ATTACHMENT I

Draft

Los Angeles County
Department of Probation

Practice Principles,
Practice Model Guide
and
Implementation Through the Breakthrough Series Collaborative Model For System Improvement

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Background

"The lives of young people matter. They matter to their families, to their neighbors, and their communities. But for those youth whose lives have taken a wrong turn, who've made poor choices…the kids we've labeled "bad" who we have written off, or for whom we have lost interest, it is these youth whose lives need to matter more. Whether we make the moral, social or economic case, the truth is that we as adults have failed these young people and, if we don't get better at what we do, we all stand to lose…be it lost human potential, loss of family, or increase social costs."[1]

For the past decade the LA County Department of Probation has been working to improve practice seeking to move away from focusing only on detention and rehabilitation of probation youth toward a more holistic approach to working in the context of their families, schools and communities.

Toward this end, early in 2007, the Los Angeles County Board of Supervisors approved the submission of a Title IV-E Youth Welfare Capped Allocation Demonstration Project (CADP) to support flexible funding strategies and improve outcomes for youth and families. The Department of Youth and Family Services and the Probation Department jointly submitted the CADP, which provides flexibility in their use of Title IV-E funds to test the effect of innovative strategies to accelerate efforts to improve outcomes for youth and families in Los Angeles County.

These efforts will build upon system improvements already underway among the Departments and their community partners and the outcomes we will achieve through these efforts include:

- **Reduce the number of youth in congregate care.**
- **Reduce maltreatment of youth in the delinquency system.**
- **Improve the number of children achieving permanency**.

[1] Current Conditions and Possible Directions for Change. (April 2006). Los Angeles County Youth Planning Council.

Why Develop a Practice Model?

A Practice Model is the depiction of what we know about emerging and evidence based practices in the field of juvenile justice.

Juvenile Probation systems across the country are looking for more direction on how to work with youth and their families and community partners to achieve the best outcomes possible.

Practice Models are a growing strategy being used by a variety of disciplines to guide the day to day work that occurs in the field.

Practice Models:

- ☞ Describe the practice case opening to case closure;
- ☞ Are informed by a way of approaching the work (Practice Principles);
- ☞ Includes sequences;
- ☞ Includes techniques; and
- ☞ Reflect evidence based, promising, and best practices in the field.

The LA County Department of Probation Practice Principles and Practice Model are described on the following pages.

The Framework for Practice and accompanying Practice Model challenge every member of the LA County Department of probation to practice to varying degrees, differently than they may have in the past.

If we want to be accountable professionals, then we should develop our practice in a systematic way.

We believe that the incorporation of these practices into our daily work and the adoption of this practice model will over time, safely reduce the number of youth entering placement as well as the recidivism rates of those same youth. It will require strong teamwork between the various units of the agency, and a willingness to look at biases, and personal values that may get in the way of effectively serving families.

About the Evidence Based Practices Included in Our Practice Model

It is important to note that over the course of the past decade juvenile probation services (nationally) has seen a growth in the evidence based services available to meet the needs of children and families involved in the juvenile justice system.

In recent years, use of the term EBP and its synonyms (i.e., proven practice, best practice, effective practice, evidence-based medicine, etc.) has proliferated. From 1900 through 1995, the

term EBP appeared in only 76 Medline citations. From 1995 through 2002, by contrast, 5,425 citations included these words. Most of the literature on EBP pertains to the fields of medicine, mental health, and education; these disciplines were the first to embrace the movement.

Although child welfare and Juvenile Justice have been slow to adopt EBP, several developments, such as state and federal funding initiatives supporting the replication of evidence based child welfare and juvenile justice programs, a special issue of Child Welfare devoted to the topic, and the creation of databases cataloging evidence-based child welfare and juvenile justice practices, indicate that the time for evidence-based child welfare programs and policies is near.

Although many disciplines, including juvenile justice, now use the term EBP, confusion still exists about what it really means. Put most simply, an EBP is an intervention, program, or tool with empirical research to support its efficacy and effectiveness. Efficacy refers to how well an intervention works to bring about change in a targeted area when tested under carefully controlled conditions. These conditions usually include screening and selection of clients who receive the intervention, highly trained interventionists, and intensive supervision. How well an intervention works in a real-world setting defines the essence of its effectiveness. Research typically focuses on establishing the efficacy of an intervention before testing its effectiveness.

EBPs differ in the quality and quantity of available research to support their efficacy and effectiveness. When thinking about EBP implementation in TFC, it is important to understand that EBP is a process that involves the selection of the most appropriate and effective interventions when providing services. EBP is "clinical practice that is informed by evidence about interventions, clinical expertise, and patients' needs, values, and preferences and their integration in decision making about individual care". Service providers adopting EBP do not simply implement an intervention because it has been deemed evidence-based; rather, they carefully integrate their clinical expertise with available research evidence to make decisions about the best interventions for an individual client.

Clinical expertise and judgment are critical components of effective EBP implementation. Service providers using EBPs must constantly use their judgment and draw on their expertise to determine if a practice, as described in this manual, is appropriate for a given client. Additionally, service providers may need to adapt an EBP to meet the unique needs of a client. Thus, the importance of clinical judgment and the potential need for adaptation must never be overlooked when implementing EBP.

The evidence based practices to be implemented over time within the Department of Probation Practice Model include Functional Family Therapy, Multi-system Therapy, Wraparound Services, Family Integrated Transition, Family Preservation Services, and Aggression Replacement Training.

Many of these practices are embedded in the Los Angeles County Practice Model **including the following key evidence based practice components**:

- Family Engagement Throughout the Life of a Case
- Assessment of Need and Informed Referrals with Clear Criteria for FFT, MST, Wrap, Family Preservation and Community Outreach
- Multi-Disciplinary Assessment
- Implementation of Family Foster Care and Treatment Foster Care
- Youth Permanency and After Care Planning
- Case Transfer Meetings
- Functional Family Probation and Parole

In an effort to assist the field in the decision making process and to improve the consistency in service utilization across the county, we are in the early stages of designing a process where referrals to services are approved, based on whether or not the youth and family meet the specified focus for each service. Additionally we are developing a mechanism to review the use of each of these services at designated intervals, rather than automatically approving additional months of service with little to no rationale.

These criteria should ensure that we more effectively target the use of each to achieve improved outcomes for youth and their families based on the findings from the Risk Assessment and goals of the case plan.

Framework for Practice (Practice Principles)[2]

1. The most desirable place for youth to grow up a in a safe, nurturing, and caring family. As such the end goal of devising improved interventions is to prevent institutionalization of youth and to the extent possible while ensuring public safety, keep them with their families and in their communities.
    - We provide prevention and intensive early intervention services so that we do not have to remove youth from their homes.
    - We search for kin to support youth when they cannot live in their own homes.
    - We facilitate a permanent connection for youth.

2. The purpose of the Probation System is to understand and meet the unique needs of youth and their families; seeking to increase protective factors and decrease risk factors.
    - Youth need to be treated differently from adults in systems of care, and appropriate treatment strategies should be defined within a youth's development framework.
    - Youth and families have strengths and we need to learn about these strengths in order to effectively meet their needs.
    - We conduct a comprehensive assessment, seeking to learn as much as possible about the youth and their family in order to ensure that the services provided meet specific, individualized needs.
    - The "victim/predator" dichotomy is not a helpful construct in serving youth –we recognize that youth have needs regardless of the system they are in and our job is to learn what they need and minimize the labeling.
    - Every youth has potential and is served individually based on their history and experiences

3. The intentional and meaningful involvement of families and youth in service planning and delivery is foundational to system success.

4. Services and treatment interventions should be strength-based and individualized, building on the capacities, skills, knowledge and assets of the youth, family and community.

    - Services are directly informed by the assessment process.

[2] These practice principles were informed by the Georgetown Center for Juvenile Justice Reform Breakthrough Series Collaborative on Child Welfare and Juvenile Justice Integration.

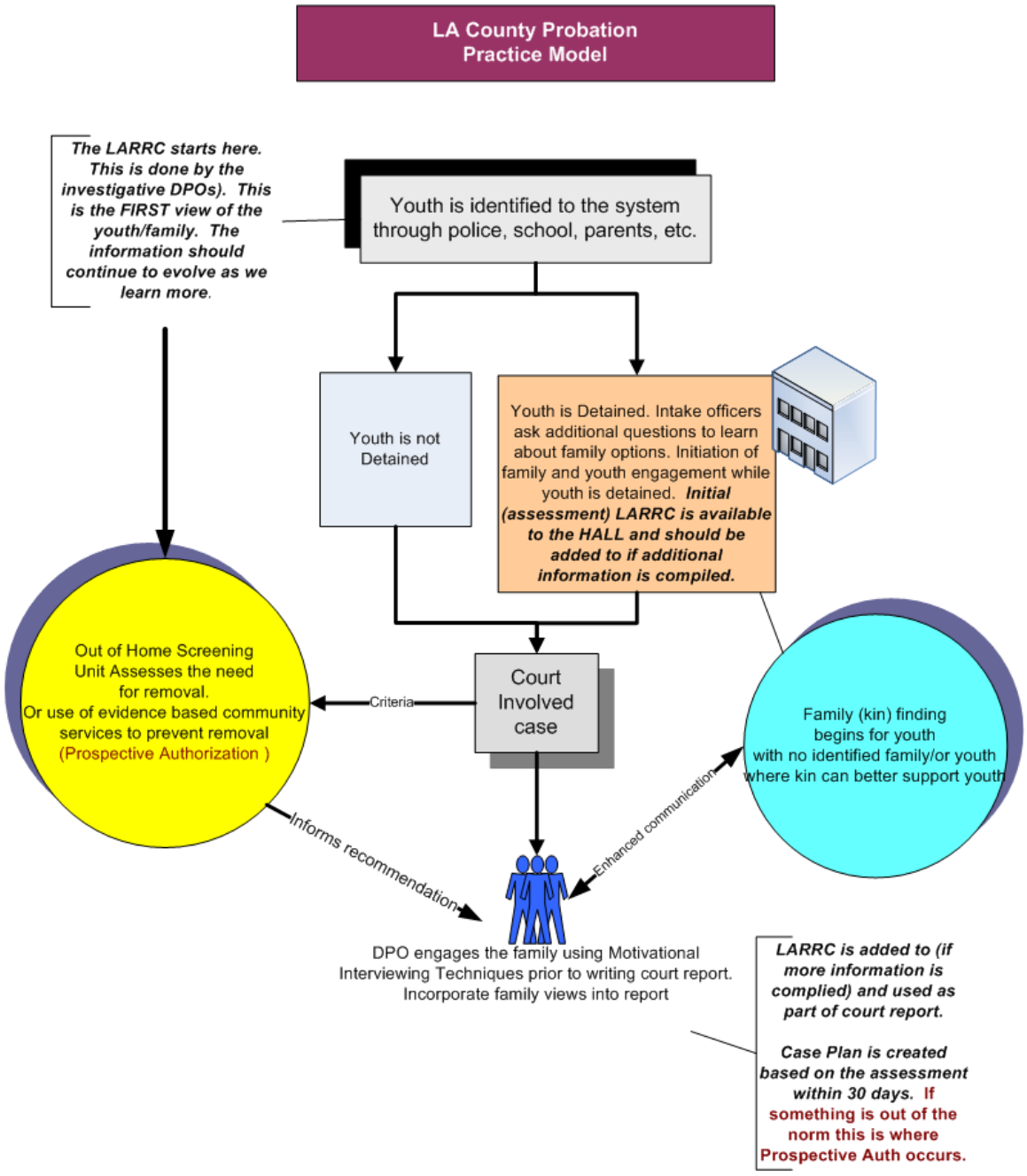
5. The youth's behavioral issues must be assessed and treated in the broader context of family, school, peer, and neighborhood.

