Juvenile Rehabilitation Administration

Integrated Treatment Model Report

September 2002

Integrated Treatment Model Design Report

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Integrated Treatment Model Committee Report

Executive Summary

In 1999, the Juvenile Rehabilitation implemented a competency-based treatment and case management model. The model focused on increasing youth accountability, skill development and measuring youth changes in skill areas throughout their stay in the Juvenile Rehabilitation continuum of care.

In 2000, the need became evident to further define and specify the appropriate interventions with both the individual youth in residential care and subsequently in families as the youth return to their home communities. Cheryl Stephani, Assistant Secretary of Juvenile Rehabilitation established a committee of JRA staff, clinicians and consultants from the University of Washington to expand the existing skills-based model and further define its implementation with research-based programs. The Integrated Treatment Model Workgroup, as it was termed, was charged with the task of developing a research-based treatment model that utilized cognitive-behavioral principles. The model was to be tailored for use in both residential and community settings in the juvenile justice continuum of care. Goals for the model included:

- Research-based effectiveness,
- Motivation and engagement of both youth and families,
- A commonly understood language to be utilized throughout the juvenile justice continuum,
- A uniform set of cognitive-behavioral skills,
- The ability to generalize and maintain positive changes, and
- Ongoing clinical consultation system to ensure the continuity of the interventions and adherence to the model.

This model views all behavior, including a youth's criminal behavior as occurring in a larger social and historical context, serving a specific function. As such, criminal behavior is a product of one's learning history, encompassing family dynamics, specific circumstances, and thoughts and feelings.

For example, in residential care, (state institutions and community facilities) the model focuses on improving the skills of the youth who is separated from his/her family and removed from the community context in which his behavior occurred. Assessment of the criminal behavior will use a behavioral analysis to identify the contextual variables and the function of the criminal behavior. Using basic behavioral change techniques of shaping, reinforcement, extinction, and contingency management, the model engages the youth in the change process, targets behavior using a hierarchy system and then teaches the youth specific behavioral skills to change his/her actions, thoughts or feelings. Much of the

theoretical basis of the residential treatment component of the Integrated Treatment Model is based on the researched-based work of Marsha Linehan, Ph.D, in her 1993 book, Cognitive Behavioral Treatment of Borderline Personality Disorder. Specific skills sets included in the model are taken from Linehan, as well as Aggression Replacement Training (ART) by Barry Glick, Arnold Goldstein, and John Gibbs, and Moral Reconation Therapy (MRT) by K.D. Robinson.

Once a youth leaves residential care and moves back into the community, the context in which his/her behavior is viewed changes. The Integrated Treatment Model reflects this difference. In community settings, where youth are monitored while on parole, the primary focus shifts to creating a more functional environment within the family where the youth resides. Again, research on maintaining and supporting behavior change for troubled adolescents indicates intervention is most effective if supported within a family context. Parole staff will work with families to shift the "problem behavior" to a relational issue between family members. The primary theoretical underpinnings for this section of the model come from James Alexander, Ph.D and Thomas Sexton, Ph.D., in Functional Family Therapy, a research-based family intervention considered to be a "Blueprint" effectiveness model from the Center for the Study and Prevention of Violence.

The model uses motivation and engagement of all family members and does so within the context of "reframes", a technique which attributes positive intent to problematic behavior. The reduction of blame and negativity through this process is key to helping families function more effectively. The new focus of the problem, therefore, becomes one that is shared by all family members and each person has a shared responsibility for its solution. Additional treatment needs will be met by referring the youth and family to community services that match the family's style of interaction and needs and continue to support the family once the youth is no longer on parole.

This report summarizes and expands on this model as it will be implemented within the Juvenile Rehabilitation Administration in Washington State. In addition to the specifics of the dual focuses of the treatment model, it also outlines costs and staff time necessary for successful implementation and ongoing support.

Member Biographies

Henry Schmidt, III., Ph.D., Committee Chair, received a doctorate in clinical psychology from the University of Washington. He is currently serving as the Clinical Director for Echo Glen Children's Center. Dr. Schmidt performed graduate research focused on the understanding of sexual offending behavior and treatment, cognitive-behavioral treatment, and treatment of suicidal behavior. Dr. Schmidt has previous experience as the director of a leadership training institute prior to his doctoral program.

Ron Baltrusis, M.Ed., has worked with at-risk juveniles since 1973, including serving as Executive Director for various state and contracted community facilities through the Juvenile Rehabilitation Administration and the Department of Social and Health Services. Currently, Mr. Baltrusis serves JRA as an Associate Superintendent at Echo Glen Children's Center, where he has provided oversight of mental health programming for over ten years. Mr. Baltrusis has been instrumental in designing, implementing, and providing staff training in suicide prevention, Dialectical Behavioral Therapy, and gender-specific programming in JRA. Mr. Baltrusis has been a key contributor in designing and implementing the 2001 Mental Health Systems Design for JRA.

Brad Beach has worked in JRA since 1982, specializing in the treatment of mentally ill offenders. In 1997, Mr. Beach facilitated the implementation of Dialectical Behavior Therapy (DBT) in the Copalis Cottage Mental Health Unit at Echo Glen, resulting in significant reductions in parasuicidal behavior and assaults. Mr. Beach has provided training and consultation in the application of Dialectical Behavior Therapy for forensic and adolescent populations in the United States and Canada since 1999 and is also a faculty member at the Washington Institute's Youth Co-Occurring Disorders Academy.

Karen Brunson, M.S.W., currently serves the Juvenile Rehabilitation Administration as the superintendent of Mission Creek Youth Camp, and has also served as the superintendent of Naselle Youth Camp and Assistant Director for Institution Programs. Ms. Brunson has over 20 years experience working with juvenile offenders and 27 years in the field of social services. She developed and implemented the Juvenile Rehabilitation Administration's offender classification system.

Member Biographies

Meredith Byars has worked with delinquent, emotionally disturbed, and developmentally disabled youth for nine years. Ms. Byars currently serves the Juvenile Rehabilitation Administration as the Mental Health Program Administrator, and has been instrumental in the development and implementation of the 2001 Mental Health Systems Design through development of training curricula, service contracts, and partnerships with other DSHS agencies. She has prior experience providing direct services and developing cognitive-behavioral programming for sexual offenders in JRA.

Nancy German, M.S.W., has worked with youth and their families in the Mental Health and Juvenile Justice fields for over thirty years providing services as a therapist, supervisor, and administrator. During her work with JRA, she has facilitated the development of statewide policy and programs in areas of crisis response, chemical dependency treatment, and sexual offender treatment. Currently, Ms. German serves JRA as the Assistant Regional Administrator in Region 4 Community Programs. In this capacity, she provides oversight of regional community facilities as well as mental health, substance abuse, and sexual offender treatment services provided to youth under parole supervision.

Alan Gregory graduated from Pacific Lutheran University and has served JRA youth since 1980. Mr. Gregory has extensive experience providing direct treatment services and developing programming for sexual offenders in JRA, and has contributed to many local and agency projects and committees to implement programs and treatment services in the areas of mental health, sexual offending, and intensive management for youth.

Jo Ann Giordano, Ph.D., served the Juvenile Rehabilitation Administration as a Psychologist 5 at Maple Lane School two years, and currently is serving the Department of Corrections as a consultant and supervising psychologist for correctional mental health programs. She has been a licensed psychologist since 1975, and has been successful in private practice as well as teaching graduate and undergraduate students. Dr. Giordano has provided consultation to public schools, and state and county agencies in Ohio, Oregon, and Washington, and has trained correctional staff in the care and management of mentally ill offenders.

Member Biographies

David Griffith, M.Ed., is a program administrator for the Division of Institution Programs within the Juvenile Rehabilitation Administration (JRA). His current duties include the oversight of the Basic Training Camp Program which he developed in 1997; chair of the Juvenile Female Offender Programs, and Youth Competencies Oversight committees; and liaison with Department of Corrections. Mr. Griffith has developed programs for working with adolescents in the area of sexual abuse, chemical dependency and the use of wilderness activity as a therapeutic tool. He has worked with at-risk youth since 1975, including 23 years with JRA. Mr. Griffith has been a college instructor and an intervention consultant for local schools.

Louise Hicks currently serves JRA as an Associate Superintendent at Maple Lane School. She has worked with youthful offenders for over twelve years and has comprehensive experience in the areas of mental health, special needs, and intensive management programming. Ms. Hicks has served on numerous local and statewide committees to develop and implement training for staff who provide services to mentally ill and suicidal youth.

Laura Holdcraft, Ph.D., is a psychologist and faculty member of the Department of Psychiatry and Behavioral Sciences at the University of Washington. Her interests include the application of empirically-supported treatments (ESTs) to community-based programs, program development, Dialectical Behavior Therapy, dual diagnosis, Motivational Enhancement Therapy, women's issues, and psychosocial treatment of chronic pain and fatigue. She is currently consulting through the University of Washington Division of Public Behavioral Health and Justice Policy in several capacities, including clinical and research consultation for the Department of Juvenile Justice in the State of Washington and for the Primetime Project, an outpatient multisystemic treatment for juvenile offenders.

Corinne Mason, M.B.A., currently serves JRA as the Sex Offender Program Administrator and is responsible for the policy, treatment, and service oversight for sexual offending youth within JRA's continuum of residential and parole care. Ms. Mason has over twenty years' work experience within JRA, including direct services and administrative work.

Kathleen McBride, **M.S.W.,** currently serves JRA as the Office Chief for Treatment and Intergovernmental Services. She has over 25 years of social service and juvenile justice experience within the Department of Social and Health Services in Washington. Ms. McBride received her graduate degree from the University of Washington in 1979.

Member Biographies

Lori Nesmith, M.S.W., received her graduate degree from Washington University in St. Louis, and has worked with youthful offenders for over ten years. She currently serves JRA as an Associate Superintendent for Green Hill Training School. Ms. Nesmith's areas of expertise and experience include sexual offender treatment, gender-specific programming, mental health programming for youth, vocational training for youth, and violent offender treatment.

Dana Phelps, M.Ed., currently serves the Juvenile Rehabilitation Administration as the CJAA Program Administrator. Ms. Phelps has served JRA for over eleven years and is currently responsible for the implementation of research-based treatment interventions for youth on juvenile probation.

Thomas Quinn, M.S.W., received his degree from the University of Michigan. Mr. Quinn currently serves JRA as the Superintendent of Naselle Youth Camp, but began his career in adult corrections, creating and administering a community corrections program in Michigan for thirteen years. Mr. Quinn later served as the CEO of Catholic Social Services in Wayne County, Michigan, a multi-service social service organization offering foster care and adoption, mental health and substance abuse treatment, and services for the aging. Mr. Quinn maintained a private practice for fifteen years, providing mental health, family, and substance abuse treatment. Mr. Quinn has served as an adjunct faculty for a community college for five years. His clinical background and training is in Cognitive-Behavioral Therapy.

Cory Redman currently serves the Juvenile Rehabilitation Administration as the Mental Health Treatment Coordinator for Region 5 Parole Services. He has worked with youthful offenders for the past six years, and has extensive experience providing treatment and supervision to juvenile sexual offenders in JRA. Mr. Redman has been instrumental in designing a multi-disciplinary treatment planning process for JRA Region 5 Parole Services, including networking with local mental health providers to ensure transitional services for youth with mental health issues.

Member Biographies

Teana Robbins currently serves the Juvenile Rehabilitation Administration as the Sex Offender Treatment Coordinator and supervisor for parole counselor assistants for JRA Region 2 Parole Services. Ms. Robbins received her degree from Washington State University in 1987, and has worked with youthful offenders in JRA since 1991. Ms. Robbins has implemented a variety of programs for youth in the areas of gang awareness, anger management, mentoring, and diversity. She continually works to build relationships with community stakeholders including law enforcement, treatment providers, and families. Ms. Robbins serves on the Criminal Justice Advisory Board for local community colleges and is a part-time instructor for Yakima Valley Community College. Ms. Robbins has served as an executive board member for the Washington Correctional Association during the past four years, promoting training and developing educational programming in the criminal justice field for members.

Robert E. Salsbury, M.S., received his graduate degree in clinical psychology from Eastern Washington University in 1984, and currently serves the Juvenile Rehabilitation Administration as the Juvenile Parole Services Administrator. Under his leadership, the first statewide replication of the OJJDP Intensive Aftercare Program (IAP) model was introduced to JRA in October 1998. Mr. Salsbury has performed a variety of services in areas of sexual offender treatment and psychology, including the development of the Washington State Sex Offender Supervision Assessment (SSOSA), an assessment tool employing dynamic risk items. His professional interests include design, management, and evaluation of creative community-based incentive programs. Mr. Salsbury also provides consultation services with the Intensive Aftercare Project Juvenile Reintegration and Aftercare Center at California State University Sacramento, and has provided technical assistance and training to numerous state and county juvenile justice programs.

Pam Shotwell, currently serves JRA as Regional Administrator of Region 3 Parole Services. Ms. Shotwell has prior experience as the Director of Lincoln County Juvenile Court in Davenport, Washington.

Sjan Talbot, M.A., has worked with juvenile offenders in institutional, community, and administrative settings for the past fifteen years. Ms. Talbot currently serves the Juvenile Rehabilitation Administration as the Training Program Administrator and Community Facility Liaison.

Member Biographies

Myrl Weaver, M.S., received his graduate degree in Environmental Education Administration from George Williams College in Illinois. He spent sixteen years with the YMCA of Bogotá, Colombia, operating a pilot residential rehabilitation program for street children. Before moving to Yakima, Mr. Weaver worked as the director of the General Convention of Sioux YMCAs, supervising community outreach programs in 27 Native American communities of South Dakota, North Dakota and Montana. He has served as the administrator of Ridgeview Group Home for JRA since 1995.

H. JRA's Residential Treatment Framework: Cognitive-Behavioral Treatment

What is cognitive-behavioral treatment (CBT)? Behavior therapy may be most simply described as teaching adaptive behavior or modifying maladaptive behavior, by systematically changing a person's environment. The basic principle underlying behavior therapy techniques is that behavior is dictated by the environmental events or outcomes that follow it. Introduced over fifty years ago, behavior therapy has become a widely-used treatment during the past 35 years, particularly with institutional populations and for children's behavior problems. (Winick, 1997) Behaviorism also has the richest research tradition in psychology, with studies establishing principles of behavior and behavior change across cultures, races and even species.

However, a strict behavior therapy regimen ignores the essential role of cognitive processes in human learning. The expansion of behavioral treatments to include the role of thoughts, beliefs and expectations in behavior resulted in the development of *cognitive-behavioral therapy*. This approach, "integrating behavioral and traditional approaches to psychotherapy, recognizes private events and intrapersonal factors along with the importance of environmental variables." (Arnkoff and Glass, 1992) Cognitive-behavior therapy regards an individual's thought processes, cognitive strategies, and beliefs as a "set of covert self-statements (private behaviors) that can be influenced by the same laws of conditioning that influence overt behaviors." (Holon and Beck, 1994) Cognitive-behavior therapy treats not only the individual's maladaptive behavior, but also attempts to restructure the cognitive processes that often produce such behavior patterns. (Winnick, 1997)

Why did JRA choose cognitive-behavioral treatment as an overarching model to treat and rehabilitate juvenile offenders in residential facilities? The National Institute of Corrections supports CBT social learning approaches as effective interventions with high-risk offenders. In his research, Robert Barnoski, Ph.D., of the Washington State Institute for Public Policy (WSIPP) cites cognitive-behavioral programs and techniques as effective in the reduction of recidivism. (Barnoski, 1997) In a 1999 review, "Research Findings on Adult Corrections' Programs", WSIPP recognized the strengths of cognitive-behavioral approaches,

> "The integration of cognitive and behavioral therapies in the field of psychology has led to treatment programs that focus on both the thinking processes and actions of an individual to implement change. According to Wanberg and Milkman (1998), cognitive therapy, which helps individuals see alternative ways of thinking

> and appraising situations, and behavioral therapy, with its focus on self-control and client responsibility, reinforce each other. Cognitive change leads to changes in behavior, which in turn strengthens a change in thought patterns."

In addition, WSIPP provided analyses of programs for offenders comparing efficacy and cost-effectiveness. In a 2001 meta-analysis, "The Comparative Costs and Benefits of Programs to Reduce Crime," WSIPP examined and supported specific juvenile programs which are cognitive-behaviorally-based or have significant cognitive-behavioral components, such as Multi-Systemic Therapy (MST), Functional Family Therapy (FFT), and Aggression Replacement Training (ART). WSIPP writes,

> "The economics of these programs are generally the most attractive of any programs we reviewed in our entire cost-benefit analysis. Most of these programs are designed for youthful offenders in a juvenile court setting...or as an alternative to juvenile court processing. There have also been some recent efforts—as yet unevaluated—to use these approaches for juvenile offenders in institutional settings, or as part of the transition from an institutional setting to the community."

Recently, WSIPP completed a study on the implementation of Dialectical Behavior Therapy (DBT) in a residential treatment unit with JRA. DBT is a specific form of CBT used to treat suicidal and acutely mentally ill patients. The program is delivered through individual therapy and group skills training. Preliminary results of this study found a decrease in recidivism rates after twelve months for youth that participated in the program. (Barnoski, 2002)

Cognitive-behavioral treatment has been utilized in specialized treatment areas such as chemical dependency treatment and sex offender treatment. The National Institute on Drug Abuse identifies many strengths of CBT, including,

- Structured, goal-oriented focus on immediate problems faced by individuals entering treatment;
- Flexible, individualized approach that can be adapted to a wide range of patients as well as a variety of settings and formats;
- Compatibility with other approaches, such as pharmacotherapy;
- Emphasis on functional analysis of problem behavior;
- Emphasis on skills training and learning of effective coping strategies;
- Motivational strategies to engage individuals in treatment.

II. Components of a Residential Cognitive-Behavioral Treatment Model

II. A. The Five Functions of Treatment

Any effective residential treatment model should fulfill certain functions or outcomes for its clients. We know that cognitive-behavioral treatment works to reduce problem behaviors and increase positive, adaptive behaviors. Outcomes for JRA youth include:

- Decrease in recidivism;
- Decrease in assaults, suicide behaviors, and escape;
- Decrease in mental health symptom severity, substance abuse, sexual abuse, and violence;
- Increase in youth displaying more self-control, self-management, and problem-solving skills;
- Increase in successful reintegration into less structured environments, with particular emphasis on reintegration with parents or support networks;
- Increase in home, school and work participation and success in the community.

The following qualities of an effective treatment model will be utilized as a basis to develop specific quality assurance measurements during implementation of this model in JRA.

II. A-1. Motivating and Engaging Clients

Cognitive-behavioral treatment is not an intrusive procedure that can work without the youth's commitment to change. In order to gain the youth's commitment to changing problem behavior and learning new skills, the treatment model must build in motivation and engagement. Changing problem behavior and practicing new skills can be a lifelong process, and the treatment model must have ongoing strategies for keeping youth committed to change.

Treatment not only involves the youth, however. In this case, "clients" can refer to the youth, the youth's family, and also to staff. The treatment model must have strategies, assumptions, and principles built into it to motivate all stakeholders to partner and invest in a youth's ability to develop new and more skillful behavior.

The residential treatment model in JRA should provide an opportunity to orient the youth to the elements and expectations of treatment. The orientation should explain what behavior will be expected and what rewards or returns a youth can expect to receive from his/her investment. The treatment model should also identify and train motivation and commitment strategies to be used by staff. These strategies can include the ability to help the youth identify attainable goals and effective shaping schedules, as well as structure the youth's participation in treatment to facilitate his or her ability to attain personal goals.

Additionally, residential treatment should focus on a need to exercise ongoing motivation and engagement strategies. The culture should foster staff who motivate and engage youth and families through:

- hopeful conversations;
- collaborative efforts;
- consistent, non-judgmental approaches;
- validating and interested involvement;
- respect;
- adapting treatment materials to match the youth's level of functioning;
- linking participation in treatment to the youth's own goals; and
- resourceful, creative, and relentless pursuit of positive outcomes.

II. A-2. Enhancing Capabilities of Clients (Skill Acquisition)

An effective treatment model should help clients become more skilled to manage their relationships, careers, and life events as a result of their participation in treatment. If the model relies strictly on punishment, which suppresses behaviors without teaching transferable replacement skills, the model has failed to meet its mission. Specific interventions to advance and cultivate learning and retention include starting with a strong assessment process, providing structured learning vehicles to present skills, reinforcement, shaping, milieu coaching, and contingency management, all within the context of individualizing treatment.

II. A-3. Skill Generalization

An effective residential treatment model will teach the art of problem solving, or understanding how to match a context or situation with a set of skills. Programs should incorporate the over-learning of new skills in low-stress, lower-risk situations. The model should then allow its clients to practice using new skills with coaching and consultation for cue exposure. Skill generalization is vital and essential to clients' learning processes and to the chance of real success in communities. A process for ensuring that skills will transfer with youth is essential to accomplish the goal of skill generalization.

II. A-4. Structuring the Environment

An effective residential treatment model should structure the environment so clients find investing and participating in treatment to be a natural, comfortable way to learn new skills in order to discard problem behaviors. Ultimately, an effective model should structure the environment, or manage the contingencies, to promote clients' success. The ultimate goal of treatment is to teach youth to structure their own environments to allow them the best possible chances for short- and long-term success.

II. A-5. Motivating and Engaging Treatment Providers

An effective treatment model should deliver not only outcomes for clients, but also for treatment providers. JRA staff are expected to be providers of treatment services to youth as well as models of effective communication and behavior. An important aspect of an effective treatment model for staff working with very difficult populations is supporting and facilitating the work of the direct treatment providers, motivating them to continue good work through:

- provision of consistent and germane consultation;
- recognition of treatment success;
- appropriate training;
- clear communication of organizational decision-making;
- policy decisions informed and driven by treatment concerns; and
- attention to morale, communication, and work ethic.

An effective residential cognitive-behavioral treatment model will provide these five functions of treatment. One should be able to measure the effectiveness of a treatment model for its participants by how well the model satisfies the five functions.

II.A-6. Implementing the Five Functions of Treatment in Residential Settings: A General Discussion.

After accurate assessment of a youth's behaviors in context, residential program staff have many opportunities to use the different strategies identified within the treatment model to fulfill the five functions of treatment. Residential staff can **motivate and engage** youth to participate in treatment by thoroughly orienting them to the expectations and rewards of treatment. Validating youth, helping youth set goals for change, and then linking the attainment of their goals to participation in treatment is an excellent way residential staff can motivate and engage youth.

Due to the 24-hour nature of residential programming, residential staff have the ongoing ability to motivate and engage youth to participate in treatment. Reinforcers to shape and reward positive, adaptive behaviors can be very effective motivators for changing problem behavior. The use of contingency management, or structuring the environment to promote success in changing problem behaviors, can motivate youth, and is a very realistic intervention in residential programs where external control of the environment is an option. The manner in which unit programs are written and implemented provide easy avenues for engagement of youth to invest in treatment.

Since research shows reinforcement provides more lasting, permanent changes in behavior, programs should be written to accent or emphasize reinforcement for positive behavior, instead of punishment for problem behavior. For example, "point systems" in which the youth start with a maximum number of points, and slowly lose points during the day for problem behavior emphasize punishment.

On the other hand, point programs where the youth starts with no points, but continues to add points during the day for demonstrating positive, adaptive behaviors emphasize reinforcement and are shown to be more effective in changing problem behavior. This inverted adaptation of an existing program in JRA is a simple way to illustrate a philosophical shift from a punitive, correctional focus to a reinforcing, treatment focus.

Such a philosophical shift can also motivate and engage staff in the behavior change process. Staff will need the ability to "catch" youth performing positive, adaptive skills in order to effectively implement programs that teach and reinforce positive behavior. Thus, training and ongoing staff support through high-quality consultation with behavioral management consultants will be key to maintaining consistent treatment delivery while maintaining staff motivation.

Motivation and **skill acquisition** accompany one other. Through structuring the general program to motivate and engage, youth are more likely to want to learn and try new adventures, including learning new skills. Learning new skills can be difficult or frustrating for youth, but structuring skills groups and shaping exercises to be fun and energetic can make growing pains easier to tolerate.

Accurate assessment of the functions of problem behavior through behavioral analysis will reveal skill deficits in youth, so that staff can then teach a skill that will specifically replace a youth's problem behavior. Therefore, residential staff must become very familiar and adept at performing behavioral analyses of problem behaviors.

Skill acquisition involves not only teaching the fundamentals in a classroom setting, but also shaping, coaching, and reinforcing the use of the skill in the "lab" or milieu setting. Youth must learn how and when to use the skill in order to effectively demonstrate positive outcomes of using their new skills.

Again, because of the degree of external control over the environment that is present in most residential programs, residential staff can use *cue removal* interventions to reduce the reactivity of a youth while teaching new skills. Knowing that eventually youth will transition to less-restrictive, but often more chaotic, environments, residential staff should take advantage of the block of time youth are in residential programs to focus intensely on teaching identified skills specifically targeted to solving problem behavior.

Skill acquisition not only applies to youth, but also to families. Residential staff can partner with parole staff to educate families on CBT concepts. The ability to teach families evidence-based interventions which work to promote positive behavior in youth is invaluable to the conclusive outcome of the reduction of recidivism.

Skill generalization is the optimal completion to treatment. Staff can teach a youth skills; however, if the youth does not know when and how the skill can be

used to solve a specific problem, teaching skills in a classroom will be ineffective. Staff can work with the families to use interventions such as *coaching, shaping, modeling,* and *cue exposure* to help youth generalize skills.

JRA staff understand families face particular challenges when navigating a complex state system, and when transitioning their children back home. Families can experience difficulties accessing services for their children through multiple systems. At times, families need assistance in learning interventions that teach their children to become functioning adults and remain crime-free.

Making families a priority focus for JRA intervention and partnerships is a must for reducing recidivism. The chances for long-term, permanent change increase dramatically if the family is motivated and engaged to participate in treatment. Therefore, the involvement of the family in treatment planning while the youth is in residential settings is paramount to lasting behavior change and community reintegration. Having family identify youth behavior that the family experiences as highly problematic, and as leading to conflict or decreasing their desire to work with the youth, can be an important means of both increasing family engagement and decreasing future treatment-interfering behavior on the part of the youth.

Residential staff can further fulfill the functions of treatment by teaching youth to generalize their new skills to different situations and environments. Residential staff have the opportunity to use *cue exposure* interventions in controlled settings, to provide youth the opportunity to practice skills. Often, youth respond well to learning skills in a structured environment where cues have been removed. However, if cues are not introduced to allow youth to practice new skills and problem-solve the cues that historically led to problem behavior, youth may struggle to generalize new skills. For this reason, many youth have not experienced success when transitioning to less-restrictive environments or to parole. They have not learned to generalize the skill through the presentation of the original cues that initiated their problem behavior.

Residential programs do not have the ability to present all of the cues that initiated youths' problem behavior. For example, residential staff could structure the environment so that the cue of a teacher using a harsh voice tone is removed while the youth learns coping skills to adaptively respond to a harsh voice tone. When the youth learns the skill, residential staff can present adults using harsh voice tones to the youth in order for the youth to practice tolerating a harsh voice tone without acting out. However, while residential staff ensure youth are not exposed to drugs while they learn new skills to refuse drugs, residential staff do not have the ability to use cue exposure in the case of chemical dependency treatment to allow a youth to practice his refusal skills.

Therefore, while the use of cue exposure in residential programs is limited in some treatment areas, the argument to use cue exposure is still valid for residential staff. As often as possible, youth who have learned new skills should

be allowed exposure to their cues in order to provide practice arenas prior to parole. This is a primary intervention to help youth generalize skills to varying settings prior to experiencing the natural bombardment to cues a youth receives in his community.

Due to the nature of residential programming, staff have a higher level of external control over the daily schedules of youth. This provides residential staff excellent opportunities to **structure the environment** to allow the best chances for youth's treatment success. Several examples of structuring the environment have been given, including the manner in which programs are styled and written, removing cues in order to teach coping skills, and introducing cues systematically to allow a youth to practice his new skills. Structuring the environment also can include:

- managing the contingencies to assist in decreasing problem behavior;
- building support systems around youth through engaging and consulting with families, specialized treatment providers, school personnel, mentors, and chaplains; and
- providing organized transitions to less-restrictive environments by networking with community stakeholders.

