Providing information to Human Service Professionals

TEACHING-FAMILY ASSOCIATION

TFA

Newsletter

Keep Your Eyes on the Prize:
Defining & Tracking What's Important in Residential Care

Jody Levison-Johnson & Jeremy C. Kohomban with Gary Blau, Beth Caldwell, Richard Dougherty & Rosa Warder

The Building Bridges Initiative (BBI) is a national effort to identify and promote practice and policy that creates strong and closely coordinated partnerships and collaborations between families, youth, community and residential treatment and service providers, advocates and policy makers. Central to the work of BBI is ensuring that comprehensive family-driven, youth-guided and culturally competent services and supports are available that improve the lives of young people and their families.

BBI provides a framework for achieving positive outcomes for youth and families who are involved with both community and residential interventions. This framework, based on a set of principles that are outlined in the Joint Resolution and other BBI products, offers guidance on how families, youth, providers, policymakers, advocates, and others can collaborate to achieve positive outcomes.

Outcomes and continuous quality improvement have been a strong foci of BBI since inception. The BBI Outcomes Workgroup has developed several products to support the field which are described briefly in the table below and can be downloaded at

ACCREDITATION MATTERS!
Joint Commission
Donna Reed – MOST

According to The Joint Commission's overview of Performance Improvement, "All organizations want better outcomes for the individuals they serve and, therefore, are concerned about improving the safety and quality of the care, treatment, and services they provide. The best way to achieve this is by first measuring the performance of processes that support care and then by using that data to make improvements."

One way to measure quality of care is through an auditing process using behavioral health professionals. At one community mental health center audits to measure quality of care are called "Golden Thread" audits. "Golden

Thread" audits look for medical necessity which should drive every treatment decision and include care from intake to discharge.

Not only are the "Golden Thread" audits used to measure quality of care they also serve as peer review, clinical supervision, ongoing competency, job performance and identification of training needs.

Due to greater external scrutiny, "Golden Thread" auditors are more readily available as well as the software to support auditing and reporting.

Critical components to providing safe and quality care involve collecting, analyzing and using information.

Are you accredited...by which organization? Let TFA know by emailing peggymcelgunn@comcast.net.

1. **ACCREDITOR:**
   A. COA
   B. CARF
   C. JCAHO
   D. TFA
   E. OTHER *(please indicate)*

2. **HOW DOES YOUR ACCREDITATION HELP YOU IMPROVE SERVICES TO CLIENTS**

DATA COLLECTION
Across an Array of Programs

Melissa Smokeyday, formerly with Closer to Home Community Services
Combining your data so that it makes sense across all of your programs will help you support your clients, advance your agency, attract funding and support and make sense of the chaos!

Closer to Home Community Services has a number of different programs serving a wide population of clients from early intervention to residential care. Closer to Home is stakeholder driven, community based and guided by a commitment to quality assurance, accountability, and measurable outcomes. Data collection, identifying outcomes and goals helps to achieve success for clients in all service deliveries. Further, our services have identifiable ways to replicate success by looking at the data we collect to achieve successful outcomes.

In turn, creating and replicating the best opportunities to provide the most effective service.

In home support programs collect data regarding family demographics, child development, and family's access to resources. Foster care program collects data regarding child behavior and development, well being and safety of youth. Group care collects the same data as foster care in addition to detailed assessments of independent living skills. By collecting data at intake, 3 month intervals and discharge from

program we are able to identify what interventions were successful in our service delivery. Most importantly, we are able to track the success of clients in our program. Closer to Home developed Program Logic Models with each program and service delivery that includes the National Outcome Measure indicators, researched and provincial outcomes. The development of Program Logic Models provided practitioners the opportunity to discuss their program and give input into how they collect data, what assess-

In the Beginning...
THERE WAS DATA

Sharon Perry, Executive Director, West Tennessee Family Solutions

The two classes I took in college that I have used the most in my long career in human services are business communication and statistics. I can't really say which course I use more than the other, but I know that statistics is always a part of my decision making as an agency administrator. The agency I work in exclusively supports people with intellectual disabilities (ID). In the world of programming, all facets of service delivery must be documented in measurable terms. Data analysis is the

stuff that drives all decisions to keep or change program interventions. Period.

I love data. It makes me look smart. Most of the management reports that I review are reflections of data. For example, my financial reports are data driven. Are net revenues up or down this month? By what percentage? If this trend continues, what will our next month look like? What are the

variables that influenced either the increase in or the drop in our retained earnings? Which homes had a surplus? Why? Which ones didn't? Why? What are we going to do about it? And on and on.

The fact is that without accurate data and spot-on analysis, my job would be impossible. I recall last year that we were

Examining the Importance of Treatment Implementation of the TFM and Youth Engagement in Services in Relation to Youth Outcomes

Kristin Duppong Hurley, Ph.D. Assistant Research Professor, University of Nebraska-Lincoln/Boys Town Center on Child and Family Well Being; Justin Sullivan, BS, (Data Coordinator), University of Nebraska-Lincoln/ Boys Town Center on Child and Family Well Being; Robert Pick, MS, Vice President Nebraska-Iowa Region, Boys Town, Nebraska; Ronald W. Thompson, Ph.D., Director, Boys Town National Research Institute for Child and Family Studies

The science of understanding how practitioners deliver services is relatively young. In general, little is known about how treatment programs are implemented with children and families. Even for treatment programs with detailed manuals and training programs, often there is minimal understanding of how the program is actually implemented by staff. Likewise, little is known about what aspects of a treatment program work best with certain clients in specific situations. The Teaching Family Model (TFM) has been at the forefront of these issues, using data-driven practices to monitor the implementation of the model at TFA member sites. Further, pioneering leaders in the TFM, Dean Fixen and Karen Blasé, are co-directors of the National Implementation Research Network (NIRN) with the goal of helping to close the science to service practice gap by improving implementation and dissemination research. In line with this current objective to better understand how services are implemented, researchers at the University of Nebraska-Lincoln have partnered with Boys Town to conduct a National Institute of Mental Health funded-study examining the role of treatment implementation on youth mental health outcomes.

This innovative project has three primary goals. The first goal is to examine the psychometric properties of TFM implementation measures designed to assess program context (e.g. staffing ratios, training completed), adherence (are services being delivered), and staff competence with the TFM (how well are Family Teachers implementing services). Assessment of staff competence is a unique aspect of the measures, which has been previously reported (Duppong Hurley, et al., 2006). Boys Town research staff and practitioners developed this comprehensive observation form addressing core components of the TFM such as teaching interactions, token economy, relationship-building with peers, family-style living, and self-government. This observation form identified over 60 essential implementation items, rated on a 5-point scale, as well as detailed operational definitions for low, mid and high-rating points, allowing the assessment of staff competence and skill implementing the TFM. Since the development of this implementation observation form around 2002, it has become a widely used tool for assessing program fidelity at Boys Town. While this tool has proven to be useful in practice, it is limited to one perspective. A key goal of the current grant was to develop implementation measures from a variety of perspectives, such as online supervisor ratings, Family Teacher self-ratings, and youth ratings of implementation in the home. These ratings are in addition to observations conducted by university grant staff. Thus, we will compare the similarities and differences of using these different implementation assessment techniques.
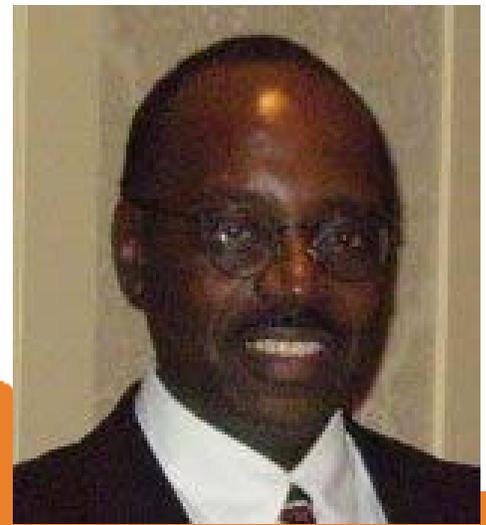
Past President's Message
By Bud Milner