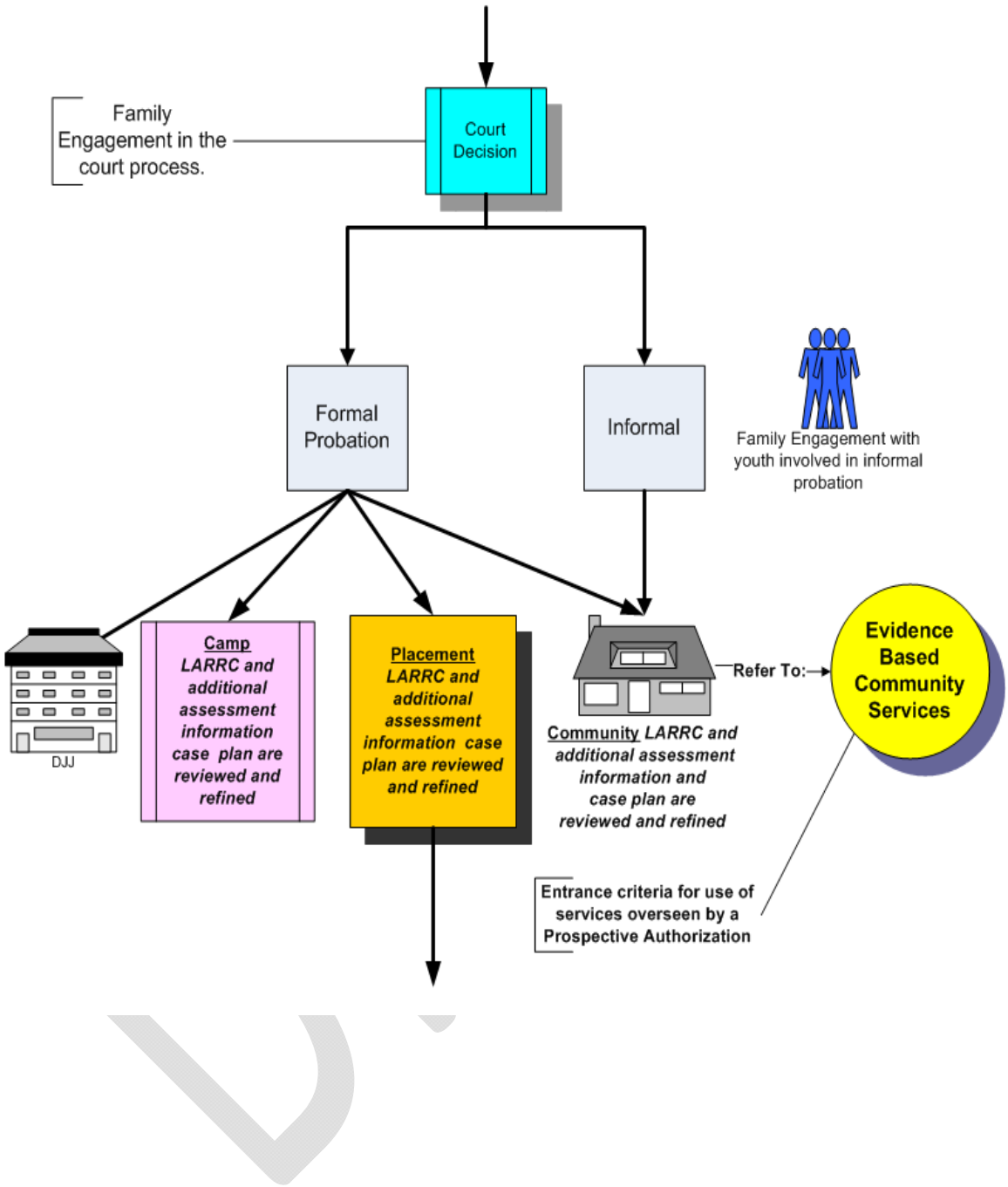
6. Delivery of services to youth and their families honors and respects the beliefs, values, and family practices of different cultural, sexual orientation, racial, religious, and ethnic groups.
    - We actively seek to eliminate disproportionality and disparities as it relates to the need for access to utilization of and/or quality of services received by youth of color.

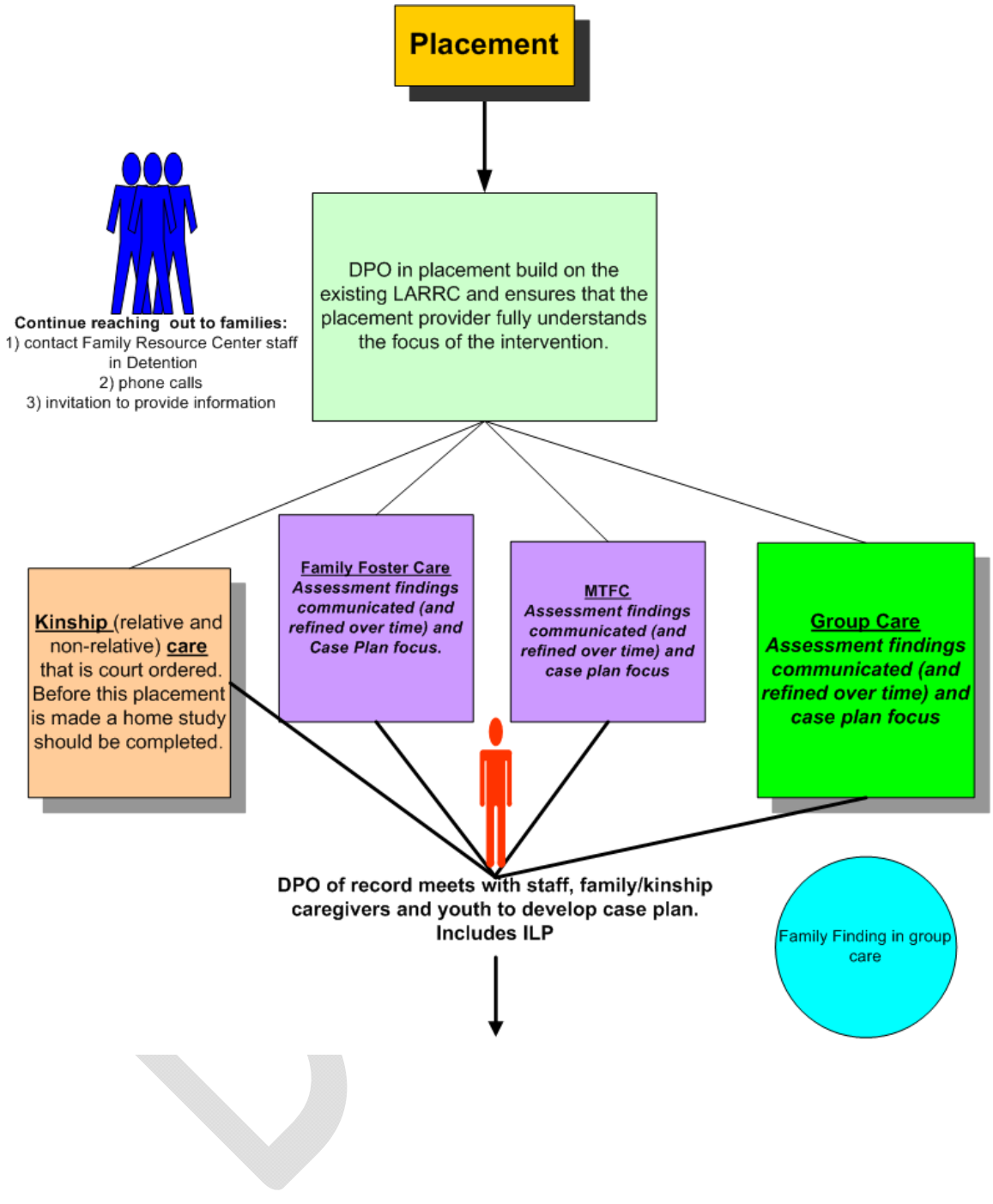
7. We recognize and address the impact of poverty and economic status on family functioning and youth development.