These concepts provide only a small snapshot of how residential staff can use a cognitive-behavioral treatment model to fulfill the five functions of an effective treatment model. By fulfilling the first four functions of motivating and engaging, skill acquisition, skill generalization, and structuring the environment effectively, residential staff can fulfill the last function of motivating treatment providers.

In this case, treatment providers are residential program staff. Working with JRA youth and families means involvement with complex individual problems and behaviors within a complex and very dynamic system. It is difficult work, and professionally and personally very demanding. At times, the many benefits of serving this population may seem lost in the high intensity and level of demand experienced. Implementing a model where staff feel effective when doing their jobs is essential to positive outcomes. Residential staff can perform many interventions which will work to keep programs and co-workers motivated to provide the most effective services to youth and also promote satisfaction among staff teams. Examples of these include:

- Establishing and fully participating in consultation teams;
- Using rewards and reinforcement to motivate co-workers; and
- Using behavioral terms to set expectations and define success; and
- Using validation with co-workers.

The underlying use of validation in fulfilling each of the five functions will change the culture of JRA significantly and exponentially as we move to implement a

cognitive-behavioral model. Residential staff have great opportunities at their disposal to implement all five functions of treatment.

II. B. Implementing the Treatment Model in Residential Programs

II. B. 1. Commitment Strategies and Validation

While proven to be very effective in decreasing problem behaviors and increasing positive, adaptive behaviors, cognitive-behavioral treatment is not a coercive, intrusive treatment capable of being applied to youth without their consent. It is the youth who must learn and practice new skills, identify situations in which the skills may be helpful, and use them. It is the youth who must remain willing to accept feedback and shape his own behavior, and it is the youth who must learn to manage his emotions while learning new, complex behavior. Participation at such a level means that the staff working with youth need to be expert at motivating, re-motivating, and engaging youth and their families in treatment.

One means of motivating and engaging youth is to link participation in treatment to their goals. If a youth wants to earn a high school diploma, then teaching the youth skills that will directly impact his ability to stay in school and complete daily assignments will be highly relevant. The reason cognitive-behavioral treatment has the potential to affect long-term change is the inclusion of the youth's goals and values in the effort to motivate and engage youth in treatment and change.

Another means of motivating youth to invest in treatment, is a strategy called "validation," described by Linehan (1993). Validation allows staff to acknowledge the youth's current level of functioning as understandable, given the circumstances in which the youth has existed to this point. Staff who use validation look for an element of truth in every behavior. This may occur through acknowledging the validity in the emotional origins of the behavior, the effectiveness of the behavior in a given situation, or the behavior's situational or cultural necessity. Validation also allows staff to acknowledge that youth are doing the best they can with the skills they have.

By using *validation* as an independent intervention, staff can engage youth to participate and continue in treatment to achieve more permanent changes. Validation may help youth to feel understood, or help bring sense to behaviors tat even the youth may not have understood, or felt control over. Validation can help staff convey to youth that some maladaptive behaviors have made it possible for them to survive in the short-term – gentle confrontation by staff can indicate that these behaviors are not working to meet their long-term goals, however, and that ultimately, youth are expected to change.

Staff who work with youth and families can increase motivation and engagement, and achieve more effective outcomes, through balancing alliances with all family members. A balanced alliance exists when each family member feels equally

close to the staff member or therapist. Each family member experiences the staff as someone who understands his or her perspective and who has interest in helping that person.

II. C. Accurate Assessment and Understanding Behavior in Context

In order to plan treatment interventions to systematically address a youth's behavioral issues, residential staff must accurately assess the drivers behind a youth's behaviors, the youth's motivation to participate in treatment, and his/her skill level in using adaptive replacement behaviors. While the following tools and interventions are highlighted as residential treatment options, the philosophies and perspectives to treatment planning are also applicable to community-based services, as cognitive-behavioral treatment can be effective in any setting to achieve behavior change.

Residential staff must become experts in assessment and treatment planning. In order to do this, certain fundamentals of cognitive-behavioral treatment must be learned. One of these fundamentals includes the way in which maladaptive behavior is viewed and interpreted.

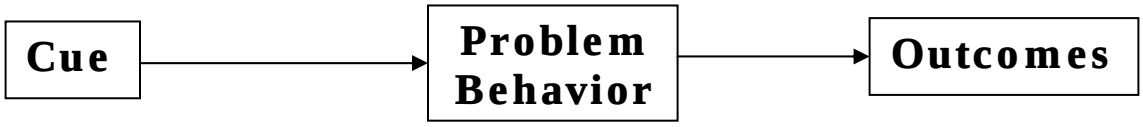
II. C. 1. Viewing Problem-Behavior and Solution-Behavior

A primary assumption of CBT is that maladaptive behavior is caused or maintained by one or more of the following:

- Skills deficits;
- History of learning where problem behaviors have been reinforced;
- Classical conditioning history, such as past trauma, which leads to cues automatically evoking problem behaviors;
- Learned expectations or belief systems about rewards to be gained or penalties to be avoided when using problem behaviors;
- Developmental issues, such as physical disorders, mental illness, effects of drug use, and developmental disorders.

Cognitive-behavioral treatment attempts to identify and address all dynamic or changeable variables that drive or motivate problem behavior. CBT also teaches clients the limitations of personal static variables, such as cognitive impairment or mental illness, and how to adapt behavior, problem solving and expectations to accommodate that specific client's limitations. To understand how to apply cognitive-behavioral principles to change maladaptive behavior, one must first understand that behavior can only fully be understood when viewed in context.

Often, maladaptive or problem behavior is interpreted linearly, as illustrated here.

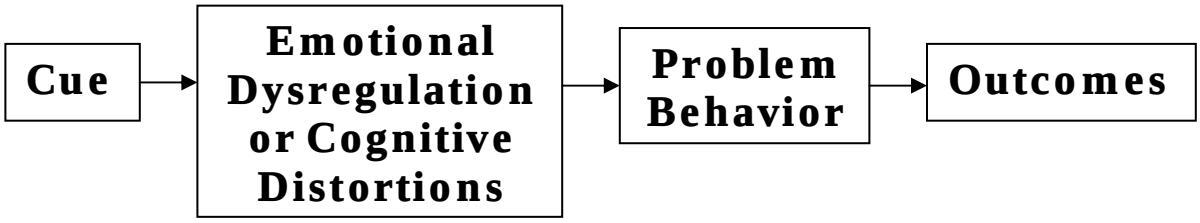


A cue is defined as any event in one's environment that elicits a response. Cues can be internal or external. Examples of external cues prompting negative behavior from a youth could be a phone call from parents with bad news or rejection from a perspective employer. An example of an internal cue could be instances of psychosis in a youth with significant mental health or chemical dependency issues. Thoughts or beliefs are other examples of internal cues or prompts of behavior.

The following example highlights a possible linear interpretation of problem behavior:

- A youth is teased at school by a classmate (the cue);
- he hits his classmate (the problem behavior); and
- he receives school suspension (the outcome).

Does this youth hit a classmate on every occasion that he is teased in school? Why does the youth hit an older classmate who teases him in front of a group of girls while he does not hit a close friend who also teases him in private? The cue of being teased at school is the same in both cases, but yields different results. Therefore, while this interpretation takes several key variables into account, it ignores the internal cognitive and emotional processes (thoughts, beliefs, and feelings) involved in human learning and behavior. An extension of this interpretation may look like this:



Using this interpretation, the same hypothetical scene would become clearer:

When the youth is teased at school by a classmate (the cue), s/he thinks, "People view me as weak if I let someone make fun of me in public," (cognitive distortion) and s/he experiences feelings of shame and anger (emotional dysregulation). The youth then hits his classmate (problem behavior) and receives a school suspension (outcome).

This interpretation of problem behavior acknowledges covert emotional and cognitive activities in order to explain the motivations behind the problem behavior, which in this case are to avoid intolerable feelings of shame and anger.

Dr. Marsha Linehan, coined the term "emotional dysregulation" in her book, Cognitive-Behavioral Treatment of Borderline Personality Disorder. We will use this term to describe the maladaptive emotional processes leading to problem behavior. Linehan describes emotional dysregulation as "high emotional vulnerability plus an inability to regulate emotions." (1993) Youth suffering from emotional dysregulation have the following traits:

- Quick emotional reactions
- Easily provoked into emotional reactions
- Extreme and intense emotional reactions to cues
- Slow return to emotional baseline

The example acknowledges the youth's emotional dysregulation and cognitive distortions; however, this interpretation does not explain what reinforces or supports the maladaptive behavior. In other words, this interpretation does not explain why the problem behavior "works" in solving the problem for this youth.

While it may be convenient to view any behavior as linearly driven by motivations or events preceding the behavior, most behavior is driven or motivated by what happens after the behavior. For example, the elevator door does not open before you push the button. The drink does not come out of the machine until you put your money in and make a selection. In both instances, button-pushing behavior is strengthened by the event occurring next. Most behavior is controlled this way, driven and reinforced by what happens afterward.

Thus, the outcome, or what happens afterward, is effective in solving the problem for the youth and keeps the youth using the maladaptive behavior to solve his problems. In his history, the youth discovered that using a maladaptive behavior worked to remove a problem, such as intensely uncomfortable emotions. This behavior will continue until the youth can be shown that it will no longer work to solve his problems.

Understanding why the behavior works to solve the youth's problem allows us to understand the "function" or "purpose" to the problem behavior. Once this is understood, staff can help youth learn more adaptive ways to solve problems.

In the above example, a school suspension does not appear to have any relationship to the problem behavior of the youth. The youth was teased (cue), and s/he experienced cognitive distortions followed by shame and anger (emotional dysregulation). Because the youth believes these feelings are intolerable, s/he attempts to alleviate them. Past experience has taught him/her one way to solve this problem is to hit someone (problem behavior). Then what? S/he receives a school suspension. The outcome for the behavior in this case does not appear to make sense, as a school suspension does not remove his/her problem of feeling shame and anger.

In this analysis, we are interpreting behavior from our perspective, rather than the youth's perspective. A more accurate interpretation of problem behavior is viewing the behavior from the youth's perspective and how he interprets his problem, including his perceptions of the relevant outcomes of his actions really are.

Table 1.2 illustrates this interpretation.

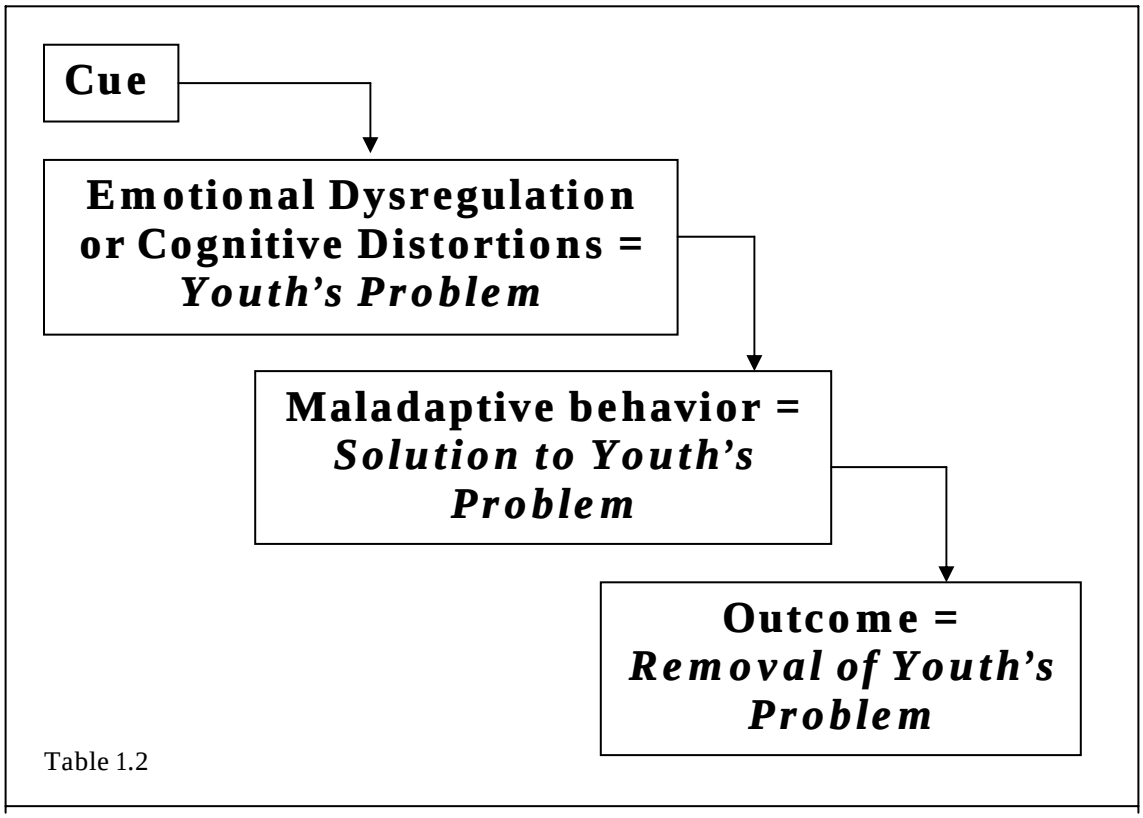


Table 1.2

This interpretation of maladaptive behavior is consistent with science's understanding of behavior and provides a clearer version of what actually happened in our hypothetical scenario. The youth was teased at school (cue) and his cognitive distortions increased his experience of shame and anger (emotional dysregulation). The emotional dysregulation represents the significant problem for the youth, as his emotions are uncomfortable and intolerable to someone with few coping skills. The youth hit his classmate, and his classmate immediately stopped teasing. In addition, the youth believes that this display of force will prevent his peers from viewing him as "weak" or vulnerable. The youth's emotional dysregulation is immediately relieved, and therefore the youth's problem was removed.

In the youth's view, the removal of emotional dysregulation was the relevant outcome to the action of hitting his classmate. The act of hitting as a solution to the youth's problem was reinforced through his painful emotions disappearing just as the condition was becoming intolerable.

Therefore, what we initially interpreted as the consequence or outcome, a school suspension, becomes irrelevant. This may clarify why using arbitrary deterrents like suspension, room confinement, and loss of privileges to curb what we perceive as problem behavior, like hitting, are usually ineffective in changing behavior. Arbitrary deterrents as outcomes are not relevant or controlling parts of the behavioral equation.

Although accurate analysis examines behavior "from the youth's perspective," most youth are not consciously aware of variables such as emotional dysregulation or cognitive distortions controlling their behavior. Like all of us, youth have been taught that behavior is caused by what immediately precedes it. Additionally, youth generally have poor introspective skills, so a youth's moment-to-moment experience is usually one of responding without much planning or weighing of pros and cons, particularly in emotionally-charged situations.

To effectively plan treatment interventions, staff and youth need to understand the true nature of behavior, i.e. behaviors are usually selected based upon expectations of what comes afterward. These expectations may or may not be conscious. Either way, past learning has taught the youth to respond maladaptively, even when these responses are viewed by society as problem or antisocial behaviors.

II. C. 2. Behavioral Analysis

A key component in cognitive-behavioral treatment is the ability to correctly analyze behavior in the context in which it occurs. Residential staff will use a tool called "Behavioral Analysis" which has a long history within psychology as a research and assessment tool. However, staff in any treatment environment may use behavioral analysis to determine the function of any individual behavior. The

behavioral analysis includes examining the links of the behavior chain previously discussed, including,

- cues,
- emotional responses (feelings),
- cognitions (thoughts),
- behavioral responses,
- outcomes that reinforce or support behavior.

An additional key link to correctly analyze behavior is the identification of vulnerabilities, or pre-existing risk factors that affect the youth's likelihood of choosing maladaptive behavior. A *vulnerability* is defined as an internal or external situation that increases the likelihood of responding or acting in maladaptive ways. These vulnerabilities can be long-term or permanent in nature, such as developmental disorders, mental illness, or lingering effects of drug use. Vulnerabilities can also be short-term in nature, such as situational stresses or lack of sleep.

Accurate behavioral analyses involve analyzing a specific chain of events moment to moment over time are necessary to develop treatment plans that will be effective in reducing maladaptive behavior. Parts of the behavior chain such as thoughts and emotions are internal to the youth and unable to be observed by staff. The youth, therefore, must be closely involved in the collection of data for the behavioral analysis. Attachments B and C provide an example of a behavioral analysis with instructions that can be used with youth to collect information regarding problem behavior.

Though behavioral analysis is highlighted heavily in residential programs, the assessment process and subsequent treatment planning can also be utilized in community parole services with individual youth without support networks or with families to analyze a particular event or behavior affecting the family.

The figure below illustrates key components of a behavioral analysis, looking specifically at an event where maladaptive behavior was displayed.

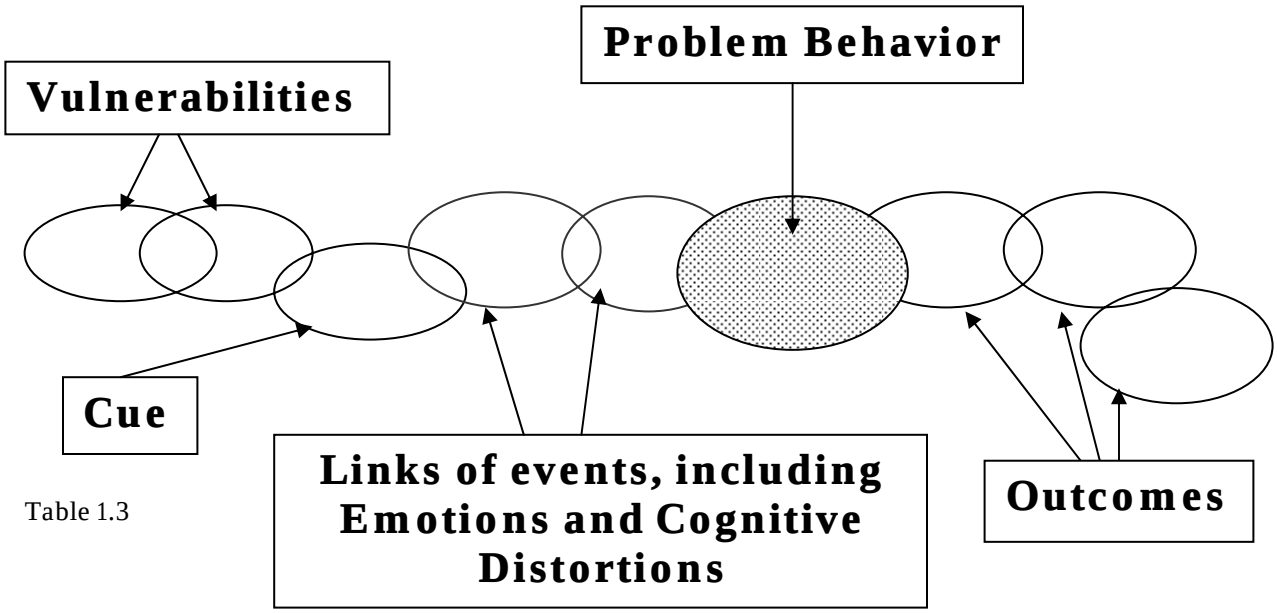


Table 1.3

Applied to an actual behavioral situation, such as property destruction, found commonly in juvenile populations, the behavioral analysis could reveal:

1. **Vulnerabilities**: Youth has a learning disability and struggles at school. Youth has few friends, and did not get picked for the basketball team. Youth's parents work many hours to support the family, and have not been able to provide adequate supervision or guidance to the youth.
2. **Cue**: Youth receives an assignment to give a speech in front of his/her classmates.
3. **Cognitive Distortions**: "I am stupid. Everyone will laugh. I will make a fool of myself in front of everyone."
4. **Emotions**: Fear, anxiety, and panic.
5. **Cognitive Distortions**: "If I get kicked out of school, then I won't have to give my speech. I knew another kid who pulled a fire alarm and got kicked out of school."
6. **Problem behavior**: Youth pulls the fire alarm at school.
7. **Outcomes**: Youth is immediately suspended from school, and knows s/he will not be present to give the speech in front of his classmates. His/her anxiety, fear, and panic are removed.

An analysis of this situation points to the removal of the youth's anxiety, fear, and panic as a negative reinforcement for the behavior of pulling a fire alarm to get out of giving a speech. This may make the youth more likely to pull the fire alarm again to remove his/her anxiety, fear, and panic the next time s/he faces an

uncomfortable situation at school. Equivalent future behaviors may include fighting, cursing at teachers, bringing a weapon to school, etc. Knowledge of behavioral principles and specific information gathered in the behavioral analysis should be used to make hypotheses about variables controlling problem behavior. These hypotheses should direct treatment planning.

II. C. 3. Treatment Planning

Once background information for a youth has been collected (to help identify long-term vulnerabilities) and a behavioral analysis is completed with the youth for a problem behavior, staff and youth can begin to develop an effective treatment plan to modify the problem behavior. Logically, the treatment plan should attempt to break the behavior chain at multiple points.

II. C. 3-a. Blocking the Outcome

One option to decrease problem behavior is by breaking the link between the problem behavior and the outcomes that reinforce it. This is called "blocking the outcome." At times, outcomes that reinforce problem behaviors may be internal to the youth, or otherwise beyond staff intervention, such as peer approval. The treatment plan should attempt to block as many reinforcing outcomes to problem behavior as possible. The options for dealing with reinforcers which remain beyond our control include reducing the value of the reinforcers to the youth, or increasing aversive or uncomfortable outcomes in an attempt to balance the reinforcers.

Options for blocking the reinforcing outcomes to problem behaviors include:

a. Decreasing positive outcomes for maladaptive behavior;
b. Decreasing consistency or intensity of positive outcomes for maladaptive behavior;
c. Increase aversive or uncomfortable outcomes for maladaptive behavior; and
d. Increase consistency of positive outcomes for alternate, positive behaviors.

In our example of the youth who commits infractions at school in order to remove himself from uncomfortable situations, one intervention to block the outcome is to ensure the youth will complete assignments at school, as often as possible, regardless of his problem behavior. For example, staff can intervene with the teacher and family members to ensure the youth will give the speech upon his return to school. Thus, the youth's fear and anxiety will not be relieved, as the teacher's expectation of giving the speech remains.

Additionally, staff should ensure the youth will be rewarded with something of value to him/her upon successfully returning to school and completing the assignment. He/She should also be reinforced for attempting any approximation

of completing an uncomfortable assignment. For example, staff could give positive accolades and award a movie rental to the youth for attempting to give his speech, even if the speech was not particularly well delivered or complete.

These interventions in combination will decrease positive outcomes for the problem behavior of pulling a fire alarm, and increase positive outcomes for the adaptive behavior of working through fear and anxiety.

II. C.3-b. Blocking Problem Behavior

Another way a treatment plan can intervene in the behavior chain is to "block the problem behavior." The components to block problem behavior include:

a. Removing access to ability to engage in problem behavior (environmental intervention);
b. Coaching/cueing significant others to block problem behavior;
c. Strictly prohibiting youth from engaging in behavior (interpersonal intervention);
d. Coaching/cueing youth to avoid behavior; or
e. Coaching/cueing youth to engage in alternative behaviors (skills training and generalization).

Examples of possible treatment plan interventions using this approach for the youth that pulled a fire alarm could include:

- Limiting the youth to specific classrooms where s/he does not have access to fire alarms;
- Escorting the youth as s/he moved through the school, particularly during periods where s/he is experiencing intense fear or anxiety as a result of assignments or social situations;
- Reminding hall monitors, teachers, and family members to supervise youth more intensely, specifically watching for anxiety-avoiding behaviors;
- Coaching youth to refrain from pulling fire alarms; or
- Teaching youth coping skills for fear and anxiety, and coaching youth when and how to use them.

Blocking problem behavior can be one of the more difficult interventions to employ, given that more intensive monitoring is required. However, the ability to coach a youth through a particularly difficult event, offering skill suggestions and support while verbally forbidding problem behavior can be instrumental in the youth gaining the ability himself to refrain from problem behavior, make better choices, and develop better habits for the future.

II. C.3-c. Problem-Solving the Cue

The link that most directly leads to problem behaviors is called the "cue". Examples of cues include actions of others, one's own actions or physiological responses, cognitive distortions and emotional distress. Treatment interventions which attempt to intervene at these links are called "problem-solving the cues". Fortunately, many cue-directed interventions exist. Ways to problem-solve the cues include:

a. Removing the cue from the youth's environment;
b. Changing how often the youth comes into contact with the cue or the intensity level of the cue;
c. Changing how the youth thinks about the cue, through cognitive restructuring and teaching problem-solving skills;
d. Changing how the youth feels about the cue, by teaching coping skills for intense or uncomfortable emotions, or pairing the cue with neutral or positive outcomes; and
e. Changing the youth's response to the cue, by teaching alternative skills for situations and responses.

Treatment plan interventions for the youth that pulled the fire alarm could include:

- Moving the youth to a smaller classroom size to minimize fear and anxiety of public-speaking;
- Teaching the youth coping skills to manage fear and anxiety, such as deep-breathing and self-soothing exercises;
- Coaching the youth to use relaxation skills when thinking or preparing for the speech;
- Teaching the youth about thinking errors, and helping the youth to change the expectations s/he has about what will happen if s/he delivers a speech;
- Teaching the youth the skill of accepting the teacher's speech assignment and understanding emotions as natural but tolerable reactions to stressers.

III. C.3-d. Treating Vulnerabilities

A v*ulnerability* is defined as an internal or external situation that increases the likelihood of responding or acting in maladaptive ways. (The opposite of a vulnerability is a "protective factor." Protective factors are short-term or long-term supports, which increase the likelihood of responding or acting in adaptive ways.) Vulnerabilities can be categorized as either long or short-term. Typically, long-term vulnerabilities tend to be chronic risk factors, while short-term vulnerabilities tend to be temporary or situational. For the most part, both have the potential to be treated or alleviated. To the extent possible, vulnerabilities

need to be recognized and included in treatment planning, especially if they will have an impact on the implementation of the treatment plan.

Effective treatment planning will attempt to address vulnerabilities in order to lower the youth's likelihood of engaging in problematic behavior. For example, a youth suffering from a long-term vulnerability such as ADHD is at a disadvantage from the start. Because s/he has ADHD, s/he has little control over his/her impulsive behavior. When staff can intervene and treat the youth's ADHD through pharmacology or cognitive-behavioral interventions, the youth's vulnerability to maladaptive behavior is reduced. s/he is better equipped to have the self-control to learn and apply new skills.

Identification and treatment of a youth's vulnerabilities are essential to give the youth an opportunity to learn adaptive behaviors. In the example case, some interventions to address the youth's vulnerabilities could include:

- Working with the family to arrange more supervision or guidance for the youth to prepare and practice homework assignments;
- Teaching the youth coping skills to express feelings of frustration to avoid stress build-up;
- Adjusting expectations for the youth, given his learning disability;
- Arranging one-on-one mentoring or tutoring for the youth from family members, teachers, or tutors to address youth's learning disabilities and subsequent frustrations with schoolwork.

II. D. Targeting Behaviors Using a Treatment Hierarchy

The goal of residential cognitive-behavioral treatment is to decrease problem behaviors and increase positive, adaptive behaviors. How do staff and youth know which problem behaviors to address first? Research on the JRA population in recent years has shown the majority of youth have multiple, complex treatment needs, making the choices of treatment priorities difficult.

Marsha Linehan, Ph.D., of the University of Washington, identifies a treatment hierarchy in her 1993 book, Cognitive Behavioral Treatment of Borderline Personality Disorder. This treatment hierarchy is based upon the degree of interference or intrusiveness a behavior has on a person's ability to engage in learning positive, adaptive behaviors. Table 1.1 lists the treatment hierarchy as it could be adapted for JRA, and gives staff guidance on prioritizing behavioral targets. Generally, more egregious behaviors are treated first, and as these behaviors are decreased, additional behavioral targets can be addressed in succession. It is important to remember that only a few behaviors can be successfully targeted at one time, so staff and youth's efforts need to be strategic and coordinated to have an impact on long-standing behaviors.