Data collection represents a significant challenge in the human services arena. It is difficult because there are many complex components: determining why data is important to your program; what to collect and why this would be significant; how to measure whatever we have determined is valuable; identifying resources for data collection; and then reporting and analyzing the data. There isn't any set way to do this and every agency is challenged with determining what is relevant and why. There is no doubt, though, that if we do not start…by writing down what is important and measurable (either quantity or quality measurements), we are not going to get anywhere. We live in a data driven world and we must determine what is important and just begin.

Organizations need and use data at every level to asses effectiveness from the executive (e.g., outcome/ effectiveness of services, products) down to the supervisory (e.g., worker productivity), and practitioner (quantity, quality, satisfaction with product, service) level. The need and importance for collecting information not only hasn't changed over time, it has gotten more intense. And in an era of information overload, we often err on the side of collecting information about everything. This Is not necessarily true in the human services/social work world.

The Model, however, continues to demonstrate a uniqueness defined by its origins. The Model was well rooted in information gathering/data collection. Mont Wolf, Dean Fixsen and others used measures from the very beginning to determine what processes worked, what elements were effective, which goals mattered. This information was used to develop and refine the TFA delivery systems as well as determine which elements were critical to effect change.

Historically, data was collected in a variety of areas to help identify areas for quality improvement. Specifically, information was gathered, and continues to be so as a

SPOTLIGH
A Special Young Lady!

By Mike Otufangavalu, Family Teacher—Alpine Academy

My wife and I had a young lady who lived with us for just over 15 months. For the purpose of this article we will call her Pearl. When Pearl came to us she was very guarded, had low self-esteem, and struggled with trusting others. Her family dynamics were pretty unhealthy and she struggled with maintaining healthy relationships with peers and adults. However, Pearl's parents are very caring and loving people. They showed us from the start that they only wanted the best for their daughter Pearl, but didn't know exactly how to provide that for her. Within the first few weeks we had spoken with them on the phone for various reasons ranging from updating them on how Pearl was behaving and how she was doing emotionally, to just shooting the breeze, which allowed us to build a relationship which made them feel more comfortable with us as "Their daughter's 2nd parents". This comfort level promoted their willingness to make some fundamental changes in their parenting styles.

One of the first things we noticed with Pearl was her innate ability to fit in with the crowd. She was very good at reinforcing others and aiding them in creating a (false) sense of comfort. The only issue with her use of this skill was she often used it to reinforce negative behaviors. Pearl showed us early on that she had a strong social skill set. She could get along with anyone and often used that as a way to mask her real feelings and emotions. In the beginning she would always go with the group decision, never ruffling anyone's feathers. This kept her safe from ever having to get vulnerable or uncomfortable. This also allowed us to transition her to the second stage of her program quickly, which helped us bring more of her treatment issues to the surface.

While Pearl was on the second stage of her program she earned the privilege to go off

practitioner spotlight:
Maggie Demott

Thornwell Home for Children

Maggie Demott began her work as a Family Teacher in August, 2006, coming to us from the local community as a recent college graduate with a degree in Early Childhood Education. While in high school and college, Maggie worked at Thornwell's recreation center, and this experience spurred her to pursue a job as Family Teacher. She achieved certification in September 2007 at her First Annual Evaluation and was re-certified at three subsequent annual evaluations, most recently in June 2010. Maggie brings lots of creativity and fun to the elementary school girls of Wilson Cottage, and she's known for "thinking outside the box." An avid photographer, she also has a keen eye for style, and the Wilson girls love her quirky sense of humor. Recently, this author interviewed Maggie for the TFA Newsletter so we can all learn from her experiences and insights.

TFA Newsletter (TFA): What do you like most about your job?
Maggie (M): Working with the kids is the best thing— developing relationships with the girls. They're all such cool kids, and I love just getting to know them, the cool things they do and say. Having a relationship with them is my favorite part.

www.buildingbridges4youth.org. A number of other tools to support the field in achieving positive outcomes are also available on the BBI website.

BBI Outcomes-Related Products	
Document	**Purpose**
Performance Guidelines & Indicators Matrix	Describes what to expect if services/supports are provided in a manner that is consistent with the Joint Resolution
Self-Assessment Tool & Glossary (including specific versions for providers/advocates & families/youth)	Provides organizations and communities a framework to evaluate themselves against the performance guidelines and indicators identified in the Matrix

Table 1

This paper seeks to advance this outcomes focus by making the case for a more assertive focus on measurement and outcomes as a part of residential and other 24-hour, out of home services. To accomplish this, the paper offers a couple of high level illustrations and an in-depth look at organizations advancing BBI in their settings.

Illustrations from the Field
Across the country, BBI initiatives provide examples that illustrate the role of outcomes in these efforts. Damar Services, Inc., a residential provider based in Indianapolis, IN used BBI to transform their services. Damar focuses on outcomes such as recidivism, residential diversion and integration of community-based services for young people enrolled in their residential programming. Hathaway-Sycamores in Pasadena, CA has begun to emphasize Family Finding activities and tracks outcomes related to discovering, connecting and engaging families as well as those related to recidivism, family contacts and connection to natural supports. These organizations represent a growing number of residential providers who are focusing their attention on what happens in the community and after discharge.

An In-Depth Look: The Children's Village
At The Children's Village, based in Harlem New York, the path to transformation began at the residential campus located 20 minutes north of Harlem in Dobbs Ferry. With over 350 beds and a 160 year history as a residential provider, The Children's Village faced a unique challenge: staying true to the residential mission that was core to the organization's charitable founding in 1848, while concurrently embracing the values exemplified in the BBI principles. The Children's Village found success by focusing on three priorities:
1. Redefining the residential mission;
2. Committing to measure what is really important; and
3. Creating an organizational culture where children and families are key partners in decision making.

Redefining the residential mission was the easiest to accomplish. The data on post discharge outcomes for teens leaving long-term residential treatment were irrefutable. Homelessness, multiple hospitalizations, crime, drugs, prison, unemployment and social isolation was unacceptably high among all cohorts reviewed. Clearly, the belief that long-term residential treatment was a far better and sometimes safer option than a child's community and family was fundamentally flawed. Children should go home to their families and communities; and this expectation must serve as the foundation for service and discharge planning. Compounding this thinking further was a medical model where the common descriptor for all children in residential care was "mentally ill." While some children in residential care are experiencing mental health challenges, the label can be unfair at best; at worst it becomes a self-fulfilling prophecy when imposed on children who are overwhelmingly poor and of color. It contributes to a sense of hopelessness and the impossibility of recovery. It was obvious to the organization that residential treatment could not be a destination. The Children's Village's strong residential capacity enables the organization to effectively stabilize, socialize, medically/clinically treat children whose behavior placed them at high-risk to themselves and others. However, children need families and unconditional belonging. These were not part of The Children's Village's residential continuum in 2004. As a result, the organization redefined their residential mission to be a highly effective "emergency room" committed to treatment, triage and discharge in the shortest and most appropriate timeframe possible. This mission offers a sense of hope to families who can now view residential services as a stabilization intervention and not as a reflection on their ability to effectively parent their child.

