Implementing Mental Health Evidence-Based Practices: The Case of Wellness Recovery Action Planning (WRAP)

Turning Knowledge into Practice, Lesson Seven: The Statewide Implementation of WRAP: Overview and Role of the IPO

(Slide 1) Welcome to Assignment Seven which is the first of a two lesson case example of the statewide implementation of an evidence based practice called the Wellness Recovery Action Plan (WRAP) developed by Mary Ellen Copeland.

(Slide 2) In Lesson 7 we will: 1.) provide an overview of the WRAP model and how its unique characteristics effect its implementation; 2.) the role of the Copeland Center which is the Purveyor organization for WRAP, and; 3) some generalized lessons learned from WRAP implementation across the country. In Lesson 8 we will explore three different examples of statewide implementation. The three cases show how local circumstances required different implementation strategies for successful program implementation.

(Slide 3) WRAP was developed by Mary Ellen Copeland as a wellness self-management intervention for those who struggle with mental health issues as well as many other life challenges. It was designed primarily as a consumer led intervention although in some cases professionals have been incorporated. WRAP is listed in the Substance Abuse Mental Health Services Administration’s (SAMHSA) NREPP (National Registry of Evidence Based and Promising Practices) and several studies, including one randomized clinical controlled trial, have shown it to be effective.
More than 10,000 copies of the WRAP curriculum have been disseminated around the world in the past two decades. Over 2000 group facilitators have been trained by the Copeland Center for Wellness and Recovery (the WRAP purveyor organization) alone and 150 persons have been trained as advanced facilitators. Many thousands have developed WRAP plans. Some people might argue that this widespread dissemination is the best evidence for the success of WRAP since it is only possible if persons using WRAP had found it helpful.

There are six major components to the WRAP. The first is a Wellness Toolkit where the consumer identifies the strategies which work best for them in both sustaining recovery and wellness and taking personal responsibility in taking control of their lives. This includes managing functional difficulties in a variety of different circumstances. This component also includes a section where the individual defines their own wellness in behavioral terms.

Secondly, there is a Daily Maintenance Plan which contains the practical strategies which can be used on a daily basis to stay physically and emotionally healthy. This may include things to avoid as well as positive steps such as having an exercise routine and keeping daily contact with key social supports.

The third component is to Identify Triggers by composing a list stressful situations or stimuli which the individual must be prepared to deal with in order to prevent a crisis.

In the fourth component, the participant identifies Early Warning Signs or the behaviors and signs that could precede a crisis. These may be idiosyncratic such as listening to Beatles songs, wearing a particular piece of clothing, or more general...
behaviors such as isolating oneself. Once the behaviors and symptoms have been identified, the additional supports and services (both formal and informal) which are most helpful in interrupting further problems are detailed.

In the fifth component, Managing when Things Break Down, signs and behaviors are listed which indicate that the situation is deteriorating significantly and it is time to take immediate and assertive action. Response plans are created to use in these situations.

The final (sixth) component is the development of a crisis plan to respond to a situation where the symptoms and behaviors indicate that someone else needs to take over the responsibility for decision making and personal care. The crisis plan is a form of a psychiatric advanced directive and indicates whom the person wants to take over care and who is willing to provide additional help. It also specifies what kind of treatment is preferred such as; medication or no-medication, hospitalization or some other secure setting, etc. Another important part of this plan is the specification of other things that need to be taken care of such as taking care of pets, ensuring the security of a house or apartment, or payment of rent.

(Slide 7) An important characteristic of WRAP is that it is a voluntary group process which focuses on enhancing self-esteem and building competence with the use of peer support. Participants benefit by hearing other consumers examples of symptoms, strategies, and supports. These examples often stimulate their own ideas in these areas and improves the overall quality of the plan. The WRAP groups are led by certified facilitators who are usually consumers/peers. Wherever possible, there are co-leaders which enriches the experience since it emphasizes that there is no “one way” to
wellness and recovery. These facilitators are also in the process of recovery and have their own WRAP plans and therefore act as role models. The plan itself is only one outcome of the process. While each component may seem rather straightforward, the reality is that for persons who might have never thought about these questions before in an organized way, it can be rather daunting. Having the chance to interact with others and share their experiences with recovery enhances the growth and recovery of the whole group. The groups are usually conducted in eight to ten 1 to 2 hour weekly sessions.