Serious suicide attempts are targeted as the highest priority in the treatment hierarchy. Logically, when the life of the youth is under immediate threat, all

other behavioral targets are secondary. Treatment interventions must be geared to keep the youth alive.

Additionally, parasuicidal behaviors, or behaviors in which there is self-mutilation or self-harm without the intent to die, as well as suicidal ideation, are included in this category as high-priority targets. Linehan explains:

> "First, parasuicide is the best predictor of subsequent suicide...Second, parasuicide damages the body, often irrevocably... Parasuicide not only damages the body, but also holds out the possibility of accidental death. Third, actions based on the intent to harm one's self are simply incompatible with every other goal of any therapy. The effectiveness of all voluntary psychotherapy is based, at least to some extent, on developing an intent to help rather than harm one's self." (Linehan, 1993)

Assault and escape behavior are viewed next as primary behavioral targets for residential treatment, principally because these behaviors directly interfere with a youth's ability to participate in treatment and learn adaptive behaviors. When a youth assaults another person, he/she is likely to be removed from interacting with others to protect others' safety. Likewise, if a youth is absent due to escape, he is not present to change maladaptive behavior and learn new skills. Severe property damage and sexual aggression are included in this category, as the behaviors are categorized as aggression and require a youth's removal from the treatment. All of these behaviors are in direct conflict with treatment progress and a youth's personal goals.

Next in succession for the target hierarchy includes those behaviors which interfere with treatment. Treatment-interfering behavior is a broad category, and can refer to any behavior that interferes with the youth's ability to increase skill acquisition and the effectiveness of treatment. Examples of such behavior include:

- Sporadic attendance or minimal participation in treatment;
- Behaviors that interfere with another youth's treatment progress, such as disrupting the treatment group with non-treatment related comments or physically disruptive behavior in a milieu setting;
- Behaviors that "burn-out" treatment providers, such as incessant pushing of staff's personal limits.

The next hierarchy priority targets behaviors that significantly interfere with the youth's quality of life. "Quality-of-life-interfering" are behaviors that interfere with the youth's ability to progress further in treatment and learn adaptive behaviors because of their inherent destabilizing natures. Such behaviors would include drug use or truancy. This category also refers to any behavior that lends to destabilization of the youth's ability to meet basic needs, such as food, shelter, education and clothing.

For example, a youth who regularly uses or binges with drugs and alcohol will not be in a stable emotional, physiological, or mental state to learn and apply new skills. A youth who engages in ongoing criminal behavior in a residential setting will likely be removed periodically from treatment settings, making it difficult for consistent participation in changing problem behavior. In the end, quality-of-life-interfering behaviors are not consistent with the stability needed to build a life worth living, and therefore, must become the focus of treatment planning.

In addition to current high-risk behaviors that are targeted in the "Quality-of-Life" section, the target hierarchy identifies research-based long-term or chronic vulnerabilities, or secondary targets, that are directly related to recidivism. Treatment or attention to secondary targets could replace or simultaneously occur with treatment for higher targets when they are assessed to directly cause the primary target behavior, or when they directly interfere with a youth's ability to receive treatment for a higher target area.

For example, if an assaultive youth has an IQ of 65 and has acute ADHD, s/he may struggle to participate in treatment for assaultive behavior when his vulnerabilities are reduced. Therefore, staff will have to alleviate symptoms of ADHD, perhaps through consultation with a psychiatrist to begin or alter medications to improve the youth's ability to respond to direction, and adapt the treatment to accommodate the youth's cognitive impairments.

The JRA treatment hierarchy includes targets for families, as well. These targets are research-based risk and protective factors for families that, when addressed, will improve a youth's likelihood of success upon release into the community.

It should also be noted that staff need to be wary of engaging in behavior that will interfere with youth's ability to address maladaptive behaviors effectively. Poor communication among staff may result in inconsistent reinforcement of youth skillful behavior. It may also result in staff targeting different behaviors at the same time rather than concentrating on the most egregious behaviors currently being exhibited by the youth. Being overly punitive, relying on harsh efforts to control the youth rather than engagement and motivation strategies, failing to effectively use contingency management, or addressing issues out of sequence in the hierarchy are other examples of "treatment-interfering behavior" on the part of the staff. Thus, staff variables as well as youth variables need to be examined and coordinated for effective treatment planning and implementation.

THE JRA TREATMENT HIERARCHY (Table 1.1)

A. Motivation and Engagement

- ☐ Youth is unmotivated for change or learning skills for positive behavior.
- ☐ Youth has a fatalistic attitude and is hopeless for the future.
- ☐ Youth resents or is hostile to pro-social values/conventions and does not see need to change.

B. Is the youth currently exhibiting suicidal ideation, threats, or behaviors?

- ☐ Youth has had a serious attempt to take his life.
- ☐ Youth engages in parasuicidal or self-mutilating behavior.
- ☐ Youth makes statements of suicidal ideation.

C. Is the youth currently exhibiting aggressive ideation, threats, or behaviors toward family, staff, or peers?

- ☐ Youth has physically or sexually assaulted a peer, staff, or family member.
- ☐ Youth has made threats to physically or sexually assault peers, staff, or family members.
- ☐ Youth has verbally assaulted or made aggressive sexual comments to peers, staff, or family members.
- ☐ Youth has engaged in passive-aggressive or covert victimization of peers, staff, or family members.
- ☐ Youth destroys property in excess of $250.00.

D. Is the youth currently exhibiting escape ideation, threats, or behaviors?

- ☐ Youth has escaped from placements and has been absent for extended periods.
- ☐ Youth routinely engages in runaway behaviors for short periods of time.
- ☐ Youth has engaged in escape ideation and threats.

E. Is the youth currently engaging in treatment-interfering behaviors?

- ☐ Youth is inattentive and disengaged during treatment groups or counseling.
- ☐ Youth interferes with others' treatment progress.
- ☐ Youth refuses to attend or participate in treatment groups.
- ☐ Youth does not attend treatment appointments regularly and on-time.
- ☐ Youth is under the influence of substances when in groups or counseling.
- ☐ Youth is not honest in groups or counseling.
- ☐ Youth is not prepared with assignments when attending groups or counseling.
- ☐ Youth is not progressing in treatment groups or counseling.
- ☐ Youth makes excuses or performs behaviors to avoid treatment.
- ☐ Youth engages in unlawful behaviors or supervision violations which contribute to his absence from treatment.
- ☐ Other: _____

F. Does the youth have significant quality-of-life issues? (Research-based risk factors related to recidivism)

- ☐ Youth is homeless.
- ☐ Youth is unemployed or cannot maintain employment.
- ☐ Youth is truant from school, has been suspended more than once, or is expelled.
- ☐ Youth regularly uses or binges with drugs and alcohol.
- ☐ Youth associates with a negative peer group or gang.
- ☐ Youth has no friends, or inconsistent relationships.
- ☐ Youth has been in possession of firearms.
- ☐ Youth has significant amounts of unstructured free time.
- ☐ Youth associates with potential victims or views pornography (Sex Offender only).
- ☐ Youth engages in unlawful behavior or supervision violations.
- ☐ Youth has inadequate problem-solving skills (inability to identify and implement solutions or inability to negotiate with others)

THE JRA TREATMENT HIERARCHY (Table 1.1 Con't)

G. Secondary Targets (Research-based risk factors directly linked to disruptive behaviors that interfere with the youth's ability to receive treatment for primary target)

- ☐ Acute ADHD
- ☐ Significant cogitive impairment (IQ below 70)
- ☐ Significant learning disabilities
- ☐ Neuropsychological factors (Fetal Alcohol Syndrome, Autism, significant brain trauma)
- ☐ Early onset of disruptive behaviors
- ☐ Early onset of substance abuse
- ☐ Early onset of aggression specifically toward peers or close friends
- ☐ Significant grief or loss
- ☐ Significant attachment difficulties
- ☐ Criminogenic beliefs or gang affiliation/lifestyle

H. Family Treatment Targets (Research-Based Risk and Protective Factors Related to Recidivism)

- ☐ Motivation and Engagement: Reducing negativity and blaming within the family
- ☐ Motivation and Engagement: Increasing hopefulness for the future
- ☐ Motivation and Engagement: Increasing positive family beliefs regarding usefulness of education
- ☐ Motivation and Engagement: Increasing positive family beliefs regarding problem solving without aggression
- ☐ Skill Acquisition: Teaching ability to supervise and monitor youth
- ☐ Skill Acquisition: Moving from punitive parenting model to reinforcing parenting model
- ☐ Skill Acquisition: Increasing warmth in family
- ☐ Skill Acquisition: Increasing chemical dependency services to family members
- ☐ Skill Acquisition: Increasing mental health services to family members
- ☐ Skill Acquisition: Increasing problem solving skills in family
- ☐ Generalization: Fostering independence in youth
- ☐ Generalization: Increasing accord and harmony between family members
- ☐ Generalization: Increasing knowledge and use of community resources and support to family (housing, employment, income, community services, and social supports)
- ☐ Generalization: Increasing positive peer groups for family members

II. E. Response Hierarchy

Youth will display different behaviors on the treatment hierarchy in different settings, based upon their **response hierarchy**. Individuals typically have a finite set of responses that they have learned to use to meet their needs in specific situations. The behaviors and the order in which they emerge will vary based upon a youth's developmental level, learning history, strengths and vulnerabilities, and access or opportunity to alternative behaviors. Some behaviors will be viewed as "skillful" or "adaptive," and some will be damaging or maladaptive. The behaviors consistently emerge in identifiable settings because they serve a function for the youth.

For example, a youth in the community who has experienced considerable trauma in the past may have learned to reduce negative thoughts and feelings by self-medicating with drugs and alcohol. This helped to manage painful emotions. What happens to this youth if she is placed in a more restrictive setting where access to her primary coping mechanism of drugs and alcohol is denied? She may resort to her own individual "Plan B," or next available option.

Perhaps, when the same youth had no money in the community for drugs and alcohol, she may have resorted to self-mutilation or self-harm to cope with painful emotions. This is not likely an overt, conscious choice for the youth, but somewhere in her learning history, she came to experience these options as effective in soothing painful emotions. So, when this youth enters an institution where drugs and alcohol are not available to soothe her intense emotional states, we can anticipate that she may exhibit self-harming behaviors if we know she has resorted to this in the past. When youth exhaust or are denied their traditional coping methods before they have learned new skills, they may exhibit unpredictable and escalating behaviors.

Although the behaviors may look different in different environments, the cues to these behaviors often remain the same. Thus, if the experience of "shame" leads regularly to maladaptive behavior (i.e., "the cue"), then the variety of situations that lead to that experience are loaded. Treatment efforts should focus on helping the youth to recognize shame and develop new responses to that experience. This fact is important to understand, so that treatment plans can identify and communicate cues and vulnerabilities across residential and community settings. Communicating cues and vulnerabilities among treatment providers makes it possible for treatment interventions to be generalized from one environment to the next, improving chances for treatment success.

II. F. Increasing Positive Behavioral Skills

Cognitive-Behavioral Treatment plans attempt to decrease problem behaviors through targeting behaviors in order, and they must also attempt to increase positive behavioral skills. A behavioral void is left when youth successfully decrease problem behavior. A replacement behavior must be available for the youth to continue to meet his needs. Cognitive-behavioral treatment combines two components that must be used in conjunction for staff, families, and youth to effectively reach treatment goals. These components are *behavioral modification principles*, and *skills training* and they can be applied in any treatment setting.

II. F-1. Behavior Modification Principles

Behavior modification principles can be divided into categories: reinforcement and punishment. Reinforcement of any behavior increases the probability of the behavior occurring again. Punishment decreases the probability of a behavior occurring again. The following sections discuss reinforcement and punishment, as well as related behavioral techniques.

II. F-1.a. Reinforcement

The use of reinforcement to increase a behavior is one of the most powerful tools staff have to change youth behavior. Reinforcement has the power to increase behavior, and to also engage and motivate the recipient. Unfortunately, no universal reinforcers exist that work with everyone. Effective use of reinforcement is always tailored to the youth's value system, current needs and individual preferences. What does the youth most like or dislike? These items, whether they are tangible, like movie tickets, or intangible, like positive accolades or recognition, can be used in treatment as powerful reinforcers.

Similarly, reinforcement recognizes what the youth needs. If a youth is satiated, having just eaten a five-scoop ice cream sundae, offering him an ice cream cone to complete a task is not likely to create much additional incentive. Individual preferences and current state of need are important characteristics for staff to be aware of in selecting reinforcers to engage and motivate youth.

Two types of reinforcement exist: positive reinforcement and negative reinforcement. A positive reinforcer adds a positive outcome or consequence to the behavior chain to make the behavior more likely to occur again. For example, a youth helps an elderly woman with her groceries (behavior), and she gives him a quarter (outcome). The quarter, or outcome, is added to the behavior chain by the elderly woman. Since the youth finds value in the quarter, the receipt of the quarter makes the youth more likely to help another elderly woman with her groceries. The quarter is an example of a positive reinforcer.

Negative reinforcers remove an aversive or uncomfortable outcome from the behavior chain, making it more likely the behavior will occur again. For example, a small child falls down on the playground and painfully skins her knee (behavior). Her mother puts a band-aid on her knee (outcome), and the child's pain disappears. The mother applying a band-aid removed an aversive aspect to the child's behavior, making it more likely that the child will seek a caregiver for a band-aid the next time she skins her knee.

Another example of negative reinforcement is when a woman takes aspirin for a headache after bumping her head. Seeking aspirin is the behavior, followed by the outcome of a reduction in her head hurting. Seeking aspirin is negatively reinforced by the pain going away, and thus is more likely to occur again in the presence of pain following a minor injury.

The use of reinforcement increases the likelihood that any behavior will occur again, whether the behavior is considered adaptive or a problem behavior. Sometimes, we unknowingly reinforce behaviors we do not want to reoccur. For example, a child asks for a candy bar from her mother in the checkout line at the grocery store. The mother refuses, and the child begins to throw a tantrum (problem behavior). The mother gives the child the candy bar (outcome) to stop the tantrum, and is successful; however, the mother has just positively reinforced

the child throwing a tantrum, making it more likely the tantrum will occur again in the future.

The lesson to be learned regarding reinforcement is that **every interaction with youth is probably reinforcing some behavior**. Understanding this, staff have the ability to choose whether the behavior that will be reinforced is something everyone will want to see again (e.g., a skill vs. a tantrum). Staff must realize the importance of correct behavioral analyses, not only to provide effective treatment planning, but also to help staff avoid inadvertently reinforcing problem behaviors or mismatching interventions within families.

II. F-1.b. Shaping

An effective use of reinforcement to reward new, positive behavior is called shaping. *Shaping* is the reinforcement of successive approximations to teach complex or difficult behaviors, and is one of the most effective skills staff can learn as a treatment intervention.

An example of shaping is learning to drive a car with a manual transmission. Few adults get into a car with a manual transmission for the first time and are able to change gears cleanly and smoothly. More often than not, an adult will stall the engine several times trying to move in first gear, before the car finally begins to move forward. The car moving forward without jerking or stalling is the reward or reinforcer to switching gears with the correct timing. The car moves forward each and every time the driver changes gears correctly, providing consistent, regular reinforcement. This is a key factor in shaping. To successfully shape a behavior, reinforcement must occur on a consistent, regular basis.

An example of shaping when working with youth is providing consistent rewards for improving approximations of success. A youth who demonstrates difficulty or resistance to participating in group discussions is rewarded with a genuine smile, positive accolades, and/or a treat for contributing relevant comments to the discussion, even if he/she only contributes one comment and requires staff prompting to do so. During the next group discussion, the youth is able to volunteer one relevant comment to the group without any prompting from staff, and the youth is immediately rewarded again. The residential counselor reminds the youth of what the goal is (to gain the skill of active participation in group discussion), and gradually, the youth begins to meet the goal.

Shaping not only rewards youth for successive approximations of goals, but also tells youth they are moving in the right direction and working on the right goal. Shaping also assists in breaking down complex behaviors into small steps which can be worked on individually. It also provides the ideal balance of reinforcement in the environment, allowing the youth to have many successes and reinforcers as he/she works toward perfecting a skillful behavior. It is important for staff and youth to clearly identify together the positive behaviors desired to shape.

II. F-1.c. Punishment

A "punisher" is any outcome that decreases the probability of a behavior occurring again. As with reinforcement, two types of punishers exist: positive and negative. Positive punishment adds an aversive or uncomfortable outcome to the behavior chain, making the behavior less likely to happen again. For example, a teenager fails to receive passing grades at school (behavior), so his parents assign him to wash dishes every night and perform yard work for a month (outcome). The addition of the outcome of washing dishes and yardwork may be an effective punishment that lessens the likelihood of the teenager failing school classes again. In this example, the punisher may motivate the teen to work harder in school to avoid future such punishment. It is not, however, directly helping to develop skills that will increase the likelihood that the student will improve the quality of homework and test scores. Requiring the youth to spend Sun-Thur evenings in the house studying (e.g., "focused grounding") until grades improve is more likely to lead to an improvement in grades, especially if combined with available assistance from a parent when needed.

Negative punishers remove something positive or of value from the behavior chain, making the behavior less likely to occur. For example, a teenager fails to meet her curfew (behavior), so her parents ground her for a week (outcome). The loss of freedom for the teenager represents negative punishment, as her parents are removing something of value from the teenager, making it less likely she will miss her curfew again.

Like reinforcement, punishment is only effective if the outcomes are of value to the youth. For example, if the youth in the first punishment example does not find washing dishes and yardwork to be aversive, these outcomes will not be effective punishers, and will likely not influence his school performance.

Punishment is most effective and necessary in situations where immediate reduction of high-risk behaviors is imperative, such as imminent risk of suicide, assault or criminal behavior. Punishment suppresses responding. For example, a youth who has demonstrated chronic, serious suicide attempts may be placed in a room devoid of potentially harmful items like sheets, pencils, and socks. This may be viewed by the youth as punishing, as items of value, like sheets and music, have been taken away from him/her. To earn items back, the youth may have to display more adaptive responses to cues. As an additional benefit, the removal of access to potentially harmful items also blocks the problem behavior of suicide for the immediate moment and keeps the youth alive so that s/he can participate in treatment and learn new skills. Punishment alone will not teach the youth new, replacement skills to suicidal behaviors.

Again, staff must understand the importance of individual assessment as it relates to punishment, in order to understand what outcomes or consequences to behavior are considered effective punishment. For example, a youth who has low

social skills, low athletic ability, and is routinely teased by his peers breaks a window (problem behavior) in the residential unit just before a group recreational activity. The youth is sent to his room and is prohibited from joining the group at recreation (outcome). Is this outcome a punisher? This outcome will probably not decrease the likelihood of the youth breaking a window again. For a youth who does not particularly enjoy recreation and views associating with peers as extremely uncomfortable, the outcome of not participating in group recreation is not aversive. In fact, this outcome actually reinforces the problem behavior of breaking a window, as the youth's shame and anxiety related to peer victimization and athletics are removed.

However, there are limits to the effectiveness of punishment as a behavior modification tool. Overwhelming research reveals that punishment used as a single tool, void of reinforcement, does not reduce maladaptive behavior in the long term. Punishment will only temporarily suppress behaviors. Punishment cannot be generalized to different settings. The use of punishment will stop behaviors superficially and only in the presence of the punisher. The behaviors will usually resurface when the punisher is not present. In addition, the use of punishment alone ha the undesirable side effects of increasing frustration and aggression, and of reducing the desire to work with the person applying the punishment.

II. F-1.d. Extinction

Extinction is an example of punishment, in that extinguishing a behavior makes the behavior less likely to reappear. Extinction is a behavioral modification term that describes the breaking of the link between the behavior and the outcome. Examples of extinction are described in Section C.3., "Blocking the Outcome". When staff block the reinforcing outcome to a problem behavior, the action is also referred to in behavioral terms as "extinguishing the behavior."

For example, a teenager constantly bombards the teacher with seemingly meaningless or trivial questions or requests (behavior), taking her time away from the rest of the class (outcome). The teacher decides to *block the outcome* and not respond to the teenager's every question, but answers only those recognized as meaningful or relevant. By ignoring trivial questions, the teacher is attempting to *extinguish* the behavior of asking irrelevant questions.

Extinction as a behavioral intervention is effective in diminishing problem behavior, but has interesting characteristics associated with its use. When implementing an extinction schedule for a problem behavior, the problem behavior will initially increase. The increase of frequency or intensity of a behavior being targeted for extinction is called an **extinction burst**. For example, the child at the supermarket who throws a tantrum when she is refused a treat will likely make her tantrum longer or more intense, if she has learned that tantrums receive results. If her mother gives in to the more intense tantrum, she has just reinforced the escalation in tantrum behavior for the child. However,

if her mother has anticipated the increased intensity of the tantrum, or *extinction burst*, the mother can maintain her refusal of the treat, and know that her child's tantrum will eventually subside and likely not return when she is denied a treat in the future.

Using extinction to decrease a problem behavior will create a void of behavior that will require a replacement choice. When planning to extinguish a problem behavior, staff will need to simultaneously choose a positive, adaptive skill to teach the youth in order to provide a replacement choice. Thus, when desiring attention, if staff are extinguishing "whining" or pestering behavior, they will need to simultaneously teach the youth a more skillful way to ask for attention. This will reinforce successive approximations in the youth's attempts to use that more appropriate behavior.

A youth will experience high levels of frustration when staff or parents initially deny an outcome the youth has learned follows specific behaviors. Adults should be mindful of this, and work with the youth to plan the extinction process prior to starting. Adults should also coach and soothe the youth during the extinction process to minimize frustration or discomfort, reminding the youth that new and better ways to meet their needs will be available to them through this process.

II. F-1.e. Contingency Management

The term "contingency" in this context refers to "what comes after a behavior," or the outcome. Therefore, contingency management as a behavioral intervention is any response that influences or creates a reliable outcome following a behavior. The strategy of "blocking the outcome" is one example of contingency management. However, contingency management in a broader sense means structuring the environment to foster a youth's success in decreasing problem behavior and increasing positive, adaptive behavior. In order to effectively use contingency management as a treatment tool, staff should always be aware of what is driving both problem and adaptive behavior, with the intention of influencing the drivers to achieve targeted goals.

For example, when thinking about reinforcement, contingency management means ensuring reinforcement is immediate and reliable when helping a youth to acquire new targeted, adaptive behaviors. Contingency management could mean being aware to reinforce positive behaviors, not just punishing or extinguishing problem behaviors. Contingency management could mean prompting or correcting only targeted behaviors, not all problem behaviors at once. It means applying known reinforcers and punishers consistently in response to identified and targeted behaviors.

Contingency management focuses the attention of staff and the family on structuring the youth's environment in a way that facilitates positive behavior change. The ultimate goal of treatment is to teach youth to structure their own

environments to foster a better likelihood for continued positive behaviors. Contingency management is a major aspect of treatment planning and delivery.

II. F-1.f. Cue Removal and Cue Exposure

When teaching or shaping new skills, two behavioral interventions known as cue removal and cue exposure are helpful. *Cue removal* involves decreasing the youth's exposure to the cues or prompting events to which s/he has learned to react negatively. The purpose behind cue removal is to create an environment, when possible, where the youth is not engaged in problem behavior initiated by the cue. This can give the youth the time to learn new replacement behaviors. Cue removal is the idea of allowing a basketball player the opportunity to practice free throws in an empty auditorium (low-intensity and demand situation) before she has to throw the game-winning free throw in front of the home crowd (high-intensity and demand).

Removing cues will enable staff to work intensively to develop behaviors that can be used when the cue is presented. Cue removal can also work within families. If arguments within the family are driving a youth's problem behavior, the family members could be asked to purposely avoid conversations over topics they would historically argue over, while teaching distress tolerance skills to the youth.

For example, through accurate assessment, staff have discovered a youth becomes verbally aggressive in school when teachers give multiple instructions in a short period of time. In treatment planning, staff and teachers agree to give instructions slowly, one at a time to this youth. In the meantime, the youth's support network will work with the youth to improve his skills of accepting multiple instructions, asking for guidance or repetition if confused, and building his tolerance to varying levels of frustration. The youth will have the luxury of learning and practicing new skills without being in a state of frustration or resorting to aggression to reduce the demands coming toward him.

However, the youth's expectations would be unrealistic if s/he were to think all teachers or future employers will give him singular instructions in order to keep his level of frustration and aggression to a minimum. Therefore, once the youth has learned the skills of processing multiple instructions or tolerating frustration, s/he can begin to practice their skills through the intervention called *cue exposure.* Staff and teachers will systematically introduce situations where the youth will receive multiple instructions in order for the youth to practice his new skills. It is important to work with the youth so that s/he is prepared for this escalation in instructions, and to coach initially to remind him/her of the skills to use as s/he begins to experience frustration. Cue exposure is part of the partnership of treatment, and youth should feel supported and encouraged for learning new skills, not punished (through the withdrawal of support) as skills develop.

It is important for staff and youth to take advantage of residential settings where cues can be removed in order to teach new, adaptive coping skills. It is also important that treatment continue in the community, as youth will be flooded with cues prompting maladaptive behaviors, such as:

- exposure to drugs and alcohol from peers;
- a distant or unavailable parent;
- a loud, impatient boss; or
- disappointing situations like rejection by a crush at school.

Thus, it is vital to be aware of the flood of cues likely to be experienced by the youth upon returning to the community, and be prepared to partner with youth in difficult times through role-plays and coaching. For example, a youth generally has difficulty accepting "No" for an answer. When the youth has been taught skills to tolerate being told "No" to a request, the parent could role-play with the youth, responding with "no" to his request and then coach the youth through the interaction. Eventually, when the parent has to respond with "no" legitimately to the youth's request, the parent can continue to coach him, even through a difficult or emotional time.

Cue Exposure has been researched to be very effective with behaviors associated with fear and shame, such as Post Traumatic Stress Disorder. Utilizing cue removal and cue exposure to facilitate treatment for these experiences has been shown to be highly effective. (Foa & Rothbaum, 1997)

II. F-1.g. Coaching and Role-Playing

Coaching and role-playing are effective cognitive-behavioral interventions to assist youth in learning and practicing new skills. Role-playing a scenario or skill with a youth provides a "trial run" opportunity for youth to succeed or fail with no serious consequences. Role-playing and coaching provides opportunities for success for the youth, helps build relationships between staff and youth, and provides a structured intervention for staff and parents to offer support and reinforcement for skillful behavior. Coaching, particularly during highly charged situations, can provide support and confidence to a youth who will eventually be able to handle the same situation on his own with equal or improving skill. Family members are particularly valuable supports who can coach youth when practicing new behaviors.

These interventions are simple, yet highly effective and empirically supported ways of teaching and practicing new skills.

II. F-1.h. Cognitive Restructuring

A powerful advance for clinical psychology was the acknowledgement that a person's thoughts as covert or unseen behaviors play an integral part in behavior. For example, if a person has a belief that "I am a smarter person than everyone

else," the person may be disinclined to back down in an argument. A person who believes s/he deserves material items may be inclined to justify stealing items from a department store when s/he does not have the means to purchase them.

Cognitive-behavioral treatment attempts to examine an individual's cognitive distortions, or "thinking errors", in relation to problem behaviors. By providing education on thinking errors, identifying the youth's individual thinking errors, cueing the youth when s/he uses thinking errors, and then helping the youth to replace thinking errors with more adaptive thoughts and generalize his use of cognitions to affect positive behavior, staff can intervene successfully on this link in the behavior chain.

II. F-2. Skills Training

Cognitive-behavioral treatment combines two components that must be used in conjunction for staff and youth to effectively reach treatment goals. These components are *behavioral modification principles*, and *skills training*.

Important to note is the understanding that **teaching skills alone is not treatment**. Staff must teach skills as replacement behaviors for youth to use when decreasing maladaptive behaviors. The skills, however, are like the ingredients in a soup. Using this analogy, treatment is the actual cooking of the soup, knowing when to add ingredients in order and at what strength, in order to bring out the flavor. Putting random ingredients into a pot is not cooking soup. In this case, teaching random skills to youth without targeting, reinforcing, coaching, and shaping the skills, is not treatment. Staff must also help the youth to understand when and how to use the skill, which is why skills training must be in conjunction with behavioral modification interventions.

