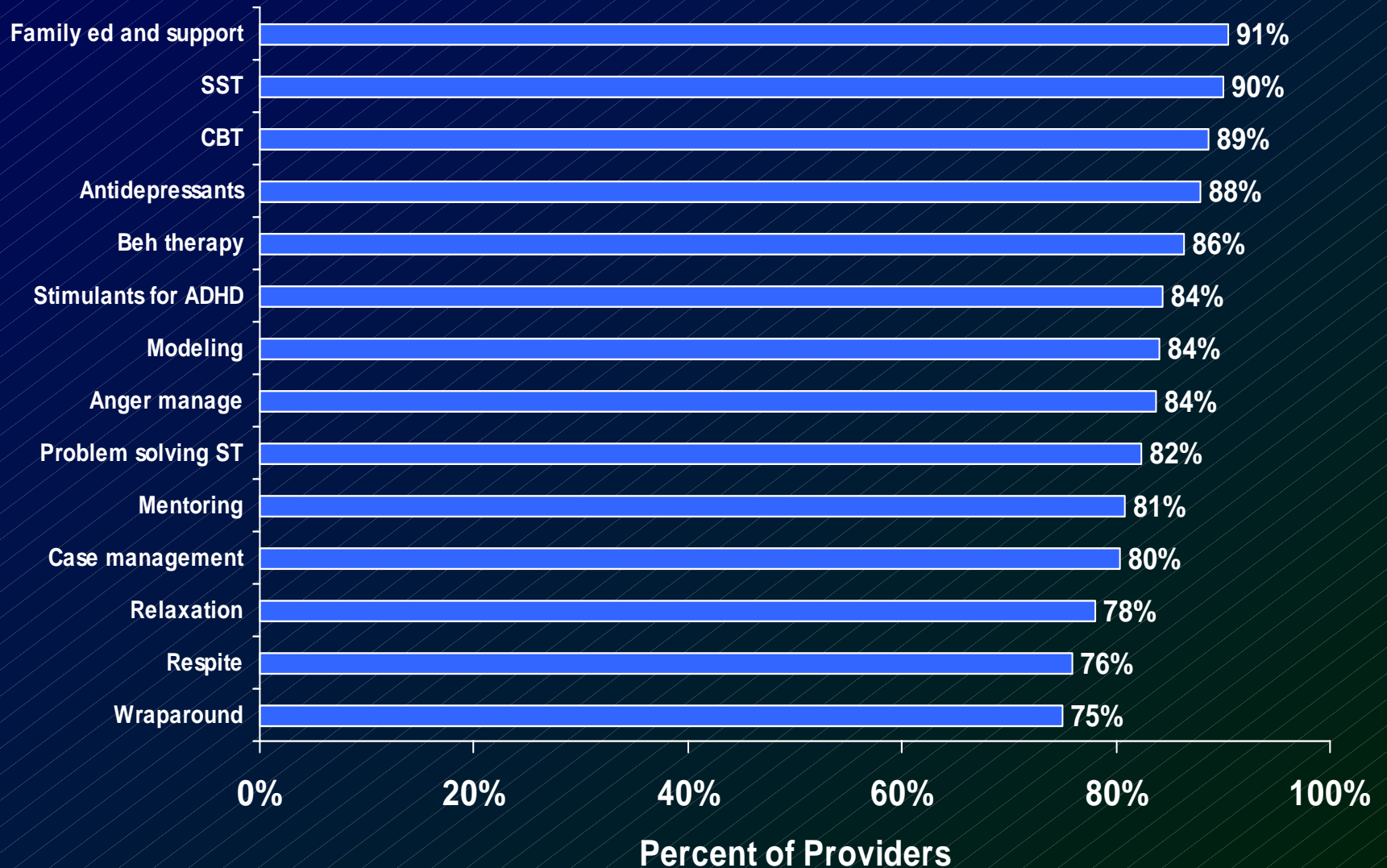


* Other includes residential treatment facility, not-for-profit/CBO, and medical clinic.

Perceived Effectiveness and Practice of Evidence- based Treatments

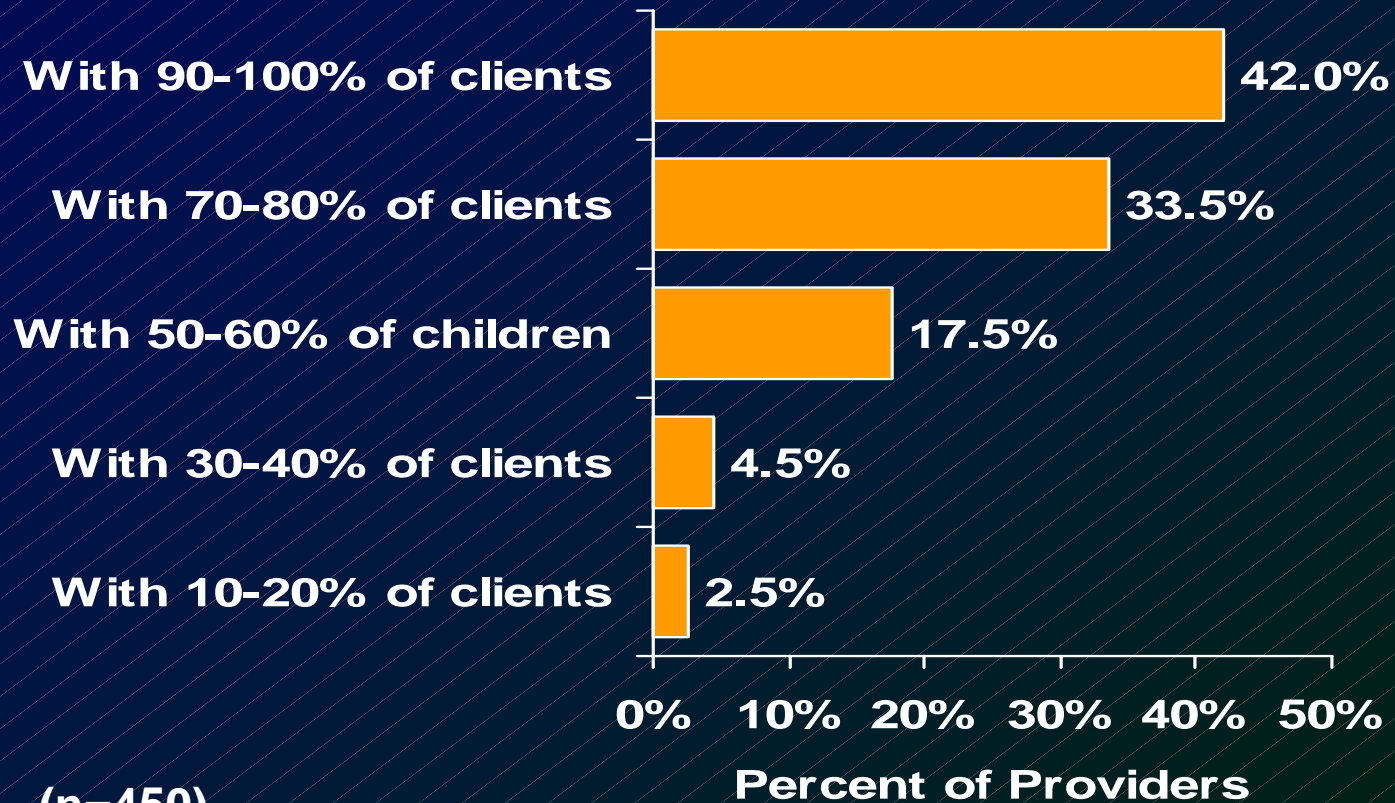
Provider Perception EBT Effectiveness

The “top 14” out of 32



Provider Practice of EBTs

93.4% of providers reported that they used EBTs.



