Understanding Wraparound

Understanding the Children of REACH

The REACH program began in 2008, working with youth and families *before* they are court-ordered or involved in the juvenile justice system, giving Wraparound the ability to further improve outcomes and reduce the likelihood of court involvement and out-of-home placement for these youth. Referrals to REACH can be made by family providers, school personnel, health care providers, the Mobile Urgent Treatment Team, and other public and private service providers. All children referred to REACH must be eligible for Medicaid or BadgerCare Plus at the time of referral.

One year after launching REACH, the staffs are moving beyond the initial implementation stage based on theory and program design and asking some quality-improvement questions that come with working with the population for a while. The information gathered through this analysis will be used to ensure that the REACH program is working as intended and that programmatic refinements can be made in order to best meet the needs of the REACH children.

How are REACH and Wraparound Children the Same and/or Different?

We know by definition and design that there is a "front door" difference between the two programs is how the children are referred: (1) a referral via Children's Court for Wraparound compared to (2) a non-court ordered, community-based or self-referral process for REACH. We also know that to be accepted into either program, the child or youth must meet criteria for seriously emotionally disturbed (SED). But what else might differentiate the youth enrolled in the two programs? Do they tend to have different needs? Do they have different family histories or experiences? Do these children exhibit different clinical profiles? Is either group more severe than the other? The answers to these questions can be used to help validate that the referral and screening processes are working as intended and that the focus of program services are meeting the needs of the youth/families in REACH. Using these kinds of quality-improvement questions will help REACH maintain both the focus and flexibility that characterizes the Wraparound approach. The information included in this report represents some basic information about several characteristics of REACH and Wraparound children. There are other similarities as well as differences that will emerge over time and bear further study.

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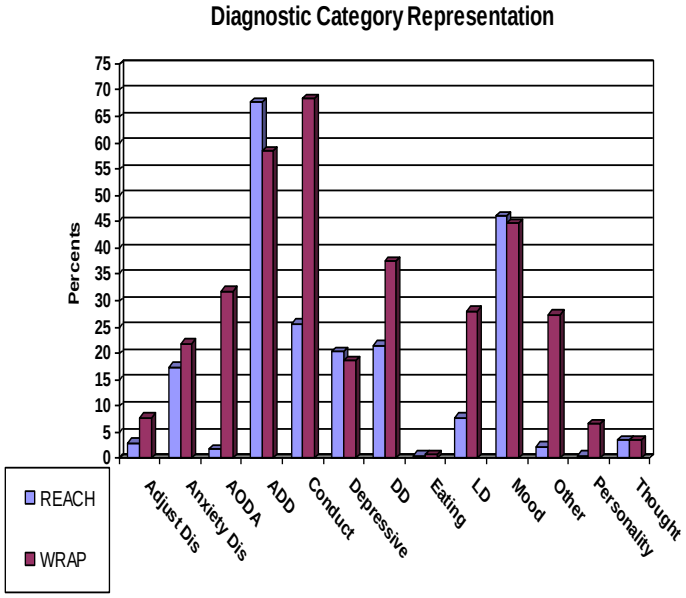
Results

Age: For **REACH** children the age range is 5 years to 18 and the **average age at enrollment is 12.2**. While for Wraparound children the age range is 6 years to 18 and the **average age at enrollment is 14.3**. The most frequent presenting ages are 15 and 16 for REACH and Wraparound respectively. So even though both programs have children in the full age range spectrum, it appears that **REACH children are indeed significantly younger** (confidence level of $p<0.001$.)

Gender: Given that specific issues and sometimes-discrete programming are related to gender, the question of gender difference between programs is relevant. As it turns out there is **no significant difference in the gender** of REACH vs. Wraparound youth, with 27% of REACH children being female compared to 25% of Wraparound children being female.

Presenting Problems: Upon entering REACH and Wraparound, the **3 top frequently presenting child problems are identical**; in descending order: school/community concerns, severe aggressiveness and ADHD (with deviations in 4th position; Wraparound youth exhibiting Drug/Alcohol Abuse and REACH group exhibiting High Risk Behaviors.