Research has shown there are several key elements in the learning of new skills. The skill or behavior should be explained. The skill should be demonstrated or modeled, and then the learner should have an opportunity to practice the skill. The learner should receive feedback or coaching, and then practice the skill again. Once the learner is relatively comfortable with the skill, then an opportunity to practice the skill in a "real-life" situation should be identified, utilized and then the results discussed. A shaping curve should be employed to allow the learner to develop "successive approximations" of a complex skill.

The actual set of skills selected to be taught should reflect the needs of the population being treated. JRA has identified five common cognitive-behavioral skill areas that address and treat the majority of youth's problem behaviors and will provide adaptive replacement behaviors. These include:

- Interpersonal Effectiveness
- Emotion Regulation
- Distress Tolerance
- Problem-Solving

- Mindfulness or Observing

Within these skill areas, JRA has selected specific skills from tested, research-based general curricula, such as Aggression Replacement Training (ART), Dialectical Behavior Therapy (DBT), Moral Reconation Therapy (MRT), and "The Prepare Curriculum" by Arnold Goldstein. For special offender populations, cognitive-behavioral treatment curricula such as the Medlin "Responsible Living" curriculum for sex offender treatment, and harm-reduction/relapse prevention approaches for drug and alcohol abuse will be employed. Each skill has been linked to measurable, relevant risk and protective factors shown to contribute to recidivism.

The JRA behavioral skill sets were selected based upon the ease and readiness with which staff can teach the skills, the needs of JRA youth, and the identification of skills that have been successful at addressing outcomes relevant to JRA stakeholders.

At this time, the five basic skill areas will be recommended; however, JRA will continue to consider the addition of evidence-based specific skills within the five areas as new research becomes available to address the treatment needs of youth.

II. F-2.a. Interpersonal Effectiveness

Interpersonal Effectiveness, as a skills category, incorporates assertiveness and interpersonal problem-solving skills. These skills,

> "include effective strategies for asking for what one needs, saying no, and coping with interpersonal conflict. 'Effectiveness' here has to do with obtaining changes one wants, maintaining the relationship, and maintaining your self-respect...The ability to analyze a situation and to determine goals is crucial for interpersonal effectiveness." (Linehan, 1993)

Typically, youth vacillate between avoiding conflict and intense confrontation. The goal of this skill area is to teach youth to evaluate what s/he wants, what his environment offers, and to apply specific interpersonal skills to get what the youth wants without violating his own self-respect or the dignity of others. Skills in this area are meant to treat a youth that has problems with unstable relationships, history of loss, grief issues, poor peer group selection, a lack of self-respect and poor social skills.

II. F-2.b. Emotion Regulation

The inability to control or tolerate strong or painful emotions can lead to problem behavior. Further, mood states such as depression and anxiety are significant vulnerabilities, reducing the ability to respond adaptively to further stressors.

The Emotion Regulation skill area teaches youth to recognize and identify uncomfortable feelings, and then to tolerate, soothe or change emotions in order to reduce the likelihood of maladaptive behavior. Emotion regulation skills also can be effective treatments for youth who have learned to hide their emotions, and, again, lack the skill to cope with intense emotions and situations.

By changing the way youth feel about situations, youth can alleviate and avoid the cues that would normally give way to problem behaviors. The Emotion Regulation skill area is effective for youth who suffer from intense anger, shame, emotional instability, and a low frustration tolerance.

II. F-2.c. Distress Tolerance

The skills in the Distress Tolerance skill area,

> "emphasize learning to bear pain skillfully. The ability to tolerate and accept distress is an essential goal for at least two reasons. First, pain and distress are part of life; they cannot be avoided. The inability to accept this immutable fact itself leads to increased pain and suffering. Second, distress tolerance, at least over the short run, is part and parcel of any attempt to change oneself; otherwise impulsive actions will interfere with efforts to establish desired changes." (Linehan, 1993)

Distress Tolerance skills teach a youth to accept situations and themselves without judgment, bias, or attempts to control. Specific skills teach coping techniques to youth, including distracting interventions, self-soothing methods, ways to improve one's current situations, and how to evaluate the pro's and con's of a situation. The Distress Tolerance skill area is effective for youth that exhibit egregious behaviors such as suicide or aggression, impulsive self-destructive actions, substance abuse or addiction, and compulsive criminal behavior.

II. F-2.d. Problem-Solving

Because youth and families are faced with complex and confusing choices with few skills to decipher the correct path, the primary purpose of this skill area is to:

- teach youth and families to recognize problems;
- define parameters of problems;
- brainstorm alternative ways for solving problems;
- decide which solution is the best way to solve the problem.

The ability to problem-solve is a transferable skill that can be used in other treatment areas to address many types of personal, interpersonal, and impersonal life events. Problem solving is also effective for youth and families who exhibit rigid, black-and-white thinking and criminogenic beliefs and expectations.

II. F-2.e. Mindfulness or Observing

The skill of mindfulness is taken from Dialectical Behavior Therapy and combines Western contemplative and Eastern meditation practices. Mindfulness takes the non-religious skills of observing, describing, and participating and performs them through taking a non-judgmental stance, by focusing on one thing in the moment, and with a focus on being effective in the activity. (Linehan, 1993) Mindfulness, or observing, allows youth to experience themselves in the moment, to observe their environment, and to be "present." Mindfulness relates to the quality of awareness that a person brings to activities, and allows the person to "show-up" to an event without being distracted or worried about something else.

This skill is transferable and can be helpful in mastering other skills, and it can also help youth to learn to trust their own perceptions, judgments, and decisions. Observing skills are necessary for good problem solving and for accurate behavioral analyses. This skill area is particularly helpful for impulsive youth or youth who exhibit cognitive rigidity or excessive judgment.

II. G Comprehensive Treatment Planning

The cognitive-behavioral treatment model that will direct our residential treatment planning and interventions includes:

- behavior analysis
- the JRA target hierarchy
- basic behavior modification principles
- a skills training model and set
- family and youth involvement

Coordination of these tools to develop treatment plans directly addresses a youth's problem behaviors.

After collecting background information and completing a behavior analysis for a specific problem behavior, a hypothesis is made to identify the best predictor of the youth's behavior. The treatment plan then strategically intervenes at points on the behavior chain in order to decrease the problem behavior. Simultaneously, staff will teach and shape positive, adaptive behavior in order to provide a replacement for the receding problem behavior. Staff must also work with the family or support network to teach them to shape the youth's positive, adaptive behavior.

The behavioral analysis of the example problem behavior of pulling a fire alarm reveals three characteristics about the youth's behavior:

1. The *emotional dysregulation* of fear and anxiety coupled with the youth's *cognitive distortions* created an intolerable situation, or serious problem, for the youth.

2. The *problem behavior* of pulling a fire alarm succeeded in reducing his/her fear and anxiety, as it removed him from the class where s/he was scheduled to give his speech. We can infer that the removal of the youth's problem of fear and anxiety **reinforced** the problem behavior of pulling a fire alarm. We can expect this youth to use the behavior of pulling the fire alarm, or a functionally similar behavior, again in the future when s/he is in an emotionally uncomfortable situation at school, since the behavior was so effective this time.

3. We may also infer that some of the youth's *vulnerabilities* may have increased his likelihood of responding to a cue in a maladaptive way. The youth has a learning disability and historically has not performed well in school. This may have influenced his fear of not performing well on this particular assignment. The youth also recently experienced a disappointment in not getting picked for the basketball team. This event put the youth in a state of frustration prior to experiencing the cue of being asked to speak publicly in class. Additionally, the vulnerability for the youth created from a lack of adequate supervision or availability from a support network may have lent to feelings of isolation and being unprepared for stressful life events, such as developing and practicing a speech.

The treatment plan should combine behavioral modification principles with skills training to intervene at specific links on the behavior chain listed above. Staff and consultants should examine the links in the behavior chain and decide,

- Which link is the most directly causal to the problem behavior?
- Which links can we most effectively intervene upon?

To begin, we determine the presence of overwhelming emotions of anxiety and fear as the most direct causal link prompting the youth to act out. A youth with low skills to tolerate such distress will act in surprising, sometimes extreme, ways, as did this youth. Therefore, the treatment plan should intervene at the emotion link in the behavior chain and include exposure-based interventions and skills training in Emotion Regulation and Distress Tolerance. The treatment plan would specify which skills will be learned and used effectively, and how they will be taught, shaped, coached, and reinforced.

It is also determined that the removal of anxiety and fear reinforced the problem behavior. To intervene upon the outcome link in the behavior chain, the treatment plan includes contingency management strategies, structuring the youth's environment to decrease rewards for problem behavior and increase rewards for adaptive behavior. Contingency management contains a wide variety

of possible interventions, including problem-solving the cue, blocking the problem behavior, and blocking the outcomes, among others. Contingency management interventions pay close attention to the reinforcing outcomes and use this information to extinguish the problem behavior and identify replacement skills to be learned.

We then question whether the youth used cognitive distortions that interfered with his ability to respond adaptively to the cue. Intervening in this link is not only effective, but also relatively straightforward for staff. In the behavioral analysis, the youth told us the thinking errors s/he used after s/he received the speech assignment. The treatment plan should include cognitive restructuring interventions as well as skills training in Problem Solving. Again, the treatment plan should specify which skills will be modeled, and how they will be shaped, coached, and reinforced.

Identified vulnerabilities should be addressed in the treatment plan. Acknowledgement of some vulnerabilities, such as impulsivity or cognitive deficits, will be necessary in the beginning. Some vulnerabilities will be beyond staff's scope to address; however, the treatment plan should identify CBT interventions such as contingency management to minimize the effects of each vulnerability. The treatment plan should also consider whether pharmacology may be helpful in treating the youth's vulnerabilities.

When addressing the issue of teaching new skills, the level of skill the youth has in each area, as well as his *level of motivation to learn new skills*, needs to be gauged. If the youth is not motivated to engage in treatment, staff need to put all of their energies into encouraging the youth and raising his level of motivation.

If the youth is motivated to participate in treatment, a skills-deficit approach instructs us to be certain not to assume a youth is proficient in any skill area. Misinterpreting a youth's lack of performance as willful non-compliance instead of genuine lack of skill can be very damaging to the motivation and engagement of the youth who receives punishment, and it directly interferes with treatment success by preventing staff from focusing on skill development. Staff and consultants can use a "Decision Tree" (Table 1.4, modified from Linehan's model) to decide:

- Does the youth have the skill?
- What is getting in the way of the youth using the skill?
- What interventions can staff use to teach the skill effectively?

Treatment will progress through the treatment hierarchy, addressing problem behaviors and focusing on skills training, while maintaining motivation and structuring the environment to reward success. The treatment plan should:

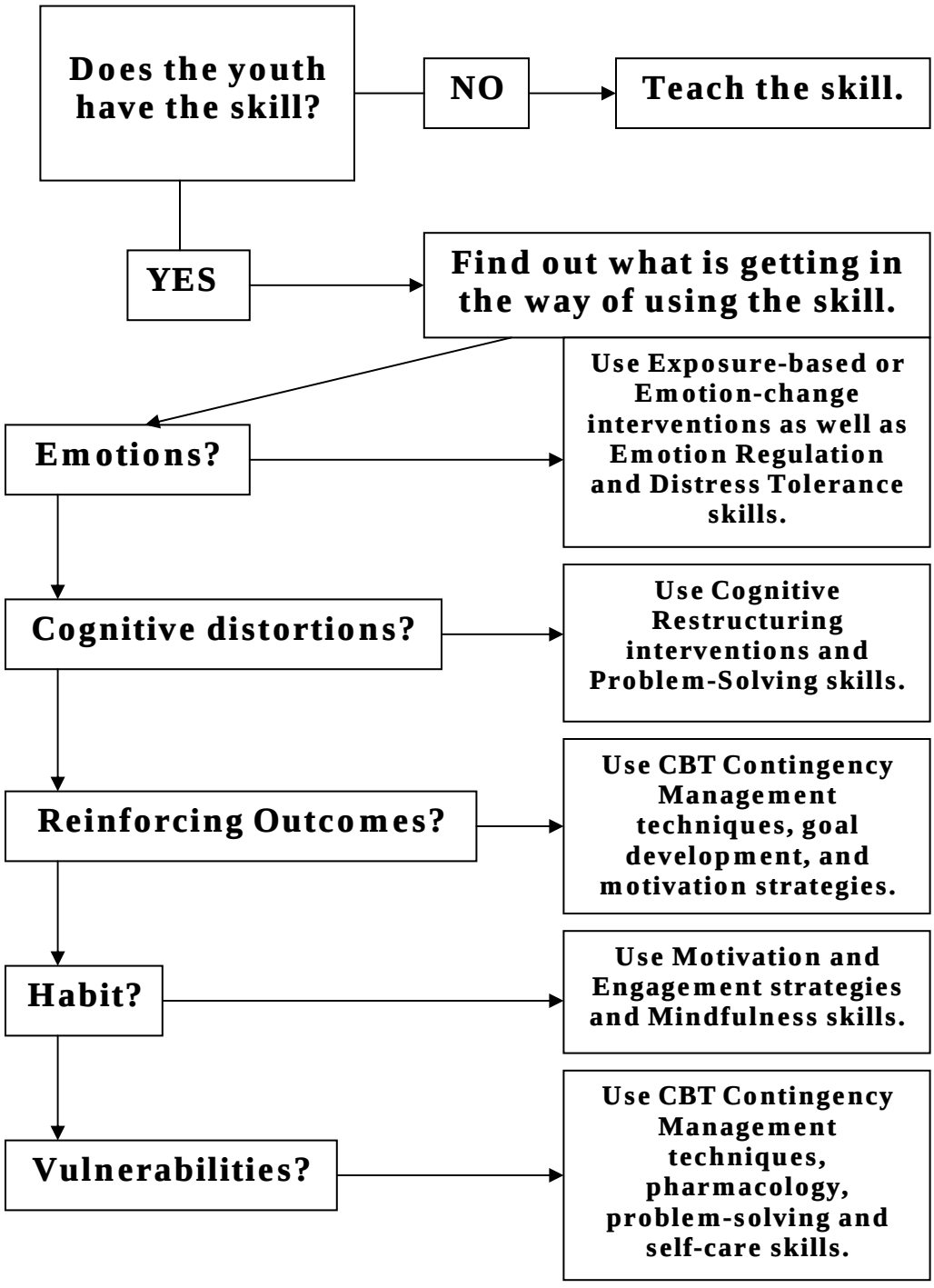
- represent a coordinated effort among staff, youth, and families;
- specify who will be performing what intervention and how often;
- orient youth and family to the structure and purpose of treatment interventions;
- identify expected outcomes clearly in cognitive-behavioral terms to all members of the treatment team, including the youth; and
- indicate a review process to evaluate progress and amend treatment plan.

Treatment interventions should be routinely evaluated with the youth for effectiveness. If an intervention does not seem to be working, the behavioral analysis should be re-examined for new information or data. Staff should examine their implementation of the plan for consistency and accurate identification of the problem and solution. If there is continued lack of success, then consultation should be sought. Otherwise, the treatment plan should be evaluated every ninety days to measure and document progress, and to add additional behavioral targets as the youth progresses.

Table 1.4

CBT Skills Deficit Decision Tree

CBT Skills Deficit Decision Tree



III. Transition

Transition begins the day a youth walks into a JRA facility. Placement planning, family reconciliation, engagement and motivation, skill assessment and skill development are all geared toward getting a youth ready to function crime-free in the community. Once a youth completes his/her residential stay in JRA, s/he will return to the community. Hopefully, the youth will have gained significant individual skills that can assist him in successful re-entry. The majority of JRA youth return to their families of origin. It is here that they attempt to sustain the positive changes they have made in residential care. It is also here that youth must generalize the skills they have developed while residing in a JRA facility. Virtually all the existing research on adolescent offenders suggests that maintaining a crime free life style is possible only by working in the context of the family or support network. In the family setting, youth can not only use their new skills but the entire focus of the "problem" changes. In the community, the family is both the source of the problems and the critical link to a partnership leading to a positive solution.

While in residence, staff will engage the youth, the family, and parole staff in parole planning and building a positive support system. Residential and parole staff can help assess the family structure and the youth's problem behavior as it relates to that structure. Staff will also be working with the youth to develop skills that will strengthen interpersonal relationships, as well as with the family to understand their child's treatment experience. Residential staff are responsible for communicating the youth's treatment progress in learning new skills and what reinforcers are known to be effective for individual youth to generalize new skills.

IV. JRA's Treatment Framework for Parole Services: Functional Family Parole

What is a family-focused case management approach in the community? In the 1960's and early 1970's, delinquent problems were individually-focused and residential placement was seen as a useful tool to take the youth out of the "problem family." Published interventions with families were not available and if youth floundered upon their return to the community, families were believed to be the source of the failure.

Family system treatment approaches have roots in the philosophies of Haley, Bell, and Patterson. The philosophies provide a conceptual framework that can guide understanding of the family. Conceptual frameworks can be useful; however, when dealing with a population of adolescents in juvenile justice, who are often difficult to treat, more extensive techniques and strategies are necessary. The following description of the development of Functional Family Therapy (FFT) illustrates the need to serve this overlooked population.

> "In the late 1960's and early 1970's adolescents in the juvenile justice and mental health systems represented a group that was difficult to treat and not particularly motivated to change. Many came from families with few resources. These youth and their families very often entered the system resistant, fearful, hopeless, disrespectful and angry, and many had already failed at many change attempts. Existing published intervention models were not available for such clients, and it appeared that the field did not know how to treat them. While clinical outcomes were poor, the usual conclusions were that the youth and their families were the source of failure." (Alexander 2002)

Functional Family Therapy (FFT) and Multisystemic Therapy (MST) are two community-based models that have been successful working with criminal youth. These two community-based treatments are family-centered. Both models examine the behavior of the youth in the context of the family and effectively change maladaptive behaviors. FFT and MST have research to prove their ability to change family behavior and to reduce future criminal behavior.

In looking for a model to use in its community parole program, JRA knows 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.

JRA also recognizes that 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 JRA.

> "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, JRA has selected Functional Family Parole (FFP) as its 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.

V. Components of Functional Family Parole

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.

FFP has specific parole counselor skills to accomplish the key goals of each phase. Three skills are:

- Reframing
- Creating a Balanced Alliance
- "Matching To" Principle

The FFP assessment process allows the parole counselor to understand the function of the family behavior. The parole counselor works to change the family definition of the problem. Instead of being individually focused, the problem is

defined as a relational issue between family members. FFP requires assessments to determine what is the best course of action with a family. Problem sequencing, relational assessment, and an assessment hierarchy are the key assessments made with every family.

While Functional Family Parole (FFP) is based on the principles of Functional Family Therapy (FFT), it is not therapy. Like FFT, FFP has three phases. FFP uses the skills of "reframing" and "matching to" to build an alliance with the family and to improve outcomes. However, the parole staff is not the "change agent" as an FFT therapist must be. An FFT therapist performs the following tasks during the Behavior Change (second phase) portion of an FFT intervention:

- selects a new behavior for the family
- teaches the family how to perform the new behavior
- modifies the new behavior if it is not working
- finds resources for the family to support the family's new behavior.

On the other hand, the parole staff in the Support and Monitor (second phase) portion of FFP makes a decision about whether the family has a skill to use. If there is not a skill, the parole counselor uses "match to" to select the best available service for the family. If there is a skill to use, the parole staff encourages the family to work with the youth to generalize (third phase) the skill.

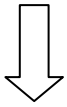
V. A. Reframing

Youth and families are more likely to participate in treatment if they have hope that change can occur. To increase hope, it is essential to reduce negativity and blame within the family. Parole staff reduce negativity by identifying the possible positive intent behind what has been labeled as "problem behavior." FFP calls this process reframing. Reframing is a form of cognitive restructuring, implemented by the parole staff. Its purpose is to change the family's emotional response to a behavior.

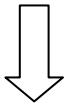
Each reframe is a four-step process. The diagram below is an illustration of the process.

1. Validate

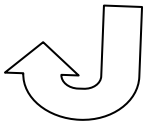
2. Reframe underlying motive or intent.



3. Assess acceptability /fit.



4. Change /Continue as necessary.



The first step in reframing is to find a way to validate the primary meaning or position of the speaker. This helps to support and engage the family member describing the problem.

For example, a common issue with adolescents centers on having independence from parents. In a family situation, the parents and youth may argue about the youth staying out late and not communicating his or her whereabouts. Faced with this conflict, the parole counselor could validate the parent's anger by acknowledging the presence of anger. The parole counselor may then suggest the parent is worried about the youth. Eventually, the parole counselor might reframe the youth's behavior by attributing it to the youth's desire for independence. The reframe statement might be: "You are angry at Sam for being

out late. I wonder if you are also especially worried about where Sam is and if he is safe." The family would then have an opportunity to respond and agree or disagree with the statement. If the family disagrees, the parole counselor could ask for more details. The next reframe might be slightly different: "You are angry that he seems to not care about how you feel, and yet part of you is sad because you know that Sam is growing up and is becoming more independent." The goal is to create a reframe statement that the family accepts and that has the ability to reduce blame and negativity in the family. The first attempt to reframe the situation may be wrong. In fact, it is sometimes helpful to be wrong because it provides an opportunity to gather more information. In the example, Sam's behavior is now explained through the reframe as triggering feelings of sadness in his parent. Reframing helps family members find a way out of the defensive, blaming, and negative behavior patterns that dominate the family.

In some ways, family members experience some confusion in response to reframes. This confusion gives the family members distance and helps stop the automatic negative reactions, such as yelling and fighting. The reframes are constructed with the family and mutually agreed upon by the parole counselor and the family. Over time the individual reframes can grow into a theme that is a complex alternative explanation of the "problem." If the family problem regularly revolves around Sam's staying out late, this reframe might develop into the theme of the family. The theme can then point the family in the direction of a service that will help with the problem. In the meantime, the reframe allows the parents to feel more than just anger at Sam.

For a parole counselor, the reframe has several useful purposes. It helps reduce the negativity that families frequently present during meetings. Second, it can suggest a way to introduce a service to the family that will lead to long term change. Finally, the reframe helps the whole family have hope that change can occur and instills motivation to change.

V. B. Balanced Alliance

To be most effective with families, a parole counselor must establish an alliance with each family member. The degree of alliance should be balanced, so each family member believes the parole counselor is on his or her side and understands his or her point of view. Outcomes with families are actually improved when the alliance is balanced.

Alliance with family members is built when the parole counselor validates the thoughts, statements, or feelings of a family member who is speaking. The validation occurs as part of the reframe described in the previous section. When each family member feels equally close to the parole counselor and experiences the counselor as someone who understands his or her perspective, the alliance is balanced. An alliance that is balanced has the parole counselor validating each persons behavior and demonstrating how each family member has responsibility for the "problem" in the family.

V. C. Changing the Definition of the Problem

Another process that occurs in the engagement and motivation phase of FFP is adjusting the family definition of the problem. When youth arrive at JRA, they are often blamed for the problems that exist in the family. This provides the other members of the family a means of escaping responsibility for the things that go on in the family. To adjust the definition of the problem, the parole counselor must shift the problem from being "someone's fault" to something relational that goes on between family members.

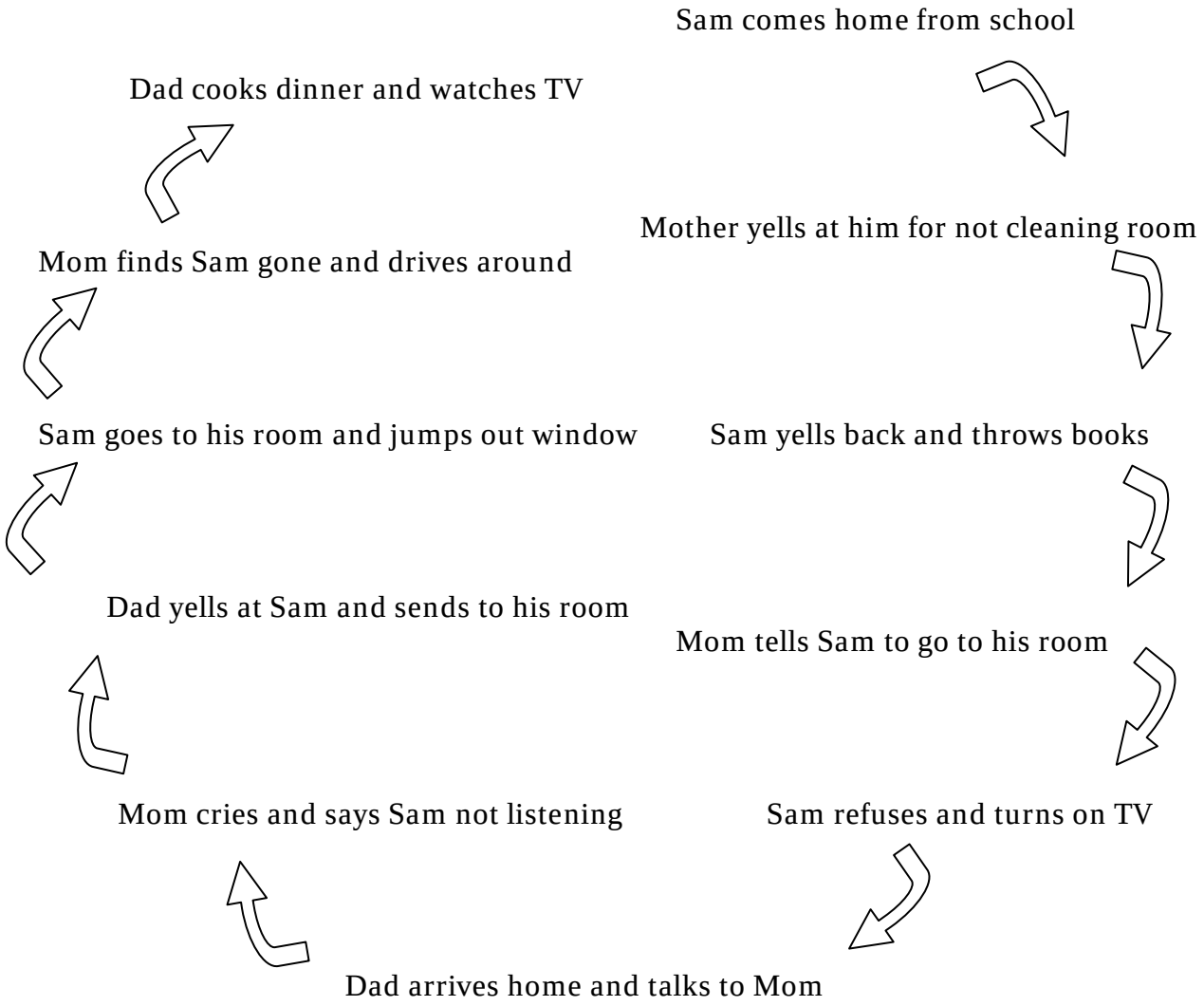
An example of making the problem relational could be a family that argues to the point of physical violence. A parent may say that the problem is the youth does not listen to parents. The parent blames the youth for the problem. The youth may accept the blame or redirect blame back to the parent. FFP attempts to make the problem relational. Reframes assist the parole counselor in making this shift. The parole counselor might suggest that the parent loves the child so much that he or she will do anything to protect the youth (overprotection). The youth wants to grow up and show the parent how they can make decisions. The problem could then be defined as a parent who cares too much and a youth who wants to be an adult. Sometimes the emotions between them get so intense that arguments and physical violence erupts.

Once the definition of the problem is shifted a solution can be found. The solution to the problem becomes finding a way that the family can still care deeply without getting into physical altercations. The family service plan will create a change that fits the family and stops violence from erupting.