(Slide 8) As noted in Lesson 6, Intermediate Purveyor Organizations (IPOs) are the primary vehicle for large scale implementation of an evidence based practice. The Copeland Center is the IPO for WRAP (http://copelandcenter.com). The center is a centralized resource and gateway to WRAP.

(Slide 9) The Copeland Center provides introductory overview training, a five day facilitator certification course, as well as advanced facilitator training to individuals. It also works with organizations and states to provide training and technical assistance in the implementation of the WRAP model. Centralizing the training and dissemination in the IPO is an important way to control the quality of the WRAP intervention.

(Slide 10) Before working with an agency, The Copland Center requires a written plan of how they will use WRAP and what they expect the end result of the collaboration will be. Technical Assistance is provided indirectly. The center identifies a knowledgeable and experienced person willing to serve as a liaison for the project.
The Copeland Center is fortunate in that the demand for its services comes from both the top down and bottom up providing funding sustainability. In contrast to most long-term evidence based interventions, WRAP touches people on a personal level almost immediately. This builds a large body of examples of the usefulness of WRAP and creates a demand for WRAP training and certified facilitators which only the Center can meet. In addition a number of states have statewide WRAP initiatives which creates a large demand for certified trainers and adds to the Center’s funding stream.

As we noted in the last unit with the ACT example, the nature of the intervention (e.g. multi-disciplinary 24/7 team) impacts the implementation requirements and strategies. There are a number of characteristics of WRAP which make it easier to implement successfully. First of all, most evidenced based interventions are developed by academic professionals, require extensive qualifications and training, and are known and only disseminated within the academic and professional communities. Even most manualized interventions such as Multi-systemic Therapy or Cognitive Behavioral Therapy are complex and require major organizational procedural and cultural changes for successful implementation. In contrast, WRAP was developed by a charismatic consumer, Mary Ellen Copeland, Ph.D. and the WRAP manual has been widely disseminated to non-professionals. The intervention itself is relatively simple and requires only 8-10 weekly 1-2 hour group sessions to successfully deliver the intervention. Once prepared the WRAP plan provides a “living” consistent guide for the consumer which can be changed to fit changing circumstances without any additional intervention.
The intervention does not require major investments in infrastructure such as highly trained staff, lengthy training, extensive supervision and fidelity monitoring. However, any statewide effort requires some investment. For example, in State A the two year implementation cost was $250,000 but compared to what the cost would be for statewide implementation of an EBP such as Multiple Systemic Therapy, this is relatively inexpensive. Cultural and procedural changes are minimized since the intervention is conducted by consumers and is usually not part of an established agency program. Also, WRAP has a short implementation timetable. The intervention, therefore, is very inexpensive to deliver compared to other EBPs.

In addition to being very inexpensive, WRAP also is a fundamental foundation for developing/mentoring and encouraging peer support specialist to live well themselves rather than simply hiring consumers/peers just because they have completed a peer support curriculum.

In the next unit we will look at the core implementation components and the multiple incentive systems framework with respect to the three implementation case studies. Here we will briefly look at the stages of implementation and the community context as they relate to WRAP.

WRAP implementation occurs in a mix of all three community implementation contexts (i.e., franchise, adopter, mandate-see Lesson five). To some extent WRAP is a franchise model in that the Copland Center is the ultimate source for facilitator training. A person cannot be an Advanced Level WRAP Facilitator (ALWF) unless they are trained by a Copeland Center Advanced Level Trainer who is a direct ALWF for the Copeland Center.

