Care Management Entities

MARYLAND IMPLEMENTATION REPORT
FY13 QTR 3 & 4 • JANUARY-JUNE 2013

UNIVERSITY of MARYLAND
SCHOOL OF SOCIAL WORK
THE INSTITUTE FOR INNOVATION & IMPLEMENTATION
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Introduction

Since July 2012, Maryland Choices, LLC collects administrative data on the youth and families they serve. These data include how many youth and families were served; length of service; reason for discharge; youth demographic characteristics; youth history of mental health and special education services; psychosocial functioning at entry into the CME, during enrollment and at discharge; and societal impact outcomes. Administrative data have been collected for youth at baseline (i.e., upon intake into the CME) and every six months afterwards until discharge from services. In addition to administrative data, The Institute conducts interviews with caregivers and youth to measure how well the CME is adhering to the Wraparound model and to better understand the impact services are having on families and youth. During this period, data were collected using the Wraparound Fidelity Index – Short Form (WFI-EZ) pilot version at 6 and 12 months into services. Youth Resiliency and Caregiver Empowerment data are also collected at baseline, six months and 12 months. The Evaluation team invites enrolled families to participate; families can opt to complete these surveys online, over the phone or by paper copies via mail. Most of the surveys were completed over the phone. The Institute received information on 98 (52%) of the families receiving services and data from youth enrolled between January 1 and June 30, 2013 are included in this report.

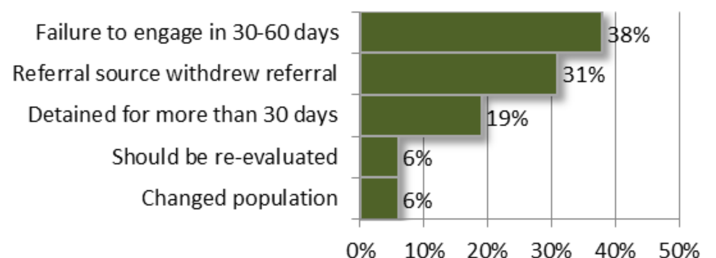
Wraparound is a team-based planning process intended to provide individualized, coordinated, family-driven care to meet the complex needs of youth. For further information on the Wraparound process and national efforts, see The National Wraparound Initiative: http://nwi.pdx.edu

Who has been served?

Admission Rate

A total of 211 new CME referrals were accepted between January 1, 2013 and June 30, 2013. Of these, 187 (89%) started services (i.e., had at least one face-to-face meeting with a care coordinator), 8 (4%) were pending their first face-to-face meeting, and 16 (8%) did not start services and were disenrolled. Of those who were disenrolled, the most common reasons for non-admission were failure to engage within 30-60 days (38%) and the referral being withdrawn by the referral source (31%). Among the youth who started services with the CME, it took an average of 17.1 days (*sd*=18.28) from the date of acceptance to have the first face-to-face meeting with the care coordinator. It is important to note that the contract specifies that initial contact shall be made within 72 hours, with the initial face-to-face meeting occurring in the next seven days. Of admitted youth with at least one Child and Family Team (CFT) meeting (n=152), the number of days from acceptance to the first CFT meeting was approximately 36.9 (*sd*=19.68).

Figure 1: CME Non-Admission Reasons, January - June, 2013



n=16

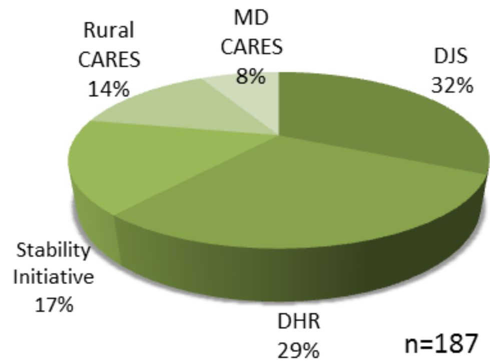
Populations Served

Youth who started CME services were from different populations including Department of Juvenile Services Out-of-Home Placement Diversion (DJS, 32%), Department of Human Resources Out-of-Home Placement Diversion (DHR, 29%), Stability Initiative (17%), Rural CARES (14%), and MD CARES (8%).

Compared to the previous two quarters (July - December, 2012), there were significantly ($p<.05$) more youth starting services who were part of the DJS population (32% vs. 19%), and MD CARES youth (7% vs. 14%) during the third and fourth quarters of FY13. The Stability Initiative was opened for new referrals effective April 22, 2013, and the Psychiatric Residential Treatment Facility (PRTF) Waiver Initiative was closed to new referrals as of October 1, 2012.

*See Appendix 1 for definitions of the different populations.

Figure 2: Populations of Youth Entering CME, January - June, 2013



Demographic Characteristics

The majority of youth starting CME services were African American/Black (65%), male (61%), and approximately 14 years old. Youth in the DJS population were significantly ($p<.05$) older than youth in other populations, with an average age of about 16 years. The DJS population also included a larger proportion of male youth (82%). The percentages of male and female youth in the DHR and Rural CARES populations were more evenly distributed than the Statewide distribution. African American/Black youth comprised the majority of youth in the MD CARES population (87%), and Caucasian/White youth were the largest racial/ethnic group in the Rural CARES (50%) population. These demographic characteristics are similar to those of youth enrolled during the previous two quarters.

See Appendix 2 for the full distribution of demographics by population.