V. D. Problem Sequencing

To better understand the family, FFP uses a type of "chain analysis" that identifies how everyone in the family is connected. Behaviors in the family usually have a predictable pattern, which is seen when "problems" are examined over time. FFP assumes that the "problems" experienced by the family are embedded in these patterns or problem sequences. To understand the pattern, the parole counselor must ask the family members to describe the events preceding and following the "problem behavior."

If the problem behavior is a verbal argument that escalates until Sam leaves the house and stays out all night, the problem sequence might look like:



In this problem sequence, Sam and his parents are engaged in a family pattern of behavior. The diagram is a picture of the problem sequence. The problem sequence helps identify the functional outcomes of the family behavior. The

functional outcome is determined by where each person is physically or emotionally when the "dust settles". From the sequence, parole staff can begin to make guesses about the relationships between the family members.

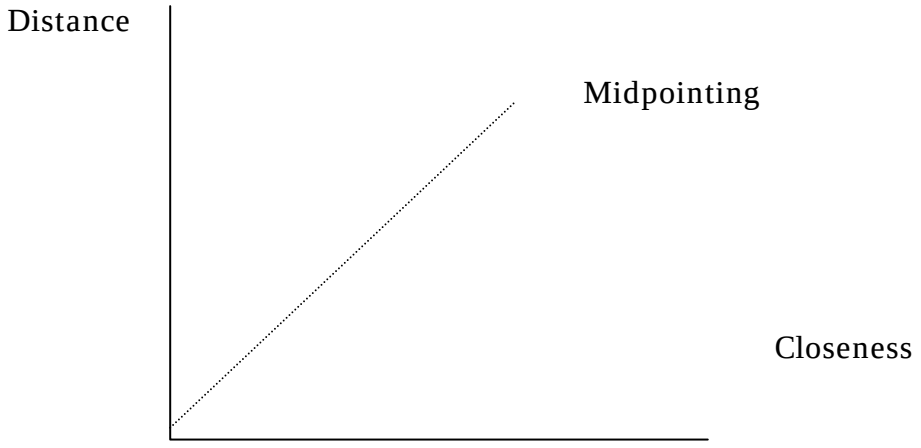
For example, Dad cooking and watching TV while his wife searches for Sam shows that he does not feel compelled to find Sam. The dad may provide a multitude of explanations for his behavior but the outcome is the same. The dad does not go looking for Sam. It is important not to judge the father's behavior, but to accept the behavior and understand what it says about the relationship between Dad and Sam. Dad does not seek to be close to Sam.

Problem sequencing is used with a family to identify which "problem" to target for change. Often the selection of the "problem" to target is the problem sequence that leads to the youth engaging in criminal behavior. FFP utilizes some specific family risk and protective factor information to decide which family "problem" if changed is likely to reduce further criminal behavior by the youth. If, for example, Sam after leaving the house meets up with his friends and steals a car to go joyriding, then the likely targeted "problem" will be the above sequence.

The problem sequence serves multiple purposes. One purpose is deciding where in the pattern of family behavior to make a change. The parole counselor reviews the problem sequence and identifies a place that the sequence can be interrupted. Interrupting the problem sequence is the first part of establishing a change in the family behavior.

V. E. Relational Assessment

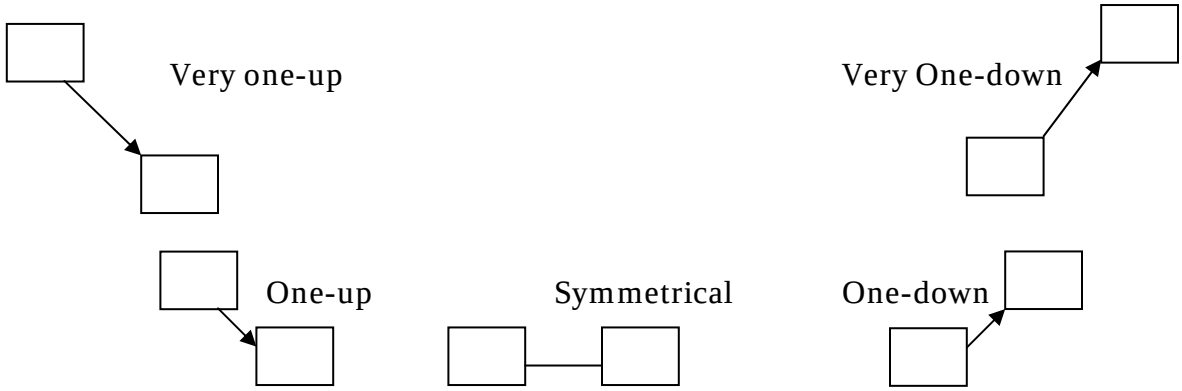
Relational assessment describes the family in two dimensions. The first is a relatedness scale, which describes the space between two people (closeness vs. distance). Closeness is more contact, physical or emotional between two people. Distance is characterized by more physical or emotional space between two people. The scale below illustrates the FFP relatedness scale:



Problem sequences are used to determine where on the relatedness scale each family member falls. There will be an assessment for Mom to Sam; Sam to Mom; Dad to Sam; Sam to Dad; Mom to Dad and Dad to Mom.

The second dimension is hierarchy (one-up vs. one-down). Hierarchy also describes the relational pattern between two people. A one-up person is more likely to be directing the second person's behavior. A one-down person is more likely to be directed by the other person.

The diagrams below illustrate the hierarchy scale.



By leaving home, Sam is gaining physical and emotional distance from Mom and Dad. When Mom goes out looking for Sam, she is attempting to find and be close to him. Dad yells at Sam and watches TV. Dad's behavior indicates he is not interested in closeness and is more distant from Sam. Dad, who talks to Mom about Sam and then watches TV while the Mom drives around, seems to be midpointing to Mom. (Midpointing is the place on the relatedness scale between closeness and distance.) Mom could be seeking some level of closeness to Dad, evidenced by her asking for his help.

The hierarchy in this example family is established by examining who directs the behavior of whom. The mother is probably one-down to the son. This can be deduced from mother telling son to go to his room, and son refusing. The father is one-up to Sam since Sam does go to his room when told by Dad. Sam jumping out the window is evidence that the father is not very one-up to the youth. From this example, it is difficult to determine the hierarchy between Mom and Dad, but it is possibly symmetrical, meaning they mutually agree on what to do.

FFP principles require that relational assessment guide the selection of interventions. The services will not attempt to change the family relational pattern, but to introduce new behaviors that lead to more functional behavior in the family. For example, the distant youth will remain distant following the

intervention. However his behavior will result in a better overall outcome for the family.

For example, Sam and his parent argue about coming home late from school. Sam argues that he should be able to spend time with his friends after school. Mom argues that she worries when she does not know where Sam is and thinks he will get into more trouble. The family might agree that Sam is allowed to spend time with his friends after school. To do so, however, he must leave his mother a message stating with whom and where he will be, and what time he will be home. If Sam fails to give the information, the family all agree that Sam will spend the following weekend at home. Sam leaving a message allows Sam to be distant from Mom.

In a community setting, it is highly likely that the relational patterns described above are playing a part in maintaining the "problem behavior".

V. E. 1. Other Assessment

In FFP, a parole staff will also utilize the Intensive Parole Supervision Assessment (IPSA) to identify risk and protective factors that contribute to the youth and family continuing to experience difficulties. The parole counselor when creating the family service plan will review the IPSA and whenever possible select an external service that:

- matches to the family relational pattern
- creates change that interrupts the problem sequence
- addresses a risk and/or protective factor identified on the IPSA

The IPSA is also utilized to select which of multiple presented problems should be targeted first for change.

V. F. "Matching To"

Once the family relational pattern has been identified, the parole counselor has several tasks and choices. One choice is whether the family will be referred to an outside service. If the family will be referred to a service provider, the parole counselor must look at the relational pattern of the family and decide what service "matches to" the family. "Match to" is determined by whether the service will work within the hierarchy and closeness vs. distance of the family. For example, the parole counselor who is working with the one-down mother would not send the mother to a "Tough Love" course. The mother being tough with the youth does not fit or "match to" the mother who is not in charge of her son. The one-down mother might be better off if she and the youth participated in a communication training that entailed more effectively making requests.

If the family is not being referred to an external provider, the parole counselor must decide how to assist the family in managing conflict and problems that are likely to arise. One possibility is using the relational pattern in the family to examine the use of what the youth learned while in the institution. For example, one youth learned assertiveness skills in the institution. His father is very one-up to the youth, meaning the father tells the youth what to do. It is likely that the youth will need help in finding ways to get what he wants from his father. The youth may need coaching on how to make requests rather than tell his father what he wants.

The parole counselor might also use a reframe with the father. The reframe might be, "You have worked hard to teach your son to do the right thing. When he listens to you, he seems to stay out of trouble. You also know your son is growing up and trying to be independent. Sometimes his not listening to you is his way of being independent." This reframe validates the father, and also attributes something positive to the son's not following directions. The reframe will reduce the negativity the father experiences and help the father see the need to change the family behavior pattern.

The parole counselor will use "match to" as a way to adjust his or her behavior with the family members. Each family member will have a manner of relating to the parole counselor. The manner can be assessed using the relational assessment (distance vs. closeness) and the hierarchy assessment. The parole counselor will be more effective working with each family member by "matching to" each family member.

For example, if a youth's father is one-up and distant from the parole counselor, the parole counselor would approach the father from a one-down position. A one-down position would have the parole counselor making gentle suggestions rather than giving directions. The parole counselor could maintain distance by speaking to the father only by telephone on a scheduled monthly basis.

On the opposite end of the spectrum, if a parent is one-down to the parole counselor and seeks closeness with the parole counselor, the parole counselor would relate to that parent by being one-up and giving the parent clear feedback and instructions. Closeness with the parent could be established but controlled by having the parent leave detailed voice mail messages weekly on what is happening in the family. The parole counselor will then be able to listen to the parent's message and call the parent back with brief directions for the parent. This saves the parole counselor time and structures the interactions with the parent.

V. G. FFP and Links to Cognitive-Behavioral Principles

For parole counselors implementing FFP, it is important to see how the FFP model ties in with the treatment provided to youth in residential facilities. Parole staff should know behavior modification principles and the skills taught to youth

in JRA residential facilities. Techniques or skills must be implemented for the entire family and follow the FFP principle of "match to". Parole staff will have some amount of cross-training in both models. Some examples of CBT interventions which will be translated for parole settings include:

- Blocking the problem behavior
- Problem-solving the cue
- Contingency management
- Reinforcement and punishment

V. H. Use and Fine-Tuning of Existing Skills

Youth will return to the community having learned new skills and behaviors in JRA facilities. The youth has been encouraged to apply the new skills to situations in the community. Youth will require encouragement to recall and use the skills they learned. The skills fall into five major categories. They are:

- Interpersonal Effectiveness
- Emotion Regulation
- Distress Tolerance
- Problem Solving
- Mindfulness or Observing

When a youth has been released to the community and has mastered one or more skills taught in the institution, s/he should be encouraged to use the skills and be given opportunities to discuss application of the skills at school or at home. The parole staff has an important role to be supportive of the youth and family as they apply new skills to real-life situations. At times, the parole staff may remind the youth of what s/he learned and ask how it could be helpful in a current situation.

Youth and families will need to adapt the skills to real-life situations to be effective. The parole staff may choose to work with the family to adapt the skill to match the family's manner of relating. The adaptation is guided by the relational assessment of hierarchy and relatedness (closeness vs. distance). An example of fine tuning a skill is provided in a later section of this report (Section VI. B.).

VI. Application of Functional Family Parole within JRA Parole Services

JRA parole staff will implement FFP following the three-phase model. It is important to recognize that the phases of this parole model overlap. As such, the activities in each phase may continue into the following phase.

VI. A. Engage and Motivate

The first task facing all parole staff when a youth is released to the community is to engage and motivate the youth and the youth's family. Family is defined broadly as the people with whom the youth lives. Engagement begins with a meeting between the parole staff and the entire family. The parole staff must immediately begin to reduce any negativity or blaming that is going on between family members. This is accomplished through the use of reframes.

For example, the parole staff sits down on the youth's first day on parole with the youth, the father, and the mother. The father may comment that things will be fine as long as Johnny keeps his nose clean and does not smoke pot. While this statement may seem true to the parole counselor, the statement also is negative toward the youth. If the parole staff agrees with the parent, the youth will feel that the parole staff is "on the parent's side". To offset this impression, the parole staff uses a reframe. Speaking to the father the parole counselor might say, "You worry that Johnny will have problems if he uses marijuana again, and yet it seems you have a belief that he can do well." The parole counselor gives the father an opportunity to reply. If the reframe fits, it has the impact of validating the father, but also bringing out the father's positive intent toward the youth.

The parole staff creating a balanced alliance with all family members increases motivation of the family. The parole staff must meet with the whole family whenever possible to create the balanced alliance. If meetings occur with parents prior to a youth's release the conversation should describe how parole is a family-focused service and not about the youth or the problem behavior.

In the example reframe of Johnny, the parole staff's reframe validates the father and builds alliance, but also builds alliance with Johnny because the parole staff demonstrates a positive belief in the youth. To balance the alliance the parole staff must reframe each family member's behavior and demonstrate understanding, support, and concern for each member of the family. In this way, every family member feels hopeful and sees the parole staff as "on my side." This alliance will be built in no less than two meetings.

VI. B. Support and Monitor

Once a family demonstrates hopefulness, engagement, and motivation for change, the parole staff moves into the support and monitor phase. At this point the parole staff has to make decisions of how to best serve the family.

First the parole staff will have made guesses about the family's relational functioning: hierarchy and relatedness (closeness vs. distance). These guesses guide the decisions about whether a family is referred to an outside service or receives support to generalize existing skills. Another factor in this decision will be if the family has sufficient skills that supporting them will lead to change.

When linking families to services in the community, the parole staff must pay attention to two things. First, what is the relational pattern of the family? Success in any service will be determined by how well the service matches the family. If the service does not match the family, they will not attend and will not be helped.

Second, the parole staff needs to know the services available in the community. This is not just knowing how to contact and refer families, but also knowing the treatment content and style of the service provider. One counseling center may employ three staff. Each of the three may have different ways of working with families. The parole staff will get the best service match if a referral to service can select not only the service provider, but also the actual staff who will see the family.

Some services will not suit a family's relational style. For example, if a mother is "one-down" to the child, she would not be referred to a parenting class that teaches her to take charge of the family. This would be a bad match.

If the parole staff decides to support existing skills, s/he will need to know the family relational pattern and to select one skill that will be generalized. For example, if the skill is "Making a Complaint" from the Aggression Replacement Training curriculum, it may work very well for a youth when speaking to his/her mother with whom s/he shares equal footing. However, if dad is one up, the skill which requires the youth to "tell the father what he would like done" does not match to the hierarchy between the youth and the father. To fine-tune the skill the parole staff would work with the family to have the youth ask the father if something different could be done. The youth might then suggest some possible options for change. The father would choose the option for the family.

In order to provide the family with this level of assistance in generalizing skills, the parole staff will need a working knowledge of the skills that are taught to youth in the residential facilities. To achieve the working knowledge of the skills, parole staff will need training and exposure to the CBT skill set that has been provided in the facilities. Parole staff must know how skills are used and be able to prompt youth to use the skills in appropriate situations. Parole staff should also have access to consultation from a person who is more expert in the use of the skill set.

Families who have learned problem-solving will initially require coaching. This is especially important so the resolution to the problem matches to the family. The goal of problem solving is not to negotiate a middle ground, but to arrive at a resolution that allows the family members to remain relationally the same, but with better outcomes. For example, a mother who is distant to her son, and a son who is in need of contact with his mother, would need a resolution that allows the mother to remain distant, while meeting the needs of a son who wants contact from her. A resolution that would meet needs of both family members could include the mother leaving her son a note he could read at the end of every day.

Another resolution includes the son calling his mother's voicemail at the end of his school day. If possible, a service provider for the family should be encouraged to teach the family problem solving that leaves the family relationally the same.

VI. C. Generalize

Once a family has either completed a service or fine-tuned the necessary skills, the parole staff moves into a role of assisting the family in generalizing change. Generalization can take many forms, but is often relapse prevention planning, coaching, and encouraging the family to use what they have learned. When families experience "failures or relapses", the parole counselor reframes the failure as an opportunity to learn and refine the skill. Coaching and cheerleading the family helps them move beyond small setbacks. The parole staff reminds the family about the discussion about how things will get worse but can get better again if they use the new behaviors they have learned.

Another activity parole staff do during generalization is assist the family in finding ongoing help, support, and resources that will continue beyond parole. This may include community mental health services, parent support groups, YMCA or Boys and Girls Club activities, or even asking a neighbor to help. Again the parole counselor attempts to match the service to the family relational pattern and build in support for the family continuing the small changes that have been made.

VI. D. Family Service Planning

Parole staff will develop a family service plan for each youth on parole. The family service plan will identify the activities or services to be provided to the youth and the family. The parole staff will create the family service plan during the engagement and motivation phase. To create the plan the parole staff must have an understanding of:

- The family relational pattern
- The family problem sequence
- The youth's risk and protective factors
- The youth's and family's skills

Once a family is engaged and motivated to work with the parole staff the parole staff must determine if the family has sufficient skills to make a small obtainable change or if an additional service will be necessary to obtain the small change.

If the family does have skills, the parole counselor will work with the family to fine-tune the skill to interrupt the family's pattern of behavior. This will often take the form of helping the youth adapt a skill learned in the residential setting to match (fit in to) the family.

If the family does not have sufficient skills to obtain a small change, the parole staff must decide what service would assist the family in achieving success at a small obtainable change. The service should be relevant to the family problem sequence and target a risk and/or protective factor. The service must also match to the family relational pattern.

If the family presents a multitude of problems needing change, the parole staff must select one problem sequence to interrupt. The selected problem sequence must reflect the youth's risk and protective factors and also be likely to reduce the likelihood that the youth will reoffend. It is possible that the family will be reluctant to address some problems; however, the parole staff must target a problem that is relevant to the youth's criminal behavior.

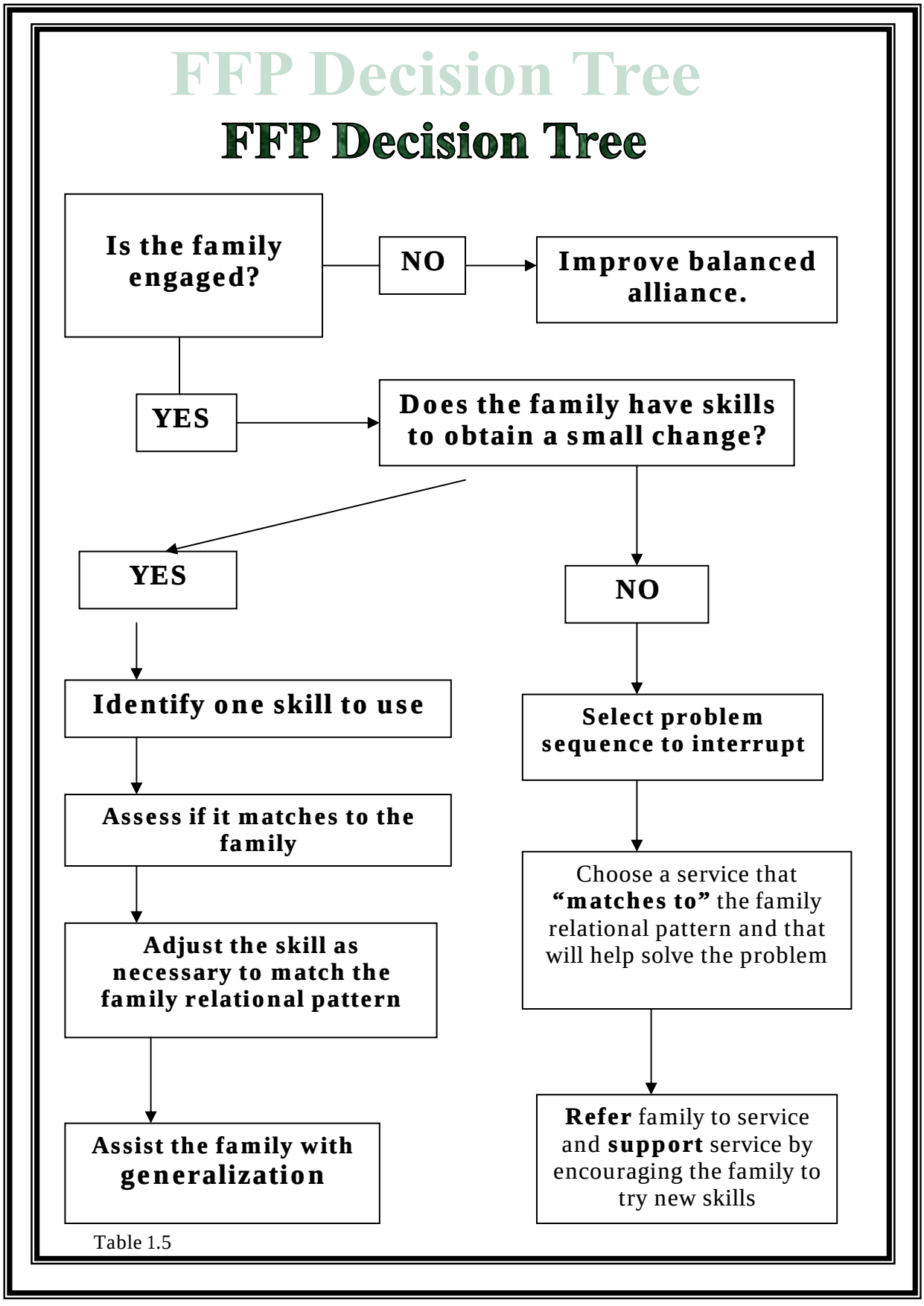

FFP Decision Tree
FFP Decision Tree
Is the family engaged?
NO
Improve balanced alliance.
YES
Does the family have skills to obtain a small change?
YES
NO
Identify one skill to use
Assess if it matches to the family
Adjust the skill as necessary to match the family relational pattern
Assist the family with generalization
Select problem sequence to interrupt
Choose a service that "matches to" the family relational pattern and that will help solve the problem
Refer family to service and support service by encouraging the family to try new skills

Table 1.5

VI. E. Integration with Parole Types

FFP will be applied to all youth on parole whether the youth is on Intensive Parole, Enhanced Parole, Transition Parole, or Sex Offender parole. Intensive Parole which is designed to follow the OJJDP Intensive Aftercare Program (IAP) model as an overarching case management model for highest risk youth (per RCW 13.40.212), fits with FFP. The key elements of the IAP model and FFP blend well, especially the model requirement that the family is the unit of intervention, not just the youth.

Youth receiving transition parole will only receive the Engagement and Motivation phase of FFP. Parole counselors will attempt to refer Transition Parole youth to available services in the community. All other parole types will receive all three phases of FFP. In addition, youth who are dependents of DCFS or live alone will also participate in all three phases of FFP. The parole staff will use the reframe skill with individuals such as teachers, counselors, group care providers, or employers in order to build a support system for youth who do not have a "family" system to support them.

VII. Use of the Integrated Treatment Model Throughout JRA

VII. A. Management and Administration

To effectively implement any treatment model across an organization, the model must be "transparent," or applicable to every individual and situation within the agency. Cognitive-behavioral treatment principles work because they are universal. They do not apply only in certain situations or to certain populations. Reinforcement and other behavioral modification principles work on all human behavior.

In order to **motivate and engage** staff and other stakeholders, managers need to be able to orient and educate them to the vision and direction of the agency. JRA proposes its vision and direction of treatment services to be grounded firmly in research-based, cognitive-behavioral treatment principles. Administrators need to understand and be able to speak plainly about CBT and FFP, as well as provide a context to staff and stakeholders for the practical decisions and resource allocations associated with execution of the treatment model.

Perhaps nothing can be more motivating or engaging to staff than the ability to effectively perform their duties and when an administration understands the function of treatment interventions and provides the resources needed. By understanding cognitive-behavioral treatment, administrators can actively support efforts at effective treatment interventions and can prioritize limited resources to get the most return for staff and youth.

Through competence in the treatment model, administrators can **structure staff's environment**, creating a likelihood of success in the treatment of youth.

An example of this is the ability to hire and promote staff and consultants who demonstrate expertise in the model, thereby furthering the effectiveness of the treatment model and services for youth. Administrators will be able to discern appropriate training programs for staff, directly influencing the **skill acquisition** of staff.

Administrators who understand behavioral modification principles will be more likely to shape and reinforce skills in staff to change behavior, thereby modeling these principles to staff for use with youth. This indicates administrators will need the skills to target behavior systematically, develop specific behavioral interventions to decrease problem behavior, and be able to use skill acquisition and **generalization** to increase adaptive behavior.

Administrators help staff generalize their skills by using behavioral interventions such as coaching, modeling, shaping, and reinforcement. Using these interventions also highlights the administrator as a member of the treatment team.

VII. B. Diagnostic Services

Diagnostic program staff are in a unique position to impact youth and families. As the first contact or representative from JRA contacting youth and families, diagnostic staff has an outstanding opportunity to **motivate and engage clients** to participate in the JRA treatment process. Although Diagnostic staff have limited contact with youth, they are able to take advantage of the adage, "Every interaction reinforces a behavior." Diagnostic staff influence the relationship between JRA and the youth and family, and can initiate a positive path for treatment investment through the attitudes and values conveyed during interactions.

Diagnostic staff motivate and engage youth and families by providing an overview to JRA, answering questions about JRA, and helping the family navigate through JRA by explaining the continuum-of-care. Diagnostic staff also motivate and engage youth and families by orienting them to cognitive-behavioral treatment, explaining programming expectations and, most importantly, what the youth can expect to receive for his or her investment in treatment. They can impact family's future participation by their use of validation and listening as parents discuss their youth's problems.

Diagnostic staff can be instrumental in developing goals with the youth and family, developing hope for the youth's future, and conveying the family's perspective to residential program staff. All of these interactions with youth and families should be completed in the context of collaboration, non-judging attitudes, interest, and validation. Interactions like these support JRA's goal to create an environment where families want to actively work together to identify ways of reducing the likelihood of problem behavior of youth.

In addition to motivating and engaging youth and families, Diagnostic staff can initiate a youth's **skill acquisition** by collecting information helpful to residential program staff in the development of initial treatment plans. The information should include,

- An effective file review for historical criminal, family, school, and treatment information;
- An evaluation of the skill level of the youth;
- Identification of youth strengths and community supports;
- Identification of the youth and family's goals and needs.

Diagnostic staff support, motivate and engage residential program staff to invest in the treatment model by providing information that is organized and conveyed in consistent cognitive-behavioral language. JRA must provide training and structure contracts to ensure Diagnostic staff are familiar with the cognitive-behavioral treatment model. They will then contribute to the effectiveness of the treatment model by fulfilling the functions of motivation, engagement, and skill acquisition of clients

VII. C. Consultants

Administrators and staff require sophisticated knowledge and skill to provide consistently effective treatment to youth. In order for administrators and staff to acquire these skills, consultants expert in the Integrated Treatment Model are required to teach and to maintain ongoing fidelity to the model. The universal cognitive-behavioral principles related to teaching new behavior should be applied to the training and support of staff.

To implement this model, JRA will need consultants to offer all JRA staff ongoing training, coaching, correction and skill development. Consultants must be skilled and knowledgeable of the treatment principles, treatment planning, and treatment delivery to youth and to their families. They should be comfortable providing training on any aspect of the Integrated Treatment Model. Consultants must also be experienced in providing services to youth and families, and have experience applying CBT principles to treat the wide range of youth behaviors seen across the JRA continuum of care or be experienced in applications of Functional Family Parole.

Consultants will participate and lead treatment team staffings, and will provide case consultation for treatment planning and regular training on every aspect of the integrated treatment model, including behavioral analysis, behavioral modification principles, and family change principles. Training and consultation can take place in formal training, during staff meetings, or in the milieu where youth and staff work together.

Ideally, consultants will have clinical oversight from a JRA Clinical Director, and will collaborate with each other and with community-based treatment providers to achieve consistency in treatment of youth and training of staff.