As part of this change in approach, measuring what's really important was difficult. The problem was that, like staff at many organizations, those at The Children's Village wanted to measure everything. In the end, The Children's Village found a way forward by agreeing that the "most important" measurement of a successful residential intervention was the post-discharge outcome. What happens to children and families after they leave the campus? The organization agreed to "own" this very difficult to predict and difficult to control outcome. The outcome strategy is straightforward and while some have called it simplistic, it works. To succeed in this, every child and family leaving The Children's Village is offered 12 months of aftercare. In some cases, the time frames can be extended up to 5 years.

The Children's Village tracks four variables believing that these four variables provides adequate information to predict long-term prognosis: (1) Stability at home, (2) Progress at school, (3) Work (for those 17 and older), and (4) Recidivism. This is borne out by the longitudinal dataset on outcomes for all youth discharged from The Children's Village campus-based programs 12 months post-discharge:

Outcomes/ Year	06-07	07-08	08-09	09-10	10-11
School		82%	81%	83%	80%
Work		25%	41%	46%	42%
Recidivism	7%	5%	19%	17%	11%
Stability at Home				86%	86%

Table 2

The transition to this approach for data collection was a gradual process. The organization began with recidivism and learned how to track recidivism well. In the years that followed they added

variables and drilled-down into the individual components that impacted that variable. Their interest is not simply in the outcome of the variable; rather in understanding the factors that impact the variable. When these more subtle and delicate factors are understood it allows organizations to better align continuous quality improvement activities and customize interventions.

Children's Village began their data collection efforts with recidivism since over the past decade this concept has taken center-stage as the primary indicator measured across the human services spectrum. The authors agree. However, while we applaud this attention on the recidivism variable, we also wish to make the unequivocal statement that recidivism *informs* us of intervention efficacy. It is an important indicator, but does not *confirm* intervention efficacy. The reasons for readmission are many and some lay well beyond the control of the provider or the funder. Recidivism rates will not likely be zero, but with a focus on this important variable, honest collaboration between the residential and community partners can keep these rates as low as possible. There are times when recidivism simply provides the opportunity to be there when "failure" happens; to be ready, willing and able to help the family recover and move forward again. For children and families who have previously experienced these "failures", demonstrating that the system is still there for then can make them feel safe. This is often the first step to recovery. It is the willingness to measure recidivism and the capacity to respond pragmatically when recidivism occurs that becomes a key to this success. It should be noted that recidivism is only one critical outcome. Poor results and terrible life outcomes can still occur even when recidivism is low.

> **"Once common outcomes are agreed to there must be adequate resources (time, people, money) dedicated to making the information meaningful, useful and actionable."**

At the Children's Village, embracing the notion that post-discharge outcomes were most important was easier than preparing the donors, staff and Trustees for their findings. The organization's first data set in 2005 was embarrassing. Fifty percent (50%) of the teens leaving the Campus were not in-school 30 days after discharge. Some in this group were out of school for 3-4 months following discharge. The schools were reluctant to admit them and they were using a legally permissible option to provide 2 hours of home-tutoring. Knowing the data allowed the organization to target the problem and within 90-days, 90% of those discharged were in school by the discharge date or within two weeks. That success continues to this day.

Finally, creating an organizational culture where children and families are key partners in decision making is a journey that Children's Village continues to make. They have made great progress thanks to their Parent Leaders and Parent Advocates, and they still have a long road ahead.

Challenges for the Field
Based on the experiences of The Children's Village as well as Damar Services, Hathaway-Sycamores, and others across the country, it is clear that success must be mutually defined and that definitions of positive outcomes must reflect the perspectives of families, youth, providers, funders and policy-makers. These same groups must work together to keep the measurement simple. Without this synergy, providers are left collecting far too much information that has little predictive identifiable value. Unfortunately this occurs far too often.

Post-discharge results have value for all. BBI has strongly advanced the premise that stability after the residential intervention is essential and has incorporated this into the Performance Guide-

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bothered by an increase in falls. Our incident management data showed that 3 people had several falls each which resulted in trips to the emergency room. In the protection from harm system in the state of Tennessee, this type of incident is called 'reportable'. Reportable incidents of this type are viewed as 'bad'. So we went to work on figuring out why and how the incidents happened. We looked at data. We did a scatter grid of where and when the incidents occurred, what conditions were present at the time (number of staff assigned to the person, etc.). After mapping the data, what jumped out to us is that all of the falls occurred on Wednesdays in the morning. One member of our incident management team made the observation that the agency's payday is on Wednesday mornings, and all of the new incidents had occurred on payday Wednesdays. The falls were almost surely related to the lack of supervision because employees were either picking up paychecks or taking them to the bank. We put a plan in place for each person to eliminate these types of falls. The outcome is that we have had no further reportable incidents of falling that resulted in trips to the ER on payday Wednesdays since that time.

The process to collect data, analyze trends, implement corrective action and measure the outcome of change really is simple. So simple in fact, that it is the first place I go before I make decisions. Recently I was talking with Peggy McElgunn about how powerful the data that WTFS collects could be for TFA. What would you say if I told you that 100% of the people currently in WTFS's services who were inpatient in a mental health facility prior to admission had not been readmitted since coming to WTFS? Pretty dramatic, right? What would you say if I was talking about 5 people of

It may be that the implementation scores given by the different groups will be very similar, or the instruments provide varied and unique perspectives on the implementation of the model, suggesting that different approaches are not equal. This implementation data is collected each quarter in all participating homes, creating a rich set of longitudinal implementation data.

The second primary goal of the grant is to examine how the quality of service delivery is related to youth mental health outcomes. A variety of outcome data such as youth behavior (e.g. Child Behavior Checklists) and psychotropic medication use were collected at intake, 6 months, and 12-months or discharge. In addition, youth behavioral incident data is collected on a bimonthly basis with point-card data that is collected quarterly. Finally, six month follow-up data will also be gathered following youth discharge. This study is in the last few months of data collection, and to date we have 145 youth and over 45 Teaching-Family Homes participating in the study. An amazing amount of treatment implementation data have been collected, including over 200 in-home observations, 190 supervisor rating forms, 400 Family Teacher self-ratings, and 800 youth ratings. This implementation data will be used to determine if treatment implementation can predict youth mental health outcomes in residential care. This dataset will allow us to examine questions regarding what core components of the Model best predict youth outcomes, and may help to identify certain patterns of Teaching Family skills sets that are essential for positive outcomes.

The third key goal of this study was to examine the inter-play of treatment implementation and common therapeutic process factors; those things "common" to service delivery, such as client motivation to change, hope for the future, satisfaction with services, and the quality of the therapeutic relationship between the client and the service provider. Regardless of what specific treatment program is delivered, these common treatment processes play an important role in the client's buy-in to the treatment and likelihood of positive outcomes. To examine the role of these common therapeutic factors, youth completed measures from the Peabody Treatment Progress Battery (Bickman et al., 2007) at intake and every two months during care. Family Teachers also completed brief bimonthly assessments of their therapeutic alliance with the youth, allowing researchers to examine the therapeutic alliance between the youth and Family Teachers as a couple, as well as individual ratings for male and female Family Teachers. By collecting comprehensive data on treatment implementation quality, youth's engagement in services, and their relationship with Family Teachers, we will be able to begin to examine the role of common therapeutic process factors in relation to service delivery and youth mental health outcomes. If common therapeutic process factors do play an important role in youth outcomes, then it will be important to examine how these factors change over time and how to best monitor them in residential care. This study will also investigate the relationships among youth engagement, alliance with Family Teachers, and quality of implementation to examine if there are optimal levels or patterns of relationships predictive of positive youth outcomes.