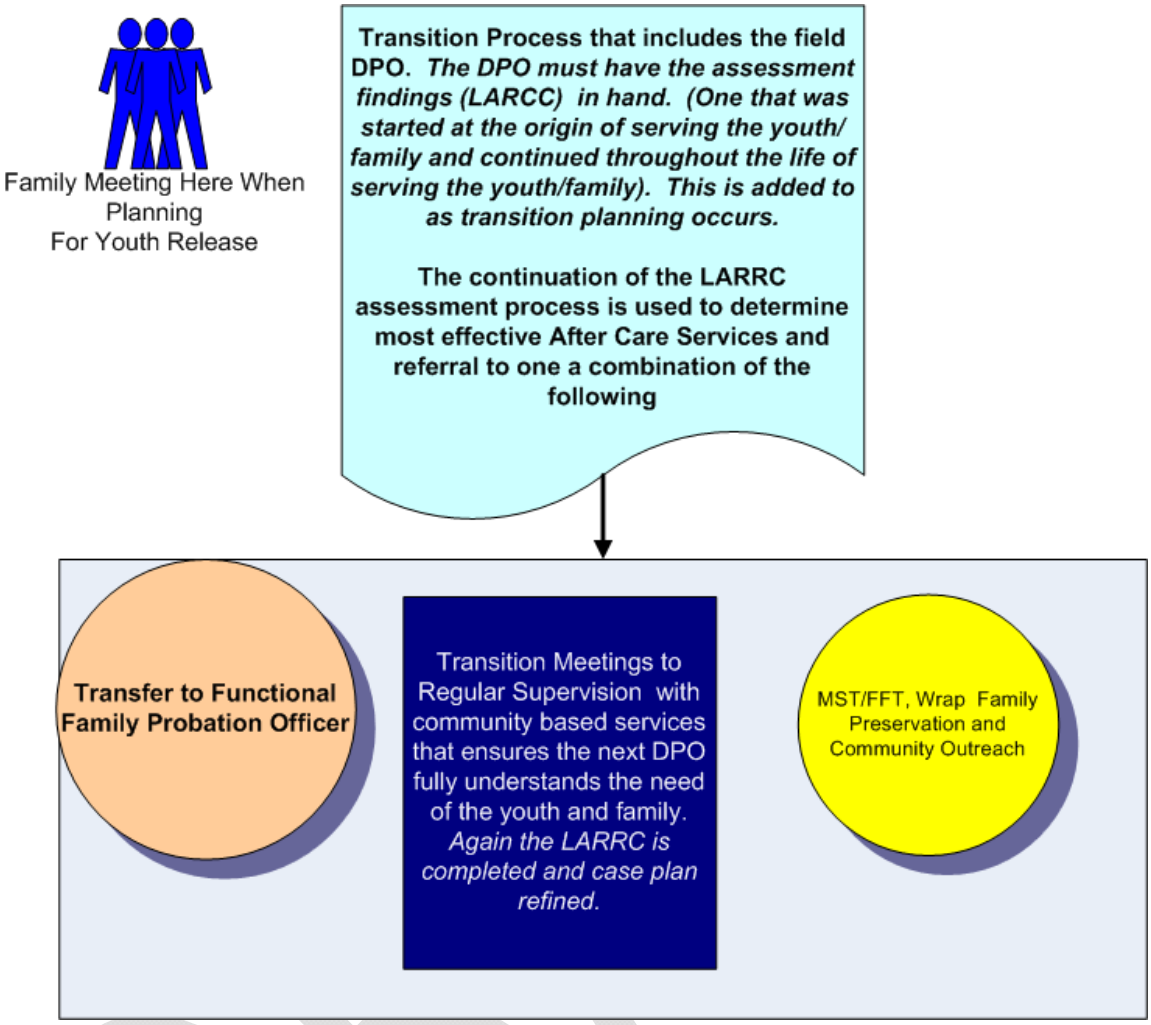
8. It is our preference to use services and treatment interventions that are research based and evidence informed.
    - This approach informs the way we plan, organize and construct services.

Practice Model Flow Chart




Family Engagement in the court process.
Court Decision
Formal Probation
Informal
Family Engagement with youth involved in informal probation
DJJ
Camp
LARRC and additional assessment information case plan are reviewed and refined
Placement
LARRC and additional assessment information case plan are reviewed and refined
Community LARRC and additional assessment information and case plan are reviewed and refined
Refer To:
Evidence Based Community Services
Entrance criteria for use of services overseen by a Prospective Authorization


Placement
DPO in placement build on the existing LARRC and ensures that the placement provider fully understands the focus of the intervention.
Continue reaching out to families:
1) contact Family Resource Center staff in Detention
2) phone calls
3) invitation to provide information
Kinship (relative and non-relative) care that is court ordered. Before this placement is made a home study should be completed.
Family Foster Care
Assessment findings communicated (and refined over time) and Case Plan focus.
MTFC
Assessment findings communicated (and refined over time) and case plan focus
Group Care
Assessment findings communicated (and refined over time) and case plan focus
DPO of record meets with staff, family/kinship caregivers and youth to develop case plan. Includes ILP
Family Finding in group care


Family Meeting Here When Planning
For Youth Release
Transition Process that includes the field DPO. The DPO must have the assessment findings (LARCC) in hand. (One that was started at the origin of serving the youth/ family and continued throughout the life of serving the youth/family). This is added to as transition planning occurs.
The continuation of the LARRC assessment process is used to determine most effective After Care Services and referral to one a combination of the following
Transfer to Functional Family Probation Officer
Transition Meetings to Regular Supervision with community based services that ensures the next DPO fully understands the need of the youth and family. Again the LARRC is completed and case plan refined.
MST/FFT, Wrap Family Preservation and Community Outreach

Implementation Process for Increased Family Engagement

History of the Breakthrough Series Model for Change

The Los Angeles County Department of Probation has decided to implement the family engagement aspect of the Practice Model using the Breakthrough Series Collaborative Model for Change.

The BSC methodology was developed in 1995 by the Institute for Healthcare Improvement (IHI) and Associates in Process Improvement (API). This quality improvement method has been used extensively in the field of health care for more than a decade. The IHI has led BSCs in over 25 different topic areas, including reducing delays and waiting times in emergency rooms; reducing Caesarean section rates; improving end of life care; and improving critical care.

In December 2000, Casey Family Programs (Casey), a national operating foundation based in Seattle, Washington, joined with the IHI to learn the BSC methodology so that it could be transferred to the child welfare field. Since 2000 Casey Family Programs has conducted BSCs in a variety of topic areas including Recruitment and Retention of Resource Families, Supporting Kinship Caregivers, Implementing Differential Response, Reducing Disproportionality and Disparate Outcomes for Children and Families of Color, Increasing Educational Stability for Children in Foster Care.

In 2008 Casey Family Programs partnered with the Georgetown Center for Juvenile Justice Reform launching a Breakthrough Series Collaborative on the Integration of Juvenile Justice and Child Welfare Practice. Los Angeles County Department of Probation is one of the seven teams selected to participate in this BSC.

The leadership from the Department of Probation has embraced the methodology and decided to use it in the implementation of this Practice Model.

***What is the Breakthrough Series Model for Change*?**

The Breakthrough Series Model for Change was developed for the following reasons:

- Large system long range planning seldom results in practice change that is sustained over time due to leadership changes and no real line staff and family buy in.
- It provides the ability for systems to learn in "real time" what works and what does not work in serving youth and families—before they implement HUGE shifts.
- It provides the ability to learn from the people who do the work everyday.
- It keeps the actions small, simple and "doable".

Several critical characteristics of the BSC Model for Change methodology help agencies quickly test and then fully implement these new practices in ways that are tailored to the individual agency and therefore sustainable over time.

1) *Rapid Plan-Do-Study-Act (PDSA) cycles are used*—PDSA cycles are one of the keys to the rapid changes that are witnessed in a BSC. Instead of spending weeks, months, or years planning for massive changes, teams are encouraged to test an idea as soon as it occurs. Teams are encouraged never to plan more than they can actually do—and if they can't complete their test rapidly, they need to make their test even smaller. The spirit of conducting rapid small-scale changes is captured in the phrase "What can you do by next Tuesday?" (See the visual below)

2) *Anyone can have and test ideas*—Ideas for practice and system improvement do not come only from management. Juvenile Probation Officers, Supervisors, Administrators all are encouraged to test their ideas and share their learnings with others within the context of a standard framework (The Practice Standards). This allows all participants to draw upon their own expertise to help improve the system. With checks and balances built in through supervisory consultation, this approach encourages the innovative probation officer to try out ideas that they believe will improve outcomes for youth and families.

3) *Consensus is not needed*—Instead of spending time trying to convince one another of a "better way" of practice, the BSC Model for Change Methodology encourages participants to *test* their ideas in the field rather than simply *talking* about their ideas in a meeting room. Participants do not need to agree with one another for an idea to be tested; the convincing comes naturally once people start to see the results of the tests. The ensuing conversations are about real results and feedback rather than assumptions or hypothetical situations.

4) *Changes happen at all levels (not just at the top)*—All people have some level of influence, whether they are the Administrator level, or a Probation Officer. It is important that every person involved is willing to test and make changes at his or her own level. This helps everyone break free of the "if only they [usually management] would do x, everything would be better" mentality.

