A. STATEMENT OF THE PROBLEM

During the past 15 years, the City and County of San Francisco has established itself as a national leader in developing alternatives to secure detention for juvenile-justice involved youth, including establishing innovative reentry and aftercare programs. Consistent with a nationwide trend, San Francisco juvenile crime has declined dramatically over the past several years. Detentions have declined by 60%, and both referrals and petitions have declined by 46%. The number of youth ordered to the California Division of Juvenile Justice (formerly the California Youth Authority) has also decreased dramatically, with only four San Francisco youth committed there in 2012, a 79% decline compared to 2000.

San Francisco's continued success in reducing juvenile arrests and detentions comes despite the ongoing disparities in arrest and detention rates. The majority of juvenile justice-involved youth in San Francisco are African Americans and Latinos originating from specific, low-income communities with high levels of violence and gang activity. In 2012, African American and Latino youth comprised 49.17% and 25.46% of juvenile probation referrals, respectively, despite the fact that African American juveniles make up only 12% of San Francisco youth ages 10 to 17, and Latino juveniles make up only 23%.

These disparities are present when reviewing long-term commitments over the past two years. Since January 1, 2011, there have been 63 commitments to Log Cabin Ranch, a county-operated, staff-secure ranch facility for delinquent boys. Of that group, 79% were African American, or Latino.

In 2008, 108 of San Francisco's 205 out-of-home placements (53%) ended in placement failure, with African American and Latino youth comprising 72% and 21% of placement failures, respectively (SF Juvenile Probation Department). Thanks in part to the Juvenile

Collaborative Reentry Team (JCRT), established as a pilot program in 2009 with the support of a Second Chance Act grant, those numbers have improved significantly with 31% of the 137 out-of-home placements in 2011 ending in placement failure. The disproportionality continues, however, with African American and Latino youth making up 65% and 21% of those failures.

These patterns, while encouraging in their continued decline, also reflect the disproportionate concentration of crime and violence in San Francisco's most disadvantaged and underserved communities. Police and juvenile probation data corroborate that juvenile offenders originate from, and return following commitment to San Francisco's most disadvantaged communities. In 2012, youth living in the Bayview Hunter's Point, Tenderloin, South of Market, Mission, Western Addition, Potrero Hill, Ingleside, and Visitacion Valley neighborhoods accounted for 75% of San Francisco's unduplicated juvenile referrals. According to data from the Socioeconomic Mapping and Resource Topography (SMART) system, census tracts in these neighborhoods are among the most disadvantaged in the country. Bayview Hunter's Point has a mean Community Disadvantage Index (CDI) of 9 (more disadvantaged than 90% of census tracts in the country), and five of its twelve census tracts have CDIs of 10 (the most disadvantaged). These same neighborhoods have been mapped as gang turf, gang conflict, and shooting hot spot areas (clustered in and near gang turf) by the San Francisco Police Department.

To further improve outcomes for juvenile justice-involved youth, San Francisco in 2012 utilized Second Chance Act funding to transform the Juvenile Collaborative Reentry Team (JCRT) pilot into the expanded Juvenile Collaborative Reentry Unit (JCRU)**,** an unprecedented partnership of key juvenile justice system stakeholders that includes integration of pragmatic, evidence-based reentry practices. A centralized collaborative unit for all reentry services, JCRU relies on team decision making practices while juvenile offenders are in custody and ensures

closely monitored planning through the reentry process. The model offers coordinated case management and brokered comprehensive services designed to reduce recidivism and maximize positive outcomes for all juveniles released in San Francisco. The goal of the program is to improve outcomes for justice-involved youth returning to San Francisco from out-of-state juvenile detention centers, as well as from Log Cabin Ranch, a county-operated, staff-secure ranch facility for delinquent boys located 45 miles south of San Francisco in La Honda, CA. The Log Cabin Ranch program is based on the nationally recognized Missouri Model and focuses on group interaction and process rather than time and compliance.