Figure 3: Sex of Youth Entering CME, January - June, 2013

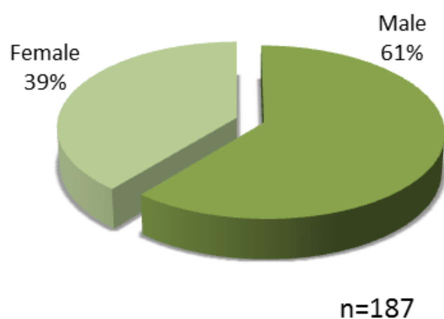
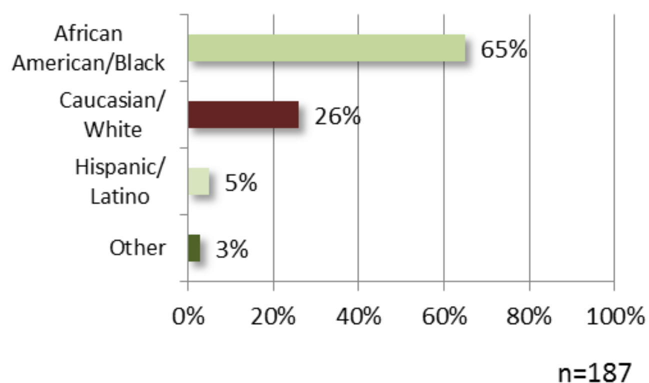
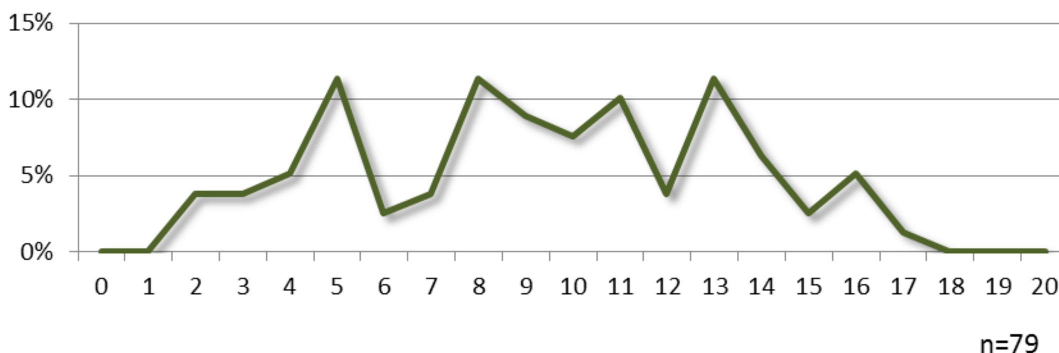


Figure 4: Race/Ethnicity of Youth Entering CME, January - June, 2013



Of the youth starting CME services who had received mental health services prior to CME enrollment (n=79)[1], a majority first received treatment between the ages of five and 13 (71%). Youth in the MD CARES population were the youngest first receiving mental health services (7.5 years), and youth in the DJS population were the oldest (11.8 years). The average age youth first received mental health services (9.7 years) was not significantly different from what was seen during the previous reporting period (9.0 years). See Figure 4 below for the Statewide distribution of ages that CME youth first received mental health service.

Figure 5: Age of First Mental Health Service of Youth Entering CME, January - June, 2013

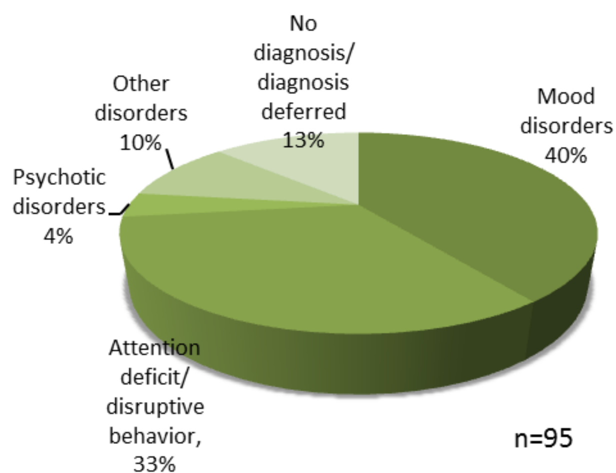


Diagnoses

Among youth who started CME services and had a psychiatric diagnosis within three months of enrollment (n=95, 51%), the primary diagnoses were predominantly mood disorders (40%) and attention deficit or disruptive behavior disorders (33%). This pattern is similar to that of youth who entered the CME during the previous two quarters. Mood disorders were more prominent in Rural CARES and Stability Initiative youth (60% and 53%, respectively). See Appendix 2 for the breakdown of all diagnoses by population.

The Statewide average Global Assessment Functioning (GAF; American Psychiatric Association [DSM-IV-TR], 2000) score was 46.2 (*sd*=8.96, n=57). Scores ranged by population from 45.4 (Stability Initiative, *sd*=7.50) to 51.4 (Rural CARES, *sd*=7.48), with no significant differences among the populations. These scores indicate that youth entering the CME generally displayed symptoms of moderate to serious impairment in social, occupational, and/or school functioning.

Figure 6: Primary Diagnoses of Youth Entering CME, January - June, 2013



[1]Prior mental health treatment data was only available for youth who had been in enrolled in the CME for a minimum of three months, thus not all youth who enrolled during this reporting period are represented; data based on self-report.

Youth Resilience

Twenty-eight (31%) of the youth who started CME services during the third and fourth quarters of FY13 completed the California Healthy Kids Survey, Resilience & Youth Development Module (RYDM)* upon entry (within four weeks). On a scale of 0 through 4 (with a higher score indicating greater resilience), the Statewide average scores on the domains measuring environmental protective factors ranged from 2.92 (*sd*=.80) on the Meaningful Participation at Home domain, to 3.41 (*sd*=.75) on the High Expectations at Home domain. Of the domains measuring personal resilience strengths, average scores ranged from 2.63 (*sd*=.67) on the Problem Solving domain, to 3.28 (*sd*=.60) on Self-efficacy. These scores indicate that youth enrolled in the CME during this reporting period generally demonstrated moderate-to-high personal and environmental resilience. As Figure 8 illustrates, a majority of youth fell into either the moderate (score 2-3) or high (score >3) categories on all domains of the RYDM.