Special Educational Needs: Based on the information that is accessible through the Plan of Care (POC), 78% of REACH children hold an Individualized Education Plan (IEP) while 66% of WRAP children have an IEP. This data, analyzed, reveals a **significant difference** between the children in the 2 programs ($p= .0028$).



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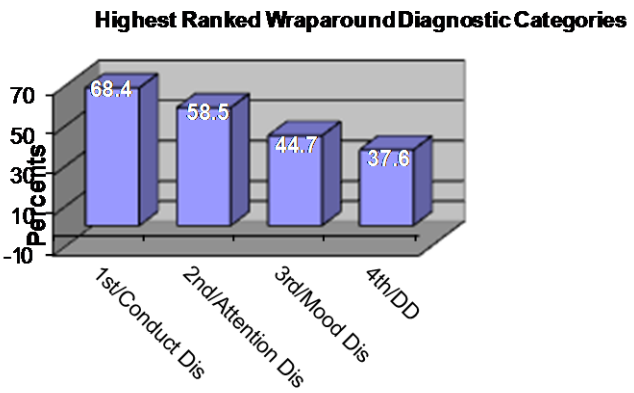
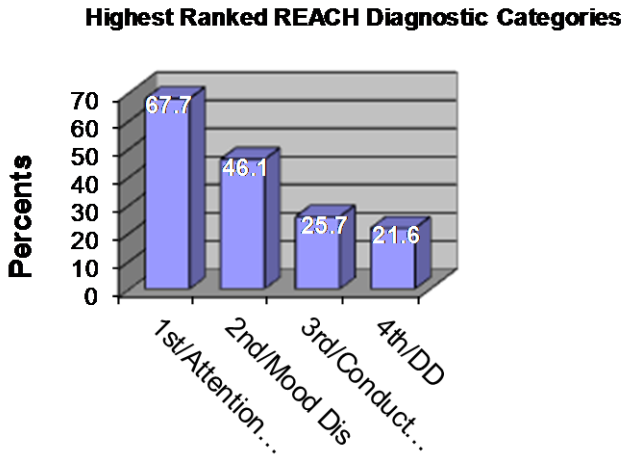
Diagnostic Categories

Using the Diagnostic and Statistical Manuel of Mental Disorders (DSM-IV), the diagnostic categories for Wraparound and REACH children were reviewed to determine how the clinical profiles differ. The graphic representation below reveals both significant similarities and differences between the 2 populations. Most prevalent are the significant differences with regard to AODA issues, Conduct Disorders, Developmental Disorders and Learning Disorders where Wraparound children are significantly higher and REACH children who exhibit significantly higher rates of Attention Disorders.

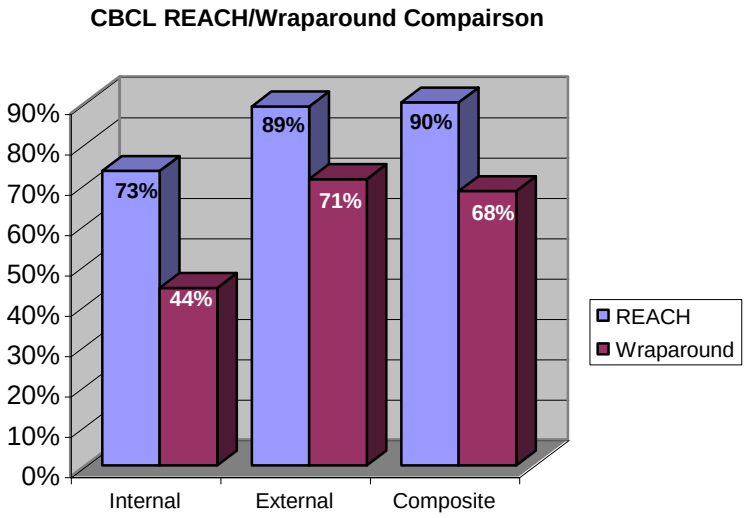
To further analyze the data, the highest ranked categories for each program were depicted (see graphs below). Interestingly, the programs revealed the **identical top 4 diagnoses**. The differences were only in their ordinal position.