Enhanced services are provided to high-need juveniles by linking them to the JCRU as early as possible in their commitment. Once a youth is referred to the JCRU, the dedicated probation officers (POs), attorneys and social work staff connect with youth and their families, conduct the initial assessments, and track their progress while they are in the assigned placement. The team uses the required local six-month review hearings to re-evaluate each youth's progress and timing for release. At the six-month release marker (coinciding with the review hearing), the PO updates the risk-needs assessment and works with the team, the youth, and the family to prepare a preliminary release plan. The JCRU team meets regularly to consult and coordinate on the youth's progress, and at three months the team finalizes the plan and begins implementation.

Reentry plans include family history, housing, education, employment/vocational training, mental health, substance abuse, extracurricular/peer activities, mentoring, and any additional services a youth may require to succeed outside of placement. At the time the plan is finalized, about 90-days prior to release, the JCRU staff begins the intensive process of preparing the youth and family for reentry. Visits to out-of-state placements by JCRU staff are coordinated with the PO's regular visits to ensure coordination and consistency. The case management

coordinator updates team members on the preparations during the team's regularly scheduled meetings. At every turn, each reentering youth and their families are involved in making decisions that impact services, education, vocational opportunities, and other areas. To facilitate family support for juveniles in reentry, the JCRU involves the family in team meetings at the six month and three month prerelease points.

JCRU was formally established in January of this year, but data from the three-year program pilot indicates that the model has a significant impact on recidivism. The following table summarizes duplicated and unduplicated recidivism rates since the introduction of JCRT in 2009:

	2009		2010		2011		2012		Net Change	
	Dup	**Undup**	**Dupl**	**Undup**	**Dup**	**Undup**	**Dup**	**Undup**	**Dup**	**Undup**
Commitments	159	140	131	121	137	118	99	93	-22	-22
Subsequent Bookings	120	61	83	52	39	31	71	47	-81	-30
Recidivism Rate	75%	44%	63%	43%	28%	26%	72%	51%	-47%	-17%
Subsequent Probation Violations	35	25	17	14	6	4	3	3	-29	-21
Recidivism Rate	22%	18%	13%	12%	4%	3%	3%	3%	-18%	-14%
Subsequent Sustained Petitions	192	109	64	41	28	25	15	13	-164	-84
Recidivism Rate	121%	78%	49%	34%	20%	21%	15%	14%	-100%	-57%
Subsequent Court Dispositions	174	79	107	62	38	28	20	18	-136	-51
Recidivism Rate	109%	56%	82%	51%	28%	24%	20%	19%	-82%	-33%

The table shows striking reductions in both duplicated and unduplicated counts of recidivism at various points of entry into the system. Perhaps most interesting are the dramatic reductions in the duplicated counts that represent youth who reoffend multiple times in the given period. The reductions shown above imply that at the end of the period, the most chronic re-offenders virtually stopped committing new offenses. While the JCRT pilot and expanded JCRU have achieved significant reductions in recidivism for youth reentering the community from

residential commitment, overall outcomes have been less than satisfactory due to the fact that many young people are returning to live in chaotic, traumatized families, many of whom have longstanding system involvement and/or reside within San Francisco's most disadvantaged communities. As a result, the San Francisco Juvenile Probation Department's (SFJPD) most recent report (January 2013) on the City's juvenile reentry program highlighted the need for intensive family therapy services to engage and support multi-problem families to develop the skills and confidence they need to exercise effective supervision and guidance of their children returning from residential commitment. The report found that in many cases, young people have undergone phenomenal changes and growth while in residential placement, only to return to a family that has not changed, so that negative triggers that remain in place may drive the young person to self-sabotage and reoffend. In addition to the need for intensive therapeutic family support, the report highlighted a high rate of marijuana and alcohol abuse among youth and family members as a serious challenge to the success of San Francisco's juvenile reentry program.

Beyond San Francisco's direct experience with juvenile reentry programming, the need for family-focused juvenile reentry services that offer treatment as well as surveillance and community restraint has also been identified by a growing number of states and juvenile justice researchers throughout the United States (Early, Chapman & Hand, 2013). While individually-focused supportive programs may arguably help youth offenders in many ways, they have yet to show a significant or consistent impact on reducing repeat contact with the criminal justice system (Abrams & Snyder, 2010). The rationale for including the family in reentry

programs is that researchers have repeatedly linked several family-related factors to delinquent behaviors, including: coercive parenting, strained parent–child relationships, inconsistent discipline, neglect, parental substance abuse, violence, sexual abuse, attachment disruption, and inadequate levels of warmth and affection (Underwood, von Dresner, & Phillips, 2006).