Figure 7a: RYDM Environmental Protective Factors

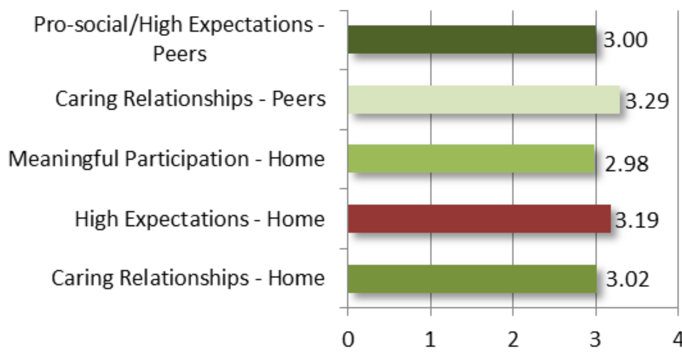
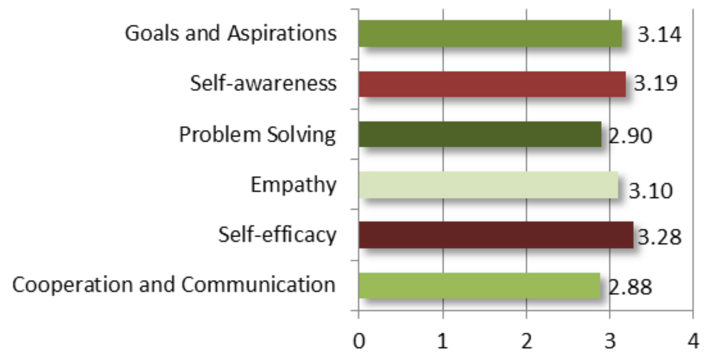
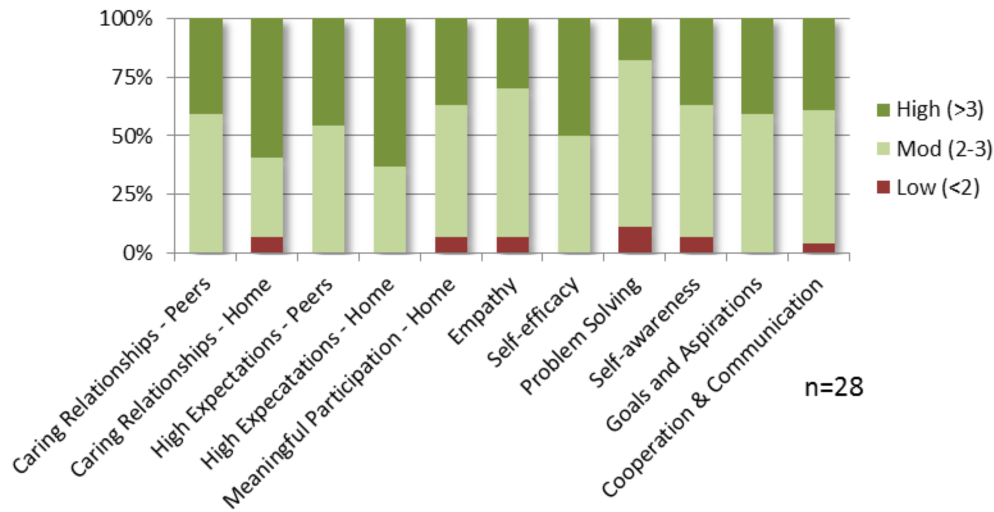


Figure 7b: RYDM Personal Resilience Strengths



n=28

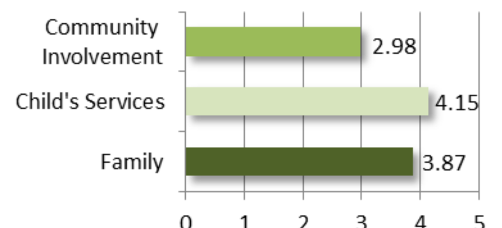
Figure 8: RYDM Domains Categorical Scores



Caregiver Empowerment

The caregivers of 57 (60%) youth starting CME services during this reporting period completed the Family Empowerment Scale (FES)* within four weeks of entry into services. Possible scores on the FES range from 0 through 5, with a higher score indicating greater empowerment. Caregivers generally reported feeling most empowered in navigating the system(s) of child services to access the services their children need (mean score=4.17, sd=.47). Caregivers felt least empowered in their community/political involvement in influencing the policies around child services (mean score=2.93, sd=.95).

Figure 8: FES Domain Scores



n=57

*See Appendix I for descriptions of the RYDM and FES instruments.

Youth and Caregiver Needs and Strengths

One-hundred and thirty of the youth who started CME services had a Child and Adolescent Needs and Strengths (CANS)* assessment completed within six weeks of admission (70%). The highest areas of demonstrated need (score of 2 or 3) included recreation (45%), family functioning (42%), school behavior (42%), and school achievement (42%), all of which fall into the Life Domains/ Functioning domain. This is consistent with the baseline CANS assessments of youth who enrolled during the first two quarters of FY13.

Youth in the MD CARES population demonstrated notably higher need for intervention in oppositional behavior (70%) and anger control (70%), compared to the Statewide rates. Further, Stability Initiative youth had higher need in depression (40%) and anxiety (40%). See Appendix 2 for the distribution of all CANS items by population.

All youth had at least one identified strength (score of 0, 1, or 2) from the Child Strengths domain. Moreover, each of the nine strengths was identified in a majority of the youth, with the most common strengths being optimism, educational, and talents and interests (each identified in 97% of the sample).

*See Appendix 1 for a description of the CANS instrument.