The support from the youth, Family Teachers, and supervisors at Boys Town to conduct this study has been superior and essential to the success of the project. We anticipate completing all data collection activities by the fall of 2011. Data analyses will begin in earnest starting in the summer of 2011, and we hope to share our preliminary results at the November 2011 TFA conference. The results of this pilot study will also be used to submit additional grant proposals that continue our investigation of the role of quality of service delivery and common process factors on youth outcomes. We will continue to disseminate our findings in professional journals and at conferences. We believe this research will provide some initial steps

lines and Indicators Matrix. By identifying indicators that focus on the time before and after residential placement, in addition to those that may be seen during a residential stay, BBI has advocated a focus that includes outcomes within the residential unit as only one of the important markers of success. From the family and youth's perspective, stability after discharge is the ultimate measure of success. It demonstrates that the residential intervention was effective and that the community-based system is sufficient to support their ongoing needs. For funders and policymakers, it sends a clear message that an investment at the correct level of service, including higher-end interventions like residential provides an efficacious outcome and is cost effective. For the providers, monitoring post-discharge results provides a gauge for residential leaders about the collaboration with the family and the community resources available. It also offers the provider the opportunity to adjust programmatic interventions to enhance desired outcomes.

Once common outcomes are agreed to there must be adequate resources (time, people, money) dedicated to making the information meaningful, useful and actionable. If providers work transparently and collaboratively with funders to define outcomes of importance, they must also commit to developing a process where information is reviewed and acted upon. Using critical indicators to make improvements in quality is the goal; collecting piles of information for meaningless reports may feel like accountability but does little to improve care. Fear, when data do not reflect the "success" that was expected or are contracted to deliver, can hamper continuous quality improvement (CQI) activities. As a field we must be willing to take risks – to be transparent with our data and to adapt our measures and/or our practice based on what we learn. Providers that are attempting to adhere to BBI principles have learned to embrace the fear and the risk that is necessary to transform services.

Call to Action

Promoting positive outcomes for young people and their families is our collective responsibility. The Building Bridges Initiative exemplifies this commitment through our simultaneous focus on outcomes and

policy. BBI supports residential and community to work more effectively and is actively working to identify the policy and financing structures that make achieving positive outcomes more likely. Advancing this work at both the local and national levels will be a focus for BBI over the coming years.

Providers can and must commit to defining their most important outcome. During these difficult economic times, funders and our communities have a right to ask us what the return on investment (ROI) is. Through intentional attention to outcomes providers can demonstrate their value be-

yond the altruistic and ensure that clearly defined and measurable results substantiate the value of the investment.

Funders can and must be transparent and pragmatic in their requests. Asking for outcomes that make no sense, imposing unfunded mandates, making dramatic statements about doing more-with-less and imposing complicated and expensive reporting requirements exhausts those on the front lines and breeds skepticism. The truth is that providers cannot always do more with fewer resources. Funders have a responsibility to ensure that funding and expectations are clear, reasonable, adequate and achievable. Simplicity and achievability are terms that we need to advance within the funding vocabulary.

Families and Youth can advance practices that involve them in residential as advocates, peer supports, and "evaluators ". They can help ensure that youth guided and family driven care are part of the or-

ganization's culture. They can also advocate for funding for values-based interventions that are aligned with BBI principles. Discharge planning must begin prior to a residential intervention being recommended and sought. With an emphasis on return to community in the shortest time possible, there must be a clear sense of the purpose and intent for the residential intervention and this must frequently be reviewed, evaluated and modified throughout the residential stay.

The Building Bridges Initiative seeks to advance partnerships that ultimately improve lives and communities. By supporting the evolution of the field, those involved in BBI offer models for best practice in human service delivery. A deliberate focus on outcomes and the collection of data that is right-sized and informative is a priority for BBI partners and for us all.

Ms. Beth Caldwell is the principal consultant in a consulting group dedicated and committed to supporting individuals with special needs and organizations who serve these individuals in achieving their missions, and fully implementing their values, so that each individual, child and family served can realize his/her full potential. She is also the Director of the national Building Bridges Initiative,. Beth Caldwell, Director, National Building Bridges Initiative. *Bethcaldwell@roadrunner.com*

Gary M. Blau, Ph.D. Is a Clinical Psychologist and is currently the Chief of the Child, Adolescent and Family Branch at the Substance Abuse and Mental Health Services Administration. In this role he provides national leadership for children's mental health.

Jeremy Christopher Kohomban, Ph.D. is the President and CEO of The Children's Village and The Center for Child Welfare Research at the Children's Village Institute. The Children's Village provides a broad continuum of programs including evidence-based support for families, shelters for homeless youth and immigrant children, alternatives to incarceration, non-secure detention, alternative schools, affordable housing, and specialized services for more than 8,000 children and families in community settings and over 1,000 children in residential settings annually.

Jody Levison-Johnson, LCSW is currently the Director of the Coordinated System of Care for the State of Louisiana where she is leading the statewide effort to advance system of care values and practices across child-serving systems. Jody also serves on the national Building Bridges Initiative (BBI) Steering Committee and as the Co-Chair of the BBI Social Marketing Workgroup. *Jody.Levison@LA.GOV*

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Rosa Warder, MS, MFA, is the Manager for the Office of Family Relations at Alameda County Behavioral Health Care Services. Rosa is the mother of five, two of whom live with serious mental health conditions. Rosa has nearly two decades of experience in health education campaigns and population-based epidemiologically driven healthcare interventions.

the 54 people (less than 10% of people served) supported in residential services? Insignificant , you might say. What if I told you that for each of the inpatient admissions that were avoided, we saved the State Medicaid plan approximately $15,340.00 (cost based on per diem rate times average length of stay data for the most used mental health hospital in our geographic area). And that each person previously was admitted 2 times per year, and their length of stay usually exceeded the hospital's length of stay by a week? Significant, you might say. I might agree with you, but first I would point out that significance of any data depends on who the data is shared with.

For the families of the 5 people who have not had inpatient admissions into mental health facilities since coming to WTFS, it is hugely important. Each of these 5 families' lives had been fraught with upheaval repeatedly when their loved one lost a community placement following a significant incident that led to their hospital admission. As a fundraiser, I can tell you that it is hugely important data to me when just one of these family members accompanies me to an interview with a prospective donor or a legislator poised to cut our funding and describes the impact that our agency has made on their families' life. And on and on.

There is always a way to present data that gives either a dramatic or minimal effect. The rub for us is to know how to use it.