To increase the availability of effective family therapeutic supports for youth released from residential custody, SFJPD has asked the Child, Youth and Family System of Care (CYFSOC) in the Community Behavioral Health Services division of the San Francisco Department of Public Health to lead the start-up and implementation of evidence-based, intensive family therapy services for this high-risk population. Toward this end, CYFSOC has partnered with the Young Adult and Family Center at University of California, San Francisco, as well as Seneca Family of Agencies (a nonprofit, youth and family mental health services provider), to develop the Family Intervention, Reentry & Supportive Transitions (FIRST) program for the highest-need youth supervised by the JCRU. The Second Chance Act grant requested in this application will support the FIRST program to provide evidence-based, intensive family therapy services for 100 youth and their families during its one to two-year pilot phase. If the FIRST program is successful in further reducing recidivism rates for this high-risk population, SFJPD will identify local and other sources of funding to sustain program operation over the longer term**.**

B. GOALS, OBJECTIVES, AND PERFORMANCE MEASURES

The primary goal of the FIRST program is to further reduce recidivism among San Francisco youth who are re-entering their communities from out-of-home placements. San Francisco's robust system of care and targeted juvenile reentry initiatives have made significant strides in reducing recidivism, and we believe that current practice will be greatly enhanced by

coordinated, family-centered, evidenced-based models. We propose to serve 100 youth per year, the majority of whom will be African Americans and Latinos originating from specific, low-income communities with high levels of violence and gang activity. Within two months prior to release, FIRST program staff will begin a comprehensive assessment of the youth, informing an individualized, family-centered treatment plan. Data collection will include tracking of individual-level OJJDP-specified performance indicators, including youth demographics, educational history, vocational history, mental health history, and family history. In compliance with GPRA regulations, we will also provide data on a semi-annual basis to OJJDP on the following measures: number of youth served by the program and reporting period, number of youth served by an evidence-based model, number of discreet services provided to youth, number of youth adjudicated or who had technical violations, percentage of youth completing program requirements, and number of youth with desired change in the targeted behavior. Research staff from UCSF and San Francisco's Child, Youth, and Families System of Care will conduct a rigorous internal evaluation of the model and will coordinate the Institutional Review Board submission for the protection of human subjects. Additionally, an independent evaluation of the model will be conducted by Mission Analytics, a local evaluation firm with expertise in public health and human service organizations.

The three goals of the FIRST program are:

1) To further reduce recidivism for high-risk and high-need youth returning from out-of-home placement.
2) To address the disproportionate representation of African-American and Latino youth who recidivate back into the juvenile justice system.

3) To demonstrate and disseminate an inter-agency collaborative approach that improves the skills and confidence of multi-stressed families in preventing delinquent behavior of their children post-reentry.

Objectives:

1) 100 youth per year will be served by the FIRST program, based on assessment of need and referral of Probation Officer or Social Worker.
2) 100% of enrolled youth and their families will receive family-centered services beginning two months prior to release, and up to 9 months post-release
3) A rigorous process and impact evaluation will be conducted to demonstrate the effectiveness of the FIRST model.

Performance Measures:

As specified by OJJDP, the FIRST program will track the following performance measures:

Process measures	*Outcomes*
➢ Number of released youth served by a reentry program ➢ Number of program youth served during the reporting period ➢ Percentage of youth served with whom an evidence-based best practice model was used ➢ The number of services provided to youth (e.g. substance use/counseling, mental health, and housing services)	➢ Number of youth who were adjudicated ➢ Number of program youth who had technical violations ➢ Percentage of youth completing program requirements (e.g. number of youth who complete all program requirements) Percentage of youth exhibiting desired change in the targeted behavior

These performance measures will be extracted from the Juvenile Probation IT department in coordination from the Public Defender's Office. Utilization and outcomes data for intensive

family therapy will be collected and analyzed in coordination with the FIRST program's internal evaluation team, led by UCSF researchers.