Figure 9a: Need in Life Domains/Functioning

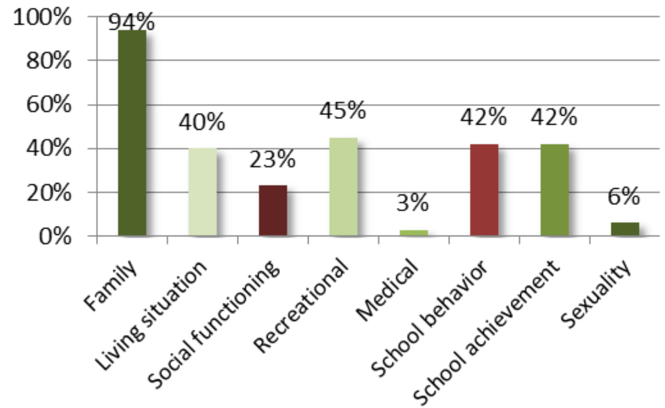


Figure 9b: Need in Caregiver Needs & Strengths

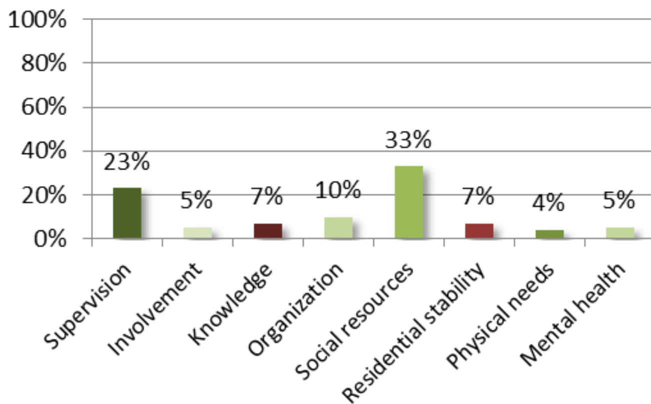


Figure 9c: Need in Child Behavioral/Emotional

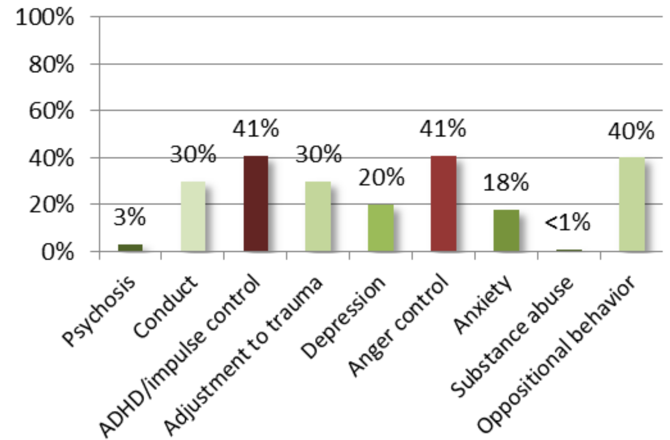


Figure 9d: Need in Child Risk Behavior

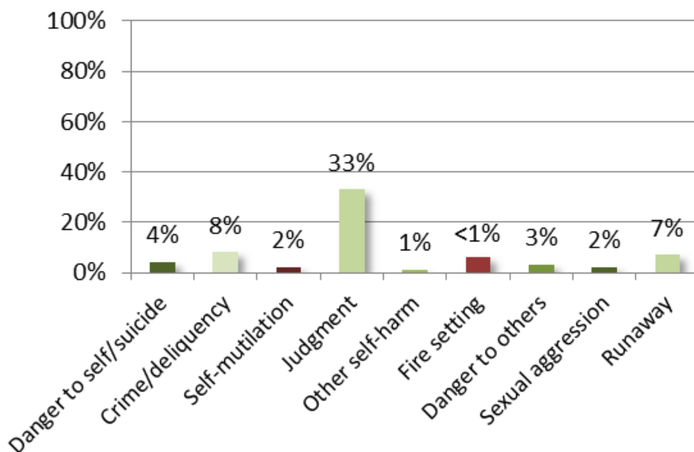
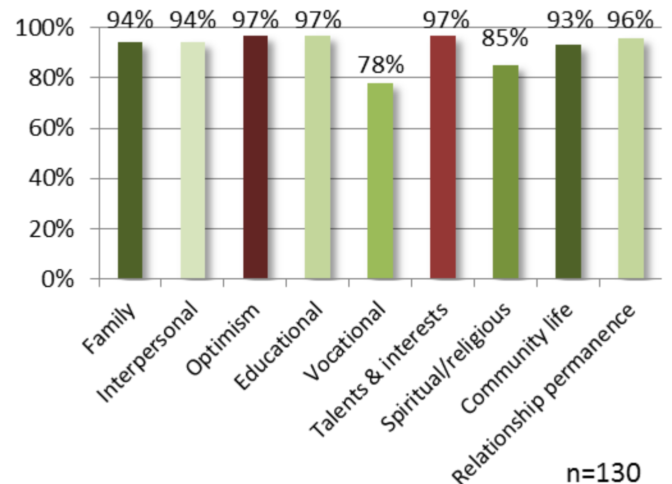


Figure 9e: Identified Strengths



n=130

How were available services utilized?

Utilization and Average Daily Population

Of the 345 average daily CME slots in Maryland during the third and fourth quarters of FY2013, the rate of utilization was 79%, with an average daily population of approximately 274 youth. It should be noted that, because the Stability Initiative was only opened for new referrals effective April 22, 2013 during this reporting period, it is expected that these slots will be under capacity while youth are initially enrolled. In addition, the number of slots available for the DHR and DJS populations were both increased from 75 each to 100 each on June 15, 2013. See Table 1 for the utilization rates of each population.

Table 1: Utilization of CME Slots

Population	Daily capacity	Average daily population	Utilization
DJS	76.8*	59.1	77%
DHR	76.8*	60.4	79%
Stability Initiative	38.1*	1.6	4%
Rural CARES	60.0	45.0	75%
MD CARES	34.0	36.8	108%
PRTF Waiver	56.0	68.3	122%
ICSA	3.0	3.0	100%

*The capacity changed during the course of the reporting period; the average daily capacity is shown.