EFFECTIVE USE OF DATA!
how to shape the families first program and improve outcomes

By Julie Martinez & Wayne Arner, LPC, Utah Youth Village

In today's treatment environments there is an ever increasing demand to provide effective evidence-based treatment in conjunction with being able to provide successful outcome data. In its attempt to provide evidence-based in-home treatment to children and families, Utah Youth Village's Families First Program has actively sought out and used outcome data. However, in the review of the current research regarding effective evidence-based interventions additional data has also been necessary to obtain and monitor. In particular, specific data regarding risk, needs, and responsivity is necessary measure. To meet these demands, the Families First Program utilizes several different validated and evidence-based assessment measures to generate data that is used to track outcomes, program effectiveness, and adhere to the Risk, Needs, and Responsivity Model. These include:

1) The Y-OQ 2.01 (Youth Outcome Questionnaire) is a brief 64 item parent report measure of treatment progress for children and adolescents (ages 4-17) receiving mental health intervention. Through the use of cutoff scores and a reliable change index, the Y-OQ 2.01 is able to compare a child's behavioral similarities to various treatment settings (i.e. inpatient, outpatient, and community populations). The Y-OQ 2.01 uses standardized data that is sensitive to change over the spectrum of six subscales (Interpersonal Distress, Somatic, Intrapersonal Relations, Critical Items, Social Problems, and Behavioral Dysfunction). Parents are asked to complete items using a 5 point rating system. High scores on the Critical Items indicate immediate intervention needs. (**http://www.oqmeasures.com/site/Measures/YOQ201.aspx**)

2) The Client Evaluation of Self and Treatment (TCU CEST) includes most of the same psychosocial *scales completed at intake (i.e., in the CEST-Intake)* plus *scales to measure treatment engagement*. Besides motivation, psychological, and social functioning, self-ratings also are obtained on *treatment needs, services received, treatment satisfaction, counseling rapport, treatment participation, peer support, and (outside) social support*-- all representing indicators related to outcomes during and following treatment. Repeated assessments overtime provide a basis for monitoring client change and care planning. Aggregated client assessments provide a basis for evaluating program-level performance. Texas Christian University Behavioral Institute includes data on Means and Norms based on over 2,000 administrations. (**http://www.ibr.tcu.edu/pubs/datacoll/commtrt.html#Form-CEST**)

3) The Jesness Inventory–Revised (JI–R) is a comprehensive, self-report measure of personality and psychopathology that is applicable to children and adolescents with more severe behavioral problems and with whom violence potential is a concern. Conventional scores are provided for the 11 subtypes while classification scores are provided for the 9 personality subtypes. An Asocial Index score is also provided. Results from the JI–R provide valuable insight into the potential causes of certain behaviors. It is particularly useful when differentiating between social maladjustment and emotional disturbance. The JI–R normative sample included 4,380 individuals from across North America — 3,421 were nondelinquent and 959 were delinquent; almost all studies using the JI–R have verified its ability to distinguish delinquents from nondelinquents. Many have demonstrated its predictive validity as well. Odd-even item correlations and Cronbach's alpha

to better understand the importance of youth engagement and treatment implementation factors that can improve the quality of services delivered, and ultimately, may help improve youth mental health outcomes following care.

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way of identifying strengths within an organization. Outcomes by public placing agencies are increasingly being demanded which makes data collection imperative. Our training, consultation, and evaluation documentation requirements, as part of the service delivery systems, support of practitioners helps agencies recognize where they need to make improvements; where focus needs to be emphasized in order to get the most out of practitioners for effectiveness. Our consultation and evaluation systems help us interpret the wealth of information and data surrounding implementation (i.e., are consultants/supervisors effective; are practitioners satisfied; is administration working supportively). The data also helps us recognize if we are drifting in any one area resulting in decreased quality for our clients in care.

The data also helps us recognize whether the elements are being used to there best intent within the programs. We do not have to rely on quality interpretation of skills rather we can look to the information and data. For example, on a motivation system review we can easily assess effectiveness resulting from sloppy applications in token economies or whether the client has advanced at a faster pace than expected or whether the practitioner does not fully understand how to apply motivators effectively. One review of data measures can answer a wealth of questions and provide us with information we can then use to improve our success with clients in care.

The Teaching-Family Model is unique – it requires us to collect data all day, every day. It was built with the understanding that data matters in volume. It is the wealth of information that can provide us with the discrete details we need to make positive changes in the lives of many – staff, clients, communities, etc. So the challenge for those using the Model (or pieces of it) is to collectively share our data so that we may continue to make improvements in the development, application and implementation of the Model. Ultimately, it is through our collective understandings and information that we can all more effectively help our clients in care. And those are the outcomes that really matter!!

The Teaching-Family Model continues to work with data and material that is 20+ years old. But this information has been consistently and continually reinforced (and interestingly, not contradicted). The data is solid. But we need to continually update the numbers…update the information. We use the Model in many more settings and with a wider range of populations served. We need to be vigilant in our efforts to update and add to our resources. The data has resulted in recognition of the Model as an evidence-based practice and we need to add to this pool and knowledge base to continue to hone our effectiveness.

Practitioners, supervisors, managers, and leaders who review and use data are more effective. It allows one to look back at what they did and how they can do it better. Change is inevitable and constant. Improvement through the use of data is necessary and constant. Those who get it will "get it".

honesty would not be held against them in any way, but would contribute to quality improvement of the program. Three emails were sent out reminding team members to turn in surveys and none were turned in. Today we have received 7 out of 12 employee surveys back from practitioners who felt that they could now communicate to administration about their job satisfaction as a CYS team member and get a response without ramification. This is an improvement in that CYS has a method to gather data for quality improvement that team members trust. Team members now feel they can contribute to quality improvement of the program as well as help develop means to improving employee satisfaction thus decreasing burnout and workforce turnover which in turn increasing the quality of care provided. Due to the recent surveys CYS administration has received. CYS is in the process of developing employee incentives, rewards, and approved leave in a way that takes in account longevity, skill level, and professional development. The challenge for CYS is being owned by a governmental subsidiary and adhering to its Human Resources policies and evaluation process while implementing that of the Teaching Family Model. CYS is working to be creative within the context of the

evaluation system of the North Slope Borough while applying the flexibility, response, and creativity necessary to provide the support needed to ensure employee satisfaction and removing barriers to implementation while manage the change from one program to another. Throughout the dissemination and implementation process CYS administration has to take into consideration employee skill development, longevity, and fit for the new program and its philosophy, ethics, and value system and create a system that increases current employee job satisfaction as well as motivates them to take professional responsibility for their development in the context of the Teaching Family Model. Facilitative Administrative supports have improved communication from team members to administration and is the perfect tool to capture the issues that arise and could be barriers to dissemination.

Prior to dissemination Orientation and training were governed by what the State required and was piecing milled from various perspectives of behavior modification not by agency philosophy and goals. The Teaching Family Modal pre-service training represents CYS philosophy, expectations, and provides the training necessary

RESULTS ARE THE BEST RECOGNITION!

By Rodreisha Dunbar, Children & Youth Services

Children & Youth Services (CYS) is a level II residential facility in Barrow Alaska, the largest Alaskan Native Village on the North Slope. CYS is an Emergency Stabilization and Assessment Center. CYS provides behavioral rehabilitation services and temporary residential care for children/youth that are in immediate danger in their present environment, who need short term placement. CYS primarily serves vulnerable Alaskan Native children and families of the North Slope and is moving to provide level III long term behavioral rehabilitative services utilizing the Teaching Family Model.