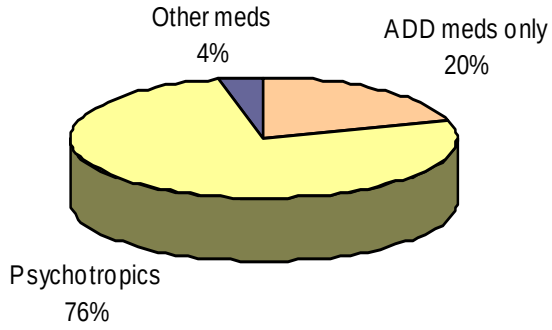
Child Behavior Checklist (CBCL):

An examination & comparison of the outcomes of the CBCL for both REACH & Wraparound children reveals a *significant overall difference* ($p<0.001$), with REACH children exhibiting higher clinical internal, external and composite scores.

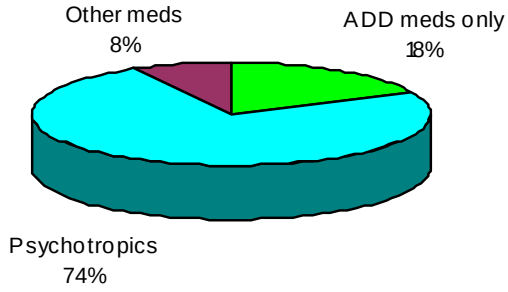


Medication: The use of medication also may provide some insight into the 2 populations. According to the data 77% of the REACH population is on medication, while only 53% of Wraparound takes medication. This data is **statistically significant** (p=<0.001). Even though a higher percentage of REACH children receive medication, the graphs reveal that the distribution of the types of medications are virtually identical to the Wraparound population

REACH Medication Distribution



Wraparound Medication Distributon



Lastly a comparison of how many children in each program take 3 or more meds reveals that the percentage is the same for each group (37%) , suggesting no difference between populations.

Discussion

So with all the above probing of the data, can we answer definitively *if the populations are different, and if so what does it mean to us programmatically*? As one might expect, the answer is a resounding "yes" in some areas and "no" in other areas. In summary, the conclusions are as follows:

1. REACH children are generally younger, and we all know that earlier diagnosis and treatment has a positive impact on being able to halt a progression toward more serious problems.
2. Given the higher rate of special education for REACH children & youth, it will be particularly important to focus on school-related needs. It is also helpful to be aware of the special education diagnosis as it allows for understanding of how a child processes information, interprets social situations and grasps abstract ideas.
3. The data of the clinical diagnostic categories revealed the most interesting results as the top 4 diagnoses were the same for both the Wraparound & REACH populations. This suggests that REACH children do not exhibit wholly different clinical pictures than the Wraparound population. Furthermore, the frequencies of individual diagnoses are lower. However, even though the frequency of any specific category, other than Attention Deficit Disorder, is lower: *REACH children appear to exhibit a greater overall severity level as indicated by the CBCL comparison*.

4. A significantly higher percentage of REACH children on medications may suggest that the REACH population does exhibit more severe emotional problems especially when considered in conjunction with the CBCL outcomes. However, the data may be confounded as REACH children and youth are seen in our medical clinic while Wraparound children are not exclusively seen through this clinic. The possible implication is that in REACH there is a greater control of medication distribution that could contribute to the outcome data, the percentage receiving medication. Further complicating the picture is the fact that the distributions of the different types of medications (psychotropic, ADD & Other) are virtually identical in the REACH and Wraparound populations (see pie graphs above.) Without the ability to control medication dispensation, one can only conjecture; are these populations more similar or what other variables are contributing to the outcomes around use of medications?

Conclusion and Recommendations

The data that has been presented sharpens our focus about these children and their needs and affirms that the REACH program has been successful in reaching out to and engaging the intended cohort of youth/children. Some findings suggest that the treatment teams pay closer attention to certain behaviors, experiences, diagnoses and/or trends. As with any analysis like this, readers are encouraged to take a second look at the data above and perhaps identify additional research questions or opportunities.

As always, after the development of generalizations and theories, it is the careful and reflective thinking process about each and every child that will make the difference. Hypotheses that are proposed, tested, evaluated and modified based on experience and out of the box thinking leads to innovative approaches to building strength in children and their families; one child… one family at a time.

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12/2009