How well were services delivered?

Wraparound Fidelity Index

The quality of services delivered was measured using the Wraparound Fidelity Index - Short Form (WFI-EZ).* Because a pilot version of the WFI-EZ was used during this reporting period, some of the items slightly differ from those in the final version of the instrument. The items collected were used to compose the Basic Information and Experiences sections of the WFI-EZ; the Satisfaction and Outcomes sections will be included in future reports.

Figure 10: WFI-EZ Basic Information Items

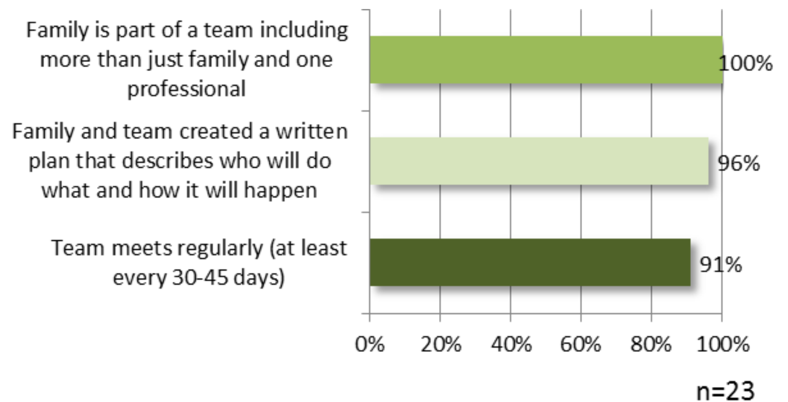
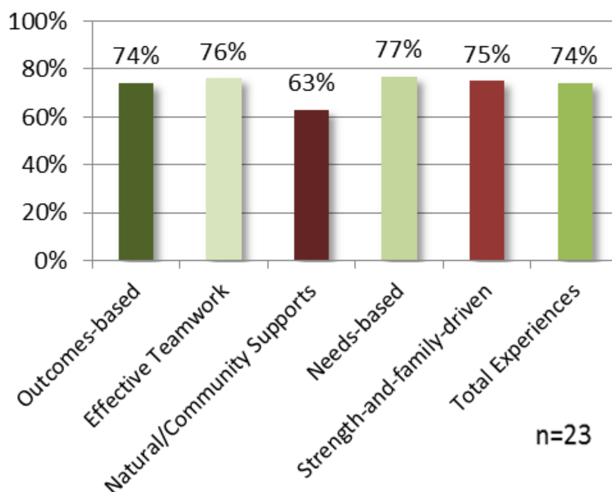


Figure 11: WFI-EZ Experiences Domains



*See Appendix 1 for a description of the WFI-EZ instrument.

Due to the low youth response rate, only caregiver responses are presented in this report, including those collected at 6 months (n=5) and 12 months (n=18) post-admission. The Institute only started collecting fidelity on all populations in January, 2013 (the start of this reporting period). Previously, these data were only collected for the MD CARES, Rural CARES, and DHR populations, thus these are the only populations for which 6- and 12-month follow-ups can be compared; hence the small sample size. All populations will have 6- and 12-month follow-ups to report from this point forward

Most caregivers responded affirmatively to all three items of the Basic Information section (see Figure 10). The average total composite score of the Experiences section was 74%, with the highest average score on the Needs-based domain (77%), and the lowest on the Natural/Community Supports domain (63%).

What were the outcomes of youth served?

Reasons for Discharge

A total of 186 youth discharged from the CME during the third and fourth quarters of FY13[2]. The most common reasons for discharge included Successful Completion (34%), More Intensive Level of Treatment Needed (20%), and Program Ended (13%). Youth in Rural CARES were most likely to discharge with a Successful Completion (50%), and those in the PRTF Waiver were the most likely to need more intensive treatment (43%). See Appendix 3 for the breakdown of all discharge reasons by population.

Compared to youth who discharged during the previous two quarters, youth who discharged during this reporting period had a significantly ($p<.05$) higher rate of successful completions (34% vs. 24%).

Figure 12: Reasons for Discharge, January - June, 2013

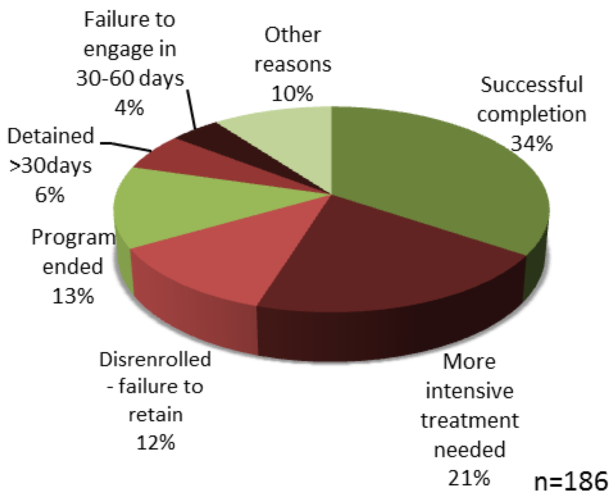
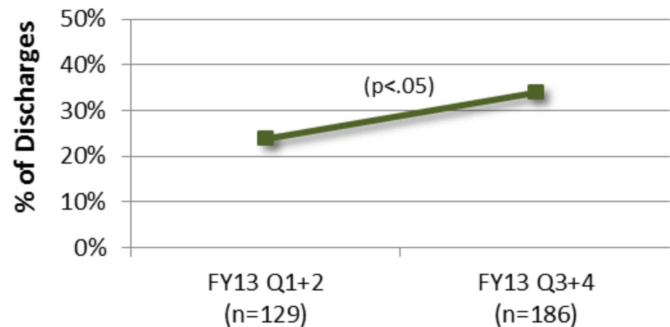


Figure 13: Semi-annual Change in Successful Completions, January - June, 2013



Duration of Services

The Statewide average length of stay for all discharged youth was 243.0 days (*sd*=153.73), and ranged by population from a low of 160.8 days (DJS, *sd*=92.57) to 381.1 days (PRTF Waiver, *sd*=225.97). Among youth who discharged with a Successful Completion (n=64), the average length of stay was 330.1 days (*sd*=167.15), ranging by population from 232.6 days (DJS, *sd*=91.00) to 554.6 days (PRTF Waiver, *sd*=235.41).