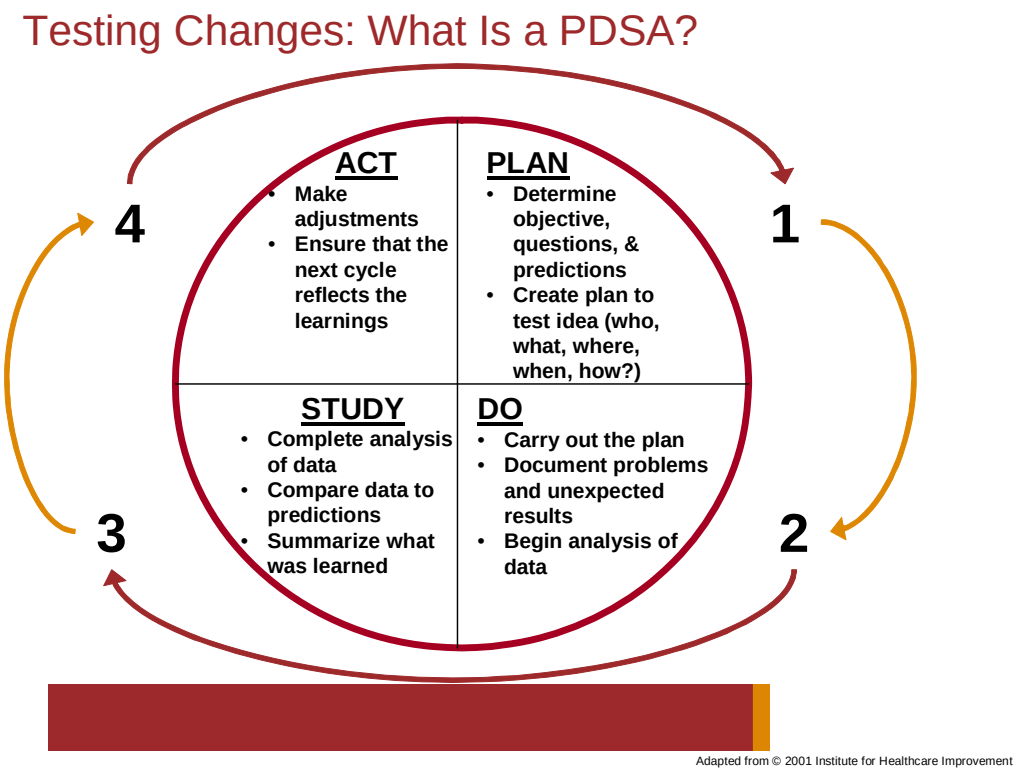
5) *All BSC work is grounded in a standard comprehensive framework*—Each BSC is based upon a comprehensive framework that guides the work of the teams. The framework for the Department of Probation Practice Model identifies seven components of an ideal system for serving youth and their families involved in the juvenile justice system.

6) *Ideas are "shared relentlessly"*—This methodology is based on effective sharing between peers. It is an expectation that when small tests of change are successful,

probation officers and supervisors will talk about these successes to one another—and practices will spread through word of mouth.

7) *Successes are spread quickly*—Many pilot projects begin and then remain in a pilot site indefinitely, or, in other instances, once a "project" is completed, the pilot disappears. The learnings from the pilot may not be effectively communicated to the rest of the system, the learnings may not seem applicable to other sites, or resources may not be committed to spreading the new practice model—and opportunity for system improvement is lost. The BSC Change Model methodology prevents this from happening. Once a change has been tested successfully, leadership considers the spreading of this practice across the agency. As successful changes continue to be spread in real time through natural peer-to-peer relationships, the culture of "sharing relentlessly" also spreads throughout the jurisdiction, creating "a micro-culture of innovation."

The visual below depicts the Plan-Do-Study-Act cycle.



Phasing In Aspects of the Practice Model

The leadership of the Department of Probation made a decision to embrace a "doable" pace --phasing in system changes in three Phases:

Implementation Phase	Component of the Practice Model
Phase I	Family Engagement Along the Life of a Case: • When the youth is in Detention • Prior to completion of the court report • During the Cross System Assessment • During treatment planning while a youth is in care • Prior to the release of a youth from care • During any transfer meeting
Phase II (a):	Assessment of Need and Informed Referrals with Clear Criteria –the LARRC will serve as the foundation for this assessment. It will be augmented with additional assessments in the areas of mental health, substance abuse and education.
Phase II (b):	Implementation of Family Foster Care and Multi Dimensional Treatment Foster Care
Phase II (c):	Intensive Services and Treatment in Group Care
Phase II (d):	Youth Development Initiatives/After Care Services and Use of Transitional Services for Youth Aging Out of Care
Phase II (e):	Case Transfer Meetings
Phase II: (f):	Functional Family Probation and Parole

Phase I: Family Engagement Along the Life of a Case

In order to learn accurate information it is imperative that families are engaged as early as possible in the process and throughout the service delivery process.

Family engagement necessitates re-evaluating and re-thinking the way we fundamentally intervene with families. It involves having an unwavering conviction that families can change. If an individual does not believe this, then they have minimal ability to impart this needed hope and conviction to the families they serve.

The process of finding new ways of thinking about the relationship between family members and professionals grows from the realization that the way we have traditionally practiced did not serve us well. Although we have come a long way from the days of "blame and shame" we are still not to the point where we are seeing the family as real partners in the process of change. We must demonstrate that it values families by radically altering the premise on which social services are based, moving from "replacing families" to supporting and strengthening them. We must look beyond exemplary or pilot programs scattered her and there, to a place where family centered values infuse all aspects of the system.

When we take the time to really listen to families and what they tell us about their treatment by the "system", we continue to hear deeply felt feelings of frustration, anger and pain. If we are to realize the potential inherent in relationships between family members and professionals, it is important to recognize that neither can accomplish their goal without the other. All players are a necessary part of the whole, with each bringing their own special set experiences, skills and knowledge to the process.

Those who work in juvenile justice encounter families of diverse cultural and ethnic background. Because ethnicity is such an integral part of people's makeup and inextricably linked to who they are and how they live, DPOs cannot afford to overlook or profess ignorance of their client's cultures. The first step in developing cultural awareness is to scrutinize our own feelings and beliefs about ethnic groups other than our own. Everyone who grows up in society has racial and ethnic stereotypes. They may be conscious or unconscious, subtle or obvious. What is important is recognizing and acknowledging these stereotypes and biases. Lack of understanding of how these biases are impacting their social work practice can create barriers to service deliver and each barrier could represent a lost opportunity to help.

Rapid Family and Youth Engagement When a Youth is in Detention

We begin the process of family engagement when youth are in detention. This occurs through the following:

- *We Seek To Understand The Family And Youth Perspective Of What Has Happened To Them.*
- *We Practice Full Disclosure and Transparency of Decision Making*
  - *We explain to the family the steps of the process and expectations.*
  - *We explain the rationale for any decisions we make.*
- *We Honor The Family's Culture*
  - *Entering another family's culture is a process that requires being a student of how culture impacts decision making, parenting and family functioning.*
  - *We do not assume that we understand the family without first learning about their history, family rituals and experiences.*
  - *We do not view the family through our own cultural lens.*
- *We Attend to our Language*
  - *We ask assessment questions in a way that engages the family and youth.*
  - *We make certain that we do not use terms or jargon that are unfamiliar.*
  -
- *We seek to avoid, to the extent possible, actions that minimize/undermine parents' expertise of their own family system. People are more disclosing, open, and cooperative if they don't feel threatened and judged.*

"Words are a form of action, capable of influencing change."

Small Tests of Change To More Fully Engage Families Along the Pathway –Case Opening to Case Closure

Early and Rapid Family and Youth Engagement in Detention
Possible Senior Leader Activity Talk with Detention Bureau Chief about establishing Detention and Placement Bureau Rapid Family and Youth Engagement Committee, inclusive of youth and parents. **DETENTION** Identify one unit of the detention centers willing to ask different questions to youth in detention or to engage families when they visit.

Early and Rapid Family and Youth Engagement in Detention
Small Test of Change: Plan: Identify staff members willing to engage youth and families when youth are in detention. Do: Meet with a youth who entered detention within 24 hours of being detained. Study: When the youth and family are engaged early do they Adjust:
Small Test of Change: Test the kind of family/youth information will be gathered
Small Test of Change: Test the best type of form or document for collecting family information/data.

Family Engagement Through Family Meetings At Various Points Along The Pathway

Family Team Meetings are planning and decision-making processes that includes parents, caregivers, youth, social workers and other service providers. They may also include extended family, friends, members of community groups, and other community partners.

The Foundational beliefs around holding family team meetings include:

- A group can often be more effective in making good decisions than an individual
- Families are the experts on themselves—we need to engage them as experts.
- When families are included in decision making, they are capable of identifying their own needs and strengths and are much more committed to the successful completion of the plan.
- Members of the family's own community add value to the process by serving as natural allies to the family and as experts on the community's resources

While a Family Team Meeting can be held at anytime throughout the case process, DPOs should attempt to hold them at the following times:[3]

- Prior to completion of the court report
- During the process of completion Comprehensive Assessment and Case Plan
- When treatment planning while a youth is in care
- Prior to the release of a youth from care
- During any transfer meeting

Honoring Culture, Race and Ethnicity

[3] These specific planning/decision making points are highlighted in the Practice Model Flow Chart.

One of the benefits of Family Meetings is the ability they provide to learn about the cultural, racial and ethnic background of the family and how their background impacts parenting decisions.

Culture includes race, religion, ethnicity, family values, lifestyle, family composition, customs, values and beliefs. The family itself is the most important source of information about its unique characteristics, historical roots, and cultural values.[4] Culturally competent workers can help families to have a positive experience in planning and participating in parenting and other family access time by:

- Respecting the client's perspective.
- Listening well enough to learn about people who are different from themselves.
- Avoiding judgment from bias, stereotypes, or cultural myths.
- Asking the family to explain the significance culture has for them, especially regarding family traditions, youth rearing and discipline practices, spiritual beliefs and traditions.

The cornerstones to effective Family Meetings are as follows:

- ***Everyone desires respect***
- ***Everyone needs to be heard***
- ***Everyone has strengths***
- ***Judgments can wait***
- ***Partners share power***
- ***Partnership is a process***

The Intent of the Family Team Meeting Is To:

- Engage the family and secure an investment in working together.
- Establish and continue to build the relationship between the DPO and the family
- Ensure a common definition of success
- Explore appropriate services that would be effective in helping the youth and family.
- Learn about family existing strengths and resources.
- Identifying a member of the team that will stay connected to the family—and help the team assess progress toward to an agreed upon definition of success.
- Being very specific about the process—and the timeframes—create a visual aide to show the flow of the case through the system. FULL DISCLOSURE!

Some of the considerations in planning Family Team Meetings are highlighted below.

Is there a clear, open-ended purpose? The purpose should be written simply, without jargon. It should also be open-ended with many possibilities for planning, decision making, and action.

4 Berg, I.K. & Kelly, S. (2000). Building Solutions in Youth Protective Services. New York: Norton.

Do the invited participants, especially family members, agree to the purpose*?* Family Team Meetings are voluntary processes; people can choose to attend. It is critical that the purpose be crafted in such a way that participants can both get their interests met and feel comfortable with the process. In other words, a successful FTM will be one where the participants want to be there and see it as relevant to them and their lives.