CYS began the implementation processes for imbedding the Teaching Family Model in September 2010. Closer to Home in Calgary Canada is CYS' sponsor agency for dissemination. The Goal of dissemination for CYS is to be a health organization that the local community can take pride in. Mayor Itta wrote on the North Slope Borough web site, health care facilities make our communities livable and provide the framework for a life that will inspire our children as it honors our ancestors. The Teaching Family Model not only allows CYS to be prepared for performance base funding in our state, by providing a frame work to deliver quality strength based family centered services that are meaningful and relevant to our local Alaskan Natives, but also creates an opportunity for the future and has the ability to assure continuity with the past, another goal of Mayor Itta's. CYS utilizes the four systems within the Teaching Family Model: facilitative administration, training, consultation, and evaluation to achieve these goals.

A key component of implementation and quality improvement of the Teaching Family Model is facilitative administration, which develops successful outcomes for consumers, Alaska Native children and families of the North Slope. It is the goal of facilitative administrative support to provide practical, dynamic, and keen attention by administration to reduce implementation barriers as well as create an environment welcoming to employees of an evidence-based program or practice, which is why it is one of the important systems in the Teaching Family Model. This system is utilized to evaluate and improve upon issues which affect the satisfaction of practitioners with administrative actions as it relates to the implementation, development, and improvement of the Teaching Family Model and the program. Administration addresses barriers to implementation with the agreement of the practitioner benefiting local vulnerable children, adults, and families.

CYS is in the beginning phases of implantation. CYS has been actively implementing TFM for the last nine months. Changes we have seen since implementation in the four systems are as follows:

CYS has improved in the area of facilitative administration, and the supports' leadership provides to improve practitioner job satisfaction as well as personal needs. Facilitative administration is a new concept to CYS and the North Slope Borough. Prior to dissemination the practitioner survey was distributed among CYS team members via email. The email solicited honesty and assured team members that their

*To find out more ways on how you can drive positive results please contact TFA at **804.632.0155** or visit our website at **www.teaching-family.org***

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5 ways to improvement
motivation

DEFINE YOUR PURPOSE

Why are you working? Why are you doing this work? Only you can answer these questions. No purpose is inherently "better" than any other — but you need to know *your* purpose.

TIE YOUR PURPOSE TO YOUR AGENCY OR TEAM GOALS

Deliberate envision your agency or team's services through which you can fulfill your purpose. The more closely you associate your purpose, the more motivated you will be!

CREATE AMBITIOUS GOALS

Now that you've got your purpose and your agency/team's purpose aligned, set ambitious goals that will create success for yourself and your team/agency. Pick exciting goals that will inspire you to achieve them.

CREATE A WORKABLE BUT FLEXIBLE PLAN

Once you have goals you can create a step-by-step plan that constantly brings you closer to your goals. That will help you build confidence, commitment and personal control. Motivation feeds on action!

TAKE MASSIVE ACTION

Success is now just a matter of executing your plan, adjusting as necessary to achieve your goals. To start on the right foot, write your plan and take action. Building momentum will carry you successfully!

ments to use and what they would like to see for outcomes. For instance, in the group care Program Logic Model, four major areas were identified as a focus for treatment implementation; the safety, well being, permanency and school performance of youth in the program. The programs had the opportunity to review their contract goals and outcomes statements, as well as review current research related to children and youth services. For instance, safety was identified as the National Outcome Measure indicator, matching regional outcomes of supporting vulnerable children and youth to live successfully in the community. Based on this research and our regional outcomes, it becomes clear in the data to collect. From this initial discussion and review, goals were clearly identified and programs identified specific activities to accomplishing those goals.

In reviewing outcomes, data was collected from initial intake demographics, morning reports, CAFAS (Children and Adolescent Functional Assessment Scale) and PECFAS (Preschool and Early Childhood Functional Assessment Scale) and Treatment Plans. From this information these are some of the goals we hope to achieve: 100% of youth's life skill knowledge and competence will increase, 100% of youth will move to a less restrictive environment. Collecting this information from the services provided gives program the opportunity to reflect best practices. In addition, it gives programs and the Agency an opportunity how to best deliver services and get effective outcomes.

The following is an example of discharge client data from our programs:

	Total # children served	Planned discharges	Moved to less restrictive setting	Discharged with family
Foster Care	83	94%	80%	62%
Group Home (Rural)	12	75%	83%	50%
Group Home (Urban)	26	100%	85%	n/a
Family Support (Urban)	41	63%	63%	63%
Family Support (Rural)	53	n/a	83%	83%
Community & Family Programs	2800 clients/year. 26 youth (12 families) received in home support	n/a	n/a	n/a

Closer to Home client data and treatment progress for period April 1, 2009 to March 31, 2010.
Another method in which we collect data is following up with clients post-discharge at three different time intervals. For example, in one of our family support programs, we contact clients at 3, 6 and 12 months post-discharge. During this contact, we find out if the family remains together, what community supports they are utilizing, maintenance of skills and overall well-being of the family. Based on these contacts and data collection we are able to report the following:

- Family preservation discharge placements: 83% of children discharged to parents and/or relatives.
- Of the youth contacted after discharge, all remain with parents. 100% of youth at home consistently for 12 months indicates maintenance of skills and security of the home placement.

The following is information based on evidence-based assessment tools (CAFAS & PECFAS). By implementing these assessments we are able to collect data on both parents and youth in our programs. The assessment tools helps us track progress of youth based on their behavior at home, school, community, behavior towards others, moods/emotions, self-harm behavior, substance use and thinking. As well, we can track the progress of parents in their behaviors in meeting the family's basic needs or seeking social support. From the time of intake to discharge, we are able to see an increase in risk behavior or a decrease in risk behavior. This helps us to determine an appropriate treatment intervention and meet our goals of keeping children/parents safe and supporting success. For instance in the table below, our Rural Family Support program tracked parents functioning on the social support scale. 100% improvement indicates families entered the program with scores in risk areas and at the time of discharge decreased risk or there was no risk at all.

Program	Treatment Progress
Foster Care	73% of youth improved or maintained score on CAFAS.
Group Home (Rural)	60% of youth maintained or improved their CAFAS score pre-post.
Group Home (Urban)	59% of youth improved or maintained their overall CAFAS scores pre-post.
Family Support (Urban)	72% parents improved or maintained risk factors, improved overall functioning.
Family Support (Rural)	100% of parents improved or maintained functioning on social support scale (CAFAS/PECFAS) and 90% improved or maintained functioning on basic needs scale (CAFAS/PECFAS). 90% of youth decreased risk factors pre-post on CAFAS.
Community and Family Programs	86% (parents) reported an increase in knowledge of community resources as a result of the contact with West Central CRC. 88% (parents) of parents reported they received information/support that helped them address a problem.

In summary, by collecting this information we are able to target intervention specific interventions across programs. By reviewing the success of clients, in programs and community we can increase our strategies in developing successful interventions. By skill building and decreasing behavior problems by examining our data we are able to develop successful treatment programs.

are presented to demonstrate the consistency in JI–R items. Test-retest reliability is presented to indicate the temporal stability of JI–R ratings. Further information pertinent to JI–R validation is available in the technical manual. (**http://www.mhs.com**)

4) The Protective and Risk Assessment (PRA) is a validated assessment process for identifying the strengths and weaknesses of delinquent youths. The PRA is used to identify dynamic (changeable) and static (unchangeable) risk factors that are used to accurately assess risk levels (low, moderate, high) as well as identify the risk factors to be focused on during the course of probation case planning as well as other outside interventions, such as Families First.