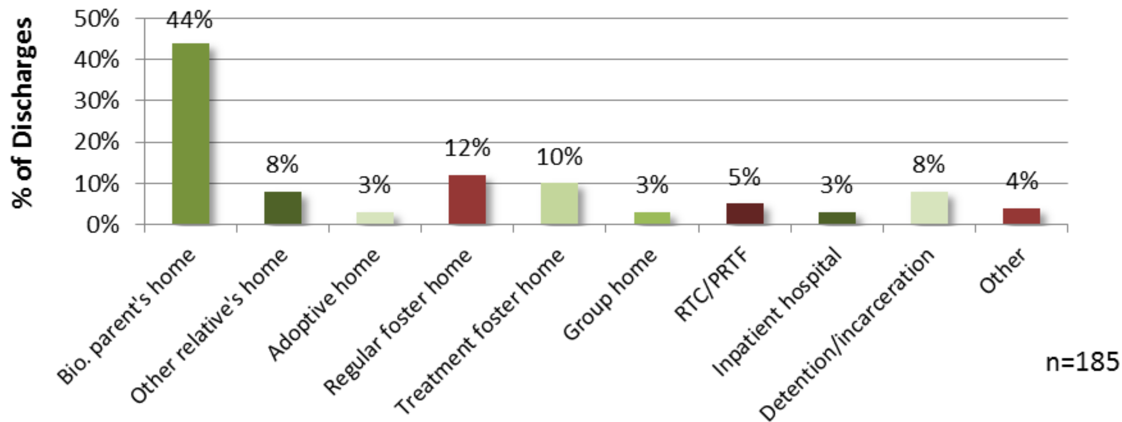
The average length of stay for all discharged youth during this reporting period was significantly ($p<.05$) longer than the first and second quarters of FY13 (243.0 vs. 177.4 days, respectively). This difference could be attributable to the higher rate of successful completions during this reporting period. The length of stay among those who completed services was not significantly different between the two reporting periods.

[2]This count excludes youth who did not have at least one face-to-face meeting with the care coordinator.

Living Situation

Data on living situation at discharge was available for 185 (>99%) of the youth who exited the CME during this reporting period. The most prevalent living situation at discharge was biological parent's home (44%), followed by regular foster home (12%) and treatment/therapeutic foster home (10%). Youth in the DJS population were the most likely to discharge to a biological parent's home (66%), and youth in the DHR population had the highest proportion residing in a regular foster home (23%). See Appendix 3 for the full distribution of living situations by population.

Figure 14: Living Situations at Discharge, January - June, 2013



Youth and Caregiver Needs and Strengths

Improvement in risk and protective factors was measured using the Reliable Change Index (RCI; Jacobson & Truax, 1991), with 90% confidence, for each CANS subscale from entry to discharge. Of the youth discharged during this reporting period who had CANS assessments at both entry and discharge (n=102, 55%), 27% showed improvement on Child Need & Risk - a composite scale comprised of items from the Life Domains/Functioning, Child Behavioral/Emotional Needs, and Child Risk Behavior subscales. Youth in the PRTF Waiver had the highest rate of improvement (35%), followed by youth in the DHR and DJS populations (29% each). The Child Strengths and Life Domains/Functioning subscales were the domains on which youth showed the most improvement (30% and 23%, respectively). See Appendix 3 for the breakdown of improvement on all CANS domains by population.

It should be noted that youth with low CANS scores at baseline have less room for improvement, and are therefore less likely to improve over time, compared to youth with higher baseline scores. Of the 102 youth included in this analysis, those who showed reliable improvement from enrollment to discharge (n=36) had significantly ($p<.05$) higher scores at baseline than youth who did not show improvement on the Child Need & Risk composite, and on all subscales except Child Strengths. Thus, baseline scores should be considered when interpreting rates of reliable improvement (see Table 2).