"People tend to support and be successful in directions that they themselves create."

Is the DPO open and willing to consider the family's ideas at this time? Sometimes the facts of the case determine decisions and actions that need to be taken. If a decision is already made, it is imperative that the meeting not be held for the purpose of making/justifying that particular decision or simply getting the family to agree with it. Likewise, if there is only one outcome that is potentially acceptable to the agency representative, then it is likely not a good time for a Family Team Meeting. Remember that family-centered practice is all about choice and empowerment. Without choice and the power to make plans and decisions, participants will feel that the meeting is a waste of time—making it a frustrating experience. Family Team Meeting should always be centered on issues where families can participate in the decisions that affect them.

Can the right people be there? By definition, a Family Team Meeting is a group process. It requires that the circle of influence and decision involve those most important in the life of the youth. This could include numerous family members like parents, siblings, grandparents.

DPOs need to set the ground rules to ensure a productive meeting:

- Engage the family in setting their own rule
- No disrespectful language, behavior or negative tones—team members have the right to call one another if they observe these behaviors.
- No talking over another person.
- No cell phones or pagers during the meetings
- Unless it is an emergency—no one leaves the meeting until the meeting is done

A Good Facilitator:

- Protects ideas and individuals from attack or being ignored through the provision of a safe, supportive environment to permit communication
- Models supportive, non-threatening, respectful behavior.
- Understands the difference between effective sharing of self—and telling people what to do.
- Finds ways to use humor to diffuse conflict—although we don't want to be afraid of conflict
- Balances the fine line between being a part of the team—and facilitating the process.

- Periodically summarizes, clarifies, reframes and identifies areas of agreement to assist the group.
- Ensures that the family's voice is heard and validates the feelings of all family members. Seeks to find the balance between task and process.
- Invites diverse perspectives without taking sides.
- Is sensitive and responsive to nonverbal cues. Manages conflict and emotions.
- Moves the group through the problem-solving/decision-making process, maintaining reasonable time frames.
- Accurately records information and decisions. Provides a copy of the safety/action steps at the completion of the staffing to all participants.

Ten Tips For DPOs For Effective Family Meetings[5]

1. Be on time.
2. Assist parent(s) with transportation if needed.
3. Explain the purpose of the meeting in advance to non-agency attendees.
4. Ensure that every person in the room feels that their perspective is validated.
5. Be sensitive and respectful of the serious nature of the staffing. Parents and others are watching, not just during the meeting but before the meeting begins and after it ends.
6. Schedule adequate time. While it is important to adhere to timeframes for the meeting, remember we are dealing with critical and emotional decisions in the lives of families and whatever time is needed to make a quality decision should be expended.
7. Come organized to present a summary of the situation and prepared with ideas and a recommendation, while receptive to the opinions and ideas of the other participants.
8. Be honest and fair in what you say. Discussion should be strengths-based, direct and straightforward.
9. Assist in keeping the group focused and productive. Invite others to share their perspectives, information and opinions

[5] *This is borrowed in part from Annie E. Casey Family to Family Team Decision Making Model*

Phase II(a): Motivational Interviewing, Assessment of Need and Case Planning

Motivational Interviewing

Motivational interviewing is a directive, client-centered approach for eliciting behavior change by helping youth and their families explore and resolve ambivalence. It is a more focused and goal-directed approach to working with youth and families. It is an evidence based practice that has been shown to effectively change youth and family behaviors.

Motivational interviewing recognizes and accepts the fact that clients who need to make changes in their lives approach counseling at different levels of readiness to change their behavior.

Motivational interviewing is non-judgmental, non-confrontational and non-adversarial. The approach attempts to increase the youth and family's awareness of the potential problems caused, consequences experienced, and risks faced as a result of the behavior in question. Alternately, DPOs help clients envisage a better future, and become increasingly motivated to achieve it. Either way, the strategy seeks to help clients think differently about their behavior and ultimately to consider what might be gained through change.

Motivational interviewing is based upon five general principles:

1. Express empathy, guides therapists to share with clients their understanding of the clients' perspective.
2. Develop discrepancy, guides therapists to help clients appreciate the value of change by exploring the discrepancy between how clients want their lives to be vs. how they currently are (or between their deeply-held values and their day-to-day behavior).
3. Roll with resistance, guides therapists to accept client reluctance to change as natural rather than pathological.
4. Support self-efficacy, guides therapists to explicitly embrace client autonomy (even when clients choose to not change) and help clients move toward change successfully and with confidence.
5. Avoid argumentation (and direct confrontation). Arguments create resistance.

The main goals of motivational interviewing are to establish rapport, elicit change talk, and establish commitment language from the client. Motivational Interviewing is a critical component of the LARRC assessment process.

Use of the LARRC Case Opening to Case Closure

A comprehensive family and youth assessment is a process of identifying family dynamics and interactions, youth risk, academic status and youth well being. It requires engaging the family and youth in an extended discussion. A good assessment goes beyond simply determining level of risk to exploring connections, strengths and protective factors of the youth and family system. A family- centered assessment is the foundation of effective case planning-- by contributing to key decisions regarding steps to be taken, services/resources to be used and outcomes achieved.

Without a comprehensive assessment, the case planning process is uninformed and is less effective in changing behaviors that resulted in youth involvement in the juvenile justice system.

In her book *Strengthening High-Risk Families*, Lisa Kaplan suggested that the most critical part of the assessment is the **establishment of the relationship**. She goes on to emphasize that those who work with youth and families must show genuine respect for families as full partners in the process and join families where they are; not where the worker wants them to be. The more involved the family in verbalizing and prioritizing their needs, the greater the likelihood that they will be committed to change.[6]

The LARRC involves assessing 60 areas that of a youth and family life. In the spring of 2009 the process of tabulating the results of the LARRC was retooled and risk/strength scores are reflected in the following areas:

Risk to Community/Risk of Recidivism (made up of scores from the following domain areas):

- Delinquent Behavior
- Delinquent Affiliation
- Delinquent Orientation
- Substance Abuse

Criminogenic Factors

- Family Interactions
- Interpersonal skills
- Social Isolation
- Academic Engagement
- Self Regulation

Completing the LARRC is a "process," not simply the completion of a "tool." This does not mean that tools are superfluous; they are helpful in documenting needs or in stimulating the conversation about assessment issues. It does mean, however, that the engagement of family members in a discussion that is individualized to their situation is vital.

[6] Kaplan, Lisa and Girard, Judith Strengthening High Risk Families 1994 Lexington Books

Assessment in the above domain areas is critical to fully assessing the needs of youth and their families and to crafting effective case plans. The only missing domain area that needs assessment is mental health. The LARRC will be augmented through the use of an ancillary assessment tool to capture mental health status. (***See Multi-Disciplinary Assessment in this chapter)***

The LARRC Assessment is completed, reviewed and refined along the pathway of serving youth and families, specifically at the following decision points:

- ➔ During the Initial Investigation
- ➔ Review of the LARRC –with some additions during the time in the Hall
- ➔ Review of the LARRC—with some possible additions prior to writing the court report
- ➔ Review/refinement of the LARRC-when placing a youth in out of home care
- ➔ Review/refinement of the LARRC prior to transition from out of home care
- ➔ Review/refinement of the LARRC during the After Care process

It is important to understand that that the way we ask questions and compile information during an assessment generates an experience for the family and powerfully impacts how subsequent work unfolds. In order to fully engage families in the assessment process, the DPOs are encouraged to consider the use of strength focused questions. *(A list of possible questions to engage youth and caregivers is included in the attachment.)*

Multi-Disciplinary Assessment

It is critical to remember than an assessment generates experience….

A multi-disciplinary assessment of appropriate placement includes information from as many available sources as possible. A multi-disciplinary assessment is multifaceted and consists of direct observation, a face-to-face interview, and interviews with parents/other adults, and family history. It includes consideration of mental health needs, substance use, educational needs and family functioning.

As many as 65% of juvenile justice youth have mental disorders, and as many as 40% of those youth have never received treatment prior to court involvement. Youth within the juvenile justice system are at high risk for psychiatric conditions, and these conditions may have contributed to the risk of offending, or may interfere with rehabilitation.

When judges have accurate mental health, substance use, educational and family information, dispositions can include appropriate treatment, hopefully improving rehabilitation and reducing recidivism.

Case Planning

Collecting and organizing comprehensive assessment information is not an end in itself; it must be used in focused ways in the service plan Effective case planning is a natural byproduct of a comprehensive assessment. When families have been active parts of an assessment process it is much easier to put that information to use in creating a service plan that really addresses what the family and youth need in order to be able to live together –so that community safety or youth safety is not jeopardized. The least effective strategy in service planning is for the DPO to develop a plan in the office and bring this plan to the families. This process communicates to the family that the DPO "knows best" about what they need and minimizes the youth and family's control over their own destiny.

Families should help guide the process of determining what interventions could best address their situation, within the context of a shared commitment to making necessary changes. This process should be transparent – the DPO should share the tools and information being used to build the service plan. The DPOis in an excellent position to coordinate and involve other service providers, specialized resources, and the family's resources toward changing youth behaviors and family dynamics.

This process of going from information to judgments is critical. There is no ready "prescription" for how these judgments are made; we must train staff to make these essential judgments.

Description of the Evidence Based and Best Practices Used in Los Angeles County

A strong assessment leads to a strong case plan using services that have optimal chance of changing behaviors that have caused the child and family to be involved with the system. Below please find descriptions of each of the evidence based services available to children, youth and families in Los Angeles County.

Multi-Systemic Therapy

Multi-systemic Therapy (MST) was developed in the late 1970s to address several limitations of existing mental health services for serious juvenile offenders.

Treatment efforts, in general, have failed to address the complexity of youth needs, being individually-oriented, narrowly focused, and delivered in settings that bear little relation to the problems being addressed (e.g., residential treatment centers, outpatient clinics). Given overwhelming empirical evidence that serious antisocial behavior is determined by the interplay of individual, family, peer, school, and neighborhood factors, it is not surprising that treatments of serious antisocial behavior have been largely ineffective. Restrictive out-of-home placements, such as residential treatment, psychiatric hospitalization, and incarceration, fail to address the known determinants of serious antisocial behavior and fail to alter the natural ecology to which the youth will eventually return. MST is one treatment model that has a well-documented capacity to address the aforementioned difficulties in providing effective services for juvenile offenders.