Consultants shall:

- Assist staff in acquiring skills and knowledge to apply with youth;
- Support staff in generalizing treatment planning skills to new cases;
- Support staff in generalizing the Integrated Treatment Model principles, such as coaching, role-playing, validating, and shaping to new environments (e.g., working with youth in community vs. institution, or working with family and youth together);
- Support management in supervision of staff, and in program and staff development;
- Motivate and engage staff to learn, understand and provide the highest level of treatment possible within given resources.

Consultants should be hired or contracted based upon evidence of their ability to explain and demonstrate the skills and principles of the integrated treatment model. Consultants should also be retained based upon their ability to effectively train staff and their willingness to meet quality and performance expectations as identified by JRA. The hours and place of service delivery will be identified in individual JRA contracts or position postings, but consultants should be willing to be available to staff in their working environments. To assess the competence of potential Integrated Treatment Model consultants, interview committees should include at least one clinical consultant or clinical expert already working with JRA.

Consultants will work individually to serve parole regions, community facilities, or institutions through contracts or as designated FTEs. However, they will also meet periodically as a clinical group to review new and current CBT research, to develop training curricula, to discuss training direction or discuss consultation issues, and to generally ensure that training is standardized throughout JRA and clinical development is being maximized.

In addition, consultants from Functional Family Therapy, Inc. will be contracted for consultation to parole counselors to train and ensure adherence to the specific Functional Family Parole program used in JRA community parole services.

VII. D. Specialized Programs

VII. D 1. Chemical Dependency Treatment Programs

Chemical dependency (CD) programming is currently offered to JRA youth in a variety of treatment formats, ranging from education and introduction to treatment through intensive in-patient treatment and aftercare. Currently, the

models of treatment offered across JRA include a mixture of cognitive-behavioral (e.g., relapse prevention) and other approaches (e.g, 12-step).

Developmental levels of juveniles require modified interventions which differ from adult CD treatment interventions. A heavy emphasis on **motivating and engaging** youth to invest in chemical dependency treatment is necessary. The inclusion of identified motivation strategies as well as CD-specific motivation strategies (e.g., Motivational Interviewing, Motivation and Engagement Therapy) must be well understood and employed by staff.

All CD programming within JRA will move to a more comprehensive and integrated model. The residential focus of JRA CD treatment programs will be primarily **skill acquisition** through functional replacement of the effects of drug-taking behavior with skills chosen from the JRA-recommended CBT skill set. Residential JRA CD treatment programs will use behavioral analysis to identify the function of drug using behavior, as youth use drugs and alcohol for different reasons. Some youths will require several chains, each representing a different instance of using. Once the function of the behavior has been identified, then replacement skills from the JRA identified skill modules will be taught and strengthened. Thus, youth will be learning the same skills to treat problem behavior in chemical dependency treatment programming as other youth in JRA, so staff will be able to coach and support youth in their treatment of CD issues regardless of specific expertise in the CD treatment area.

Skill generalization interventions are also a focus in chemical dependency programs. Currently, abstinence is the ultimate goal of treatment, but a harm-reduction/relapse prevention approach is also presented. In a harm-reduction approach, abstinence is the goal, but in case of relapse, work immediately shifts to getting "clean" again and remaining in treatment. Thus, understanding the function of drug use through behavioral analysis, developing skills for abstaining, or for reducing likelihood to use, and developing relapse prevention plans are the key elements of treatment focused on skill development and generalization.

Education about traditional "twelve-step" programs will continue in residential programs and will be recommended as a community support for skill generalization after youth have received treatment in institutions or community-facilities. Plans to cope with cue exposure to drugs and alcohol needs to be addressed by residential staff, parole staff, youth and families together as key treatment planning and transition factors for youth receiving treatment in institutions.

Involving parents in supporting treatment for their youth will be important for youth returning to the community, and for parole services. FFP model which put the drug use in a family context, will also be utilized.

Motivating contracted or community treatment providers to work with JRA youth is very important. JRA staff responsible for contracting with these

providers will ensure that, if possible, the provider is offering treatment to the youth that is consistent with the Integrated Treatment Model. JRA has taken the responsibility of direct treatment for youth on parole where community-based resources were not available. While this is one option in providing effective treatment, JRA staff should continue to network and seek partnerships with community and state agencies to jointly provide chemical dependency treatment to youth.

JRA will provide treatment guidelines, programming expectations and individual treatment plan specifics to contracted treatment providers to facilitate their ability to offer services that are consistent with the Integrated Treatment Model. When possible, contracted treatment providers should be provided opportunities to attend JRA treatment training and consultation, and should be encouraged to invest time and energy to understand the JRA treatment model in order to offer services that build upon the work already accomplished with youth. Contracted treatment providers will assist youth to understand how 12-step programs fit with the Integrated Treatment Model, and how they may be part of an ongoing recovery program.

VII. D.2. Sex Offender Treatment Programs

The sex offender (SO) treatment model currently offered to youth in JRA is an example of a cognitive-behavioral approach. It provides instruction and treatment consistent with the Integrated Treatment Model.

JRA offers cognitive-behavioral treatment through a model consisting of nine components. The SO treatment curriculum includes the Medlin "Responsible Living" curriculum, as well as other treatment workbooks, which provide education about sexuality, legal issues, cognitive distortions and sex offending patterns. The curriculum includes coursework and instruction for group processes to help youth take responsibility for offending behavior, to identify their own offending patterns and cognitive distortions, to understand victimization and the experience of the victim, and to devise individual relapse prevention plans that will reduce future sex offending behaviors.

Specific recommendations for JRA SO treatment programs include emphasis on:

- Functional analysis of sexual offending behavior
- Cognitive-behavioral skill sets
- Fulfilling the five functions of cognitive-behavioral treatment
- Networking with community-based SO treatment providers
- Completing specific outcome measures for juvenile sex offenders identified by JRA
- Transition work with families of sex offenders

Residential sex offender treatment programs will incorporate the use of behavioral analysis to identify the function of sex offending as the identified

maladaptive behavior for each youth, as each youth offends for a different purpose. Some youths will require several chains, each representing a different instance of offending. This work will be familiar and adaptable to staff, given the similarity between behavioral analysis and sex offender offense cycles. Once the function of the behavior has been identified, then skills from the JRA identified skill modules will be taught, reinforced, and shaped. Youth will be learning the same skills in sexual offender treatment programming as other youth in JRA, so staff will be able to coach and reinforce youth working on sex offending issues, regardless of specific expertise in the SO treatment area.

The skill sets approved in the JRA Integrated Treatment Curriculum will be taught in sex offender treatment programs as replacement behaviors for maladaptive behaviors. The SO treatment program will focus on skill replacement to treat the function of a youth's sex offending behavior.

Sex offender treatment programming will fulfill the five functions of CBT identified earlier, specifically addressing the need to **motivate and engage youth**, to facilitate **skill acquisition and generalization**, and to **structure the environment** to support youths' treatment progress. The means of delivering programming, developing skills and extending those skills into the community as the youth progresses through the JRA continuum will be consistent with the expectations of all other JRA programs.

Youth in the community and in community facilities are working with contracted sex offender treatment providers. JRA staff responsible for contracting with these providers will ensure that the provider is offering cognitive-behavioral treatment. JRA will provide treatment guidelines, programming expectations and individual treatment plan details to contracted treatment providers to facilitate their ability to offer services that are consistent with JRA treatment. When possible, contracted treatment providers should be afforded opportunities to attend JRA treatment training and consultation, and should be encouraged to invest time and energy to understand the JRA treatment model in order to offer services that build upon the work already accomplished with youth. The FFP model will also serve families of sex offenders.

VII. D.3. Mental Health Treatment Programs

Youth with significant mental health or developmental needs are assessed upon entry into a JRA institution, and services will be offered to every youth who meets the criteria for the Mental Health Target Population as recommended in the 2001 JRA Mental Health Systems Design. The definition is:

> "Any youth who meets one or more of the following criteria:
>
> - Axis I DSM-IV diagnosis, excluding sole diagnoses of Conduct Disorder, Oppositional Defiant Disorder, Pedophilia, Paraphilia, or Chemical Dependency; OR

- Currently prescribed psychotropic medication; OR
- Exhibited suicidal behavior within the last six months."

In keeping with the recommendations for the Integrated Treatment Model, interventions will be adapted to meet the youth's level of functioning in order to maximize **skill development** while maintaining **motivation and engagement**.

Youth with mental health issues across JRA will receive the same cognitive-behavioral treatment regimen and family services as recommended for all other youth. CBT-based approaches are empirically supported for a variety of disorders, having proven effective at relieving a variety of mental health symptoms. (Barlow, 1993) A skill-based approach will identify the function of maladaptive behaviors, skill deficits, and will teach replacement behaviors.

Consultation with psychiatry and psychology should be used to address severe mental health symptoms or lack of treatment progress. Resources prevent ongoing individual psychological services (i.e., counseling with an individual psychologist) being available for individual youth in institutions; however, in-house contracted psychiatric consultation and treatment will be accessed to reduce vulnerabilities (symptom reduction).

Community-based psychiatric and psychological services will be arranged upon transition for youth in community facilities or in the community. If a choice of psychological services is available in the community, a provider offering a CBT approach should be selected. JRA staff will involve families in this referral process, and assist them in navigating community-based mental health options.

Using the JRA treatment hierarchy, traditional mental health programming such as 'grief and loss,' 'sexual abuse,' and 'trauma survivors groups,' will not be broadly offered to youth. While JRA youth may benefit from treatment surrounding these issues, current best practices concentrate on solution-focused approaches, identifying specific areas of egregious problem behavior and treating these using a skills-based model, rather than insight-oriented or primarily expressive treatment models. As cognitive-behavioral treatment models for treating such issues are identified, and demonstrated to have the ability to be implemented by Bachelor's level staff, then treatment packages for working with youth around such issues will be adopted or adapted for JRA use.

Cognitive-behavioral materials should be adapted to address specific needs. Reduction of mental health vulnerabilities in preparation for treatment participation should be met through medication management, or through intensive skill development that precedes other treatment concerns. Some youth may need psychiatric involvement to *reduce* medications they are currently taking, as the number or dosage of medications may unnecessarily interfere with cognitive functioning.

Many youth will be adjusting to the issues surrounding their own mental illness while under JRA supervision. Working with youth to understand their illness, and more importantly, to understand the impact of their illness and develop the skills for best treating it, will be important.

Family members may also need education concerning mental illness. For youth who are adamant about not taking medication in the community, or if consistent medication regimens cannot be maintained, reasonable expectations about the effects of being unmedicated should be discussed. Psychiatric consultation about tapering medication prior to release may be necessary to best serve the youth.

VII. D.4. Programs for Cognitively-Impaired Youth

Because few JRA programs specifically exist for youth with significant cognitive impairment, these youth are included in JRA's general population. All staff should be aware of special issues and interventions with cognitively impaired youth. Researched best practices for cognitively impaired youth are behavioral or CBT approaches. Thus, this proposed Integrated Treatment Model should be effective in working with this population.

Specific recommendations for working with cognitively impaired youth include emphasis on:

- **Skill Acquisition and Motivation**
- **Structuring the Environment**

Treatment material and expectations must be adapted to the comprehension level, impulsivity, ability to receive and retain instruction, and performance thresholds of cognitively impaired youth. Instruction by staff in day-to-day living must be adapted, with short, succinct instructions given youth. Staff must be aware of the probability of intense emotions interfering with cognitive processing for these youth.

Skills should be carefully selected to address youth needs, and an abbreviated skill set may be taught to developmentally delayed youth, with focus on overlearning a few key skills rather than being able to implement an entire range of skills. Short time-outs, limited punishment, and willingness to repeat instruction are examples of adjustments to programming that may be necessary.

In addition, seeking structured environments in which to transition youth upon re-entry to the community, helping families find the services they need (e.g., school, family support, vocational, etc.), and communicating treatment methods or strategies that have been effective in programming for a given youth will be important transition goals.

VII. D.5 Programs for Youth With Multiple Treatment Needs

The majority of JRA youth present multiple special treatment needs. In these instances, following the JRA treatment hierarchy will assist staff to focus on the behaviors most impacting functioning or ability to receive treatment. For example, a youth exhibiting egregious suicidal behavior and also in need chemical dependency treatment would receive treatment for suicide, the higher behavioral target priority.

When all else is equal, meaning serious suicide attempts, assaults, and escape behaviors have been stabilized, youth exhibiting multiple special treatment needs should be placed in treatment settings that best addressing factors affecting recidivism. Thus, an individual needing both sexual offending and chemical dependency treatment, as well as being identified as cognitively-impaired, will receive the treatment that is most related to the crime of conviction. For example, if accurate assessment reveals that the sex offending would not likely have occurred had there not been substance use, then CD treatment would be the best treatment to offer first, with SO treatment offered next. Either treatment will need to be adapted for the youth's cognitive level.

VIII. Implementation Plan for the Cognitive-Behavioral Treatment Model

The implementation plan recommendations can be divided into four sections:

- Staff Training
- Staff Consultation
- Documentation
- Outcome Measures

VIII. A. Staff Training

Initial and continuing staff training is a vital component to the implementation and sustainability of an effective treatment model. Staff must be proficient in assessment, motivation and engagement, the target hierarchy, behavior modification principles, treatment planning, the identified skills set, specific research-based programs, and the documentation requirements associated with the Integrated Treatment Model, as well as the skill set related directly to working with families. Staff must receive initial training in these basic requirements, with regular, ongoing, interactive training on components of the model in order for staff to continue to improve their clinical skills in treating youth using treatment principles and specific programming in JRA.

Trainers should be not only competent, but energetic and engaging. Training should have identified outcome measures, in order to gauge the effectiveness and identify improvements and adjustments for increased relevance to staff. In most cases, consultants will provide both local case consultation and formal classroom

training. However, JRA's goal is to nurture talented staff within JRA to provide training as well. Because training and consultation are two distinct functions requiring different skills at times, trainers and consultants may or may not be the same individual.

The committee recognized both the strengths of training milieu staff teams as cohesive treatment teams, and also of cross-system training where staff from different service areas in JRA can train together, to exchange ideas and experiences about how training concepts can translate into various areas.

The committee recognizes "line staff" as any staff supervising or having prolonged direct contact with youth. This includes security staff, medical staff, kitchen staff and DNR staff in residential programs. "Support staff" and contracted staff include administrative support staff, business managers, teachers, and contracted treatment providers in residential programs and parole services offices. This estimate will provide a cost-analysis for training based upon these definitions.

The Integrated Treatment Model Committee (ITMC) recommends the following three modules of training be developed for JRA:

Module #1: CBT for Managers

This sixteen-hours module will be attended by Directors, Superintendents, Regional Administrators, Associate Superintendents, Assistant Regional Administrators, Program Managers 1 and 2, Central Office Program Administrators, Juvenile Rehabilitation Coordinators, and Juvenile Rehabilitation Supervisors. The module will include components specifically geared toward implementing the treatment model from a managerial or administrative perspective:

- Cognitive-behavioral treatment overview;
- Behavior modification components;
- Interactive behavioral analysis;
- Functional Family Parole;
- Treatment hierarchy;
- Treatment planning
- Brief skill set overview;
- CBT documentation.

Module #2: CBT for Residential and Parole Line Staff

This 24-hour module will be attended by Program Managers 1 and 2, Juvenile Rehabilitation Supervisors, Juvenile Rehabilitation Counselors (Parole and Residential), Juvenile Rehabilitation Counselor Assistants (Parole and Residential), Security Managers, Security Supervisors, Security Officers 1,

Intermittent Security Officers, and any other direct care staff including kitchen workers, maintenance, DNR, chaplains, recreation, and nursing staff. The module will include components specifically geared toward implementing the treatment model in milieu settings such as institutions, community facilities, and parole/community venues.

- Cognitive-behavioral treatment overview;
- Behavior modification components;
- Interactive behavioral analysis;
- Functional Family Parole;
- Treatment hierarchy;
- Treatment planning;
- In-depth skill set overview;
- CBT documentation.

The committee also recommends this module, or an adaptation, be offered to JRA staff during the Criminal Justice Training Academy.

Module #3: CBT for Support Staff

This four-hour module will be an audio-visual format in two (two-hour) sessions. This module will be viewed by all new employees in New Employee Orientation, and by Business Managers, non-direct-contact staff, information technology staff, and administrative support staff. This module will contain the following components:

- Brief cognitive-behavioral overview including behavior modification components and CBT research;
- Family treatment interventions;
- Treatment planning; and
- CBT documentation.

The following tables (2.1-2.4) outline estimated CBT training costs, estimating only backfill costs for line staff positions.

Table 2.1 Estimated Institutional Start-Up Backfill Costs for CBT Modules #1 (16 Hours) and #2 (24 hours)					
	MLS	EGCC	GHTS	NYC	TOTAL
Juv. Rehab. Supervisor*	$5,548.00	$7,767.20	$6,102.80	$3,328.80	$22,746.80
JRRC	$21,637.20	$24,633.12	$20,971.44	$13,648.08	$80,889.84
JRCA	$13,315.20	$4,660.32	$4,327.44	$5,326.08	$27,629.04
Security Officer 1	$9,986.40	$18,974.16	$13,648.08	$4,993.20	$47,601.84
Security Manager	$332.88	$332.88	$332.88	--	$998.64
Security Supervisor	$1,331.52	$3,661.68	$1,331.52	$332.88	$6,657.60
Nursing Staff**	$3,790.08	$2,842.56	$ 1,895.04	$1421.28	$9,948.96
DNR Staff	--	--	--	$1,664.40	$1,664.40
Kitchen Staff	$6,657.60	--	$2,330.16	$2,995.92	$11,983.68
Benefits* **	$5,615.00	$5,640.00	$4,569.00	$3,024.00	$18,848.00
TOTAL	$68,213.88	$68,511.92	$55,508.36	$36,734..64	$228,968.80

Backfill estimate based upon # of FTEs in job class x hours of training x WA State DOP General Gov't SO1 salary range step F (hourly rate of $13.87).
*JRS position expected to attend both modules, totaling 40 hours. All other positions expected to attend only Module #2.
**Backfill for nursing staff based upon Range 47N, Step F ($19.74/hr).
***Partial benefits based on 8.97%: 6.2%=Social Security; 1.32%=Retirement; 1.45%=Medicare.

Table 2.2 Estimated State Community Facility Start-Up Backfill Costs for CBT Modules #1 (16 Hours), #2 (24 hours), and #3 (4 hours)								
	Canyon View	Sunrise	Parke Creek	Twin Rivers	Ridgeview	Woodinville	Oakridge	TOTAL
Supervisor*	$554.80	$554.80	$554.80	$554.80	$554.80	$554.80	$554.80	$3,883.60
JRRC	$1,664.40	$1,331.52	$1,997.28	$1,331.52	$1,331.52	$1,331.52	$1,664.40	$10,652.16
JRCA	$665.76	--	--	--	$332.88	$332.88	$332.88	$1,664.40
Sec Officer 1	$332.88	$332.88	$332.88	$332.88	$332.88	$332.88	$332.88	$2,330.16
Contracted Providers**	$240.00	--	--	$240.00	$240.00	--	--	$720.00
Kitchen Staff	$332.88	--	--	--	$332.88	$332.88	$332.88	$1,331.52
Benefits* **	$340.00	$199.00	$259.00	$221.00	$280.00	$259.00	$289.00	$1,846.00
TOTAL	$4,130.72	$2,418.20	$3,143.96	$2,680.20	$3,404.96	$3,143.96	$3,506.84	$22,427.84

Backfill estimates based on # of FTE x # of training hours x WA State DOP General Gov't SO1 Range 37 Step F (13.87/hr.).
*Supervisors are expected to attend both modules (40 hours); all other line positions expected to attend only Module #2 (24 hours).
** Contracted provider are expected to view Module #4 (4 hours). The rate: $50/hour, includes MH, SO, DA services not covered through other arrangements such as federal aid or complimentary community-based services.
***Partial benefits based on 8.97%: 6.2%=Social Security; 1.32%=Retirement; 1.45%=Medicare.

Table 2.3 Estimated Contracted Community Facility and Camp Outlook Start-Up Backfill Costs for CBT Module #2 (24 Hours)*									
	Griffin Home	Ruth Dykeman	Dyslin's Ranch	Carson Home	Puget Sound	Our Sister's	Touchtone	Camp Outlook	TOTAL
Supervisor	$665.76	$1,331.52	--	--	--	--	$332.88	$998.64	$3,328.80
Counselor	$4,993.20	$4,993.20	$665.76	$665.76	$665.76	$665.76	$2,330.16	$1,331.52	$16,311.12
Counselor Assistant	--	--	$1,664.40	--	$1,664.40	--	--	$2,330.16	$5,658.96
Security Staff	--	--	$998.64	$2,330.16	$665.76	--	--	$1,664.40	$5,658.96
Kitchen Staff	$332.88	$332.88	$332.88	$332.88	$332.88	$332.88	$332.88	$332.88	$2,663.04
TOTAL	$5,991.84	$6,657.60	$3,661.68	$3,328.80	$3,328.80	$998.64	$2,995.92	$6,657.60	$33,620.88

Backfill estimates based upon # of training hours x # of staff x WA State DOP General Gov't SO1 position Step F ($13.87/hr).
*Contracted Community Facilities and Camp Outlook only offered Modules #2 and #3.

Table 2.4 Estimated Start-Up Backfill Cost for CBT Training Package	
Institutional Training Backfill	$228,968.80
State Community Facility Backfill	$22,427.84
Contracted Community Backfill	$33,620.88
TOTAL	**$285,017.52**

Table 2.5 estimates the number of new intermittent and permanent staff for institutions and state community facilities in one year. Since actual numbers of new hires for the entire agency are not readily available, actual numbers for staff hired at one facility, Maple Lane School, were collected for FY2002. The ratio of new staff to budgeted staff was calculated and applied across all sites in JRA to estimate the number of new staff for FY2003. This table does not account for staff who promote or transfer within JRA, but only new staff hired into JRA within a given year, who would require an introductory baseline of training services on the cognitive-behavioral treatment model. It is assumed that staff who promote from within would have received initial training through start-up funding, and ongoing training from regular consultation.

Table 2.5 Estimated Number of New Residential Intermittent and Permanent Staff for One Year in JRA (Basis of Cost Estimate for Maintenance Training Plan)

	Budgeted FTEs FY2002			Estimated New Hire FTEs (Based Upon MLS Ratio)		
	Direct Care	Non-Direct Care	Intermittent	Direct Care	Non-Direct Care	Intermittent
Maple Lane	214	75	12.2	10.5*	13	31*
Echo Glen	164	58	8.2	9	10	24
Green Hill	167	66	26	9	11	75
Naselle	92	39	6.7	5	7	19
State CFs**	78	38	5.6	4.4	6.5	16
TOTAL	**715**	**276**	**58.7**	**37.9**	**47.5**	**165**

Assumptions:
(Actual MLS new hire direct-care FTE)/(Budgeted MLS direct-care FTE)= MLS direct-care turnover ratio = 0.0560
(Actual MLS new hire non-direct FTE)/(Budgeted MLS non-direct FTE)= MLS non-direct turnover ratio = 0.1733
(Actual MLS new hire intermittent FTE)/(Budgeted MLS intermittent FTE) =MLS intermittent turnover ratio = 2.868
*Ratio is applied to decrease in budgeted FTE (214 FTE decreased to 189 FTE, 12.2 intermittent FTE decreased to 10.7 intermittent FTE) for MLS during FY2003.
**Includes Camp Outlook.

All new staff hired will be expected to view the introductory overview of CBT in Module #3 (four hours) through New Employee Orientation (NEO) training. This cost will be subsumed within current funding for NEO training. Table 2.5 indicates approximately 80% of institutional and community facility direct-care staff will be expected to attend more intensive training on the cognitive-behavioral treatment model through Module #2 (24 hours). Using the estimates above for new staff hired into JRA, we can estimate ongoing training costs for the CBT Modules.

Table 2.6 Estimated Cost Per Year for New Staff Maintenance-Level CBT Treatment Training Module #2 (24 Hours)

JRA Site	Total Annual New Employees	80% of New Employees Targeted for CBT Module #2	Total Annual Cost for Module #2
Maple Lane	54.5	43.6	$15,549.50
Echo Glen	43	34.4	$12,268.41
Green Hill	95	76	$27,104.64
Naselle	31	24.8	$8,844.67
State CFs*	26.9	21.5	$7,667.76
TOTAL	**250.4**	**200.3**	**$71,434.98**

Formula based upon WA State DOP General Gov't JRCA Range 38 Step F ($14.86/hr) x 24 hours x number of FTE.
*Includes Camp Outlook.

VIII. B. Clinical Consultation

Formal yearly refresher training for staff is unnecessary as a standard training package, as regular, ongoing training will be incorporated through the use of consultation. While formal training provides intensive classroom opportunities to learn, consultation provides a laboratory in which to practice and hone skills in working environments.

Consultants are expected to provide not only case consultation for treatment planning, but also training, coaching, and modeling to staff teams as part of staff's ongoing education of cognitive-behavioral treatment model. Staff teams should receive one- to two-hour monthly training from consultants on various aspects of the model such as reinforcement, shaping, modeling, behavioral analysis, family therapy interventions, and validation, so that each staff receives approximately 24 additional hours of refresher training per year. These trainings

occur during staff meetings and do not require additional funding or backfill resources.

Training without ongoing consultation will not produce lasting effective results for implementing a cognitive-behavioral treatment model. **Consultation is essential to the success of implementing these recommendations.**

Due to the 24-hour nature of institutions, staff have ongoing contact with youth throughout the day, indicating a need for more intensive consultation compared to regional parole office, where contacts are fewer. In addition, institutional programs do not have access to community-based resources as do the parole offices and community facilities, also increasing the need for increased clinical consultation.

The model proposed in community facilities and parole offices reflects the researched community-based treatment model Functional Family Therapy (FFT) in their use of consultation, where consultants are available to staff for 4-8 hours per week for case consultation, staff training, and quality assurance to ensure fidelity to the treatment model. The formula JRA expects to use for consultation in community facilities and parole offices includes 4-8 hours per week, with some of that time donated directly to teaching and assisting staff in motivating, engaging, and assisting families in the treatment of their youth.

The use of consultation in both residential and parole settings will exponentially improve the retention of information learned in the CBT classroom training modules, and will bring relevance and context to the material as staff will have the expectation to use the treatment concepts in the performance of their duties as treatment providers.

The 2001 Mental Health Systems Design estimated the need for psychological services for the mental health and non-mental health population within JRA, and provided formulas for clinical and consultative services. Any residential psychologist position funded through the 2001 Mental Health Systems Design in JRA will be required to serve as a CBT expert and consultant, in order to avoid duplication of resources.

While JRA's goal for consultation is to hire licensed psychologists, JRA recognizes the overall lack of licensed forensic psychologists in the community who are experts in CBT. JRA will continue recruitment and retention attempts for these professionals; however, CBT experts can also present themselves in the forms of licensed social workers, ARNP's, or bachelor's degree-level staff, depending on their CBT expertise and ability to energetically and competently train and coach staff. All consultants' qualifications need to be reviewed and clinically supervised by a JRA Clinical Director who is a licensed psychologist and an expert in cognitive-behavioral treatment.

Because the committee anticipates less than full-time hours for FFP consultation at parole offices and community facilities, contracts allow for flexibility in recruiting professionals at various geographical sites within one region. The committee recommends a contracted hourly rate of $60.00 for consultation, which is standard and comparable to other cognitive-behavioral programs such as MST and FFT.

The following tables outline the committee's recommendations for consultation resources across the continuum. The tables reference and utilize the formulas for mental health services from the 2001 Mental Health Systems Design to estimate functions and a formula for resources for CBT consultative services. All services for mental health and CBT consultation and training are estimated based upon the number of youth requiring services.

Table 2.7 Mental Health Target Population (MHTP) Fluctuations Between September 2000 and August 2002

Site	MHTP Sept 2000 Per Total Population		MHTP August 2002 Per Total Population		Non-Mental Health Youth August 2002	
Maple Lane	206/296	70%	187/243	77%	56	23%
Echo Glen	114/208	55%	156/208	75%	52	25%
Green Hill	68/224	30%	88/228	39%	140	61%
Naselle	36/148	24%	58/158	37%	100	63%
TOTAL	424/876	48%	489/837	58%	348	42%

Table 3.7 illustrates a steady, significant increase in the mental health target population in JRA institutions over approximately two years. These numbers are used to calculate the estimated need for cognitive-behavioral psychological and psychiatric services and resources at the institutions. Resources are based upon the number of youth who require mental health services, based upon the Mental Health Target Population Definition adopted by JRA in the 2001 Mental Health Systems Design Report.