Outcomes:

The short-term outcomes we expect to see include an improvement in youth and family functioning, as captured by the Child and Adolescent Needs and Strengths (CANS) assessment tool, which was developed by John Lyons, PhD, and is administered at intake, at six month intervals, and at discharge. A Reliable Change Index is calculated to determine the statistically significant change in CANS items from intake to reassessment or discharge. The CANS has been adopted widely by many local and statewide jurisdictions, including the City and County of San Francisco. UCSF has also adapted additional tools to track family efficacy.

Parents/caregivers, and adolescents completed surveys at least three points: at intake, after twelve sessions, after twenty-four sessions, and/or at exit from the program. Families on the waitlist completed an initial survey to serve as a comparison group. The surveys included the following:

Family Efficacy Measures

- Collective Family Efficacy: perceived ability to meet family members' needs, exert influence, be involved with one another, and carry out specific courses of action. (*e.g. Resolve conflicts when family members feel they are not being treated fairly*)
- Parenting Efficacy: perceived ability to parent her/his adolescent child (*e.g. Express disagreement with your child without getting angry*).
- Co-parenting Efficacy: perceived ability to co-parent their adolescent child (*e.g. Deal with co-parenting problems together without blaming each other*).

- Adolescent Efficacy: perceived ability to relate to parents (e.g. Talk with your parents even when your relationship with them is tense).

Additional Measures

- Family Communication: (Barnes and Olson, 1985) Participants rate statements about their family's communication using a modified 5-point Likert scale (ranging from "strongly disagree" to "strongly agree" *e.g. Family members are satisfied with how they communicate with each other*).

- Family Satisfaction: (Olson and Wilson, 1986) Participants rate their level of satisfaction with their family in various situations using a modified 5-point Likert scale (ranging from "dissatisfied" to "extremely satisfied", *e.g. With how your family deals with conflicts?*).

- Kessler 6 inventory Screening Scale for Psychological Distress: (Kessler et al., 2002). Participants rate how they have been feeling during the past 28 days using a 5-point Likert scale (ranging from "none of the time" to "all of the time", *e.g. During the past 4 weeks, about how often did you feel hopeless?*).

We will collect satisfaction surveys from family members and any youth who is 18 or over. Finally, the reflecting teams and ongoing consultation from UCSF will provide fidelity checks to ensure the intensive family therapy models are implemented consistently and reliably.

C. PROJECT DESIGN AND IMPLEMENTATION

With the support of Second Chance Act grants in 2009 and 2012, San Francisco has made great strides in establishing a strong infrastructure of juvenile reentry and aftercare services for high-need and high-risk youth returning from residential commitment. The Juvenile Collaborative Reentry Team (JCRT) pilot, followed by its expansion into the Juvenile

Collaborative Reentry Unit (JCRU), have provided the opportunity for SF JPD to utilize emergent best practices to implement a streamlined and dynamic system of care for committed youth to achieve a successful return to their homes and communities. The result has been a dramatic drop in recidivism since the implementation of the JCRT/JCRU in 2009.

San Francisco's juvenile reentry services are implemented according to the Juvenile Justice Local Action Plan, which is developed annually by the San Francisco Juvenile Justice Coordinating Council (JJCC), a collaborative of 21 system stakeholders including the Public Defender, Juvenile Probation, the Superior Court, the District Attorney, the San Francisco Police Department, the San Francisco Unified School District, the Public Health Department, community-based organizations and other local stakeholders. The Local Action Plan, overseen by the JJCC, serves as San Francisco's strategic document for responding to, and reducing youth violence, including reentry services. To ensure seamless coordination with the reentry programming for adults, the JJCC works closely with the San Francisco Reentry Council, which serves as the coordinating body for reentry services for adult offenders.

San Francisco recognizes the value of collaboration and communication between juvenile justice system stakeholders and the community including community based organizations, and the need to maximize collaboration and minimize duplication across systems. As such, the Chief of the Juvenile Probation Department (SFJPD) meets regularly with a 25-member coalition of service providers, the Juvenile Justice Providers Association, to discuss systematic hurdles and to move toward appropriate and near-term solutions. In addition, SFJPD has established the Juvenile Advisory Committee (JAC), a group of formally system involved youth who provide the Department with a youth perspective in policy matters. The JAC also supports probationers

and their families as they navigate the complex and sometimes intimidating juvenile justice system.