5) The evidence based Correctional Program Checklist (CPC) is a tool developed to assess delinquency and correctional intervention programs. It is used to ascertain how closely correctional programs meet known principles of effective intervention. Studies conducted by the University of Cincinnati on both adult and juvenile programs were used to develop and validate the indicators used by the CPC. These studies found strong correlations with outcome items on overall scores, domain areas, and individual items (Holsinger, 1999, Lowencamp and Latessa, 2003, Lowenkamp, 2003, Lowencamp and Latessa, 2005b), and were used in formulating the CPC. The CPC is divided into two basic areas; content and capacity. The capacity area is designed to measure whether a correctional program has the capability to deliver evidence-based interventions and services for offenders. The content area focuses on the domains of Offender Assessment and Treatment Characteristics. This area includes an assessment of the extent to which the program meets the principles of risk, need, responsivity, and treatment. (The

TFA: What do you like most about the Teaching-Family Model?

M: I like the way that we at Thornwell been able to individualize it and make it age-appropriate, especially working in an elementary home. Like, if we have a child who isn't quite mature enough to connect points with behavior, using the "chip-chart" (in which FTs use poker chips to symbolize points) works great for them. And having their goals be so personalized helps a lot, too. It's not just a formula; there's a lot of individualizing we can do with it all.

TFA: How do you see the T-FM helping your kids?

M: The Model has definitely been a big motivator in our house, especially since we've been able to modify it for elementary kids. For the girls who are mature enough to be on the Elementary Recognition card, just being on that level is a huge motivator for them. And the younger ones are really motivated by wanting to get on that level. It's also been really great to see how even elementary kids can learn independence and responsibility, and they see that we recognize their growth and efforts.

TFA: Tell me about a particular child the Model has helped, and how.

M: "Kelley"—she was one of our "guinea pigs" with the Elementary Recognition system. We tested it out with her, and she started having trouble keeping her room clean and being organized with her assignments at school. So she went back on the Elementary card and had "Get back on Rec" as a goal. There were specific things she had to do to keep her room clean and be organized with her schoolwork to show she was responsible enough for the Rec level. So she saw the things she needed to fix, and she earned her way back on there. She's doing great! Last year she was forgetting assignments all the time, but this year I think she's turned every project in early! We're so proud of her, and I'm so glad she's learned to stay on-top of her schoolwork so well, because she'll be in middle school next year and she'll have a lot more to keep up with. She's also really become a leader in our cottage. As far as other kids the Model has helped, when we've had younger

kids who didn't understand the points, the chip-chart was a great tool. Just having something tangible (i.e. the poker chips) was really helpful, something they could see.

TFA: What's something you feel other practitioners at other sites might want to know? Do you have any words of advice? You've been here at Thornwell a few years now; what keeps you here?

M: The kids! I absolutely love the kids. You just have to remember why you're doing what you're doing. And keep in mind that you're not always going to see the effects of what you're doing. It's not just a job, but you're investing in lives. We're helping kids make good memories, and that's important!

This interviewer also asked Maggie's girls at Wilson Cottage a couple of questions. Here's what they had to say about Ms. Maggie:

1) How has Ms. Maggie made you feel special?

"Sometimes she paints our nails, and sometimes we paint our own nails."
"When she does fun things with us, like 'Birthday scavenger hunt.'"
"When she tells me I did a good job and when she encourages me, that makes me feel special and want to keep doing what I'm doing."
"When we were playing soccer, sometimes she would come to our games and yell stuff to encourage us. She encouraged me and Kelly to work really hard, and even if we didn't win the game, to play hard and not get depressed, but keep trying and be good sports."
"A while ago I had trouble with my temper, but for a couple of weeks I didn't have any tantrums, and Ms. Maggie kept on encouraging me not to have tantrums. That helped me a lot."
"She buys us souvenirs and makes us stuff. She bought us shark teeth at the aquarium."
"Every year she gets us Christmas presents, and not all the FTs do that."
"On school mornings, sometimes she puts our hair up."
"We do fun stuff, and she takes us places."

campus, away from adult supervision. She went with a girl from another house to a movie. They had specific expectations set for the activity which involved them going directly into the theater and watching the movie. They were not allowed to engage with people who were not previously approved by their treatment teams for additional interactions. After the movie, Pearl came out of the theater and said that she enjoyed the movie and thought it would be a good one for the rest of the girls to see. What she failed to mention, when checking back from her activity, was that her and the other girl went to an unapproved and inappropriate movie. During this other movie, they met some boys and decided to make out with them in the theater. This information was given to us the following day by the other girl who was involved in this story. As a result of this behavior and other similar situations we, as a program, chose to change our off campus policy to restrict our clients from no supervision excursions. This was a great teaching for us and a great learning opportunity for Pearl. This experience helped Pearl learn how precious a trusting relationship really is. She began earning trust back from us by being very accountable and holding her peers to that same expectation.

As a result of this new perspective of trust and honesty, she began working on her relationship with her parents. This is where the real work began.

We witnessed Pearl make firm decisions that turned things around in her life. She made a commitment to her sobriety, building and maintaining healthy relationships, and working very hard on improving her academic standings. Pearl began keeping healthier boundaries with her parents, which involved her filling the role as their daughter, rather than their peer, and being open to their feedback and direction.

Pearl graduated Alpine Academy on July 15th 2011. There wasn't a dry eye in the room of over 30 people, which included her peers, Teachers, Therapist, and us her Family Teachers. This proved how powerful she was and how big of an impact she made through establishing healthy relationships and truly caring for those around her. She plans on finishing high school, earning her diploma, and going to college to study art.

   Evidence-Based Correctional Program Checklist, Families First, Third Evaluation, August 2010)

The integration of these assessment measures has been greatly influenced by the Risk, Need, and Responsivity Model. During the last century, increased attention has been focused on the need for assessment tools that adequately evaluate the level of risk for an offender to reoffend. Traditionally, the assessment of risk was a matter of professional judgment. However, research reviews repeatedly show that actuarial instruments involving static factors such as offense history, and later the addition of dynamic items investigating the offender's current and ever changing situation contributing to a diminished risk, performed better than professional judgment (Andrews and Bonta, 2007). As a result of the research, it has been shown that focusing on the dynamic "What Works" principles significantly contribute to the offender's reduction in reoffense (Andrews and Bonta, 2007) through the focus on the risk, need, and responsivity principles.

The risk principle states that offender recidivism, the likelihood for them to reoffend, can be reduced if the level of treatment services provided to the offender is proportional to the offender's risk to reoffend (Andrews and Bonta, 2007). The risk principle has two components; the first emphasizes the importance of reliably predicting criminal behavior and thus, the need for evidence-based risk instruments. The second component highlights the necessity to properly match the level of service to the offender's risk level. That is, as the risk level increases the amount of treatment needed to reduce recidivism also increases. Inappropriate matching of treatment intensity with offender risk level can lead to wasted treatment resources and, in some situations, actually make matters worse. The Risk principle calls for intensive treatment services to be reserved for the higher risk offender (Andrews and Bonta, 2007).

The need principle calls for the focus of correctional treatment to be on criminogenic needs, dynamic risk factors that are directly linked to criminal behavior. Although there may appear to be many needs deserving of treatment not all of these needs are associated with their criminal behavior. The specific criminogenic needs that are worth assessing and targeting during the course of an intervention (Andrews and Bonta, 2007) include antisocial personality pattern, procriminal attitudes, social supports for crime, substance abuse, family/marital relationships, school/work, and pro-social recreational activities.