The formula in the Mental Health Systems Design Report used to calculate the amount of psychological resources needed is broken into seven categories:

- **Consultation**
- Individual Assessment
- **Intake Multi-Disciplinary Treatment Planning**
- **Transition Multi-Disciplinary Treatment Planning**
- Suicide Risk Assessment
- **Training**
- **QualityAssurance**

The functions of CBT consultation are met through five (in bold) of the seven psychological functions identified above; therefore, the CBT treatment model initiative can avoid unnecessary duplication of resources. The CBT treatment model uses the original formula and resources used to treat mental health youth and applies them to the non-mental health youth. Therefore, JRA can capitalize on resources already garnered through mental health initiatives and add the difference for non-mental health youth for a complete behavioral modification treatment consulting package.

The formula for CBT consultation include services not met by the original formulas in the 2001 Mental Health Systems Design, including additional consultation time for mainstream mental health youth and youth without mental health issues. The additional time estimated results in 20 minutes per youth per month for mainstream mental health youth to receive CBT case consultation for treatment planning, and 20 minutes per youth per month for non-mental health youth to receive CBT case consultation for treatment planning. Eight hours per month was also added for consultants to provide formal classroom CBT training to staff, which is training beyond what is allotted for mental health issues, and not estimated with resources for staff and managerial CBT training.

While the formulas outlined in the 2001 Mental Health Systems Design will have to continue to be estimated as JRA's mental health population rises, we can estimate the amount of additional resources required at this time for CBT services in institutions.

Table 2.8 Estimated Additional Institutional CBT Consultation Resources July 2002				
	MLS	EGCC	GHTS	NYC
Hours CBT Consultation Mainstream MH youth*	19.00	15.33	8.66	5.66
Hours CBT Consultation Mainstream Non-MH Youth*	18.00	17.33	47.00	33.33
Training**	8.00	8.00	8.00	8.00
Total Hours/ Month	45.00	40.66	63.66	46.99

*Formulas: Mainstream MH requiring CBT consultation: 20 min/youth/month
Mainstream Non-MH requiring CBT consultation: 20 min/youth/month

**Classroom CBT Training Modules #1-#2 average 8 hours/month.

For CBT consultation in community facilities, the same formula applies: 20 minutes per youth per month. Regional parole offices will receive consultation totaling 56 hours per month for both CBT and Functional Family Parole in each regional office. JRA estimates consultation for FFP to be provided by internal FTEs for 25 hours per month, leaving a balance of 31 hours of contracted CBT consultation requiring additional resources. Table 2.9 outlines estimated resources required.

Table 2.9 Integrated Treatment Model Committee Estimated Annual Contracted CBT Consultation Resources for JRA		
JRA Site*	**Proposed Hours of CBT Consultation Per Month**	**Total Annual Additional CBT Consultation Resource**
Maple Lane School	45.00 hours/month	$32,400.00
Echo Glen Children's Center	40.66 hours/month	$29,275.20
Green Hill Training School	63.66 hours/month	$45,835.20
Naselle Youth Camp	46.99 hours/month	$33,832.80
Region 1 Parole Sunrise CF Canyon View CF	41.66 hours/month	$29,995.20
Region 2 Ridgeview CF Twin Rivers CF Parke Creek CF Camp Outlook	54.99 hours/month	$39,592.80
Region 3	31 hours/month	$22,320.00
Region 4 Griffin Home CF Ruth Dykeman CF Woodinville CF	46.99 hours/month	$33,832.80
Region 5 Carson Home CF Dyslins Ranch CF Puget Sound CF Our Sister's House CF Oakridge CF	57.65 hours/month	$41,508.00
Region 6 Touchtone CF	36.33 hours/month	$26,157.60
TOTAL	464.93 hours/month	**$334,749.60**

Formula for all estimated resources: # of hours per month x $60/hour x 12 months per year.
Consultation for Regional Parole Offices to be contracted with Functional Family Therapy, Inc.
Community Facility formulas based upon 16 youth (Mainstream MH and non-MH) x 20 minutes CBT consultation per month
Boot Camp formula based upon 24 youth (Mainstream MH and non-MH) x 20 minutes CBT consultation per month.
Region formulas based upon 31 hours of CBT consultation per month.

In summary, implementing the training and consultation components to an overarching statewide CBT model will cost the following for the first two years:

One-Time Start-up Training For All Staff (Backfill for line staff):	$285,017.52
Annual Maintenance Training for New Staff:	$71,434.98
Annual Cost for CBT Consultants/Trainers:	$334,749.60
Total Cost For First Year Integrated Treatment Model:	**$619,767.12**
Total Cost For Subsequent Years:	**$406,184.58**

Research shows implementation of cognitive-behavioral treatment programs has wielded positive results for lowering recidivism rates, decreasing problem behaviors, and increasing and generalizing adaptive skills. It should be recognized that no state has attempted implementation of a research-based treatment model across an entire statewide government agency or for as complex a juvenile population as Washington State currently serves. The committee recognizes the task ahead, particularly in consideration of limited resources in the presence of complicated economic conditions. The committee recommends exploring funding opportunities through grant requests from national agencies and organizations to subsidize the cost of model implementation.

VIII. C. Documentation

Documentation for the Integrated Treatment Model should fulfill the following functions for staff and stakeholders:

- Directs treatment priorities;
- Collects and measures data on relevant risk and protective factors related to recidivism of individual offenders;
- Promotes fidelity to treatment model, providing immediate feedback to user;
- Efficiently and reliably communicates a youth's treatment progress to the reader;
- Reflects continuum-of-care and responds to evolving treatment needs of youth; and
- Aggregates information easily and is able to be completed within given resources.

The committee recognized the enormity of JRA staff's current documentation workload, including mandatory notifications, behavioral log entries, transition documents, and treatment plans. The committee desired to create or compile treatment planning, progress measurement, and data collection into one streamlined document or process in order to improve communication regarding youths' treatment planning and transition progress among all stakeholders.

Documentation should accurately reflect the cognitive-behavioral interventions staff use to treat youth's problem behaviors. The primary purpose of a treatment document is to communicate simply and reliably to stakeholders a picture of the youth's treatment needs and the progress he/she has made in addressing his/her needs. In families, the need is communication of relational problem assessments in the family.

The committee examined current documentation forms in JRA and attempted to combine the strengths of two documents, the Youth Competency form and the Intensive Parole Supervision Assessment (IPSA). The Youth Competency form emphasizes a strength-based skills approach in treating youth's problem behaviors and identifies skill areas or domains for youth to increase and demonstrate adaptive behaviors. The IPSA contains research-based domains and identifies target behaviors related directly to recidivism. Both forms emphasize the measurement of progress the youth makes in treatment while in JRA.

While these documents meet some individual needs for stakeholders, neither meets all of the functions of efficient documentation needed to accurately reflect a cognitive-behavioral treatment approach or a family therapy approach. Using the forms together is lengthy, and will not alleviate the time management burden staff currently face.

Documentation should be applicable to the treatment setting in which it is used. At this time, the Integrated Treatment Model Committee (ITMC) proposes two preliminary templates for efficient, reliable documentation to accompany the cognitive-behavioral treatment model, one for residential settings and one for community parole settings. These forms will combine the strengths of the Youth Competencies by maintaining adaptive skill areas and will incorporate the IPSA tool to measure a youth's progress in research-based domains related to recidivism. However, the forms will highlight the form of cognitive-behavioral treatment focused in each setting: Individual treatment planning for residential settings and family therapy for parole services.

The streamlined residential document will be accurately reflective of JRA's cognitive-behavioral treatment model and will contain the following items:

- Identification of problem behaviors related to the target hierarchy;
- Synopsis of specific behavioral analysis;
- Identification of specific skills to be taught and reinforced in order to provide adaptive replacement behavior alternatives;
- Identification of discreet cognitive-behavioral interventions to be implemented by staff, such as extinguishing, shaping, reinforcing, blocking the outcomes, cue removal and cue exposure that specifically intervene at links on the problem behavior chain;
- Simple, reliable measuring device for risk and protective factors.

The parole document will also reflect JRA's cognitive-behavioral treatment model and will contain the following items:

- Identification of problem behaviors related to the target hierarchy;
- Synopsis of family relational analysis;
- Identification of specific family goals to be achieved and skills to be reinforced in order to provide adaptive replacement behavior alternatives;
- Identification of discreet cognitive-behavioral interventions to be implemented by staff, such as extinguishing, shaping, reinforcing, blocking the outcomes, cue removal and cue exposure that specifically intervene at links on the problem behavior chain;
- Simple, reliable measuring device for risk and protective factors.

Automated versions of these documents will allow staff to communicate to stakeholders in cognitive-behavioral terms treatment targets, interventions, and skills the youth is working on, and will allow the IPSA to be used to measure the youth's progress in addressing risk and protective factors. Each cognitive-behavioral skill that JRA has identified to use to treat youth can be directly and virtually linked to risk and protective items on the IPSA, in order to demonstrate a clear path from JRA treatment interventions to improvements in risk and protective factors related to recidivism.

These documents are intended for use in multi-disciplinary treatment planning (MDT). To satisfy the National Commission on Correctional Health Care (NCCHC) standards effective in 2003, treatment planning should be initially performed within fourteen days of a youth's intake into an institution, and then every ninety days until discharge. Because of the versatility of the documentation, staff could also use the document to develop interim treatment plans during the ninety days for particularly egregious behaviors that would normally require specialized programming.

Because of the integration with the IPSA, JRA will now have the opportunity to measure progress toward risk and protective factors for every youth in JRA at least every ninety days with little impact to staff. Automation will allow JRA to chart the progress of CBT interventions for individual youth, or aggregate information for populations of youth.

While only in preliminary stages, Attachment A is a draft template recommendation for JRA's residential documentation, which contains components to identify target behaviors, communicate the treatment plan, and measure progress based upon risk and protective factors. Attachment B is a draft template recommendation of JRA's parole documentation. Again, both documents will use the IPSA as the measuring device for youth and family progress.

Upon approval by the JRA Executive Team and in consultation with JRA stakeholders, the committee recommends the templates be finalized, formatted, and automated to coincide with cognitive-behavioral training and consultation in JRA. The committee cautions the agency against implementing an overarching, cognitive-behavioral treatment model without supporting the model with complimentary case management protocols, including documentation.

VIII. D. Quality Assurance

In order to build a sustainable, coordinated continuum-of-care based upon a cognitive-behavioral treatment model, JRA must focus on implementing quality assurance protocols. Quality assurance initiatives include measurements of individual staff and program integrity and fidelity to the CBT and FFP models, as well as outcome and progress measurements.

Examples of measurement methods for individual and program fidelity include:

- Paper and pencil testing for individual knowledge of treatment model concepts and interventions;
- Program review by consultants for CBT theory and family relational assessments;
- Demonstration of individual skills through role-play or practice with CBT or FFP consultants;
- Expert or peer observation and rating of programs for implementation of CBT and FFP fundamentals;
- Documentation and treatment plan reviews; and
- Youth and family interviews for treatment knowledge and application.

Quality assurance protocols should be initiated both internally and externally. The Clinical Director proposed in the 2001 Mental Health Systems Design becomes a integral component in the implementation of the CBT treatment model, and plays a key role in organizing internal quality assurance protocols. As the expert and driver for treatment implementation and fidelity for the agency, the Clinical Director supervises all other consultants for consistent implementation and delivery of training and consultation in the treatment model. The Clinical Director also utilizes local consultants to measure program fidelity and to collect and assess relevant outcome measures.

The Clinical Director should work with Directors, Superintendents, Regional Administrators, Program Administrators, and the Mental Health Oversight Committee to design outcome measurements and program adherence measures early, so that progress of the model can be charted from the start of implementation. A baseline study or pre-evaluation of the agency is recommended in order to facilitate accurate measurement of future progress.

The position of the Clinical Director was designed in the 2001 report as a part-time position, to share a full-time Mental Health Administrator position with the part-time Medical Director for research and staff work. The Clinical Director position and the Mental Health Administrator positions have yet to be funded; however, the committee strongly supports a recommendation for funding of these positions and believes these positions to clearly influence the success of the CBT treatment model initiative.

The implementation of a statewide integrated treatment model for juvenile offenders is unique and progressive in the United States. External quality assurance is recommended to implement and maintain the viability of the model. Organizations such as the National Institute of Corrections (NIC), the Office of Juvenile Justice and Delinquency Prevention (OJJDP), and the National Institute for Mental Health (NIMH) should be approached for grants and assistance in both review and implementation of the model as well as ongoing quality assurance programs.

In order to garner external assistance, JRA must become proactive in the areas of grant writing and self-advocacy on the national level. The Clinical Director should partner with the JRA Medical Director, and other key figures in JRA to relate JRA's treatment model, implementation experience, and outcomes to national audiences. In addition, the committee proposes funding for resources to be directed toward grant writing to assist in obtaining funding and support for the integrated treatment model initiative.

IX. Conclusion and Prioritization Discussion

The Integrated Treatment Model Committee produced recommendations for the application of an overarching treatment model across a diverse juvenile justice continuum-of-care. The review produced several outcomes, including the development of:

- A research-based treatment model designed to motivate and engage youth, families, and staff to partner in changing behaviors tied to recidivism;
- Evidenced-based CBT interventions that can be implemented across all settings in JRA and are effective in changing youth behavior;
- A common treatment language for JRA;
- A model focused on functional analysis of problem behavior;
- A treatment hierarchy and problem sequencing to assist staff and youth in addressing problem behaviors successively and logically;
- A succinct skills set, simple and effective in teaching adaptive replacement behaviors for any youth in JRA;
- Recommendations for streamlined case management and treatment planning documents, combining the strength-based philosophy of the current Youth Competencies system with the research-based

measurement domains of the Intensive Parole Supervision Assessment; and

- An implementation plan for training and clinical consultation that will ensure sustainability of the model and produce effective outcomes for youth and families.

The final recommendations of the committee include a workplan of priority actions steps designed to implement the proposed Integrated Treatment Model over the next several years. The committee proposes three phases of implementation:

Phase 1

1) Recruit and train CBT and FFP consultants at respective sites in JRA.
2) Examine all JRA forms for compliance and compatibility with the integrated treatment model.
3) Finalize recommendations for automated forms, including treatment planning documentation and transition forms.
4) Automate forms.
5) Finalize the training curricula (Modules #1, #2, and #3).
6) Field-test forms on select group of youth or site.
7) Identify potential internal JRA trainers.
8) Identify local consultation schedules for all sites (when and where staff will be able to receive consultation).

Phase 2

1) Train pilot sites in integrated treatment model and paperwork.
2) Train management and administration (Module #1).
3) Implement use of automated forms.

Phase 3

1) Train staff teams as quickly as possible (Module #2);
2) Train support staff (Module #3).

The addition of consultants and automated paperwork will structure the environment for staff to retain the concepts learned later in formal CBT training. The committee anticipates a significant learning of CBT concepts and application to be gained through weekly contact with consultants, making the addition of consultants a top priority.

Unfortunately, the treatment model initiative enters JRA at a time of significant reductions and limitations in resources. The committee made recommendations for interventions and immediate steps which can be taken by JRA in an effort to maintain momentum and further the implementation process within current resources. These include:

- Automate CBT treatment planning and transition forms;

- Recruit CBT experts/consultants within current resources at the institutions;
- Circulate of the Integrated Treatment Model Report containing the explanation of the overarching model to all staff and stakeholders;
- Use focus groups to teach and practice model components, such as reinforcement and shaping;
- Use grass roots education of the overarching model and the progression from Youth Competencies;
- Finalize CBT training curricula modules;
- Post CBT literature and websites on JRA Intranet;
- Finalize pre-evaluation concepts and action steps;
- Utilize current clinical contracts to obtain CBT consultation for the JRA Executive Team;
- Utilize a portion of the University of Washington contract to gain CBT consultation; and
- Recruit and train potential internal JRA trainers through current clinical contracts.

These lists reflect recommendations for initial steps for JRA to implement the Integrated Treatment Model. The lists are not finite, but intended to continue the momentum toward implementation and sustainability of an overarching treatment model begun by JRA through the Youth Competency initiative in 1999.

The objective of the Integrated Treatment Model Committee is to continue the work initiated over the past months through the systematic establishment of an infrastructure designed to support sustainability and efficacy of the model. In addition to garnering resources to meet this task, the following areas should be examined, as each area will be vital in supporting the success of this project:

- Collaborative agreements with other agencies;
- Development of a quality assurance and improvement system regarding CBT programs and interventions;
- Establishment of performance and outcome measures that can be used to evaluate progress and determine efficacy of CBT programs with a juvenile offender population; and
- Evaluation of current custody staffing patterns to determine the impact on CBT programming and outcomes.

Significant resources are needed to implement the proposed Integrated Treatment Model, but continual improvements in the system will ultimately result in measurable, positive outcomes for youth, families, and communities. Only through sustained, collaborative efforts, coordinated planning, and effective analysis of outcomes can JRA successfully continue to meet the ongoing complex needs of this population.

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Pearson, F.S. & Lipton, D.S. (1999). A meta-analytic review of the effectiveness of corrections-based treatments for drug abuse. *Prison Journal, 79(4)*, 384-410.

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Trupin, E.W., Stewart, D.G., Boesky, L., McClung, B., & Beach, B. Effectiveness of a Dialectical Behavior Therapy program for incarcerated female juvenile offenders.

Wanberg, K.W. & Milkman, H.B. (1998). Criminal conduct and substance abuse treatment: Strategies for self-improvement and change: The participant's workbook. Thousand Oaks, CA, US: Sage Publications, Inc.

Winnick, Bruce J. (1997). The Right to Refuse Mental Health Treatment. The American Psychological Association: Washington, D.C.

WEB SITES:

http://www.wagntrain.com/OC/
http://www.dontshootthedog.com/
http://www.kuddlekids.com/
http://www.interventioncentral.org/
http://www.envmed.rochester.edu/wwwvgl/jaba_articles/

ATTACHMENTS

DRAFT COMPONENTS OF RESIDENTIAL REPORTING MECHANISM FOR TREATMENT PLAN: ATTACHMENT A

Youth's Name	Date of Birth	JRA Number	Report Date
Joe Offender	**09/23/86**	**820-999**	**02/05/02**
Case Manager's Name **Meredith Byars**	Location/Living Unit **Naselle Youth Camp/Harbor Lodge**		Region **3**

Specialized Treatment Needs

☐ **Mental Health Target Population**
☐ **Chemically Dependent/Abusive**
☐ **Sex Offender or SA on SAVY**
☐ **Special Education, Mental Retardation, or Developmentally Delayed**

☐ **Initial Treatment Plan** (completed in first 30 days for behaviors on committing offense)
☐ **Follow-Up Treatment Report** (to be completed every 90 days on behaviors analyzed for last 90 days)
☐ **Specialized Treatment Report** (on 90-day cycle, but specializing on behaviors in specialized treatment area)
☐ **Intermittent Treatment Update** (for egregious behaviors during 90-day period, i.e. IMU behaviors)

I. TREATMENT HIERARCHY

A. Is the youth motivated and engaged to participate in own treatment progress? **YES** ☐ **NO** ☐

- ☐ Youth is unmotivated for change or learning skills for positive behavior.
- ☐ Youth has a fatalistic attitude and is hopeless for the future.
- ☐ Youth resents or is hostile to pro-social values/conventions and does not see need to change.

B. Is the youth currently exhibiting suicidal ideation, threats, or behaviors? **YES** ☐ **NO** ☐

- ☐ Youth has had a serious attempt to take his life.
- ☐ Youth engages in parasuicidal or self-mutilating behavior.
- ☐ Youth makes statements of suicidal ideation.

C. Is the youth currently exhibiting aggressive ideation, threats, or behaviors toward family, staff, or peers? **YES** ☐ **NO** ☐

- ☐ Youth has physically or sexually assaulted a peer, staff, or family member.
- ☐ Youth has made threats to physically or sexually assault peers, staff, or family members.
- ☐ Youth has verbally assaulted or made aggressive sexual comments to peers, staff, or family members.
- ☐ Youth has engaged in passive-aggressive or covert victimization of peers, staff, or family members.
- ☐ Youth destroys property in excess of $250.00.

D. Is the youth currently exhibiting escape ideation, threats, or behaviors? **YES** ☐ **NO** ☐

- ☐ Youth has escaped from placements and has been absent for extended periods.
- ☐ Youth routinely engages in runaway behaviors for short periods of time.
- ☐ Youth has engaged in escape ideation and threats.

E. Is the youth currently engaging in treatment-interfering behaviors? **YES** ☐ **NO** ☐

- ☐ Youth is inattentive and disengaged during treatment groups or counseling.
- ☐ Youth interferes with others' treatment progress.
- ☐ Youth refuses to attend or participate in treatment groups.
- ☐ Youth does not attend treatment appointments regularly and on-time.
- ☐ Youth is under the influence of substances when in groups or counseling.
- ☐ Youth is not honest in groups or counseling.
- ☐ Youth is not prepared with assignments when attending groups or counseling.
- ☐ Youth is not progressing in treatment groups or counseling.

☐ Youth makes excuses or performs behaviors to avoid treatment.
☐ Youth engages in unlawful behaviors or supervision violations which contribute to his absence from treatment.
☐ Other: _____

F. Does the youth have significant quality-of-life issues? (Research-based risk factors related to recidivism) **YES ☐ NO ☐**

☐ Youth is homeless.
☐ Youth is unemployed or cannot maintain employment.
☐ Youth is truant from school, has been suspended more than once, or is expelled.
☐ Youth regularly uses or binges with drugs and alcohol.
☐ Youth associates with a negative peer group or gang.
☐ Youth has no friends, or inconsistent relationships.
☐ Youth has been in possession of firearms.
☐ Youth has significant amounts of unstructured free time.
☐ Youth associates with potential victims or views pornography (Sex Offender only).
☐ Youth engages in unlawful behavior or supervision violations.
☐ Youth has inadequate problem-solving skills (inability to identify and implement solutions or inability to negotiate with others)

G. Secondary Targets (Research-based risk factors directly linked to disruptive behaviors that interfere with the youth's ability to receive treatment for primary target) **YES ☐ NO ☐**

☐ Acute ADHD
☐ Significant cogitive impairment (IQ below 70)
☐ Significant learning disabilities
☐ Neuropsychological factors (Fetal Alcohol Syndrome, Autism, significant brain trauma)
☐ Early onset of disruptive behaviors
☐ Early onset of substance abuse
☐ Early onset of aggression specifically toward peers or close friends
☐ Significant grief or loss
☐ Significant attachment difficulties
☐ Criminogenic belief system/ gang affiliation or lifestyle

H. Family Treatment Targets (Research-Based Risk and Protective Factors Related to Recidivism) **YES ☐ NO ☐**

☐ Motivation and Engagement: Reducing negativity and blaming within the family
☐ Motivation and Engagement: Increasing hopefulness for the future
☐ Motivation and Engagement: Increasing positive family beliefs regarding usefulness of education
☐ Motivation and Engagement: Increasing positive family beliefs regarding problem solving without aggression
☐ Skill Acquisition: Teaching ability to supervise and monitor youth
☐ Skill Acquisition: Moving from punitive parenting model to reinforcing parenting model
☐ Skill Acquisition: Increasing warmth in family
☐ Skill Acquisition: Increasing chemical dependency services to family members
☐ Skill Acquisition: Increasing mental health services to family members
☐ Skill Acquisition: Increasing problem solving skills in family
☐ Generalization: Fostering independence in youth
☐ Generalization: Increasing accord and harmony between family members
☐ Generalization: Increasing knowledge and use of community resources and support to family (housing, employment, income, community services, and social supports)
☐ Generalization: Increasing positive peer groups for family members

II. BEHAVIORAL ANALYSIS (OF MOST SERIOUS BEHAVIOR ON TREATMENT HIERARCHY)

A. **Vulnerabilities** **Long-Term Risk Factors:** Dx of Major Depression, Bi-Polar Disorder, DD
Immediate Risk Factors: Not sleeping; victimized in unit by peers; not doing well in school; disappointed b/c did not get accepted by basketball team.
B. **Cues** Family promises to visit, then doesn't; staff promises phone call, but didn't give it
C. **Thoughts** Nobody cares. Everyone lets me down. I am a victim. I am no good.
D. **Feelings** Sadness, depression, anger, loneliness.
E. **Problem Behavior** Destroys property; refuses program including tx grps; won't come out of room
F. Outcomes Stress relieved; staff and peer attention when youth destroys items in room; gets out of school; more loneliness.

III. TREATMENT PLANNING: INTERVENTIONS FOR TARGETED BEHAVIOR

A. Youth is engaged in his/her own treatment progress. **Yes** ☐ **No** ☐ **Intermittently** ☒
Please identify interventions taken to motivate and engage youth: [Text Box]

B. Identify specific link in Behavior Analysis to be targeted:
- ☐ Vulnerabilities
- ☐ Links (Thoughts, Feelings, Physical Sensations)
- ☐ Cue
- ☐ Problem Behavior
- ☐ Outcomes

C. Identify Overarching Skill Area and 1-3 Specific Skills Taught to Youth to Address Targeted Link Identified in III.B.:
- ☐ Emotion Regulation
  - ☐ [All DBT, ART, MRT skills will be listed here]
- ☐ Interpersonal Effectiveness
  - ☐ [All DBT, ART, MRT skills will be listed here]
- ☐ Distress Tolerance
  - ☐ [All DBT, ART, MRT skills will be listed here]
- ☐ Mindfulness or Observing
  - ☐ [All DBT, ART, MRT skills will be listed here]
- ☐ Problem Solving
  - ☐ [All DBT, ART, MRT skills will be listed here]
- ☐ Chemical Dependency Treatment
  - ☐ [All components of model to be listed here]
- ☐ Sex Offender Treatment
  - ☐ [All components of model to be listed here]

D. Does treatment plan identify steps to extinguish problem behavior/block outcomes? **Yes** ☒ **No** ☐
State progress. Staff will remove items of value to the youth from youth's room immediately for a period of time following a tantrum that involves destruction of property. Staff will not react to youth destroying property, but will follow the removal protocol quietly and quickly. Youth is prescribed medication to alleviate vulnerability of Bi-Polar Disorder and Depression. Youth will be locked out of his room when he refuses to come out of his room to program or go to school.

E. Does treatment plan identify shaping steps to reinforce replacement behavior? **Yes** ☒ **No** ☐
State progress. Joe can immediately earn back valuable items from his room (if previously taken away) and also rewards (points, positive feedback, crayons/paper, and line leader privileges) upon demonstrating use of self-soothing, thinking of pros and cons, and half-smiling skills. Staff will watch for times when Joe is frustrated or experiences disappointment and will reward Joe with points, verbal positive accolades, crayons/drawing paper and

late-nights depending on how little property he destroys, how many group activities he attends, and how often he attends school. Staff will recognize Joe in front of the group for consecutive days of using his skills and not destroying property, and going to school and groups.

F. Does treatment plan identify a cue removal or cue exposure plan to allow youth to learn and practice new skills? **Yes** ☒ **No** ☐

State progress. Joe has responded to staff taking the time to explain and prepare Joe when they find out his parents will not visit. Staff have contacted Joe's parents to problem-solve their lack of visitation, and they seem to understand the importance of keeping their promises, or not making promises to visit. Staff have also made an effort to keep promises of phone calls and other commitments to Joe within short time frames, considering Joe's DD status. When Joe improves his competence in learning Distress Tolerance skills, staff will gradually introduce cues of disappointment, like not receiving a scan call, to Joe.