(n=450)

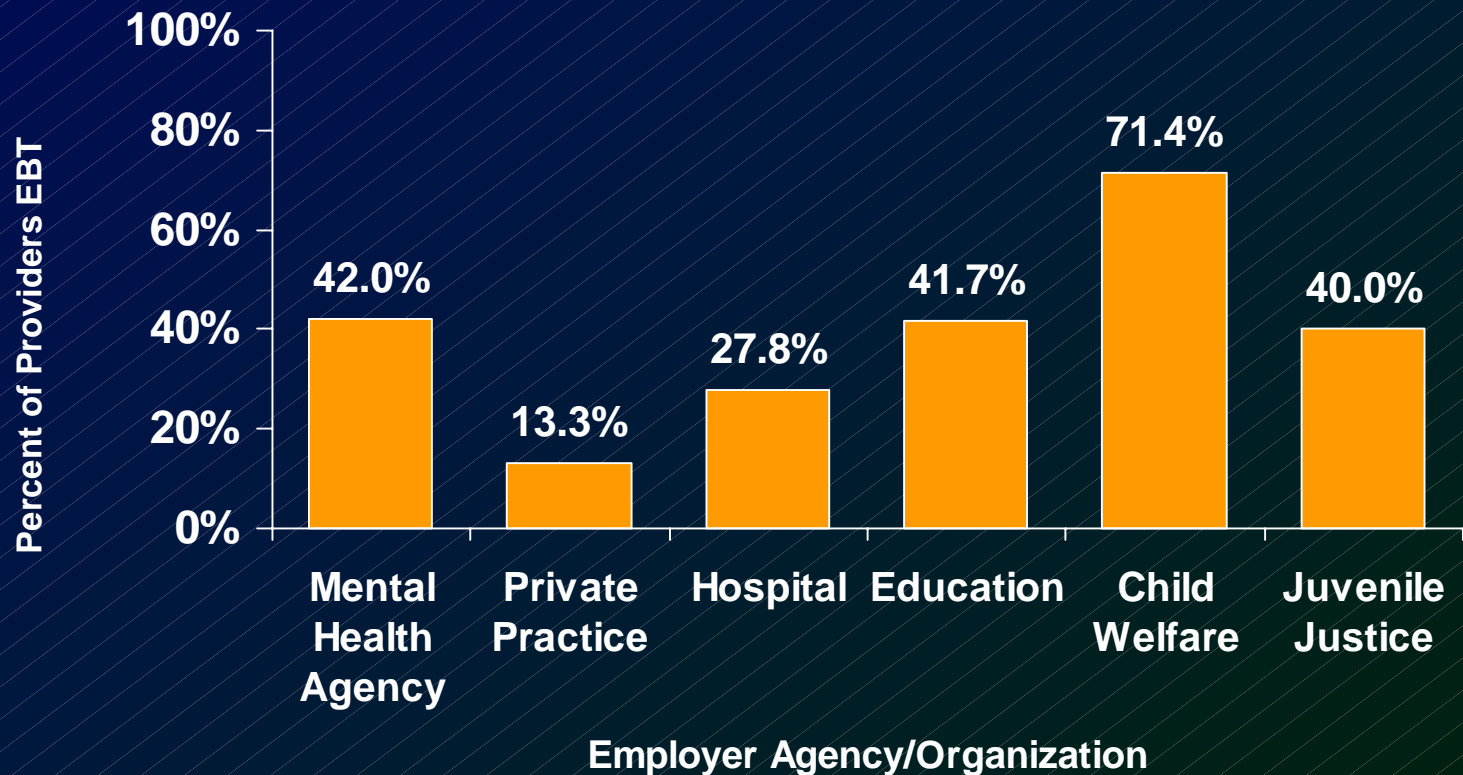
Provider Practice of EBTs

- ▶ Providers were asked to list up to three **PRIMARY** EBTs, other than medication that they used in their work
 - 44 types of treatments were named

<i>Other than medication, list the three primary evidence-based treatments that you use in your work.</i>	
Reported Treatments (n=446)	(%)
Cognitive Behavioral Therapy	61.7
Wraparound	18.2
Anger Management	14.6
Social Skills Training	13.5
Case Management	11.4
Rational Emotive Therapy	10.1

Required Practice of EBT

36% of providers (n= 389) reported that they were required by their employer to provide EBT



Summary from Evidence-Based Treatment Survey

- Variation in knowledge of EBTs
- Variation in practice of EBTs
- Service sector variation in employer requirement to use EBT

Question:

How do these results relate to your community or your family?

Part 2:
EBT Survey

Wraparound and evidence-
based practices

Wraparound process

- Emerged in the mid-1980s as an attempt to address fragmented, overly professionalized, and overly restrictive treatments
- Through the wraparound process, a family and their team develop, implement, and fine-tune a plan of care that is individualized to achieve positive outcomes for the family

The evidence base and wraparound

- Wraparound is a process, not a treatment
- Wraparound is individualized, which makes it hard to standardize and study
- Research base on wraparound is weak (but growing)
- Additional evidence for wraparound's effectiveness lies in its “face validity”
 - Providers believe in it
 - Families like it

The evidence base and wraparound

- Wraparound is an opportunity to engage families, mobilize natural supports, and “fit” effective treatments to a family’s needs
 - This can increase effectiveness of treatment...
- However, wraparound requires adequate supports to implement well
 - ...just like other evidence-based and promising practices

Using the **EBT Survey** to compare wraparound providers to other providers

- How do wraparound providers get trained to do wraparound?
- Are wraparound providers well-supported to implement wraparound?
- Are wraparound providers supported to implement EBTs?
- What treatments do wraparound providers use? What do they think works?
 - Answers to these questions may help us understand **what wraparound providers need** to implement effective treatments and to do high-quality wraparound...

Sample of Providers

Characteristic	Wrap Group (n=82)	Non-wrap (n=371)
Gender = female	65%	68%
Race = non-white	12%	14%
Age / Yrs as MH provider	43 y.o. / 12 years	41 y.o. / 11 years
Employed by MH agency	73%*	58%
Education: Master's or higher	79%*	93%
Type of Position:		
Case manager/care coordinator	16%*	5%
Clinician/therapist	47%*	53%
Clinical Social Worker	8%*	15%
Counselor	1%*	8%
Psychologist	7%*	3%
Other **	21%*	16%

*Significant difference between groups at $p < .01$

** Includes supervisor, nurse, paraprofessional, intern, graduate student

Differences between wraparound and non-wraparound providers

- No differences with respect to gender, race, age, or length of time as mental health provider
- Wraparound providers more likely to work in a mental health agency
- Wrap providers less likely to have a graduate degree
- Wraparound providers less likely to be clinician, therapist, clinical social worker, or counselor
- Wraparound providers more likely to be a case manager or care coordinator or a psychologist