Brief Description of Intervention

MST is a pragmatic and goal-oriented treatment that specifically targets those factors in each youth's social network that are contributing to his or her antisocial behavior. Thus, MST interventions typically aim to improve caregiver discipline practices, enhance family affective relations, decrease youth association with deviant peers, increase youth association with prosocial peers, improve youth school or vocational performance, engage youth in prosocial recreational outlets, and develop an indigenous support network of extended family, neighbors, and friends to help caregivers achieve and maintain such changes. Specific treatment techniques used to facilitate these gains are integrated from those therapies that have the most empirical support, including cognitive behavioral, behavioral, and the pragmatic family therapies.

MST services are delivered in the natural environment (e.g., home, school, community). The treatment plan is designed in collaboration with family members and is, therefore, family-driven rather than therapist-driven. The ultimate goal of MST is to empower families to build an environment, through the mobilization of indigenous youth, family, and community resources that promotes health. The typical duration of home-based MST services is approximately 4 months, with multiple therapist-family contacts occurring each week.

Although MST is a family-based treatment model that has similarities with other family therapy approaches, several substantive differences are evident.

- ***First, MST places considerable attention on factors in the adolescent and family's social networks that are linked with antisocial behavior.*** Hence, for example, MST priorities include removing offenders from deviant peer groups, enhancing school or vocational performance, and developing an indigenous support network for the family to maintain therapeutic gains.
- ***Second, MST programs have an extremely strong commitment to removing barriers to service access (see e.g., the home-based model of service delivery).***
- ***Third, MST services are more intensive than traditional family therapies (e.g., several hours of treatment per week vs. 50 minutes).***
- ***Fourth, and most important, MST has well-documented long-term outcomes with adolescents presenting serious antisocial behavior and their families.*** The strongest and most consistent support for the effectiveness of MST comes from controlled studies that focused on violent and chronic juvenile offenders.

Empowering Caregivers to Manage Future Difficulties

The ultimate goals of MST are to provide the youth's primary caregivers with the skills and resources they need to address independently the difficulties that arise when rearing teenagers with behavioral problems and to give youth the skills to cope with family, peer, school, and neighborhood problems.

- MST focuses on changing the known determinants of offending, including characteristics of the individual youth, the family, peer relations, school functioning, and the neighborhood.
- MST treatment plans are designed jointly with family members and are family-driven rather than therapist-driven.

Evidence of MST Effectiveness

Research has shown that youth anti-social behavior is multi-determined from factors across the youth's social network. Thus, treatment must have the capacity to address a broad range of problems.

The first controlled study of MST with juvenile offenders was published in 1986, and since then, numerous randomized clinical trials with violent and chronic juvenile offenders have been conducted. In these trials, MST has demonstrated:

- reduced long-term rates of criminal offending in serious juvenile offenders,
- decreased recidivism and re-arrests,
- reduced rates of out-of-home placements for serious juvenile offenders,
- extensive improvements in family functioning,
- decreased behavior and mental health problems for serious juvenile offenders,

- favorable outcomes at cost savings in comparison with usual mental health and juvenile justice services.

Functional Family Therapy

Functional Family Therapy (FFT) is a family-based prevention and intervention program that has been applied successfully in a variety of situations to assist youth and their families.

Brief Description of Intervention

The model consists of a systematic and multi-phase intervention map that provides a framework for clinical decisions, within which the therapist can adjust and adapt the goals of the phase to the individual needs of the family. The three intervention phases are as follows:

Phase 1: Engagement and motivation

Phase 2: Behavioral change

Phase 3: Generalizations are sequentially linked to specific goals for each family interaction.

The range of treatment is three to 30 sessions over a three-month period, with a median timeframe of 12 sessions. This is consistent with current practice and can be applied across agencies for youth with multiple needs. FFT can be conducted in a clinic setting, as a home based model or as a combination of clinic and home visits. FFT program implementation targets teams of up to eight clinicians who work together by regularly staffing cases, attending follow-up training, and participating in ongoing telephone supervision.

Family and Youth Engagement and Cultural Perspectives

Family Perspective

In a recent article regarding FFT in King County Washington, parents noted that FFT worked for their youth because of "the emphasis on working with the youth as part of the family (Loughran, 2002). The therapist focused on real, every day solutions to dealing with missed curfews, truancy and drug use. Families learned not to blame the youth or the parents but to talk about differences and talk about attainable goals as a group. A therapist usually meets with families in their homes, at their convenience, and provides continued support after the formal sessions have concluded" (Loughran, 2002).

Youth Perspective

It is important that young people are seen as part of the family in this therapy model. In addition, FFT should be accessible to all and according to need. FFT should promote communication between the parents and the young person. The focus of this model needs to be on the total family, not just the young person's issues. Additionally, FFT should consider working with interventions that have made a positive difference in the family.

Cultural Perspective

Culture and language affect the perception, utilization, and potentially the outcomes of mental health services. Therefore, the provision of culturally and linguistically appropriate services designed to meet the needs of diverse racial and ethnic populations should include language access for persons with limited English proficiency, services provided in a manner that is congruent, rather than conflicting with cultural norms; and the capacity of the provider to convey understanding and respect for the client's worldview and experiences. (DHHS 2001)

The flexible integration of clinical theory and in home engagement and sustaining strategies as part of FFT design offers an opportunity to meet families where they are most comfortable, understand and encourage their natural social networks and to provide culturally and linguistically responsive services as truly part of the treatment process. As with any "in home" intervention, staff's cultural knowledge needs to include understanding of the many cultural considerations influencing the effectiveness of treatment.

Evidence of Program Effectiveness

The FFT program is supported by 30 years of clinical research, which supports its foundation as an evidence-based practice for youth with substance abuse problems or antisocial behavior problems. FFT has been applied to a wide range of youth and their families in various multi-ethnic, multicultural contexts and with pre-adolescents and adolescents diagnosed with conduct disorders, violent acting out and substance abuse (Sexton & Alexander, 2000).

In December of 2000, Office of Juvenile Justice of Delinquency Prevention issued Juvenile Justice Bulletin on FFT by the founders of FFT (Sexton & Alexander, 2000). The OJJDP Bulletin cited recidivism rates for the FFT treated population at just over 20% while the residential treatment cases had a recidivism rate of approximately 90%.

Aggression Replacement Training (Art)

Aggression Replacement Training® (ART®) is a multimodal psycho-educational intervention designed to alter the behavior of chronically aggressive adolescents and young children. The goal of ART® is to improve social skill competence, anger control, and moral reasoning. The program incorporates three specific interventions: skill-

streaming, anger-control training, and training in moral reasoning. Skill-streaming uses modeling, role-playing, performance feedback, and transfer training to teach pro-social skills. In anger-control training, participating youths must bring to each session one or more descriptions of recent anger-arousing experiences (hassles), and over the duration of the program they are trained in how to respond to their hassles. Training in moral reasoning is designed to enhance youths' sense of fairness and justice regarding the needs and rights of others and to train youths to imagine the perspectives of others when they confront various moral problem situations.

The program consists of a 10-week, 30-hour intervention administered to groups of 8 to 12 juvenile offenders thrice weekly. The 10-week sequence is the "core" curriculum, though the ART® curriculum has been offered in a variety of lengths. During these 10 weeks, participating youths typically attend three 1-hour sessions per week, one session each of skill-streaming, anger-control training, and training in moral reasoning. The program relies on repetitive learning techniques to teach participants to control impulsiveness and anger and use more appropriate behaviors. In addition, guided group discussion is used to correct antisocial thinking. The ART® training manual presents program procedures and the curriculum in detail and is available in both English and Spanish editions. ART® has been implemented in school, delinquency, and mental health settings.

Family Integrated Transition (Fit)

The Family Integrated Transitions (FIT) program provides integrated individual and family services to juvenile offenders who have mental health and chemical dependency disorders during their transition from incarceration back into the community. The goals of the FIT program include lowering the risk of recidivism, connecting the family with appropriate community supports, achieving youth abstinence from alcohol and other drugs, improving the mental health of the youth, and increasing pro-social behavior.

FIT is based on components of three programs: multi-systemic therapy (MST), dialectical behavior therapy (DBT), and motivational enhancement therapy (MET). The overarching framework of FIT is derived from MST, a preservation model for community-based treatment. This treatment component uses therapists to coach caregivers in establishing productive partnerships with schools, community supports, parole, and other systems and help caregivers develop skills to be effective advocates for those in their care. While the MST component concentrates on the extent to which environments around the youth support pro-social behavior, FIT incorporates elements of DBT to address individual-level characteristics by replacing maladaptive emotional and behavioral responses with more effective and skillful responses. Finally, FIT uses aspects of MET to engage youths in treatment, with the objective of increasing their commitment to change. FIT therapists use MET techniques to develop the initial engagement of all parties and to maintain the commitment throughout the treatment.

Family Preservation Services

Family preservation services are short-term (4-6 weeks), family-based services designed to assist families in crisis by improving parenting and family functioning while keeping children and communities safe. These services developed largely in response to the over-reliance on out-of-home care that characterized services in the 1970's. Family preservation services grew out of the recognition that children need a safe and stable family and that separating children from their families is traumatic for them, often leaving lasting negative effects. These services build upon the conviction that many children and communities can be safely protected and treated within their own homes when parents are provided with services and support and empowered to change their lives. Family preservation programs are designed to help families cope with stress, maintain needed services, and obtain other needed services.

Wraparound Services

The wraparound process provides individualized, comprehensive, community-based services and supports to youth with serious emotional and/or behavioral disturbances so they can be reunited and/or remain with their families and communities. Often these serious emotional or behavioral disturbances evidence themselves in the family setting, educational setting or even work setting.