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Center. However, ALWF’s can train/facilitate independently (as long as they are current with the Copeland Center’s refresher requirements) as part of another project.

Inquiries for WRAP training are directed to the Copeland Center which protects the “brand” to that extent. Without certified trainers, a program cannot legitimately call itself a WRAP Program. In practice, however, it is essentially an adopter model since the center responds to requests from individuals and organizations and does not need a lengthy recruiting or screening process.

(Slide 15) The nature of WRAP prevents a pure mandated context. WRAP is not diagnosis specific so a state cannot mandate that only specific EBPs be used for that diagnoses. More importantly, the voluntary and consumer driven principles of WRAP further prevents mandating its use. However, states can mandate that WRAP be one of the interventions made available to consumers.

(Slide 16) Because of its simplicity, WRAP implementation does not require the extensive adherence to each of the implementation stages which are essential to the implementation of more complex behavioral health interventions. The exploration stage only applies to those cases in which the Copeland Center works on an organizational level. In this case the exploration stage is greatly shortened and basically requires the agency provide a written plan of how they will use WRAP and what the end result will be. There is no need for a full readiness assessment looking at all aspects of the organization as is required with most EBPs since large scale organizational and cultural change is not required for implementation success. The initial implementation stage is also much shorter as it requires only a structure for the recruitment and training of
trainers and consumers, and a location where the training can occur. Consequently, the starts up costs are relatively negligible.

(Slide 17) The actions required for the “Full Implementation” stage are also minimal since extensive supervision and coaching are not required and dissemination and recruitment are greatly simplified as well. Similarly, the Fidelity stage is much simpler since the model only entails assuring that the required material was delivered in the groups and a plan was developed. Refresher training and a facilitator network for mutual support are the only other major requirements.

(Slide 18) The innovation stage is also important for WRAP. While fidelity may be easy to maintain, creativity in how it is used and opportunities for expansion of the use of WRAP requires effort and ongoing work. Creating a plan is one thing, working the plan is something entirely different. Addressing ongoing WRAP support for those who have developed plans requires innovation. For example, in addition to the initial WRAP classes, WRAP follow-up support groups in order to address other life issues such as back to work, physical issues, trauma, relationships, etc. are an important innovation. It becomes a support for quality of life.

(Slide 19) Since WRAP is low cost intervention, the sustainability stage is not as critical a stage as it is in more expensive interventions. Facilitator retention is directly correlated to the support and ongoing engagement of those who are facilitating. In one state the retention rate with such support was 50% which is a significant return on investment. This is particularly true since some of the turnover is due to the successful recovery of facilitators using their WRAP plans who have moved on to other jobs. However, while
retaining facilitators has proven to be an issue in some locations, new facilitators can be recruited and trained quickly and is both inexpensive and cost effective.

(Slide 20) Based on the Copeland Center experience from a number of state and agency WRAP implementations there has been no consistency across states in how they implemented WRAP initiatives. WRAP initiatives have been developed for a number of different circumstances such as: to make it widely available as a recovery oriented evidence base practice; to reduce seclusion and restraints; and, as part of transformational grants.

(Slide 21) Across the statewide interventions there have been some common pitfalls. As might be expected, in times of scarcity and human service cutbacks, some budgets have not been adequate. States or organizations have tried to fit the process into the budget limitations and not all the necessary steps were implemented. For example in some cases clear standards were not adopted or the state provided its own training to line workers rather than the certified facilitator training to consumers. In some cases WRAP was not implemented in a recovery oriented environment which had the effect of slowing its adoption. The absence of strong state leadership support of WRAP and the insistence that WRAP be implemented according to best practices were two other pitfalls.