Figure 15: Reliable CANS Improvement (90% C.I.) from Entry to Discharge

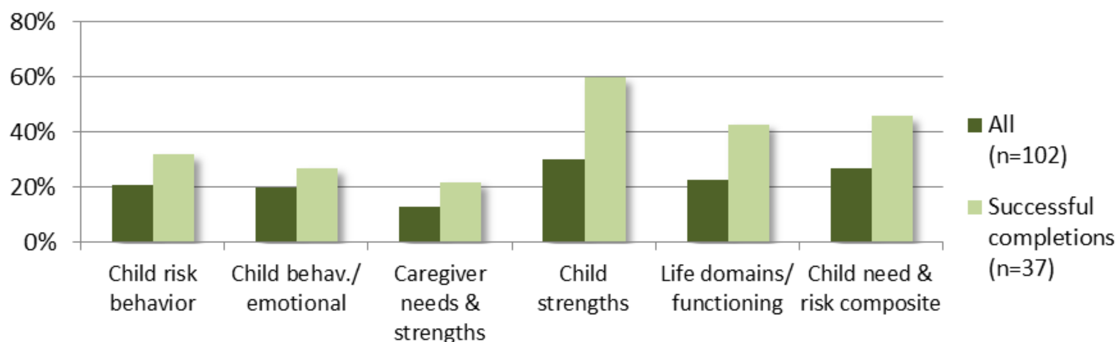


Table 2: Average CANS Scores and Change from Baseline to Discharge

CANS Domain	Average (SD) baseline score	Average (SD) discharge score	Average (SD) change, baseline to discharge	Youth showing reliable improvement
Child Risk Behavior	.39 (.27)	.36 (.31)	-.03 (.31)	21 (21%)
Child Behavior/ Emotional Needs	.79 (.42)	.78 (.48)	-.002 (.43)	20 (20%)
Caregiver Needs & Strengths	.52 (.41)	.53 (.46)	.01 (.48)	13 (13%)
Child Strengths	1.50 (.42)	1.31 (.55)	-.19 (.47)	31 (30%)
Life Domains/ Functioning	.85 (.41)	.77 (.50)	-.08 (.55)	23 (23%)
Child Need & Risk Composite	.68 (.32)	.63 (.38)	-.04 (.36)	27 (27%)

Implications

Recognizing quality front line practice requires organizational support and supervision, the Institute, in collaboration with Maryland Choices, is focusing coaching primarily on the enhancement of the skills sets within the supervisory and lead staff within the next two quarters. The certification requirements have shifted in an effort to create a certification process that reinforces quality Wraparound work by putting a stronger focus on specific supervisor skills as well as ensuring a quality process from engagement to transition. The new requirements set up a stronger inter-agency structure for capacity building, sustainability, and positive outcomes despite front line staff turnover rates by increasing and monitoring the skills of the supervisor as well as the front-line staff. This will include targeted coaching and training in observations in the field with supervisors and their care coordinators as well as supervisory sessions to enhance the transfer of skills from supervisor to care coordinator as it relates to Wraparound model.

The Institute has held core certification trainings in centralized locations across Maryland. The Institute conducted two three-day Introduction to Wraparound trainings, one one-day Engagement within the Wraparound Process training and one two-day Intermediate Wraparound: Improving Wraparound Practice training. Fifty-Six staff members from the CME attended one or more of these offered sessions. Unfortunately, forty one percent of the trained staff has turned over within these past two quarters.

The Institute also provided smaller group sessions across the State each month with particular focus on the initial phase of the Wraparound process: Engagement and Team Preparation. Small group trainings were provided monthly across the State in support of development of engagement skills. To address concerns with staff turnover and enhance the skill level within the CME's leadership team, coaching by The Institute has begun to focus on the CME's management and supervisory level staff. Two supervisor trainings were conducted by The Institute to coach the management level staff on the Wraparound Practice Improvement Tools designed to be used during supervision with care coordinators to build the skill of the care coordinator to ensure quality and high fidelity to the Wraparound process. Seven of eight CME management staff attended the first training and five of eight CME management staff attended the second training. In addition to core trainings and group sessions, regular in person and virtual coaching was offered weekly by The Institute to each CME supervisor and their respective team to include field observations, document reviews and supervisory sessions.

There were no Wraparound Practitioner or Wraparound Supervisor Certifications completed during these two quarters. One provisional certification was awarded to a care coordinator to allow an expanded timeframe for demonstrating the skills sets associated with high-quality implementation of the Wraparound process. This was in response to the new Wraparound Practitioner certification model that was instituted in September 2012. This care coordinator has since left the CME. There are currently five care coordinators and two supervisors that have completed the initial Wraparound Practitioner certification process in total and all are working towards their recertification this year. The low number of certified staff can largely be attributed to the staff turnover rates as well as the implementation to the new certification model. Coaching and training will continue as will organizational efforts to increase retention rates of CME staff.

References

American Psychiatric Association. (2000). *Diagnostic and statistical manual of mental disorders* (4th edition, text revision). Washington, DC: Author.

Jacobson, N. S., & Truax, P. (1991). Clinical significance: A statistical approach to defining meaningful change in psychotherapy research. Journal of Consulting and Clinical Psychology, 59(1), 12-19. doi:10.1037/0022-006X.59.1.12

Appendix 1: Definitions

Populations Served by the CME

- Psychiatric Residential Treatment Facility (PRTF) Waiver - Youth who meet the need for a residential treatment center-level of care, can be adequately served in the community with waiver supports, and meet Medicaid eligibility requirements.
- Department of Human Resources (DHR) Out-of-Home Placement Diversion - Youth who are diverted from a Voluntary Placement Agreement (VPA) to prevent out-of-home placement; diverted from a group home; diverted from out-of-home placement; or reunified with family and meet additional requirements -established by DHR.
- Department of Juvenile Services (DJS) Out-of-Home Placement Diversion - Youth who are re-entering the community after an out-of-home placement (in-State and out-of-State); or who have been identified by a DJS-appointed gatekeeper to be at-risk for an out-of-home community residential placement (group home). This population will include youth who have been through adjudication and may be in pending-placement status in a detention facility or in the community. Youth must also meet additional requirements established by DJS.
- Maryland Crisis and At Risk for Escalation diversion Services (MD CARES) - Youth with a diagnosis of Serious Emotional Disturbance (SED) and who are served by, or at risk of entering the Maryland foster care system in Baltimore City.
- Rural CARES - Youth with a diagnosis of Serious Emotional Disturbance (SED) and who are served by, or at risk of entering the Maryland foster care system in Caroline, Cecil, Dorchester, Kent, Queen Anne's, Somerset, Talbot, Wicomico, or Worcester Counties.
- Stability Initiative - DHR- or DJS-referred youth who have a diagnosis of Serious Emotional Disturbance (SED) and are in or at risk of an out-of-home placement. Youth must also meet additional requirements established by DJS and DHR.
- Interim Case Service Account (ICSA) - Youth with developmental delays and/or Serious Emotional Disturbance (SED) requiring intensive services, being served in the least restrictive level of care possible. Services are limited to youth in Montgomery County who are currently enrolled.