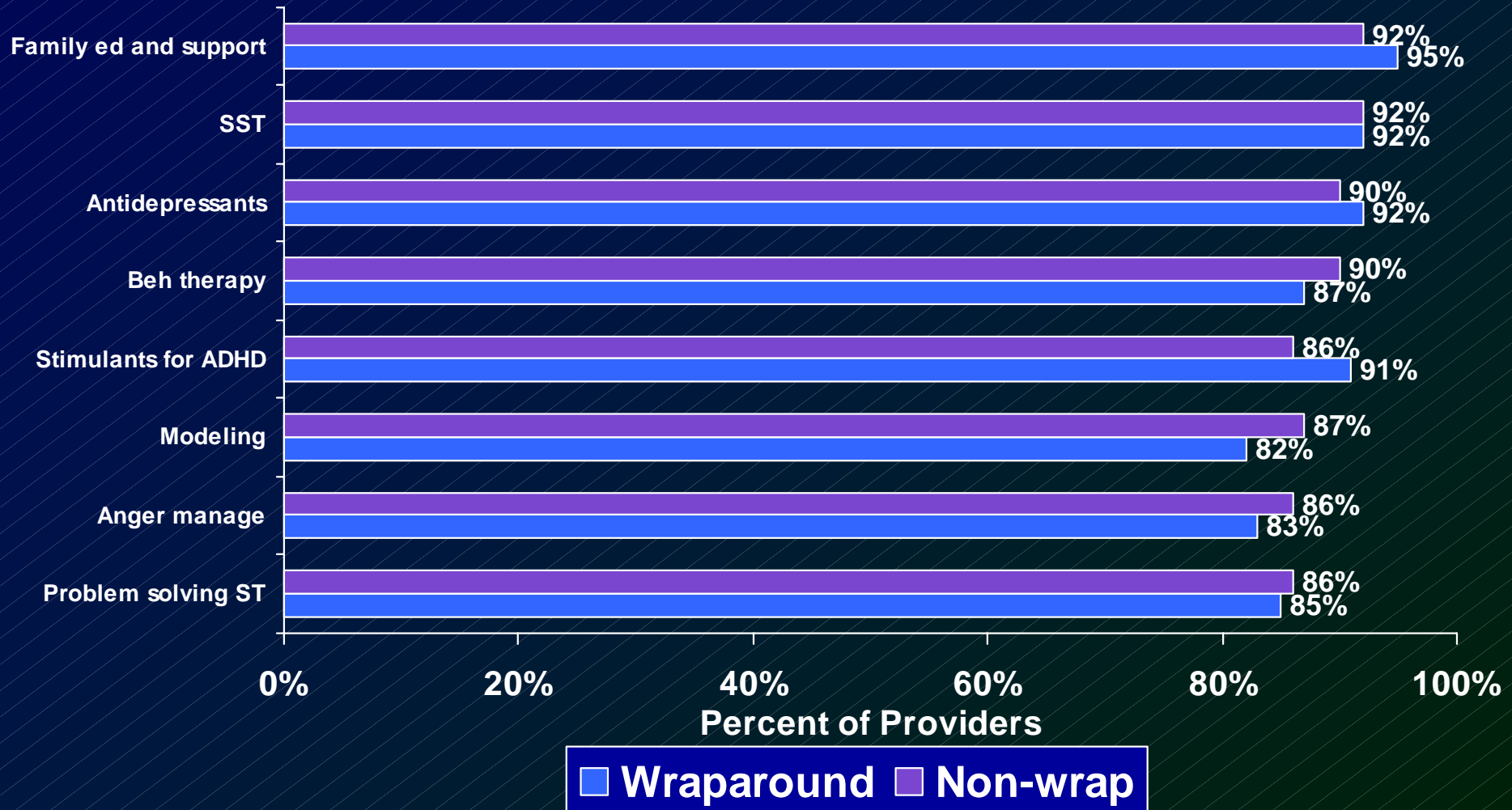
Differences in perceived effectiveness of treatments

- Treatments that **wraparound providers** were more likely to perceive as effective:
 - Mentoring (92% vs. 81%)
 - Respite (86% vs. 75%)
 - Case management (88% to 81%)
 - Parent management training (72% vs. 67%)
 - Wraparound (95% vs. 78%)

Differences in perceived effectiveness of treatments

- Treatments that **non-wraparound providers** were more likely to perceive as effective:
 - Cognitive-behavioral therapy (93% vs. 85%)
 - Relaxation training (84% vs. 71%)

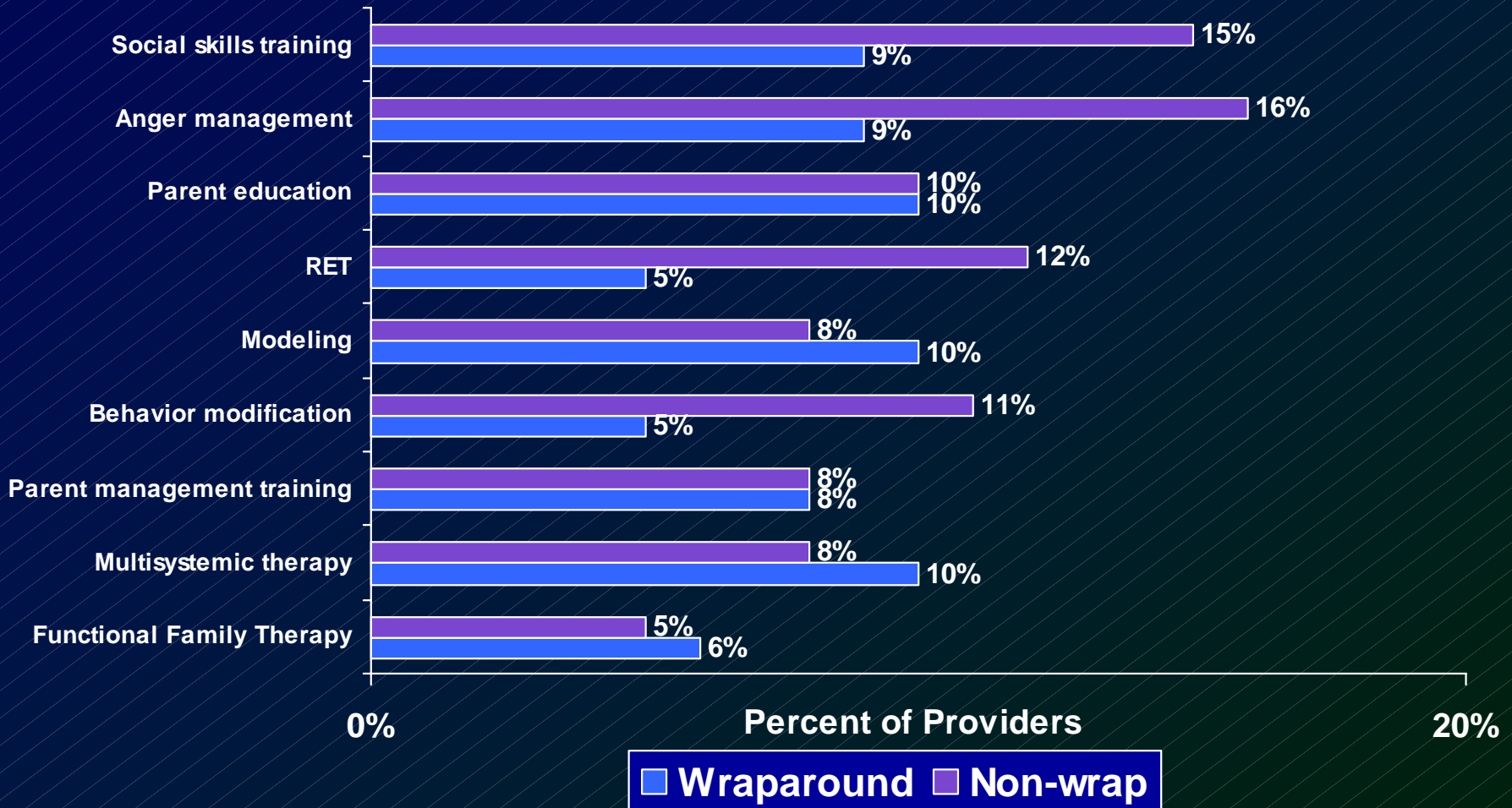
No significant difference between groups for effectiveness of most treatments



Differences in treatments used

- Wraparound providers more likely to use:
 - Case management (28% vs. 7%)
 - Therapeutic foster care (7% vs. 2%)
 - Respite (4% vs. 0%)
- Non-wrap providers more likely to use:
 - Cognitive-behavioral therapy (71% vs. 31%)
 - Behavior therapy (11% vs. 4%)
 - Relaxation therapy (9% vs. 0%)

No significant difference between groups for use of most treatments



Training characteristics

Differences between wraparound and non-wraparound providers on how they were trained on the treatment

Training characteristic	Wrap Group (n=82)	Non-wrap (n=371)
Initial training delivered via in-service	49%*	24%
Manual provided with training	41%*	60%
Years since initial training	Mean = 6.2* (SD = 5.6)	Mean = 10.0 (SD = 6.7)
Frequency of follow-up training (range from 0-4)	Mean = 2.18 (SD = 0.85)	Mean = 2.0 (SD = 0.96)

*Significant difference between groups at $p < .01$

Implementing treatments

Differences between wraparound and non-wraparound providers on how they implement the treatment

Training characteristic	Wrap Group (n=82)	Non-wrap (n=371)
Required by agency to provide EBTs?	55%**	35%
Extent to which treatment guidelines in manual are followed (range from 1-5)	Mean = 4.28* (SD = 0.78)	Mean = 3.93 (SD = 0.84)
Extent to which full protocol is implemented (range from 1-5)	Mean = 3.81** (SD = 0.94)	Mean = 3.38 (SD = 1.06)

**Significant difference between groups at $p < .001$

*Significant difference between groups at $p < .1$

Summary of results:

Endorsement and use of treatments

- No difference between wrap and non-wrap providers in knowledge of EBTs
- Wraparound providers more likely to endorse mentoring, respite, parent training, case management as effective
 - Non-wrap providers more likely to endorse CBT and relaxation training
 - Overall, no differences between groups for 26 of 32 treatments listed
- Wrap providers more likely to use case management, TFC, respite; non-wrap providers use CBT and behavioral therapies
 - Overall, no difference between groups for 38 of 44 treatments

Summary of results: Training and supports

- Wraparound providers more likely to receive training via inservice, but less likely to receive a manual
 - Wrap providers also received training more recently
- Agencies employing wrap providers are more likely to mandate implementation of EBTs
- Despite not receiving a manual, wrap providers say they are more likely to fully implement wraparound protocol

Conclusions and implications

- Must be careful with conclusions, because wraparound and non-wraparound providers are inherently different
- Wraparound providers may work in contexts of greater support for implementing EBTS
 - This supports wraparound's role as mechanism to fit effective treatments to the needs of families
- However, wrap providers less likely to receive manual to support training and implementation
 - Even though they are more likely to say they fully implement the protocol

Conclusions and implications (cont'd)

- Need to develop clear guidelines for wraparound implementation
 - Manuals, support materials, and training strategies
- Need to develop more systematic education on care management practices in our education and formal training programs

Conclusions and implications (cont'd)

- We need to examine the role of evidence-based treatments in implementing wraparound
 - The wraparound process provides a great opportunity to fit them appropriately to the needs of a family
 - However, the needs of families receiving wrap are often very complex – a single EBT is unlikely to provide a “silver bullet”

Part 3

Wraparound Milwaukee:

Real-world examples of
Wraparound training and using
evidence-based practices

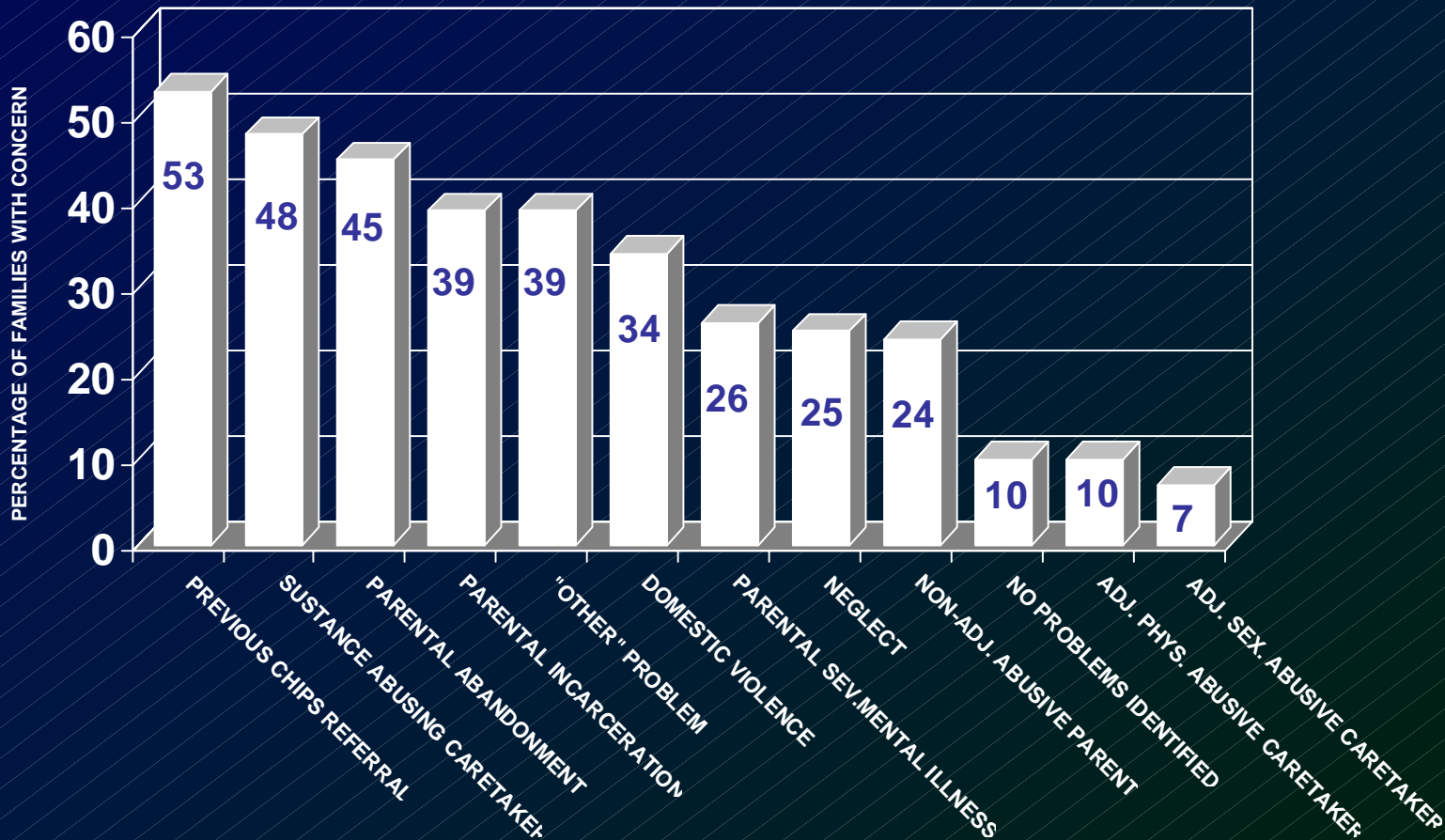
What is Wraparound Milwaukee

- A system of care developed based on Wraparound and managed care principles.
- We serve families whose children have complex needs and are involved in the juvenile justice or child welfare system.
- Families are assigned a care coordinator trained in the Wraparound Process who assists them in navigating the system of care to get their needs met.

A Summary of Our Current Population

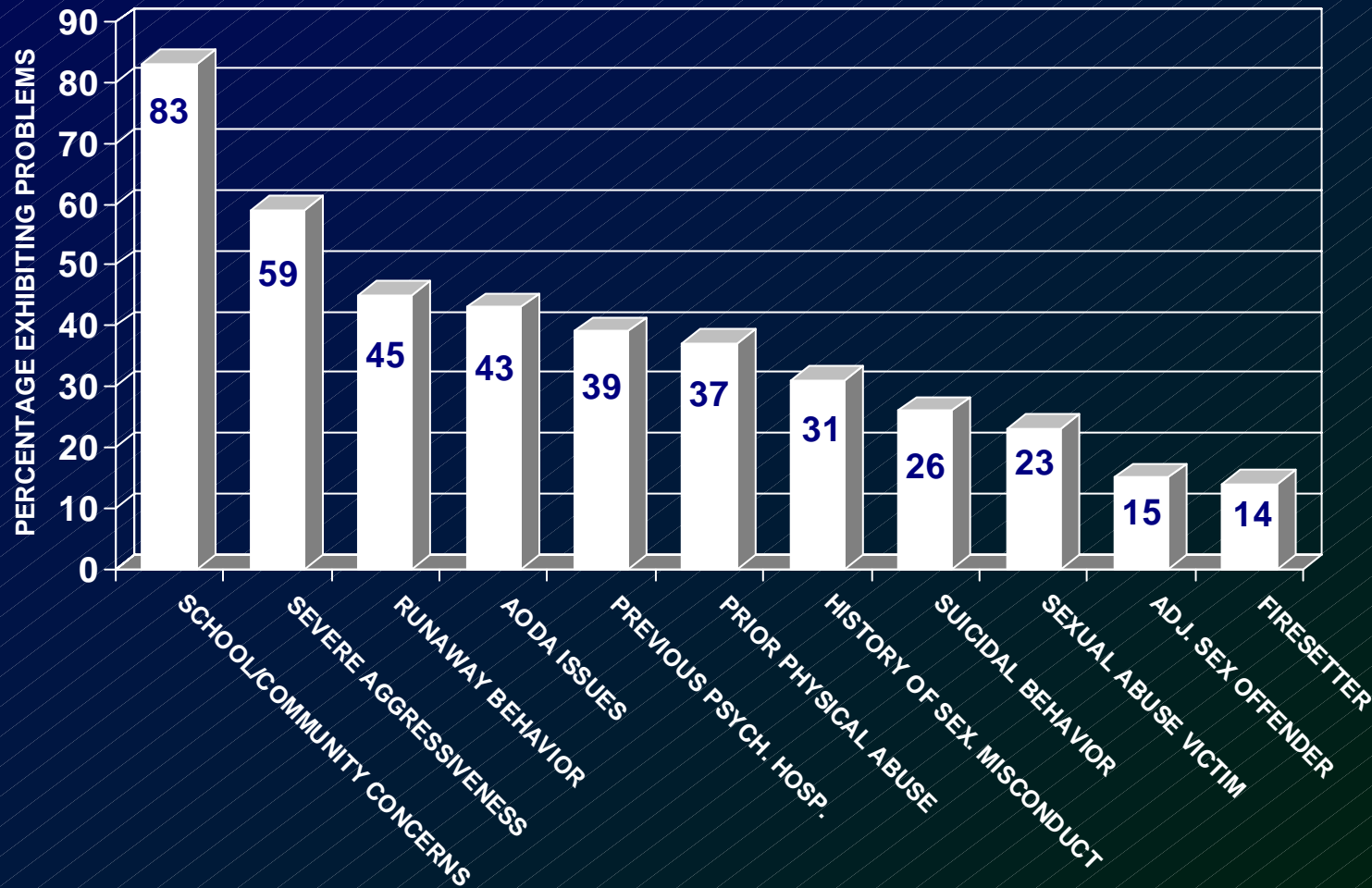
- 625 kids and families, 145 are considered high risk (adjudicated sexual offense)
- 74% of the youth are male, 26% female
- Average age of enrollment is 13.8 yrs
- Ethnic representation: 67% African American, 24% Caucasian, 7% Hispanic, 1% Native American, 1% Asian
- Most of our kids are being raised by single women who are living in poverty (48% less than \$15,000 per year)
- 61% of our youth are under a delinquency order, 28% CHIPS (Children in Need of Protection and Services)