The responsivity principle consists of two categories which are comprised of general and specific responsivity factors. General responsivity factors refer to the cognitive social learning interventions which have been found to be the most effective way to teach new behaviors regardless of the type of behavior (Andrews and Bonta, 2007). These are important to identify because they fundamentally reflect an individuals predisposition for personality traits and the learning of criminal behavior. Additionally, these factors are governed by the expectations an individual holds and the actual consequences to his or her behavior and, at the broadest level, speaks to an understanding of human behavior (Andrews and Bonta, 2007).

Specific responsivity calls for treatment interventions to consider personal strengths and socio-biological personality factors (Andrews and Bonta, 2007). Offenders, like all human beings, change their behaviors as a consequence to environmental demands and through their own deliberate autonomous, self-directed change. Treatment can be enhanced if the intervention pays attention to personal factors that can facilitate learning and that involve increasing motivation and reducing barriers. For example, treatment providers may need to first deal with an individual's debilitating anxiety or mental disorder in order to free the individual to attend and participate fully in a program targeting criminogenic needs (Andrews and Bonta, 2007).

In review, the Risk principle speaks of who should be treated (the higher risk offender), the need principle speaks to what should be treated (criminogenic needs), and the responsivity principle helps determine how to treat the offender (Andrews and Bonta, 2007).

In conclusion, through the integration of data generated by the use of Risk, Need, and Responsivity Model, outcome data, and along with program evaluative data, the Families First Program has been able to document an evidence-based treatment intervention with nearly dou-

to develop practitioner knowledge and skill based on competencies within the teaching family model. The training exceeds what the state requires. Not only does it provide the training necessary for implementation but the values and philosophy are consistently evident throughout. The training is also tied into the evaluation and consultation process and holds practitioners accountable for the information that they have learned as well as provides means for improvement. The training component of the teaching family model has enabled CYS to train employees with clear cut expectations, knowledge, and skills with ethics, values, and philosophy evident throughout, which CYS never had in the past. Pre-Service training also allows CYS to train to cultural competency of the local native population as well as provides CYS with the opportunity to develop and train to skills that correspond to the Inupiat Value System as the value system of the local culture is parallel to that of the model. CYS is in the process of working with local elders to help develop the Alaskan Native Cultural Competency training for pre-service. CYS will also collaborate with local elders to develop a skills curriculum that is meaningful and relevant to the local Natives.

Consultation & evaluation are the two systems of the model that entail supervision, mentoring support, guidance, feedback, Professional Development, skills based performance appraisals leading to certification, a 360 approach to evaluating progress of implementation, skill development of practitioners, and areas the model can be improved. These two systems provide means to teach and evaluate Practitioner skills as well as holds partitions accountable for

what was learned in pre-service training. The knowledge, skills, ethics, values, and philosophies of the agency and the Model that they are expected to adhere to and practice. These two systems are the most difficult for CYS to manage, as we are at the beginning stages of implementation and managing the change between one program while developing another. CYS has currently developed a job description for program support aid, which will work to support teaching parents. CYS is in the final stages of developing the Teaching Parent positions and until that point we are in a holding pattern of skill development, which means our consultation and evaluation systems are not fully in place until we make the transition from current positions to Teaching Parent's and program support aids. At this time CYS has modified this evaluation and consultation process to manage the different skill levels of practitioners who may or may not be future Teaching parents and program support aids depending on where they choose to be once the transitional process is complete, as we are going to be opening two group homes and a resource center. Some team members will apply for new positions and other may choose that the new direction of our program is not them for them.

Currently, some CYS team members have made the commitment to see CYS through the transitional process, others struggle with their skill development and have expressed a desire to look for a different job. In the last year CYS has had two positions open out of 10. In the last nine months CYS has interviewed for both positions. The people identified for the positions both turned down the offer due to the stress of the transitional process. One was a temporary hire

employee who was working with CYS prior to dissemination after pre-service and working for a little over a month afterward they chose to leave the program. The second candidate worked a day and choose to leave the program because they said, "did not anticipate how difficult the job was". CYS then hired an Emergency Temporary hire who worked for a week and choose to leave the program because, "it was too difficult and was not the job for them. They were black and white and needed to count on what their day would look like day to day." CYS in the last three months has had four trained practitioners consider leaving the program and a team member who was a key to dissemination and trained as a consultant quit. With managing the change from one program to another it has been difficult to implement the evaluation and consultation systems. Once the transition has taken place, and CYS has Teaching Parents and program support aids in place the Evaluation system and consultation system will be fully embedded and practiced.

The implementation of the Teaching Family Model has been positive for the community and CYS. Our usage rate for the State of Alaska has increased by 32% from FY 10 to FY11. Our referrals from the State of Alaska, the North Slope Borough School District, and other local agencies have increased. CYS cannot grow fast enough to meet the needs of our local vulnerable children & families. CYS believes all kids deserve to be with their families and in their home community and culture. CYS is dedicated to provide local long term treatment that includes the family and community in which the child lives.

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ble what is considered "clinically significant" change. Brief data summarizing these results includes:

- In regards to programmatic functioning, the overall score for the Families First Program in August 2010 was 71 percent which places it in the Highly Effective category with only approximately 7% of over 400 programs assessed falling into this category.
- A five-year pre-post survey across 951 families which documented an average 24 point improvement in youth behavior over the course of the Families First intervention- nearly double the number

needed for statistically reliable change. (Hess, 2009)

- In satisfaction surveys over the last three years, 99% of parents report that the Families First intervention had been effective at reaching the family's goals, 95% of youth report that the Families First intervention had been effective at reaching their goals, and 97% of associated agencies and other professionals also report that the Families First intervention had been effective at reaching their goals. (Hess, 2009)

Without the collection and integration of all of these multiple data points the overall benefit to children and families, as well as

the Families First Program's ability to continue to serve more children and families, would be diminished. Accordingly, in order to achieve the mission of helping change the lives of children and families, Utah Youth Village and the Families First Program will endeavor to allocate the resources necessary to support the ongoing collection of data related to risk, needs, responsivity, outcomes, and program evaluation data as an integral part of its treatment programming.

References

Andrews and Bonta' Hess- YOQ for 951; Hess-Consumer Satisfaction; CPC-Families First 2010

TFA Mid-Year Meeting

The TFA Mid-Year meeting is one that is dedicated to the business of TFA. This includes a full day of meetings for the Certification & Ethics Committee. This Committee is charged with the responsibility of reviewing agency compliance with the Teaching-Family Model standards. Upon meeting the standards requirements, agencies are accorded accreditation (certification) which confirms fidelity to the Teaching-Family Model. Only agencies that reach this level of implementation are entitled to be identified as Teaching-Family Model agencies. All members — accredited (certified), developing, and supportive, — are invited to attend the C&E meeting. This meeting is a great opportunity to learn about the process. In addition to the C&E meeting, TFA also hosts a board meeting and new this year, a leadership meeting.

TFA Mid-Year:

April 19-20

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TFA 35th Annual Conference:
NOV. 12-14 IN RICHMOND

TFA's 35th Annual Conference is being hosted at the Omni Richmond in downtown Richmond. This year's venue is located in the heart of historic Richmond. As a full-service hotel, all amenities are available including gourmet dining, fitness club, business center and convenience. Special rates have been obtained for conference registrants. Call 1-800-THE-OMNI to secure $149 S/D rates. Reservations must be made by October 12 in order to ensure space/rate availability.

Building COMMUNITIES of Love — TEACHING-FAMILY ASSOCIATION | 35TH ANNUAL CONFERENCE

Teaching-Family Association Collective — An International Organization

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