SF JPD has fully implemented the YASI for probationers reentering the community from residential commitment. This comprehensive risk, need, and protective factor assessment instrument is designed for use in juvenile probation and other high-risk youth service settings. Critical to JCRU's focus on coordinated case management and team decision making, the YASI tool includes an in-depth assessment of the family environment. Questions address the family history, the adults living in the home, the opportunities for learning, parental caring and supervision, and how the family responds to conflict and applies consequences. Answers allow JCRU staff to begin the service planning process with the family immediately after assessment. Other important areas addressed by the YASI include legal history, school history and enrollment status, community and peer relationships, alcohol and drug involvement, physical and mental health history, skills, and employment relationships.

Through the operation and evaluation of its juvenile reentry program, San Francisco, like many other jurisdictions around the United States, has identified the need for intensive family therapy services to engage and support chaotic and traumatized families to develop the skills and confidence they need to exercise effective supervision and guidance over their children returning from residential commitment. In early-2013, SFJPD asked the Community Behavioral Health Services—Child, Youth and Family System of Care (CYF SOC), a division of the San Francisco Department of Public Health, to begin the planning and program development process to address this increasingly urgent need. Under the leadership of Dr. Kenneth Epstein and Dr. Emily Gerber, the CYF SOC began researching promising evidence-based practices and recruiting academic and service provider partners, toward the goal of implementing the most effective

family-focused treatment services for high-risk youth returning from residential placement. The result of these planning efforts was the conceptual development of the Family Intervention, Reentry & Supportive Transitions (FIRST) program, designed to address the treatment needs of high-risk youth supervised by the JCRU.

In addition to CYF SOC and SF JPD, FIRST program partners include (1) the Young Adult and Family Center (YAFC) at University of California, San Francisco (UCSF), which has developed and tested intensive family treatment models that integrate evidence-based practices such as Brief Strategic Family Therapy and Dialectical Behavior Therapy, along with (2) Seneca Family of Agencies, a statewide provider of evidence-based and promising practices for juvenile justice-involved youth and their families in multiple Bay Area counties. In its choice of these expert training/research and service provider partners for the FIRST program, CYF SOC has sought to incorporate the research of the National Implementation Research Network (http://nirn.fpg.unc.edu/), in order to ensure that the selected evidence-based practices are implemented with fidelity both during and sustained beyond the period of the requested Second Chance Act grant. The mission of the National Implementation Research Network (NIRN) is to contribute to the best practices and science of implementation, organization change, and system reinvention to improve outcomes across the spectrum of human services.

The primary roles of the FIRST program partners are as follows:

- Dr. Emily Gerber and the CYF SOC will assume administrative and contractual leadership of the project, including partnering with SF JPD to assess (using the Child and Adolescent Needs and Strengths (CANS) research-based tool) and identify reentering youth for enrollment in the project's evidence-based, intensive family treatment services.

- CYF SOC Family Mosaic Project supervisors (Program Director and Psychiatrist) and 3 clinicians will receive training and coaching on and provide the project's intensive family treatment services.
- SF JPD will enable all of its JCRU staff to receive training and coaching on the project's family treatment services, so that they can be effectively incorporated into the six to 12-month individualized reentry plan for each youth returning from residential commitment.
- The Young Adult and Family Center (YAFC) at UCSF will provide overall clinical leadership for the project, including training and coaching Seneca clinicians, JCRU and Family Mosaic Project staff in the delivery and case management of FIRST intensive family treatment services. UCSF will provide research expertise and support for the evaluation of the FIRST program, including expanding the empirical base for family-focused juvenile reentry/treatment services, toward the goal of replication.
- Seneca Family of Agencies will employ a team of direct practice staff (three master's level clinicians, a part-time supervisor, a part-time psychiatrist, and case assistant) responsible for providing, with sustained fidelity, the evidence-based family treatment services offered by the FIRST program. Seneca will also provide research expertise and support for the evaluation of the FIRST program.