Primary Identified Family Concerns of Clients in the Wraparound Milwaukee Program



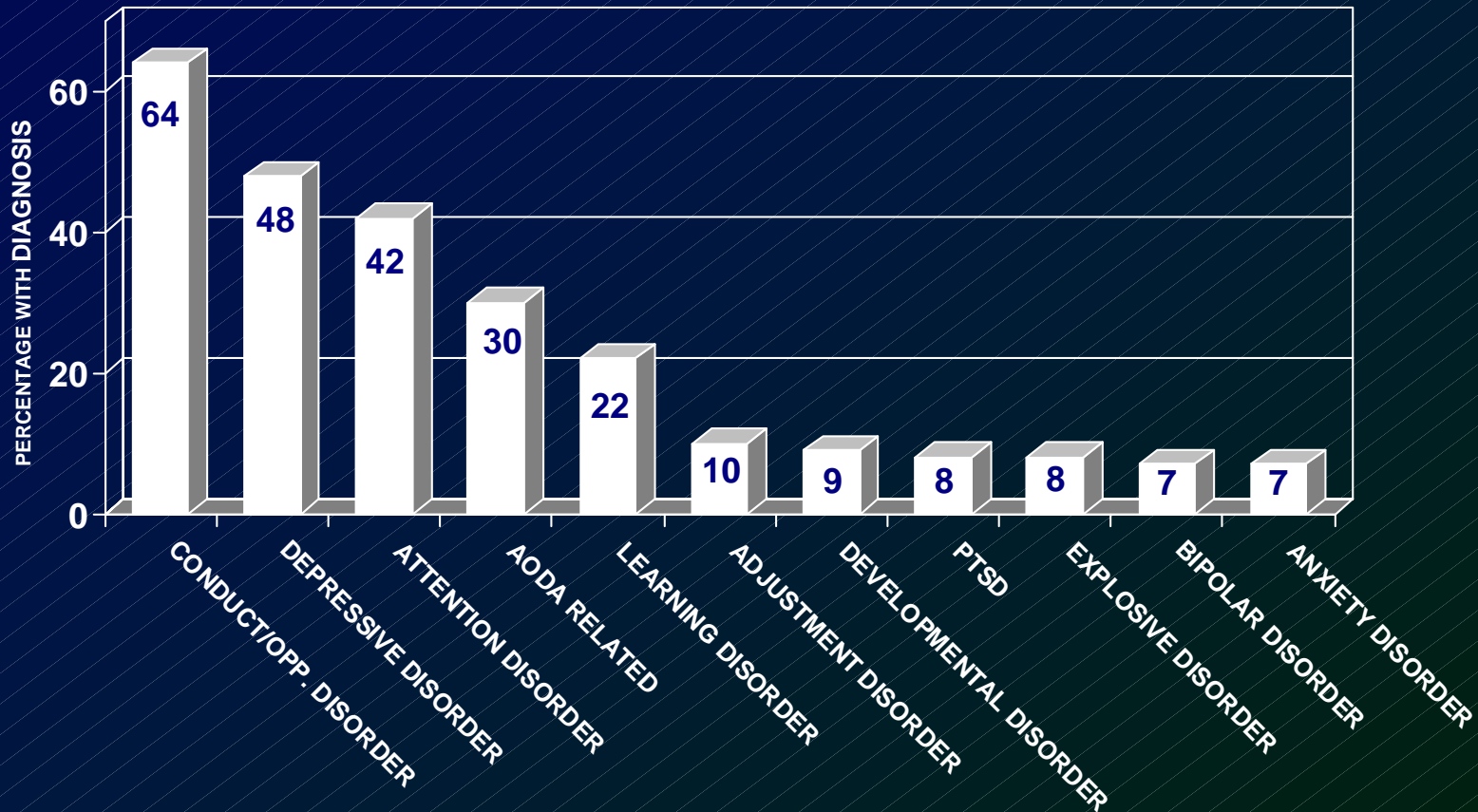
n = 2767

Primary Identified Concerns of Clients at Intake into Wraparound Milwaukee



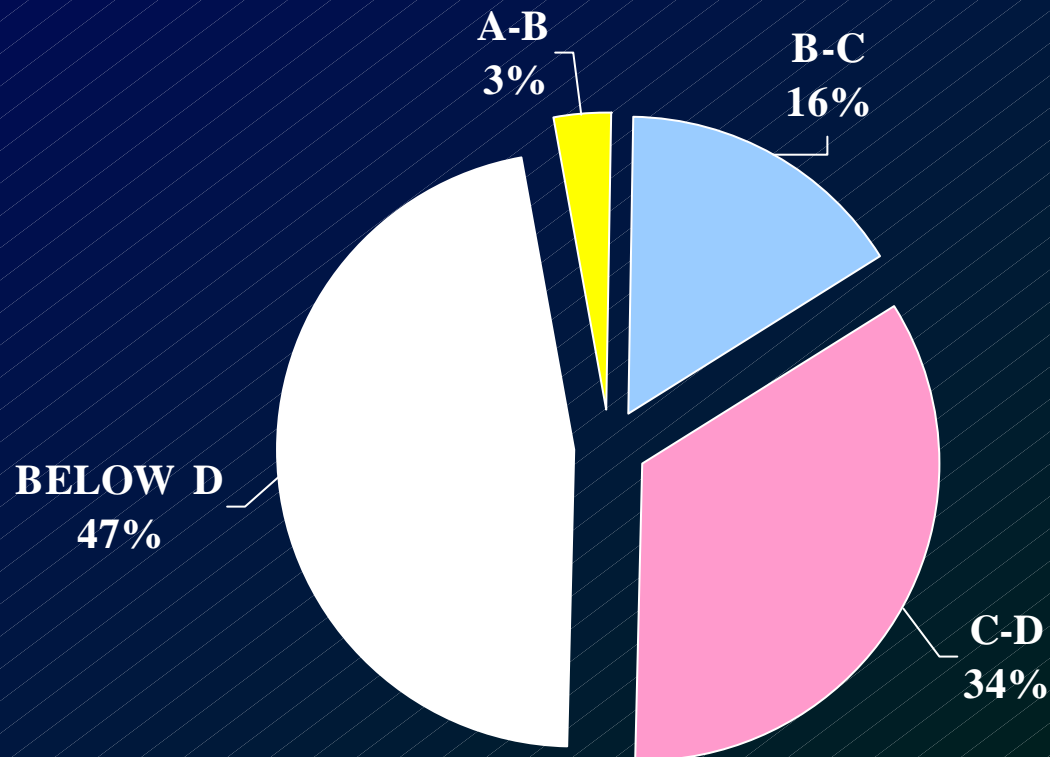
n = 2775

Most Common DSM-IV Diagnostic Categories of Clients in Wraparound Milwaukee



n = 2611

Grade Point Average of Wraparound Milwaukee Clients Prior to Enrollment



n = 747

Data through 5/31/05

System of Care Components

- Administrative Service Organization
- 9 Care Coordination Agencies
- Provider Network
- Families United
- Mobile Urgent Treatment Team
- Community Resources