(Slide 22) In those states where Managed Care has been a major player in the delivery of behavioral health care there have been some consistent problems relating to policy and funding. Most of these issues relate to reimbursement and the documentation required for filing a successful claim when the MC organization has not made a
distinction between WRAP and other behavioral health interventions. The MC entity wants to verify if the WRAP service has been provided adequately so they look at the WRAP plan filed in the consumer’s record rather than the process. Consequently, if the worker has developed the plan without consumer input, the consumer has never attended a WRAP group and has not consented for “their plan” to be placed in the record, the agency might still be reimbursed. This undermines the whole intervention and does not provide the agency with an incentive to ensure fidelity to the model.

(Slide 23) This can create a major issue for fidelity because having a plan is a matter of consumer choice but in these cases the plan becomes what the provider has whether or not it is a true WRAP plan. Because of such documentation requirements supervisors frequently work with the practitioner to produce a plan that fits the MC’s documentation format (e.g., containing a diagnosis), rather than use the plan a consumer has developed in a WRAP group.

To counteract this tendency, several states have gone so far as to distribute a letter prohibiting providers from mandating or strongly “encouraging” a WRAP plan or expecting them to put it in their agency record since it runs counter to WRAP values and ethics. Consumers, of course, may decide to include the plan in their record.

(Slide 24) Another example of a policy which does not take into account the WRAP characteristics is the Veterans Administration’s intention to implement a standardized recovery plan in the interest of maintaining quality standards. This goes against the basic principle of a consumer developing an individualized plan tailored to their personal experience and needs. As noted before, this places the emphasis on the product rather
than the process, which is in fact an equally important part of the WRAP model. As with the MC issues we just discussed, a worker oriented plan could “pass” this standard and in no way reflect fidelity to the WRAP model.

(Slide 25) Because Medicaid reimbursement rules such as diagnosis based treatment and medical necessity contradict the wellness and consumer driven principles of WRAP, many states have written WRAP facilitation into the job description of a peer support specialist as a way of getting around these problems. Some states have gone even further and carefully written all of the characteristics of the WRAP process into their Medicaid rules and state plans as a way of ensuring fidelity.

(Slide 26) As has been covered in the prior lessons successful interventions are most likely to occur when there is both top down and bottom up demand and support for the intervention. Because our case examples are all statewide initiatives they of necessity employed a top down approach, although in many settings there was a consistent demand from consumers, advocates and family members which helped stimulate the state’s interest. Because WRAP is wellness, not illness oriented, intervention and it is not tied to any particular diagnosis or stage of recovery, it is attractive to a much wider audience than other mental health treatments and therefore lends itself to the creation of a high demand for the service.

Since WRAP is not a replacement for other treatments, is quick, inexpensive, self-directed, can adjust to changing circumstances, and is suited for any behavioral health problems or diagnoses, it can be easily seen why it is so popular. In addition, for well over a decade thousands of copies of the WRAP book have been distributed in addition
to countless presentations promoting WRAP. As a short term group intervention, thousands of participants have also written WRAP plans and have testified to its benefits. This has helped generate consumer demand particularly in areas where there have been WRAP groups and trainings on a regular basis.

(Slide 27) An important lesson learned from these statewide initiatives has been the importance of maintaining momentum, particularly by reducing turnover. Two strategies have been frequently cited as a means of maintaining the momentum of a WRAP Initiative. Refresher courses for facilitators to keep their skills up to a high level have been seen as very important. This is not just for getting additional practice, supervision and support but also for maintaining morale and an "esprit de corps". It has also proven to be extremely important to develop facilitator networks or learning communities where both positive and negative experiences can be shared and multiple persons can discuss possible solutions to a problem. Supporting persons in recovery from any chronic illness is a "one day at a time" process with its natural ups and downs and places great demands on facilitators. These support groups are essential in maintaining morale and reducing turnover.

(Slide 28) A critical part of successful EBP implementation is identifying sources of resistance and developing strategies to overcome this resistance. Across the statewide implementations there were certain groups who tended to initially be more resistance to implementing WRAP. Generally speaking, the more clinical and medically trained a staff person was, the more resistant they were to WRAP. While psychologists were less conflicted over WRAP than psychiatrists, the culture of non-disclosure was a big barrier.
Case managers were most likely to be supportive and embraced WRAP. However, if presented correctly, the barriers break down and all types of staff will be supportive.