Given the current scarcity of research on family-focused treatments for juvenile reentering from residential commitment, UCSF suggested to Dr. Gerber that the FIRST project implement and test the evidence-informed family treatment models created by the YAFC in 2006, particularly since they were developed for adolescents in disorganized, difficult-to-engage families. The YAFC's Intensive Family Therapy (IFT) model draws substantially upon the theory and methodology of Brief Strategic Family Therapy (BSFT), while the YAFC's Multi-Family

Group (MFG) model draws upon the theory and practices of Dialectical Behavioral Therapy (DBT). Following are detailed descriptions of the two models, which will be trained/coached by the YAFC Clinical Supervisor/Trainer and implemented by Family Mosaic and Seneca clinicians, with case management support provided by JCRU.

Intensive Family Therapy (IFT) Model

The IFT model is designed to help engage families experiencing chaos and conflict related to multiple problems including exposure to trauma, violence, substance abuse, loss and the impacts of poverty and inequity. Destructive and pervasive family' disruptions, chaos and conflict can have a devastating impact on children, youth, adults, families, and communities across generations (Cummings & Davies, 2010). The IFT practice model focuses on engagement and safety in order to help families recover and develop; the model is built on a family-centered approach, meaning that the family itself identifies and creates treatment goals that are culturally relevant, include family or community members the family identifies as meaningful, and prioritize the issues that the family chooses. The core of effective practice in diverse community-based settings requires accessible, affordable, and flexible services that incorporate empirically tested interventions and are grounded in a theoretical and developmental framework that are adapted to meet the needs of the community being served. IFT will adapt its model to ensure services are field and community-based, and to be flexible in working remotely, or working with subsystems of the family when youth are in placement.

The goals of IFT are to reduce and/or eliminate internalizing and externalizing youth behavior problems that are interfering with family, social and school functioning. This is accomplished by helping parents/caregivers and youth regain hope, increase family efficacy, promote positive and open communication, help parents and caregivers develop effective

parenting skills and to support children and adolescents in their successful growth into young adulthood. IFT emphasizes treating the whole family, and not just the "identified patient." Families are typically seen at minimum of once or twice weekly, sometimes for extended meetings in a clinic, home or school setting.

IFT uses a time-limited approach (3-9 months) in order to build and sustain youth and family motivation and to aggressively target symptoms and family issues. IFT is a four-phase modular treatment model. Modular treatment models help provide guidance for clinicians and a context to assess progress in therapy while continuing to respect the diversity of the families seen, the problems they present, and their therapeutic needs. YAFC's modular framework, referred to as the Four Cs, is outlined below:

- Phase 1: Coming Together & Care Management – Defining the problem systemically, developing a co-constructed and culturally responsive treatment plan, and developing a more reflective stance of family members towards changing behavior. Ensuring that basic needs of family are being met sufficiently to support engagement in IFT.
- Phase 2: Containment & Change – Focusing on symptom reduction to reduce the incidence of dangerous and challenging internalized and externalized symptoms contributing to family and social disequilibrium. Support family in making structural changes in the family system.
- Phase 3: Consolidation – Reinforce changes the family has made; support generalization to other family challenges; Help to restore and/or develop positive family communication and structure.
- Phase 4: Closure & Collaboration: Support a structured and appropriate ending, using culturally informed and relevant rituals to support and sustain re-entry to family or

community life within the context of a natural and intentionally defined community support structure.

Multi-Family Group (MFG) Model

One predominant common attribute among adolescents entrenched in the juvenile justice system is their struggles with judgment, risk taking and emotional regulation. To address these issues FIRST will adapt the Dialectical Behavior Therapy for Adolescents, multifamily skills group (MFG) curriculum developed at UCSF, YAFC in order to help youth and their families learn how to tolerate distress, increase interpersonal effectiveness, regulate strong emotions and reduce impulsive risk taking behavior. MFG is a two-hour group where the first 50 minutes are comprised of mindfulness, administration and homework review. Following a ten minute break a new set of skills are taught. There are typically two or three group leaders for up to five families (typically 15 group members). Each group has a rotating entry point, so that each module is comprised of five sessions and new members may enter at each new module point. The first session of each module focuses on orienting families to treatment, introducing the biosocial theory, reviewing the rules and assumptions and introducing the mindfulness skills. All skills are taught within 20 weeks and families typically graduate after 30 weeks of treatment.