Wraparound Milwaukee Provider Network

- Array of 80 Different Services
- Over 200 Providers
- Providers Paid on a “Fee-For-Service” Basis
- Rates and Service Descriptions are Established by Wraparound Milwaukee
- QA/QI Performed by Wraparound Milwaukee
- Care Coordinators Integral to the Process of Requesting/Authorizing Services

List of Available Services in Social / Mental Health Plan

- Case Management
- Referral Assessment
- Medication Management
- Outpatient
 - Individual/Family
- Outpatient - Group
- Outpatient - AODA
- Psychiatric Assessment
- Psychological Evaluation
- Mental Health
 - Assessment/Evaluation
- Inpatient Psychiatric
- Nursing
 - Assessment/Management
- Consultation with Other Professionals
- Daily Living Skills - Individual
- Daily Living Skills - Group
- Parent Aide
- Child Care
- Housekeeping
- Mentoring
- Tutor
- Life Coach
- Recreation
- After School Programming
- Specialized Camps
- Discretionary Funds
- Supported Work Environment
- Group Home Care
- Respite
 - Respite - Foster Care
 - Respite - Residential
- Crisis Bed - RTC
- Crisis Home
- Foster Care
 - Treatment Foster Care
- In-Home Treatment (Case Aide)
- Day Treatment
- Residential Treatment
- Transportation

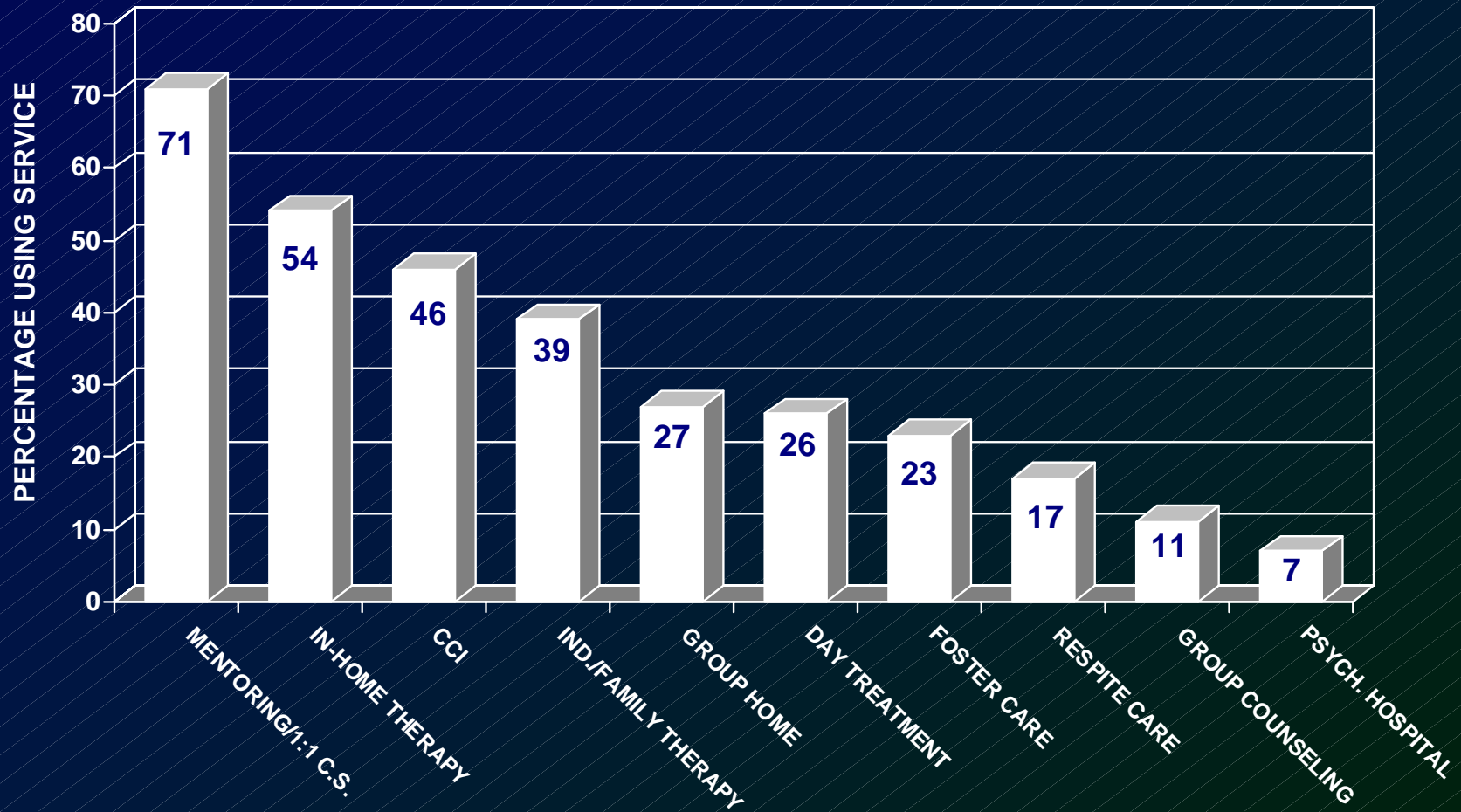
Qualifications and Training of Care Coordinators

- Care Coordinators are bachelors degree level, supervisors are masters.
- All must complete a 10 module, 48 hour certificate training within 6 months of employment. A Wraparound process Training Manual is provided.
- Monthly 2 hour in-services are mandated.
- Yearly certification in Wraparound (12 hours) is required.

Qualifications and Training of Providers

- Qualifications are service specific.
- In some cases, agencies are required to develop service specific training curriculums for their staff.
- Outpatient mental health services follow State Administrative Code and Medicaid requirements.
- Mobile Crisis staff provide training for crisis service providers.
- Wraparound provides a 1 day, 6 hour training on Wraparound process - training manual is provided.

Primary Services Used During First Year of Enrollment in Wraparound Milwaukee (1998-2004)