Wraparound service delivery is a community-based solution for meeting the needs of behaviorally challenged youth who are at risk of being placed outside the community in residential or foster home settings. The goal is to turn what resources we have into what the youth and their family needs. Resources are created and organized around the youth and their family. This collaborative process focuses on identifying the strengths of the youth and his or her family and extended family. These strengths are used as the basis of the wraparound plan. Rather than sending the youth to a placement away from his or her family and community, community-based services are wrapped around him/her.

Phase II (b): Use of Kinship Care, Family Foster Care and Multi-Dimensional Treatment Foster Care

Kinship Care

Kinship care is an option that is effective when youth cannot live with their own families and have relatives or adults who know and care about the child willing to care for him/her.

In order to identify kin willing to care for youth involved in the juvenile justice system family engagement must occur as soon as the youth is identified to the system. Experience has taught us that as family members become more comfortable with the system and more trusting that the DPO is working for them, they are more willing to share names of kin who might be willing to assist in taking care of their child.

In spite of the numerous benefits associated with kinship care, myths remain.

Many people struggle with the idea that "The apple doesn't fall far from the tree" and if youth move into kinship care homes, they will face the same parenting styles that may have caused problems in the first place. In fact, research shows that children living with relatives are no more likely—and are perhaps less likely—than children living with traditional foster parents to experience abuse or neglect or enter the juvenile justice system after being removed from their homes. A 1997 study found that non-kin foster parents were twice as likely as licensed kinship foster parents to have a confirmed report of maltreatment.

In fact, the research tells us that *many children who cannot live with their parents benefit from living with grandparents and other family members*. Supporting kinship caregivers in their efforts to address the needs of these children thus provides an opportunity to improve the lives of many children who have already experienced trauma or have acted out significantly on their own family system.

What We Know About Kinship Care Effectiveness

Research tells us that kinship care minimizes trauma of loss, maintains healthy family connections and reduces placement disruption. When possible and safe, (for the youth and the community) kinship care offers a way for youth to stay within the community, in a family setting where adults support ongoing connection with the child's family and culture.

Youth in kinship care experience greater stability.

- Youth in kinship foster care have been found to experience fewer placement changes than children placed with traditional foster parents.
- Fewer youth in kinship care report having changed schools (63 percent) than do children in non-relative foster care (80 percent) or those in group care (93 percent).
- Youth who reunify with their birth parent(s) after kinship care are less likely to re-enter the system than those who had been in non-relative foster placements or in group care facilities.
- Youth in kinship care report more positive perceptions of their placements and have fewer behavioral problems.

Compared to youth in traditional foster care and those in group care, youth in kinship care are:

- More likely to report liking those with whom they live (93 percent vs. 79 percent [non-relative foster care] and 51 percent [group care])
- More likely to report wanting their current placement to be their permanent home (61 percent vs. 27 percent and 2 percent)
- Less likely to report having tried to leave or run away (6 percent vs. 16 percent and 35 percent)
- More likely to report that they "always felt loved" (94 percent vs. 82 percent [non-relative foster care]).
- In terms of scores in physical, cognitive, emotional, and skill-based domains, youth in kinship care have scores more like those of youth who are able to remain at home.
- Both teachers and caregivers tend to rate youth in kinship care as having fewer behavioral problems than do their peers in other out-of-home placement settings.

Treatment Foster Care

Treatment Foster Care (TFC) or Multidimensional Foster Care (MTFC), has its roots in social learning principals. It is defined broadly as:

…a distinct, powerful, and unique model of care that provides children with a combination of the best elements of traditional foster care and residential treatment centers. In Treatment Foster Care, the positive aspects of the nurturing and therapeutic family environment are combined with active and structured treatment. Treatment foster programs provide, in a clinically effective and cost-effective way, individualized and intensive treatment for children and adolescents who would otherwise be placed in institutional settings.

MTFC has its roots in social learning principals and is commonly associated with the work of Patricia Chamberlain who developed the Oregon Multidimensional Treatment Foster Care Program. Children and youth who cannot be effectively managed in traditional foster care settings are often placed in MTFC programs. MTFC provides more intensive therapeutic, supervisory, and case management services than traditional foster care for children exhibiting chronic disruptive or anti-social behavior who might otherwise be incarcerated, in residential or group treatment, or in the hospital (152). Treatment typically lasts 6-9 months.

MTFC programs require close collaboration between all of those involved in a youth's life, including the program supervisor, case worker, parole or probation officer, if any, the child's teachers and/or work supervisors, foster parents, and birth parents. MTFC foster parents receive a

great deal of support and training from program staff and are expected to provide a structured, supportive home for the child. Foster parents are contacted seven times per week regarding their foster child, including a two-hour group session, five ten-minute phone calls, and additional calls as needed. Foster parents use behavior management techniques with their foster child, provide close supervision, and keep the child away from delinquent peers.

The goal of MTFC is to return the child to his/her birth parents. While their child is in MTFC, birth parents receive support from the therapist, who teaches them how to use the behavior management skills being used in the foster home. Additionally, birth parents attend a one-hour group session each week to build skills.

Throughout a child's placement, birth parents are encouraged to attend supervised home visits with their child band maintain communication with their child's therapist (152).

What We Know About Program Effectiveness

MTFC has been subject to extensive research. Two studies comparing MTFC to group home or hospital placement found positive effects of MTFC, including improvements in behavior problems, less recidivism, and less movement to more restrictive treatment environments. MTFC, in comparison to traditional foster care, was associated with greater behavioral improvement and a lower likelihood of running away or incarceration.

Phase II (c) Inclusion of Intensive Services and Treatment in Group Care

Narrative Description:

The general philosophy underlying the proposed reform system in LA County Department of Probation is to embed evidence based practices within residential placement settings and to create incentives to return youth as quickly as possible to family settings after a residential stay becomes necessary, providing community-based care including intensive home-based services. This approach emphasizes that it is key for the transition from residential care to community-based care happens planfully, is supported and is experienced as seamless by the youth and their family.

This group care model includes:

- Intensive treatment focused on diagnostic, crisis stabilization work and treatment services.
- Family Engagement strategy will be created to ensure family engagement for each youth identified as needing residential treatment.
- A Team Process – the team process is not a simple intervention, but rather a process that is owned by the family and can be sustained after all formal supports are no longer needed. Thus, the team remains the constant planning process for the youth regardless of the involvement of other services.
- Screening, Assessment and Decision-making that engage families and youth fully in the process. The placement recommendation will include the LARRC assessment and a recommendation for appropriate placement.

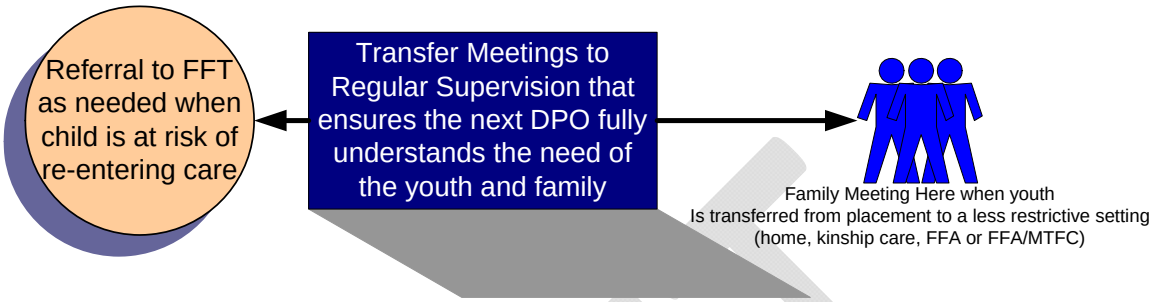
Within this transformed system, the residential care provider will be responsible for facilitating and staffing using EBP principles, treating the youth using evidence-supported therapeutic modalities, providing educational support, working with the current or potential family, and securing lower level care (rel/non-rel) for youth whose treatment is complete after three months but whose family is not ready to receive them. The provider may also provide respite for youth who have been returned to their family but need sporadic returns to a structured setting to maximize treatment gains.

Practice guided by three principles:

- Services are driven by the needs of the youth and preferences of the family and are addressed through a strengths-based approach.
- Services should occur in a multi-agency collaborative team and are grounded in a strong community base.

- The services offered, agencies participating, and programs generated are responsive to cultural context and characteristics.

Phase II(d): Transfer Meetings Between Placement-Aftercare- Field Probation Officers



Narrative Description:

A Transfer Meeting should occur any time there is a change in probation officers. between This meeting ensures that the dynamics between the youth and his/her family, the strengths of the family system, educational or peer issues the youth may be facing, dangers and long and short term intervention goals are fully understood by the new probation officer.

If these meetings are held with the family and youth (through a Team Meeting) it provides an opportunity for information to be clarified and expectations of all members of the team [birth family, foster family/kinship caregiver (if the youth remains in out of home care), youth and probation officer are fully understood. It also provides an opportunity to identify additional members of the family or extended family who might be able to offer support to the youth. If this transition is occurring when a child moves from placement (group or residential care) to a less restrictive community setting additional supports may be imperative for success.

If the youth is being transitioned out of care into the home, this transfer meeting provides an opportunity to discuss the youth's risk of recidivism and to plan for specific services and interventions recommended to minimize this risk. Again, additional support from kin often makes the difference between successful re-entry into the home and community and recidivism.

Research tells us that often 60 days of working with youth and families are lost whenever a change in probation officers occur. This often occurs because it takes some time for the new probation officer to "get up to speed" on the issues of the case. This can result in recidivism. Transfer Meetings are a way to ensure that this loss in case activity is minimized.

Phase II (f): Implementation of Family Functional Probation and Parole

Narrative Description:

In looking for a model to use in a community parole program, staff need a program specifically targeted to engage and motivate families to participate in treatment with their children. These families usually have multiple previous unsuccessful experiences with the "system". Many families have feelings of anger, shame or frustration that compound the sense of being blamed by the "system". All these circumstances lead to the decision that parole staff must have concrete skills to work with families.

Additionally making families a priority for intervention and partnerships is a must for reducing recidivism. The chances for long-term, permanent change increase dramatically if the family is able to be motivated and engaged to participate in a youth's treatment progress. The challenge is finding a way for parole staff to make use of the research on family therapy models such as FFT and MST.