Reflecting Teams/Collaborative Consultation

A unique component of the Intensive Family Therapy program is the collaborative nature of the work that the therapist will be doing with the family. One way in which this is accomplished is through the use of an intensive consultation model and the use of a reflecting team of clinicians and outside witnesses who observe and/or consult with the practitioners and family about what they were curious about and found meaningful in the conversations they were having. The process of reflective consultation helps families and practitioners collaborate more effectively to

see themselves in a new way that can cause a shift in thinking and functioning together, and increase motivation needed for change within the family system.

The UCSF Young Adult and Family Center will adapt its evidence-informed and empirically-driven models to support the goals of the FIRST program by building a flexible, community-based intervention model. UCSF will provide the following contracted services:

1. Develop an adapted modular IFT model and train all FIRST clinicians and JCRU/Family Mosaic case managers in the IFT model (Clinical director, Supervisor/Trainer)
    a. Adapt IFT model to client population and to community-based work in field
    b. Didactic training in structural family therapy and IFT model
    c. Clinical demonstration
    d. Ongoing clinical consultation
2. Co-develop an evaluation tool that will be used to continuously improve the model and quantify outcomes. (Research Director)
    a. Client satisfaction and program improvement
    b. Measure and track outcomes
3. Develop a research protocol. (Research Director)
    a. Obtain human subjects approval and develop research protocol for quantitative study on impact of FIRST program
4. 1.0 FTE Clinical Supervisor/Trainer(s) will be designated by UCSF for the FIRST program. The supervisor/trainer spend time in the field with the clinicians actively teaching the model and building clinician skills. The supervisor/trainer will provide ongoing coaching to field staff.
    a. Lead weekly “huddles” or meetings to respond to immediate needs

b. Lead supervision groups to review cases and fidelity to the model
c. Provide daily check-ins and on-call availability for as-needed consultation
d. Provide in the field coaching and modeling
e. Provide individual clinical supervision to clinicians as needed

5. In collaboration with FIRST Seneca clinicians and JCRU/Family Mosaic case managers, YAFC will develop a community based reflecting/training team. This team will include the clinical supervisor/trainer, one UCSF Psychiatry faculty member, one senior clinician from the community with cultural connection to the family being served, and one young adult who has successfully transitioned out of probation. (Clinical Director, Supervisor/Trainer)
    a. Adapt and develop flexible community-based model
    b. Train FIRST clinicians and JCRU/Family Mosaic staff in reflecting team model
    c. FIRST staff and clients will also have access to the reflecting team for modeling, observation, or to bring clients for participation
6. YAFC DBT staff will provide consultation and supervision of a multi-family skills-building/support group. (Supervisor/Trainer)
    a. Adapt DBT skills model to client population (focus on relevant emotional regulation, validation, mindfulness, target behavior skills)
    b. Provide didactic training
    c. Provide modeling and co-facilitation as needed
    d. Provide ongoing weekly supervision/consultation
    e. Provide on-call availability for consultation as needed.

The YAFC utilizes a fully HIPAA compliant private social network (TIATROS), which allows for confidential case collaborations, as well as offers a platform for remote video conferencing and teletherapy. Using this technology we can create collaborative health care communities where providers can work together to manage and coordinate care, including video chats, the ability to post confidential notes or updates on the case, post common resources that would be useful in the case, etc – critical for cross-agency collaboration. By providing a confidential and monitored private setting, providers can also utilize the platform for live video family sessions where the youth may be in placement in a different state, or where another family member may be located remotely; or where providers may need to hold a conference from different locations. This platform has been approved for use by the University of California for clinical use and can store private health data. It has also been approved to store clinical research data, and is being used for that purpose by a number of groups at UCSF including the Pediatric Device Consortium, as well as by the Scripps Institute.