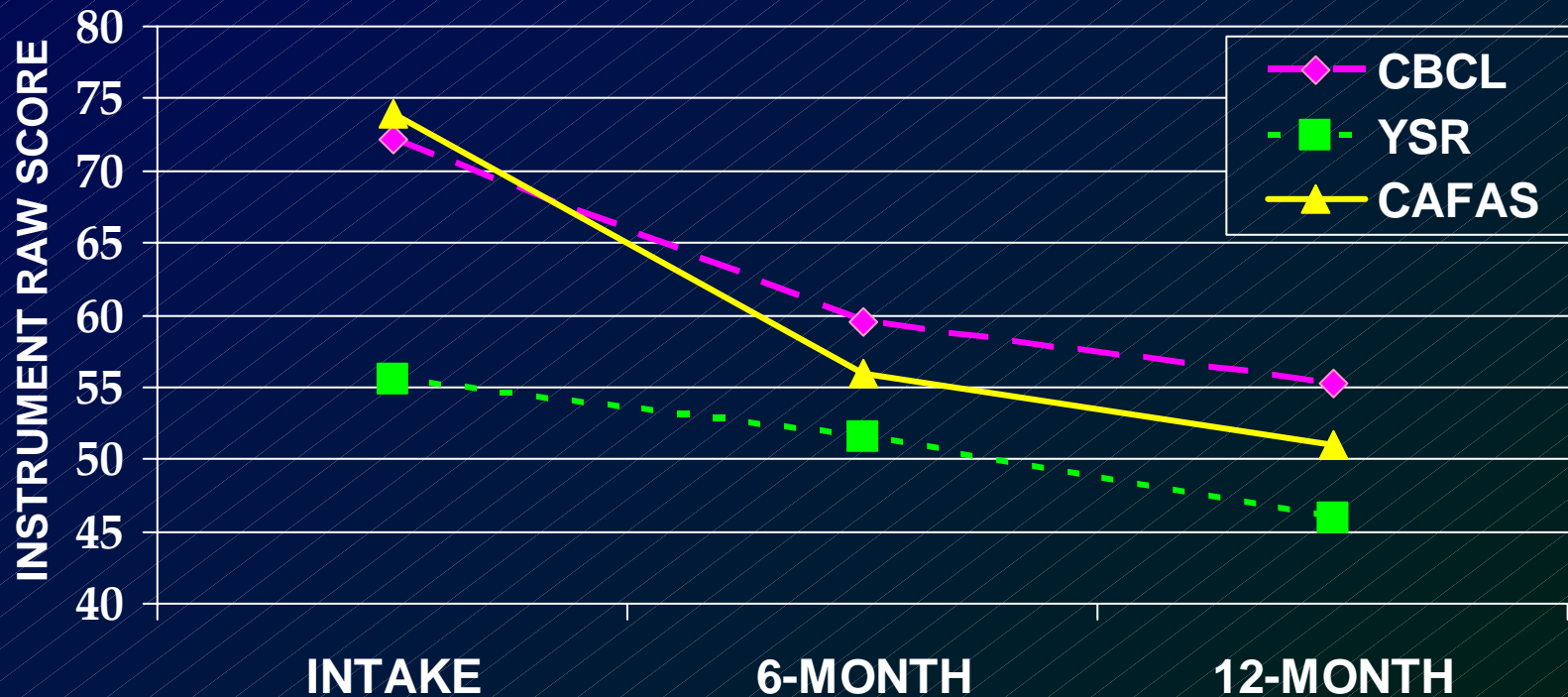


SERVICE UTILIZATION BASED ON 649 RANDOMLY SELECTED ENROLLMENTS

Outcome Indicators Include

- Clinical ie: CAFAS, CBCL, YSR
- Community Safety ie: reduction in recidivism rates for Juvenile Offenders
- School Attendance
- Cost ie: cost of Wraparound Milwaukee less than cost of residential treatment or correctional placement
- Family Satisfaction
- Successful Disenrollments ie: based on Medicaid standards
- Permancy of Youth in Placement at Discharge ie: reunificaion, adoption, subsidized guardianship

Caregiver, Care Coordinator, & Youth Reported Improvement in Functioning

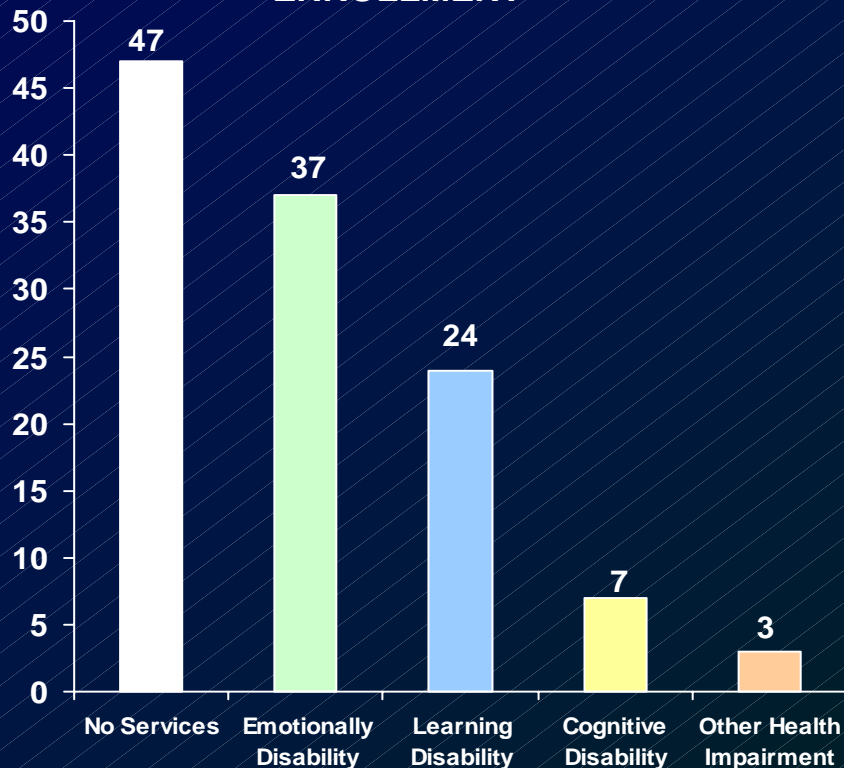


Child Behavior Checklist (CBCL), n=735; Youth Self-Report (YSR), n=553; Child & Adolescent Functional Assessment Scale (CAFAS), n=1095. Reductions are significant at the $p < .001$ level of significance using a repeated measures analysis of variance.

Data through 5/31/05

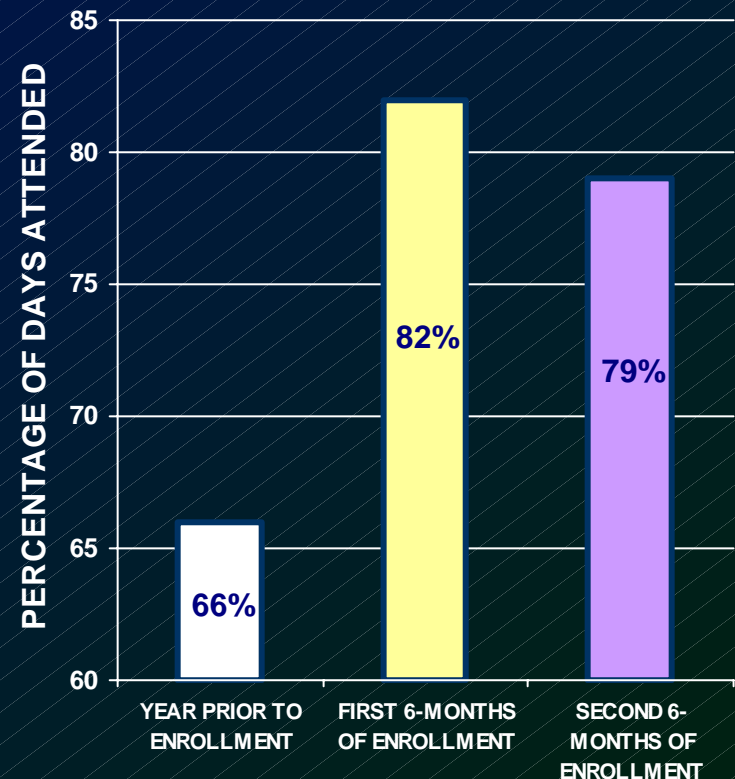
Special Education & Attendance Concerns of Clients enrolled in Wraparound Milwaukee