G. Does the youth have limitations that are addressed in the treatment plan? **Yes** ☒ **No** ☐

Explain. Joe is diagnosed with Bi-Polar Disorder which lends itself to rapid mood swings. He also is diagnosed with Major Depression; however, both of these conditions seem to respond well to medication. Joe has been compliant on medication and earns rewards for taking his medication daily. Forced participation in program also seems to alleviate Joe's depression symptoms. Joe is also DD. The skills have been modified to fit his cognitive level. Joe performs the Pros and Cons skill verbally with his peers, staff or himself, instead of writing them down.

H. Please identify areas of programming in which youth currently participates: Joe attends night school part-time and his attendance is regular. Joe is a team member on a DNR crew and his supervisor reports no major issues. Joe is always ready for work on the DNR crew on time, and seems to be motivated by his work experience. Joe is on the waiting list for D/A treatment.

I. Please identify progress with family:

☐ Family is motivated and engaged to participate with youth's treatment progress.
☐ Family requires more intervention in order to engage them in youth's treatment progress.
☐ Youth does not have identified family or support network.

Please identify contacts, motivation and engagement strategies, and progress made with family during this reporting period: [Text box]

[Signature lines below.]
[For automated version, specific questions on IPSA will be linked to skill areas on this form in order to measure progress of each skill area, so that we can have researched data to collect on the efficacy of programming

PAROLE REPORTING MECHANISM FOR TREATMENT PLAN: ATTACHMENT B

Youth's Name	**Date of Birth**	**JRA Number**	**Report Date**
Case Manager's Name	Region		

Specialized Treatment Needs

☐ **Mental Health Target Population**
☐ **Chemically Dependent/Abusive**
☐ **Sex Offender**
☐ **Special Education or Developmentally Delayed**

☐ **Initial Treatment Plan** (completed in first 30 days)
☐ **Follow-Up Treatment Report** (to be completed every 90 days on behaviors analyzed for last 90 days)

Type of parole

☐ Intensive Parole ☐ Enhanced Parole ☐ Transition Parole ☐ Sex Offender Parole

I. PAROLE TREATMENT CONCERNS

A. Is the youth currently exhibiting suicidal ideation, threats, or behaviors?

☐ Youth has had a serious attempt to take his life.
☐ Youth engages in parasuicidal or self-mutilating behavior.
☐ Youth makes statements of suicidal ideation.

B. Is the youth currently exhibiting aggressive ideation, threats, or behaviors toward family, staff, or peers?

☐ Youth has physically or sexually assaulted a peer, staff, or family member.
☐ Youth has made threats to physically or sexually assault peers, staff, or family members.
☐ Youth has verbally assaulted or made aggressive sexual comments to peers, staff, or family members.
☐ Youth has engaged in passive-aggressive or covert victimization of peers, staff, or family members.
☐ Youth destroys property in excess of $250.00.

C. Is the youth currently exhibiting runaway/absconder ideation, threats, or behaviors?

☐ Youth has run away from placements and has been absent for extended periods.
☒ Youth routinely engages in runaway behaviors for short periods of time.
☐ Youth has engaged in escape ideation and threats.

D. Is the youth currently engaging in treatment-interfering behaviors?

☐ Youth is inattentive and disengaged during treatment groups or counseling.
☐ Youth interferes with others' treatment progress.
☐ Youth refuses to attend or participate in treatment groups.
☐ Youth does not attend treatment appointments regularly and on-time.
☒ Youth is under the influence of substances when in groups or counseling.
☐ Youth is not honest in groups or counseling.
☐ Youth is not prepared with assignments when attending groups or counseling.
☐ Youth is not progressing in treatment groups or counseling.
☐ Youth makes excuses or performs behaviors to avoid treatment.
☐ Youth engages in unlawful behaviors or supervision violations which contribute to his absence from treatment.
☐ Other: _____

E. Does the youth have significant quality-of-life issues? (Research-based risk factors related to recidivism)

☐ Youth is homeless.
☐ Youth is unemployed or cannot maintain employment.
☐ Youth is truant from school, has been suspended more than once, or is expelled.
☒ Youth regularly uses or binges with drugs and alcohol.
☒ Youth associates with a negative peer group or gang.
☐ Youth has no friends, or inconsistent relationships.
☐ Youth has been in possession of firearms.
☐ Youth has significant amounts of unstructured free time.
☐ Youth associates with potential victims or views pornography (Sex Offender only).
☐ Youth engages in unlawful behavior or supervision violations.
☒ Youth has inadequate problem-solving skills (inability to identify and implement solutions or inability to negotiate with others)

F. Secondary Targets (Research-based risk factors directly linked to disruptive behaviors that interfere with the youth's ability to receive treatment for primary target)

☐ Acute ADHD
☐ Significant cogitive impairment (IQ below 70)
☐ Significant learning disabilities
☐ Neuropsychological factors (Fetal Alcohol Syndrome, Autism, significant brain trauma)
☒ Early onset of disruptive behaviors
☐ Early onset of substance abuse
☐ Early onset of aggression specifically toward peers or close friends
☐ Significant grief or loss
☐ Significant attachment difficulties
☐ Criminogenic belief system/ gang affiliation or lifestyle

G. Family Treatment Targets (Research-Based Risk and Protective Factors Related to Recidivism)

☐ Engagement and Motivation: Reducing negativity and blaming within the family
☒ Engagement and Motivation: Increasing hopefulness for the future
☒ Engagement and Motivation: Increasing positive family beliefs regarding usefulness of education
☐ Engagement and Motivation: Increasing positive family beliefs regarding problem solving
☐ Engagement and Motivation: Increasing warmth in family
☒ Support and Monitor: Improving parent supervision and monitoring of youth
☐ Support and Monitor: Improving parenting skills
☐ Support and Monitor: Increasing services to family members
☒ Support and Monitor: Increasing problem solving skills in family
☐ Generalization: Fostering better family functioning
☐ Generalization: Increasing accord and harmony between family members
☐ Generalization: Increasing knowledge and use of community resources and support to family (housing, employment, income, community services, and social supports)
☐ Generalization: Increasing positive peer groups for family members

II. FUNCTIONAL FAMILY PAROLE SERVICES STAGE

A. Engagement and Motivation ☐
B. Support and Monitor ☒
Fine Tuning Skills ☒
Referred to Service ☐
Name of Service:_____
C. Generalization ☐

III. INTERVENTIONS FOR PROBLEM BEHAVIOR (Form can have 3-4 intervention boxes identical to B-C.)

A. Is the family engaged and motivated to participate in a family service plan? ☒ Yes ☐ No

B. Family Service Plan **[Drop-down box listing specific available DBT, ART, MRT, SO, and DA skills.]**

Mindfulness
Interpersonal Effectiveness
Distress Tolerance
Emotional Regulation
Problem Solving
D/A Treatment

DISTRESS TOLERANCE

DISTRESS TOLERANCE skills generalized (Pick 1):

Wise Mind Accepts
Self-Soothing
Improving the Moment
Thinking of Pros and Cons
Radical Acceptance
Half-Smiling
Observing Your Breath
Awareness
Willingness vs. Willful
Reducers: Deep Breathing
Counting Backward
Pleasant Imagery
Reminders
Getting Ready for a Difficult Conversation
If…Then

THINKING OF PROS AND CONS

2. **Does family service plan identify steps to accomplish small obtainable change? Yes ☒ No ☐**
   State progress.
   Parents are currently asking Johnny before he leaves the house to see friends about the pros and cons of using drugs and alcohol. Johnny lists on pro and five cons every time he leaves home. Johnny also leaves his mother a phone number where he can be reached.

3. **Does family service plan reinforce new behavior? Yes ☒ No ☐**
   State progress.
   The family has agreed to have a five-minute conversation before Johnny leaves the house. Johnny and the parents continue to have the conversation. The parents thank Johnny at the end of the conversation every time.

4. **Does family service plan identify a generalization plan and services to support the practice of new skills? Yes ☒ No ☐**
   State progress.
   The family has not moved into generalization; however, the mother has made phone calls to a parent support group and will begin attending it next week.

Please rate the youth on his progress in learning and demonstrating this skill: [IPSA pop-up boxes]

Section 2: Aggression Management

1. Believes use of verbal aggression to resolve a conflict is
- ☐ **rarely appropriate.**
- ☐ **sometimes appropriate.**
- ☐ **often appropriate.**

2. Believes use of physical aggression to resolve a conflict is
- ☐ **rarely appropriate.**
- ☐ **sometimes appropriate.**
- ☐ **often appropriate.**

3. Violence/Anger: Reports ☒ No Reports ☐ of displaying a weapon, fighting, threatening people, violent outbursts, violent temper, fire starting, animal cruelty, destructiveness, volatility, intense reaction.

Section 5: Life Skills

1. Structured recreational activities: Youth participates in structured and supervised pro-social activities such as religious group/church, community group, cultural group, club, athletics or other community activity.
- ☐ **two or more activities**
- ☐ **one activity**
- ☐ **not involved but interested**
- ☐ **no interest in any activities**

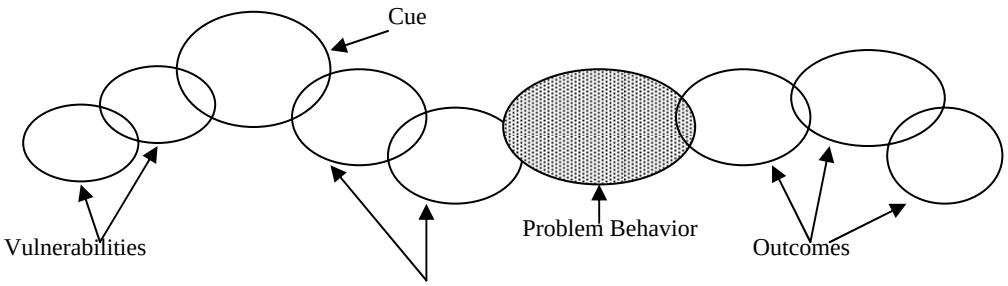
2. Unstructured recreational activities: Youth engages in activities that positively occupy the youth's time, such as reading, hobbies, sports, etc.
- ☐ **two or more activities**
- ☐ **one activity**
- ☐ **not involved but interested**
- ☐ **no interest in any activities**

[IPSA areas continue…and are integrated with original IPSA data from Diagnostic. Saved to new IPSA file with new score. IPSA ratings do not print out with treatment report, but staff can print new IPSA from CATS]

BEHAVIORAL ANALYSIS WORKSHEET
"Completing Your Behavior Chain"

Your Name: Date of Problem Behavior:

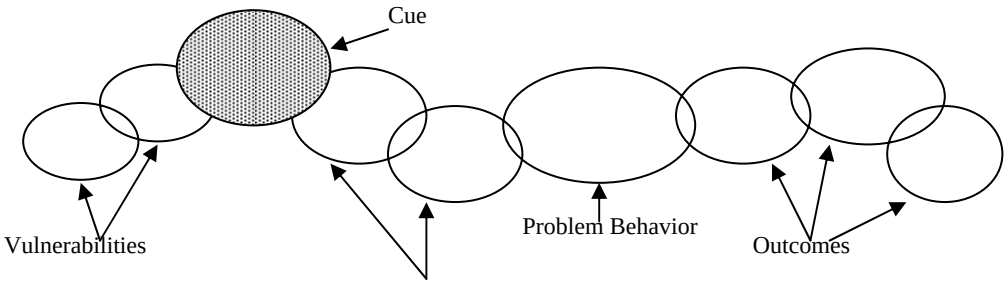
Completing Your Behavior Chain: The Problem Behavior



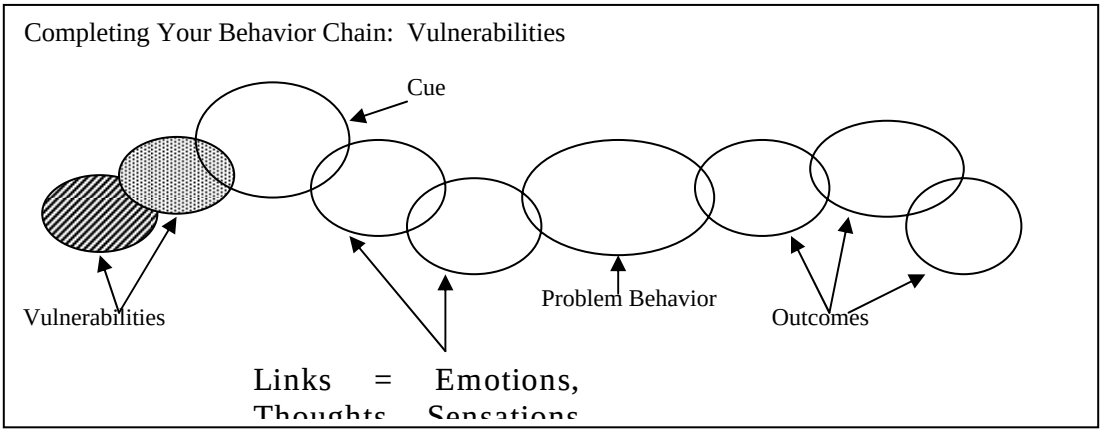
1) Describe your **Problem Behavior**:

2) Who was present at the time of your problem behavior?

Completing Your Behavior Chain: The Cue

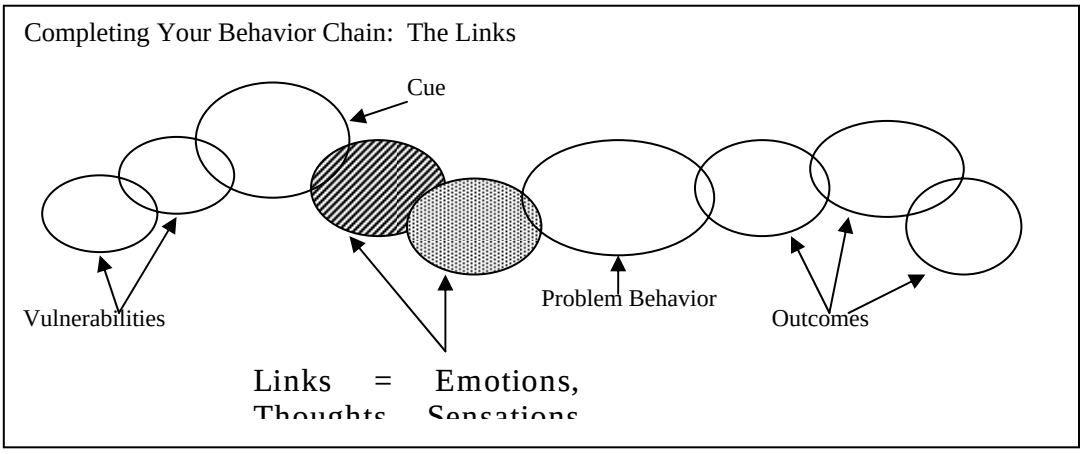


3) What **Cue**, or prompting event, started you on the **Chain** to your behavior?



4) What things inside yourself made you **Vulnerable** or more likely to act out negatively?

5) What was going on around you that made you **Vulnerable**?



6) Complete the **Links** in Your **Behavior Chain.** (Circle one category per line and remember what you were thinking and feeling moment by moment after the Cue. Also think of actions that you or someone else did after the Cue. Write the thought, feeling, sensation, or action. Use more space on the back of the page if you need more room.)

A. What was I thinking What was I feeling Body Sensations What I did What happened

B. What was I thinking What was I feeling Body Sensations What I did What happened

C. What was I thinking What was I feeling Body Sensations What I did What happened

D. What was I thinking What was I feeling Body Sensations What I did What happened

E. What was I thinking What was I feeling Body Sensations What I did What happened

F. What was I thinking What was I feeling Body Sensations What I did What happened

G. What was I thinking What was I feeling Body Sensations What I did What happened

H. What was I thinking What was I feeling Body Sensations What I did What happened

I. What was I thinking What was I feeling Body Sensations What I did What happened

J. What was I thinking What was I feeling Body Sensations What I did
What happened

K. What was I thinking What was I feeling Body Sensations What I did
What happened

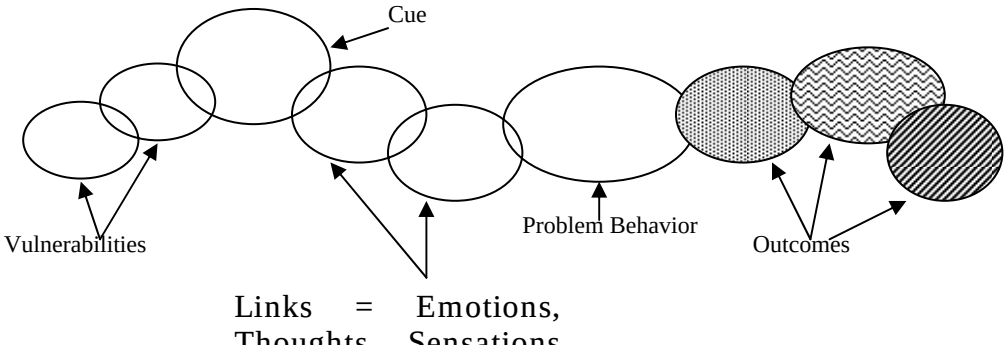
L. What was I thinking What was I feeling Body Sensations What I did
What happened

M. What was I thinking What was I feeling Body Sensations What I did
What happened

N. What was I thinking What was I feeling Body Sensations What I did
What happened

O. What was I thinking What was I feeling Body Sensations What I did
What happened

Completing Your Behavior Chain: The Outcomes



7) How did the **Chain** end? What were the positive outcomes that happened to you? What were the negative outcomes that happened to you?

8) Go back over the chain and put a star (*) by each spot where you could have broken this chain by changing your behavior.

9) How did your **Problem Behavior** cause **Hurt** to others?

10) How will you **Correct** the **Harm You** caused with your **Problem Behavior**?

11) Look at your answers in #4 and #5. What will you do to be **Less Vulnerable** the next time?

12) Look at your answer in #3. Can you **Avoid** the **Cue**? If so, what will you do to avoid the cue?

13) Look again at your answer in #3. If you cannot avoid the cue, what skills can you learn and practice to help you react better to the cue in the future?

14) How does your behavior chain compare to your **Offense Cycle**? What is the same? What is different?

Reviewed and signed by staff: _____

Reviewed and signed by counselor: _____

Presented to peer group on _____.

Peer group comments:

Staff comments:

HELP SHEET FOR COMPLETING A BEHAVIOR CHAIN

1) Describe your PROBLEM BEHAVIOR so that someone reading about it could act it out. For example:
    - throwing a chair
    - banging on your door with your foot
    - cutting arm with paper clip
    - threatening by saying "I'm going to beat you up"
    - assaulting a peer in the face with my fist
    - damaging your room by smearing toothpaste
    - yelling at staff
    - stealing a peer's jacket

2) Write the names of the people who were there when you did your Problem Behavior.

3) Write about the CUE, or prompting event, that started you on the way to your Problem Behavior. Think about what happened around you, and ask yourself these questions:
    - What happened <u>right</u> before you engaged in the problem behavior?
    - When did the problem start?
    - What was going on the moment the problem started?
    - What were you thinking, feeling, or imagining right then?
    - Why did the problem behavior happen right then, instead of some other time?

4) and 5) Write about stuff that was going on that made it tough for you to handle this situation better. These things are called VULNERABILITY FACTORS. Ask yourself:
    - Were you under a lot of stress, good or bad?
    - Were you experiencing strong feelings like sadness, shame, anger, fear, or loneliness?
    - Did you skip or otherwise not take your meds?
    - Did you get really good or really bad news from home?
    - Did your visitor not show up?
    - Were you up all night the night before?
    - Were you sick?
    - Were you in a high-risk situation?
    - Were you having problems in school or work? With friends or family?

6) Imagine that your PROBLEM BEHAVIOR is chained to the CUE. How long does it stretch? Where does it go? What are the links? Write out all the links moment to moment, no matter how small, as if you were writing a play. Think of all of your thoughts, feelings, sensations, actions and events that happened until you reach the moment of your PROBLEM BEHAVIOR.
    - What exact thought, belief, feeling, body sensation, or action followed the one before it? What thought, belief, feeling, body sensation, or action followed that one? What next? And so on...
    - For each link in the chain, ask yourself if there is a smaller link you could write about.

7) What made the chain stop? Think about:
    - What positive outcomes happened to you after your PROBLEM BEHAVIOR?
    - What negative outcomes happened to you after your PROBLEM BEHAVIOR?
    - What happened immediately after?
    - What happened later on?
    - How did you feel right after doing the problem behavior?
    - What happened that might make you repeat the behavior again later?

8) Put a star by all the spots on the Chain where you could have ended the chain sooner by doing a different behavior (using a skill, reacting differently, thinking about something differently, etc.). Write down what you could have done. (Writing in a different color makes it easier to read later)

9) How did your PROBLEM BEHAVIOR affect others? Think about:
    - How did other people react right away?
    - How did people react later on?

10) How will you make up for any damage or hurt you may have caused others?
    - What negative OUTCOMES of your problem behavior can you fix? How?

11) Go back to the VULNERABILITY FACTORS you listed in questions 4 and 5. List several ideas on how you can reduce each one.
    - What would be a good prevention plan for avoiding the chain of behaviors that you did after the Prompting Event?

12) Go back to question 4. Can you avoid the CUE? What is a good plan for avoiding the CUE?

13) If you can't avoid the cue, what are some skills you could use instead to handle the CUE better next time? What is your plan for learning and practicing skills?

14) Have you completed a behavior chain on your committing offense? It may be a good idea to complete a behavior chain on the crime that you were locked up for. Compare it with this behavior chain. Write down what is the same and different about your Behavior Chain and your offense cycle.

GENERAL BEHAVIORAL ANALYSIS HELP SHEET: ATTACHMENT E

Juvenile Rehabilitation Administration
Site:
Residential Multidisciplinary Team (MDT) Intake File Search

Date of File Review: **Case Manager:**

Youth:	**Date of Birth:**	**Age:**
JRA #:	**Minimum:**	**Maximum:**
Race/Ethnicity:	**Primary Language Spoken:**	**Dependent of State?** ☐ **YES** ☐ **NO**
ISCA Score:	**Last CRA Scores:**	**Date of CRA Score:**
MDT Transition Review Date:	**Community Eligibility Date:**	**Anticipated Transition Date:**

SECTION A: OFFENSE HISTORY

Attach Chain Analysis on Committing Offense for Use in Treatment Planning

1. **Current Offense(s):**
2. **Description of Offense:**
3. **Prior Offenses (Adjudicated and Non-Adjudicated):**
   a. **Violent Offenses:**
   b. **Non-Violent Offenses:**

Please make a psychiatric referral if the youth is any one of the following:
1. SPL 1-4
2. Taking MH medication
3. Level 3 DMHS
4. Current or past parasuicide history
5. Suicide Red Flag on MAYSI
6. Current DSM-IV Dx

SECTION B: MENTAL HEALTH HISTORY

1. **Date of Last SRA:**
   Results: SPL 1 ☐ **SPL 3** ☐ **NO SPL** ☐ **SPL 2** ☐ **SPL 4** ☐
2. **Is youth currently prescribed psychotropic medication?**
   ☐ **YES**
   ☐ **NO**
3. **If prescribed medication, please list:**
4. **Results of Diagnostic Mental Health Screen (DMHS):**
   a. **Total Score:** ☐ **Level 1** ☐ **Level 2** ☐ **Level 3**
   b. **Elevated Scores:** ☐ **Anxiety/Thought Content**

☐ **Suicide/Self-Mutilation**
☐ **Detention Behavior/Mental Status**

5. Recent Parasuicide Events? ☐ **NO** ☐ **YES**

a. Date of most recent event:

b. Cue or Prompting Event:
c. Method:
d. Rate youth's intent to die:
low ☐**1** ☐**2** ☐**3** ☐**4** ☐**5** ☐**6** ☐**7** ☐**8** ☐**9** ☐**10 high**
e. Did youth tell anyone before? ☐ **NO** ☐ **YES**
f. Did youth tell anyone after? ☐ **NO** ☐ **YES**
g. Was hospitalization required? ☐ **NO** ☐ **YES**
h. Lifetime number of events:

If 'Yes" in this area, attach Chain Analysis for use in Treatment Planning

6. History of Parasuicide? ☐ **NO** ☐ **YES**
(Complete Chain Analysis)
a. Lifetime number of events:
b. Total # of events with high intent to die:
c. Total # of events requiring hospitalization:
d. Total # of events not previously disclosed:

7. Please check # of MAYSI Red Flags: ☐ **D/A** ☐ **Suicide** ☐ **Trauma**
☐ **Impulsivity** ☐**Anger**
☐ **Depression** ☐**Thought**
☐ **Anxiety** ☐**Somatic**

8. Prior community-based MH treatment services? ☐ **NO** ☐ **YES**
☐ **Inpatient** **Dates:**
☐ **Outpatient** **Dates:**

9. DSM-IV diagnoses within past two years? ☐ **NO** ☐ **YES**
a. Please list with dates:
b. List any historical diagnoses:

10. Does this youth require a psychiatric referral? ☐ **NO** ☐ **YES**

SECTION C: CHEMICAL DEPENDENCY, SEX OFFENSES, and EDUCATIONAL NEEDS

1. Is the youth chemically dependent? ☐ **NO** ☐ **YES**
2. Is the youth chemically abusive? ☐ **NO** ☐ **YES**
3. Does the youth require treatment? ☐ **Inpatient** ☐ **Outpatient**

4. Is the youth a sex offender?

- ☐ **Adjudicated Felony**
- ☐ **Adjudicated Misdemeanor**
- ☐ **Non-Adjudicated**

Please consult with coordinators and educators for this information.

5. Please check SAVY score:

- ☐ **Sexually Aggressive**
- ☐ **Sexually Vulnerable**
- ☐ **Both**
- ☐ **Neither**

6. Does the youth appear to meet the criteria as a sexually violent predator (RCW 71.09)?

- ☐ **YES**
- ☐ **NO**

7. Preliminary Notification Level:

☐ **1** ☐ **2** ☐ **3** ☐ **N/A**

8. The youth has completed grade .

9. Does the youth qualify for Special Education? ☐ **NO** ☐ **YES**

a. List reason:

- ☐ **Health Impaired**
- ☐ **Mental Retardation**
- ☐ **Behaviorally Disturbed**
- ☐ **Learning Disability**

b. Specify details:

10. The youth has not been in school b/c:

- ☐ **Excessive truancy or runaway**
- ☐ **Multiple suspensions or expulsion**
- ☐ **Family transient or many moves**

11. Learning styles or strengths:

12. WRAT or WIAT grade level functioning: **Reading**
Math

Consult with Clinic Staff

SECTION D: MEDICAL CONCERNS

1. **Does the youth have any history of head trauma?** ☐ **NO** ☐ **YES**
2. **Does the youth have medical conditions which require ongoing attention by an M.D.?**

   ☐ **NO** ☐ **YES**

   a. **Please list:**

3. **Does the youth have any physical or developmental condition that would interfere with his/her ability to participate in treatment programming or physical activity?**

   ☐ **NO** ☐ **YES**

   a. **Please list:**

SECTION E: PLACEMENT & TRANSITION NEEDS

1. **Current parent or guardian:**
   a. **Name:**
   b. **Address**
   c. **City/Zip:**
   d. **Phone:**

2. **Does the youth have a history of leaving or escaping placements?**
   ☐ **NO** ☐ **YES**
   ☐ **Runaway from home**
   ☐ **Short-term**
   ☐ **Long-term**
   ☐ **Escape from JRA or DCFS group care placements**
   ☐ **Left inpatient CD or MH treatment programs**

3. **Does family/guardians have treatment issues?** ☐ **NO** ☐ **YES**

☐ **Chemical Dependency**	☐ **Unstable living accommodations**
☐ **Physical abuse**	☐ **Emotional/Verbal abuse**
☐ **CPS involved**	☐ **Family not committed to youth's tx progress**
☐ **Suicide History**	☐ **Mental Health**

4. **List family/guardian strengths (including cultural issues):**

5. **List youth's strengths or protective factors:**

6. List any supports the youth may have in the community:

- ☐ **Church:**
- ☐ **Mentor:**
- ☐ **Extended family or friends:**
- ☐ **State or County agencies:**
- ☐ **Tribal Affiliation:**