Functional Family Parole Services (FFP) is a family-focused parole model that makes use of cognitive-behavioral principles, primarily a form of cognitive restructuring called reframing. The FFP curriculum teaches parole staff specific skills to improve outcomes with families and youth. The family-based principles come directly from Functional Family Therapy (FFT). The specific principles are designed to train parole staff to work with families first, to provide an environment for service providers that maximizes support for the intervention, and to build upon research of effective interventions for adolescent offenders and their families.

FFT and FFP target risk and protective factors for youth and families. FFT and FFP provide concrete techniques to improve the outcomes achieved with families involved with the Department.

"Many of the risk factors that recur in the literature with respect to youth violence, substance abuse, and delinquency (e.g., poverty, disrupted caretaker history, family conflict) also place youth and families at risk for low engagement and non-retention in change programs…FFT has demonstrated significant positive impact by responding to this problem by first focusing almost exclusively on the motivation family members experience to participate in change. In particular, FFT emphasizes cultural, family and individual respect and sensitivity, alliance with each family member, and the reduction of the toxic effects of blaming, anger, and hopelessness…Interventionists avoid a message that they are attempting to impose change, and instead...emphasize the use of relationship skills to reduce defensiveness in all family members, including when they are blaming each other. Further, it is emphasized that the interventionist is an advocate for all family members, not the ally of one against the other." (FFT Blueprint 1998)

For these reasons, Functional Family Parole (FFP) is an excellent model of services to youth under parole supervision. This program is designed as a brief intervention, which steers families of delinquent youth in a new direction. FFP's success is directly related to the three-phase approach, which stages the change process in a very deliberate way. The three phases are Engagement and Motivation, Monitor and Support, and Generalization.

Brief Description of the Intervention

The parole counselor implementing FFP has several tasks. The focus must shift from changing a youth's behavior to creating a more functional environment within the family. The shift is important because individuals who see themselves as part of an entire family issue will more readily involve themselves in a family-based solution.

FFP targets small, obtainable change in the family. Such changes have the immediate effect of modifying the "problem behavior." Additional impacts are generated later when the family applies the change to future situations. In effect, the new family behavior spirals the family in a more positive direction. Parole counselors using FFP principles work with youth and their families using a ***three-phased model.***

The first phase of service is engagement and motivation.

In this phase, the primary goal is to increase the entire family's motivation to participate in services as well as to engage every family member in the process. A parole counselor has two complementary tasks: reduce blame and negativity and increase hope. The FFP model uses a specific set of skills and assessment tools to accomplish these tasks.

The second phase is support and monitor.

During support and monitor, parole counselors may refer youth to services that increase the family functioning or teach skills. Improved functioning allows family members to perform tasks that contribute to success. Parole counselors might also work with youth and families on fine-tuning the new skills and behaviors that youth learn in residential settings. Fine-tuning is sometimes necessary since any behavior change must respond to the unique nature of the family relational system. The parole counselor provides support and encouragement to the family and youth during the support and monitor phase. Keeping the family motivation high and keeping negativity low are two ongoing goals of the parole counselor during this time. Through praise and reinforcement, the parole counselor supports the family as changes are made.

The last phase of FFP services is generalization.

During generalization, the parole counselor links with any external provider as services end and coaches the family and youth to implement what has been learned. Maintenance of change occurs through relapse prevention techniques. The family must expect that things "will get worse, but can get better again." This builds family confidence over time that the newly acquired skills will work. The parole counselor is available to families as they struggle

through use of different behaviors. The coaching often helps families view the situation differently or adapt the new skills to fit a new set of circumstances.

FFP may use cognitive-behavioral techniques. These techniques are vehicles to accomplish change. All techniques used must match the family and meet the goals of the phase of service.

Family service plans may include skills training or behavior modification principles; however, the plan must include activity for all members of the family. In FFP, plans to change family behavior are only implemented after the family is engaged and motivated to participate in the process. Efforts to keep family motivation and engagement high are made during all three phases.

Addendum

POSSIBLE QUESTIONS TO ENGAGE YOUTH AND THEIR FAMILIES WHEN COMPLETING THE LARRC

(Note: It Is Not Expected That DPOs Will Ask All Of These Questions, But A Select Few Based On The Youth And The family)

INITIAL FAMILY AND YOUTH ENGAGEMENT

Ask caregivers and youth separately

- How are you feeling about being involved in the juvenile justice system?
- What scares you the most about involvement in the juvenile justice system?
- What provides the greatest encouragement/hope about involvement in the juvenile justice system?
- Are you afraid of what your family might think?
- We are all afraid to be judged…are you afraid of how I might perceive you?

RISK TO SELF OR COMMUNITY/RISK FOR RECIDIVISM

DELINQUENCY ORIENTATION

- If someone would describe you, would they say that you had integrity? (that you do what you said you were going to do). Why?
- What is the way that you usually handle it when someone makes you angry?
- Would people who know you say that you had a temper?
- When is one time that you lost it and why?
- How do you usually get things to go your way?

DELINQUENCY AFFILIATION

- Who is your most supportive friend?
- In your community do you have anyone who you trust?
- When is one time that you wanted to get into a fight but did not?

SUBSTANCE ABUSE:

- How do you get through a bad day?
- Have you ever felt like you should cut back on your drinking or drug use—or felt bad or guilty about it?
- Has your drinking or drug use caused school, family, or legal problems?
- Do your peers ever pressure you to drink or use drugs? What do you say?
- How easy is it to get drugs or alcohol?

FAMILY INTERACTION

- What do you think that your child needs from you as a parent with regard to supervision and day to day interaction?
- On a scale of 1-10, where are you at in comparison with where would you like to be as a parent? What will it take you get to the next level?
- What is the most positive thing that you can tell me about your child? What can he/she do that makes you most proud?
- Describe your family traditions that are important to you-- (Birthdays, holidays, first day of school, church activities)
- As a child did you ever experience any type of abuse? Were you involved in the child welfare or juvenile justice system growing up?
- Who raised you? How were you parented when you grew up? What is your relationship with your parent now?
- What are some things you would like to do that are the same as your parents, what are some things that you would like to do differently?
- Does your child have any behavioral problems that worry you? If so, please describe your child's behaviors.
- Has your child ever been evaluated for mental health issues by anyone? If so, what was the outcome? What were you told to do to help your child?
- Does your child have any medical issues that cause you to worry about him/her?

PARENT'S MENTAL HEALTH

- Do you ever feel like you just can't take it anymore?
- Do you ever have a hard time just getting going in the morning? When you cannot "get going" who takes care of your child?
- Do you have a mental health diagnosis? If so, are you on any medications? Do you take them regularly?

PARENT SUBSTANCE ABUSE

- How do you get through a bad day?
- Has your drinking or drug use caused job, family, or legal problems?
- Do you ever use prescription drugs in ways other than prescribed?
- Do others in the home abuse alcohol or other drugs?

FAMILY VIOLENCE

Ask the caregivers

- On a scale of 1-10 where would you rate your relationship with your partner/spouse/significant other? What would bring you closer to a 10?

- How do you resolve conflict in your family? Have the police ever been called to your home?
- Have you ever been concerned about the safety of your children when you argue with your partner?
- Has your child ever scared you or threatened to physically harm you?

Ask the youth

- What happens when there is an argument in your family?
- Have you ever seen or heard someone in your family hurt another family member?
- Are you ever afraid something is going to happen to you or to your parents?
- Do you have a pet—if so have you ever been worried about the safety of your pet?
- Has any of your siblings scared you or threatened to physically harm you or any member of the household?

FAMILY FINANCIAL STABILITY

- Is your income enough to meet your basic needs?
- Do you ever have concerns about your house or your neighborhood being safe for you or your children?
- Do your children ever go to bed hungry because there was no food in the house?
- Are you working so much that you don't get to spend time with your family?

SOCIAL ISOLATION OF THE YOUTH

- Who do you consider family/kin? Are you close to anyone in your church or community?
- What do you identify as your race or culture (i.e. tribal affiliation) How has your race/culture influenced your parenting?
- Who really matters to you (friends or family)?
- Who do you go to when you need someone to listen to you?
- When you grow up who would you like to be most like in your extended family?
- On a scale of 1-10 how would you describe how happy you are? Scared you are? Confident you are?
- How do you handle stress in your life?
- Do you ever feel so down that you think about "ending it all"?

ACADEMIC ENGAGEMENT

Ask the caregivers

- What about your child/youth's school performance makes you proud?
- What is your child's best subject?
- Where does your child struggle in school?

- Was your child ever held back in school?

Ask the youth

- What grade are you in?
- Is school important to you?
- For those students in special education:
    - What is it like for you to go to your classes everyday?
    - Has anyone ever told you that you are smart? Dumb?
    - Do you feel stupid in classes sometimes?
    - When is one time you have been proud of yourself in school?
- What is the best part of the school day (other than when it is over?)
- Do you ever have problems understanding what your teacher is saying? Do you have any trouble reading the board?
- What is the hardest part of school for you?
- What is your best subject? Who? Why?
- Do you ever skip school? If so, where do you go when you skip school?

SELF REGULATION

- When is one time you said no to your peers when they were encouraging you to do something that you knew you should not do?
- How hard is it for you to say no to your peers?
- What part of your life is most stressful to you?
- How do you manage stress in your life?
- What is one thing that you have accomplished that you are most proud of?
- What do you think is one thing that your parent's should be proud of that you have done?
- How do you go about solving problems in your life?
- What is your most effective strategy for solving problems?
- Would people say that they can rely on you to do what you say you are going to do?

INTERPERSONAL SKILLS

- Who taught you how to get along with people?
- On a scale of 1-10 how would you rate your relationship with your parent(s)? (Whatever number they say ask this question…What would it take you to get to a ___ (next number))?
- Which of your friends do you feel safest with? Why?
- Which friend do you think is the best influence on your behavior?

- When you walk into a group of people you do not know do you feel scared or comfortable?
- How easy is it for you to make friends?
- When you disagree with someone how do you handle it?
- When was the last time you needed to defend yourself?
- What is the most effective way that you have of defending yourself?