PERCENTAGE OF CLIENTS IN SPECIAL EDUCATION PLACEMENT PRIOR TO ENROLLMENT



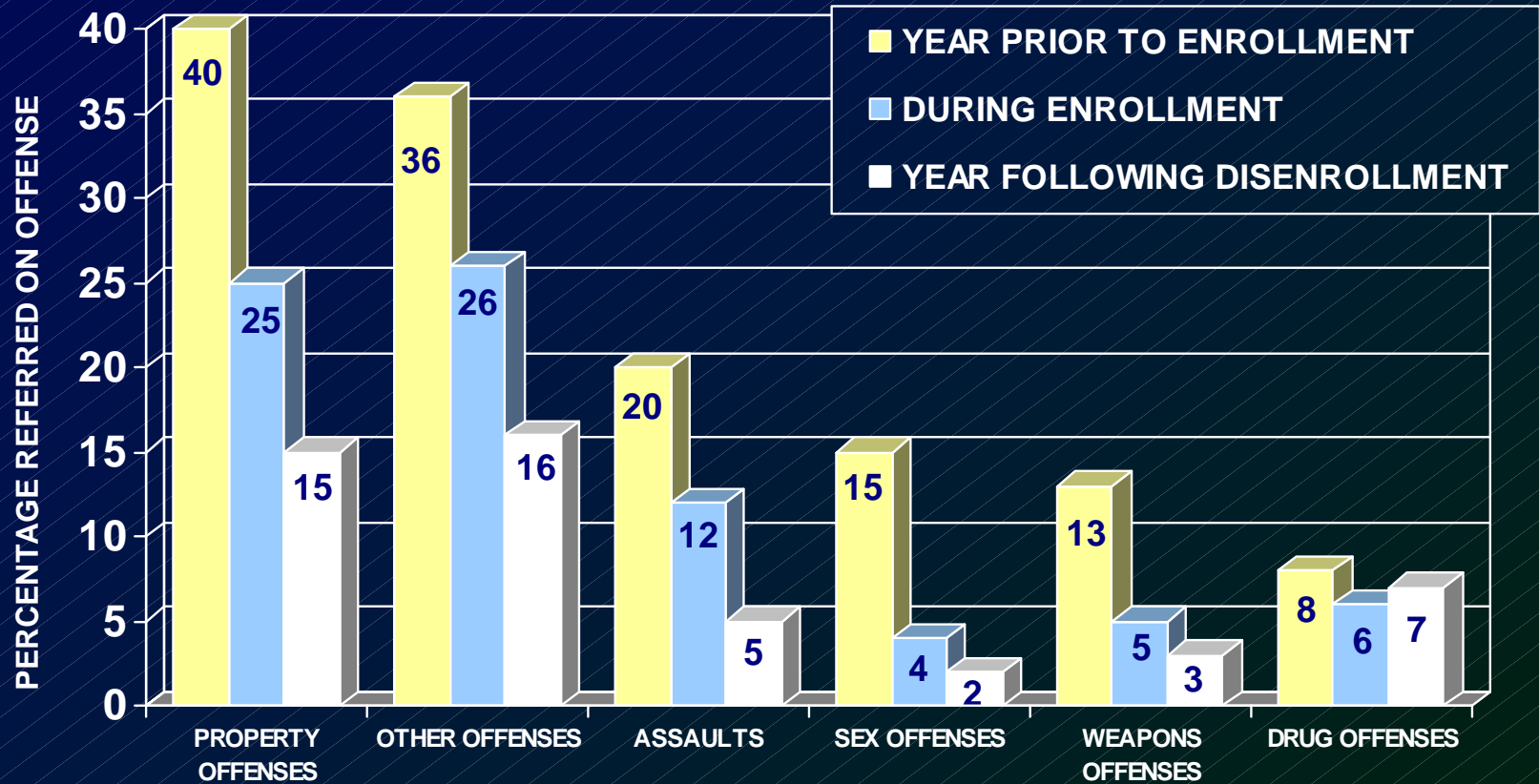
n = 2518

INCREASE IN ATTENDANCE DURING ENROLLMENT



n=840. Reductions are significant at the $p < .001$ level of significance using a repeated measures analysis of variance.

Reductions in Specific Legal Offense Referrals During Enrollment & After Disenrollment

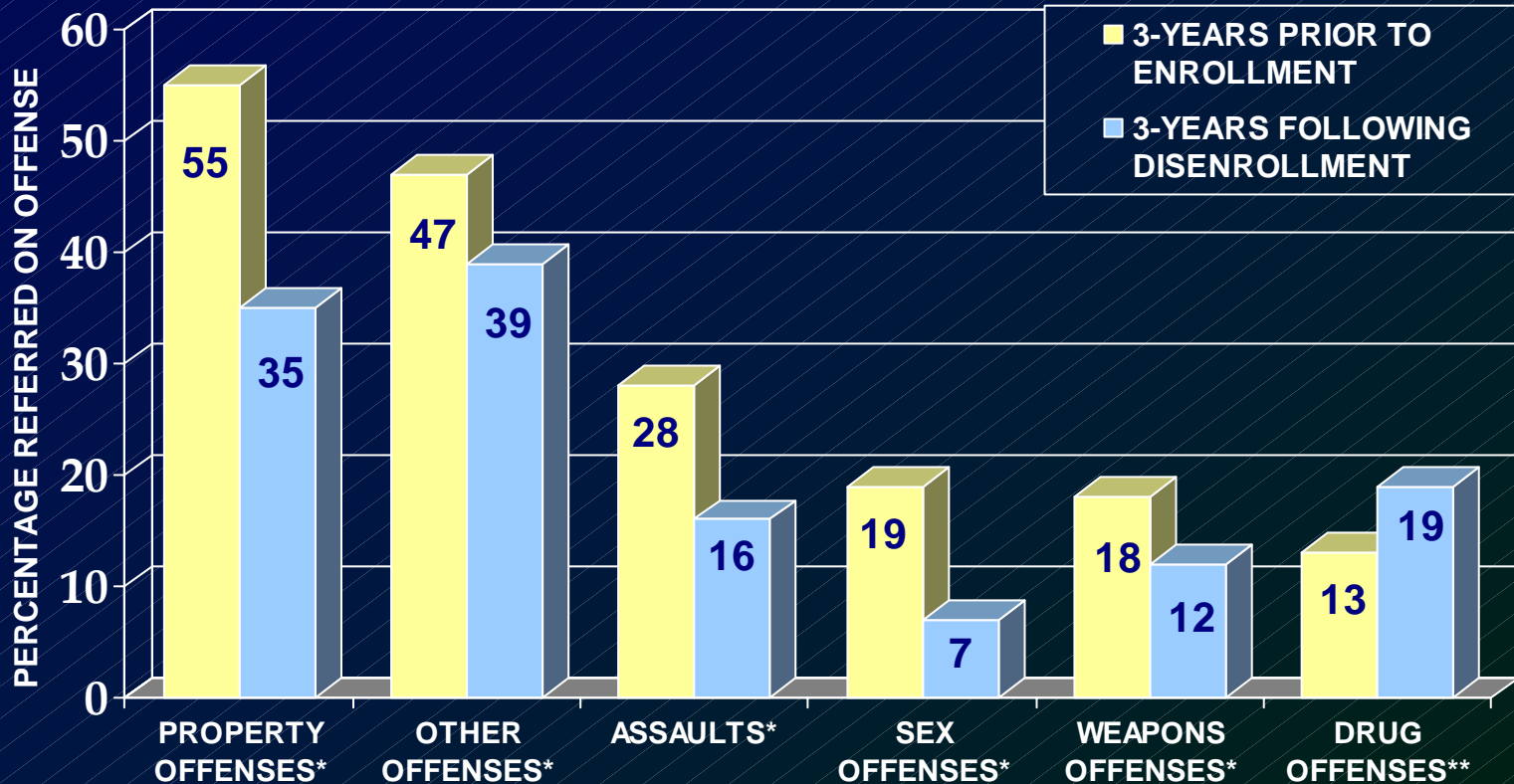


*Other offenses consist primarily of disorderly conduct

n = 890

Data through 5/31/05

Specific Legal Offense Referrals 3 Years Prior to Enrollment & 3 Years Following Disenrollment



Other offenses consist primarily of Disorderly Conduct (58%) & Obstructing Justice/Fleeing (29%)

*Reductions are significant at a $p < .01$ level using a Chi-Square comparison.

**Increase is significant at a $p < .01$ level using a Chi-Square comparison.

n = 648

Important Questions

- Where are the families at related to EBT?
- Why is the Wraparound process being considered treatment?
- How do you have a control group for something which is values driven?
- How does EBT relate to a community's desired outcomes?

Obvious Conclusions

- Families need and deserve to be informed about the choices they are making.
- Families deserve options which have been critically reviewed and researched.
- All providers should be subject to required trainings, ongoing education standards, and continuous QA/QI.
- The field of mental health has always been a field of subjectivity and will only benefit by continued striving for quality care, however it is measured.