California Healthy Kids Survey, Resilience and Youth Development Module

The Resilience and Youth Development Module (RYDM) of the California Healthy Kids Survey assesses the supports and opportunities (protective factors) and the strengths and outcomes (personal resilience strengths) associated with positive youth development.[1] The RYDM is administered to youth via online survey, paper survey, or telephone interview upon entry into the CME, and at six and 12 months after admission. Items from the RYDM compose the following domains and subscales:

(Protective factors)

- Home Environment - These subscales assess the youth's feeling connected to family and having positive family experiences.
    - *Caring Relationships* - The presence and involvement of a primary caregiver in the youth's life.
    - *High Expectations* - The family's expectation, encouragement, and support for the youth's success in academic and other life domains.
    - *Meaningful Participation* - The youth is acknowledged as a valued participant in the family.
- Peer Environment - These subscales measure the positive influence and support of peers in the youth's life.
    - *Caring Relationships* - The youth is forming caring, empathic student-to-student relationships.
    - *High Expectations: Pro-Social Peers* - The youth's friends display traits that help foster positive peer relationships focused on pro-social activities.

(Personal resilience strengths)

- Cooperation and Communication - The youth's social competence, including effective communication and cooperation with others.
- Self-efficacy - The youth's belief in her/his own competence and ability to make a difference.
- Empathy - The youth's understanding and caring about others' experiences and feelings.
- Problem Solving - The youth's ability to plan, be resourceful, think critically and reflectively, and creatively examine multiple perspectives before making a decision or taking action.
- Self-awareness - The youth's understanding of how her/his thinking influences behavior, feelings, and moods, as well as personal strengths and challenges.
- Goals and Aspirations - The youth uses her/his dreams, visions, and plans to focus on the future, and has high expectations and hope for her/himself.

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[1] Austin, G., Bates, S. & Duerr, M. (2013). *Guidebook to the California Healthy Kids Survey: Part II: Survey content – RYDM module, 2013-14 edition.* San Francisco, CA: WestED. Retrieved from: http://chks.wested.org/resources/chks_guidebook_2_rydm.pdf

Family Empowerment Scale

The Family Empowerment Scale (FES) assesses how caregivers of children with emotional disabilities handle the challenges of caring for the child and managing the family; navigating the systems of child services to access the care that their children need; and being involved in the community and politics that influence child service policies.[2] Caregivers complete the FES via online survey, paper survey, or telephone interview upon their children's entry into the CME, and at 6 and 12 months after admission. The items from the FES are used to calculate scores for the three aforementioned domains: family, child services, and community/political.

Child and Adolescent Needs and Strengths

The Child and Adolescent Needs and Strengths (CANS)[3] instrument helps to inform decision-making in areas of youth behavioral and emotional functioning, as well as caregiver needs and strengths. The care coordinators complete CANS assessments of CME-enrolled youth at intake, and every three months throughout the course of enrollment. The score for each Needs item ranges from zero - indicating no evidence of need - to three - indicating the need for immediate, intensive action; a score of two or three is indicative of the need to intervene on that item. The score for each Strengths item ranges from zero - identifying the strength as a centerpiece of treatment - to three - indicating that the strength has not been identified; a score or zero, one or two is indicative of the strength being identified in the youth.

The items load onto different subscales that comprise the following CANS domains:

- Life Domains/Functioning - Youths' struggles in major areas of life, such as school, family, [physical] health, etc.
- Child Behavioral and Emotional Needs - The impact of mental health challenges on youth functioning.
- Child Risk Behaviors - The extent to which youth pose a danger to themselves and/or others.
- Caregiver Needs and Strengths - The degree to which caregivers' needs inhibit their parenting.
- Child Strengths - Youth protective factors.

Wraparound Fidelity Index, Short Form

The Wraparound Fidelity Index, Short Form (WFI-EZ) is an instrument that measures the nature of the Wraparound process that an individual family receives, effectively capturing fidelity to the Wraparound model while reducing the time and burden to families of previous versions of the WFI instrument.[4] The WFI-EZ is administered via brief online survey, paper survey, or telephone interview to caregivers and youth (11 years of age or older) at 6 and 12 months after the youth's admission to the CME. The items of the WFI-EZ compose four general domains including basic information about the Wraparound process, the family's individual experiences with Wraparound, the family's satisfaction with the Wraparound process, and the youth's outcomes from involvement in the Wraparound process. The family experiences domain breaks down further into the following five subscales:

- Outcomes-based - The family feels that their involvement in the Wraparound process has improved their access to needed services, and made them more confident in their ability manage problems independently, both presently and in the future as they transition out of formal services.
- Effective teamwork - The Wraparound team members – who are agreed upon by the youth and family – work together and share responsibility for delivering all aspects of the plan of care, based on input from the family.
- Natural/community supports - Services help the youth and family build strong relationships with others in their community (e.g., family, friends, faith), and include them as means of support in the formal Wraparound process as well as in other areas of their lives.
- Needs-based - The Wraparound team helps the family identify and prioritize its service needs, links the family to the appropriate services to address these needs, and regularly reviews its progress towards meeting them.
- Strength- and family-driven - The family is heavily involved in choosing the Wraparound team members, and services are customized for each family to fit their unique values, preferences, and goals.

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[2] Koren, P. E., DeChillo, N., & Friesen, B. J. (1992). Measuring empowerment in families whose children have emotional disabilities: A brief questionnaire. *Rehabilitation Psychology, 37*(4), 305-321.

[3] Lyons, J. (2009). *CANS Executive Summary.* Retrieved from: http://praedfoundation.org/About%20the%20CANS.html

[4] Sather, A., Bruns, E. J., & Hensley, S. (2012). Pilot test of the Wraparound Fidelity Index, Brief Version (WFI-EZ). Wraparound Evaluation and Research Team, University of Washington: Seattle, WA.