(Slide 29) Previously, we discussed how the effect of an intervention on a worker’s job was critical in the success of the implementation. If it made the job more difficult or was seen as less effective, it was not likely to be adopted. Fortunately, once a WRAP initiative was implemented most workers felt it made their job easier. It helped them do their job well and they stayed longer because of this. For peer support workers the biggest challenge was feeling co-opted by professionals. Peers often felt that they lost their place on the team, that their opinions were discounted, and that social issues affecting them were ignored. The statewide implementations showed that it was important that other professionals did not define who was a peer as they often introduced their own biases as to who could qualify (e.g., were they “ready”).

(Slide 30) There were also a number of general issues which were common themes across the statewide interventions. An important one was how behavioral health agencies traditionally viewed group work. The functioning of groups in a traditional behavioral health setting creates operational issues involving billing, time and process. These agencies have a culture of professionally led groups which is in conflict with the WRAP model which involves participants in an equal way and encourages disclosure in an environment of non-disclosure and confidentiality. In other words, it is viewed as critical that professionals maintain strict boundaries with respect to consumers. While no one can argue that professionals need to respect boundaries with respect to their personal lives, this is often applied rigidly to all areas which might appropriately build rapport (e.g., tricks to growing vegetables, a shared interest in a type of music).

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Another important consideration proved to be the use of co-facilitators. Co-facilitation in most agencies is looked at as a cost issue rather than as a deliberate strategy which enhances consistent modeling of successful recovery. Co-facilitation demonstrates that there is no single best path towards recovery and provides more than one person with whom a participant can connect. “Chemistry” is an important factor in creating interpersonal rapport. If there is only one facilitator, if there is no connection there can be no rapport. Adding a second person considerably increases the probability that some connection will occur and will model cooperative, supportive and mutual relationships where power is shared equitably. In the event that there is very good co-facilitation and one is a “professional” and one is a peer, there is modeling of mutuality in humanity.

(Slide 31) In some agencies group members are screened for participation based on “readiness” determined by behavioral norms such as “can't sleep” rather than on the desire of the consumer to join the group. In many research studies particularly those connected to supported employment or supported housing this has proven to be a non-issue. Instead, motivational interviewing is used to create such readiness once the individual is included. The fact that an individual voluntarily wants to be included in WRAP to learn how to manage their recovery is evidence of their motivation and “readiness”. Also, WRAP groups are seen as a way to develop a network which can provide peer support at the end of the group. This is not seen as a legitimate function in a traditional “therapeutic” group.
One to one sessions generate more revenue for agencies and this can drive decisions rather than the need of the individual consumer. In addition, agencies frequently have a belief in the superior effectiveness of individual therapy.

(Slide 32) Retaining a strong cadre of WRAP facilitators over time has been an ongoing problem. There is little support or encouragement to refresh skills so The Copeland Center is pushing for ongoing refresher courses to maintain skills and re-engage facilitators. More facilitators are needed to go on and provide mentorship and additional coaching. The Copeland Center is encouraging Advanced facilitators to do mentoring, coaching and troubleshooting in the field.

(Slide 33) There is an ongoing confusion with the WRAP plan as the only final desired outcome of the WRAP process. Some people fail to appreciate the process is also designed to enhance other areas of a person’s life such as empowerment, self-efficacy, competence, hopefulness and peer support. All of these are also important for wellness and recovery.

(Slide 34) In this unit we have looked at the overall issues in the implementation of WRAP. These include: How the characteristics of the WRAP contribute to its successful implementation; The Copeland Center; the WRAP IPO; The community implementation context for WRAP; How WRAP characteristics affect the stages of implementation; and, the common problems and lessons learned in statewide implementation.

(Slide 35) How do you think the characteristics of the WRAP model would facilitate or inhibit a WRAP implementation in your particular situation?