FIRST Family Treatment Implementation Approach

A critical strength of the proposed FIRST program will be its focus on engaging families in assessment and treatment at least two months before their sons and daughter return to the community, whether from San Francisco's Log Cabin Ranch or out-of-state juvenile detention centers. Engage, motivate, reengage. Engagement is the key and we have to stress that this has been a major barrier to success and often evidence based practices are not applied to this population because they do not qualify or are screened out due to complex problems, motivation, inability to engage or the lack of culturally sensitive engagement strategies. For youth placed in out-of-state facilities, the program will support long-distance travel of JCRU staff, FIRST clinicians and family/caregivers to the residential placements, along with using TIATROS video

sessions to facilitate additional "face-to-face" contact among each youth, his/her family members, JCRU case manager and FIRST clinician. These and other family/youth engagement activities will be tracked as part of the FIRST program evaluation. Some examples of engagement will involve developing a family team that discusses and plans for reentry. This may involve putting together photo and memory albums, developing letter writing, blogging or other communication plan, collecting stories of success and accomplishment and reinforcing the possibility of success, addressing family barriers that may have complicated reentry in the past. The youth will be working on a similar plan simultaneously. This is all to address the fact that the major cause of reentry failure is how family members do not feel prepared. The primary goal with engagement is to ensure all along family mentors, community members, peer parents, youth advocates, friends, clergy will be incorporated into the nothing but success plan. For youth and families that have limited family and community connections, FIRST staff will utilize existing JPD Family Finder staff person who currently conducts relative notification per AB938, to reach out to family members who may have been separated from the youth. This process of notification is an entry point for engagement to create a supportive network for justice-involved youth preparing for transition back into the community.

Once FIRST program-enrolled youth return to San Francisco, access to IFT sessions and Multi-Family Groups will be flexible, based upon CANS (Child and Adolescent Needs and Strengths) actionable items and initial/ongoing clinical assessment conducted by the Seneca therapist in collaboration with JCRU/Family Mosaic case managers. The CANS is an evidence-based assessment tool designed to guide service delivery decisions for children and adolescents with emotional and behavioral health needs, developmental disabilities, and juvenile justice involvement. San Francisco administers the CANS for all detained youth.

All families will be assessed using formal (e.g. CANS) and informal assessment tools to help develop an appropriate Family Plan. Some enrolled families may start in the group and begin IFT before or after their completion of group's therapy. Other families will benefit from IFT and then matriculate into the Multi-Family Group. The Multi-Family Group together with IFT provides a way to learn and practice content areas that contribute to prosocial and more regulated behavior, including making better choices and achieving more consistency at home. IFT provides an opportunity for families to address what YAFC clinicians refer to as SEARCH (Structure, Emotion, Accommodation, Reflection, Communication and History), as well as to address the impact of trauma, mental illness, substance abuse, unstable living environments, learning disabilities, family conflict and abuse on family functioning. The Multi-Family Groups will be facilitated using a skills-based curriculum designed to teach youth and families how to regulate their emotions, communicate more positively, make better choices, and be more mindful, as well as to build a supportive community among the families.

Ensuring the Implementation of IFT and MFG with Fidelity

Implementation science is the study of methods to promote the successful uptake of evidence based and validated interventions into routine practice and policies. Implementation science has demonstrated time and again that simply training staff in new practices, often referred to as the "train and hope" approach, rarely leads to meaningful impact and reliable benefits. Rather, as identified by the National Implementation Research Network, there are a range of ***competency, organization***, and ***leadership drivers*** that enable and compel the consistent use and results of new practices. The FIRST program provides support to strengthen and address each of these drivers to support the full and successful implementation of the model with fidelity. *Competency drivers* in the designed program include training, structured individual and group

supervision, and ongoing in-field coaching. *Leadership drivers* include the activities of the reflecting teams and collaborative consultation process which insure that the model is flexible and responsive to the field and challenges that may arise, gathering feedback from participating families, clinicians, and the community. The ability of the multiple participating systems to respond to changes in enhanced by the embedding and strong investment of top leadership within the program. This also acts an important *organization driver*, as does the thoughtful and intentional use of data that has been built in to the model. Data systems have been used both for identifying the most pressing needs to inform the program design as well as for providing ongoing progress monitoring.

Reflecting Teams/Collaborative Consultation: build a reflecting model that is flexible, in the field and involves the family, clinicians, and supportive individuals in the community.

Leveraged Resources and Plan for Sustainability

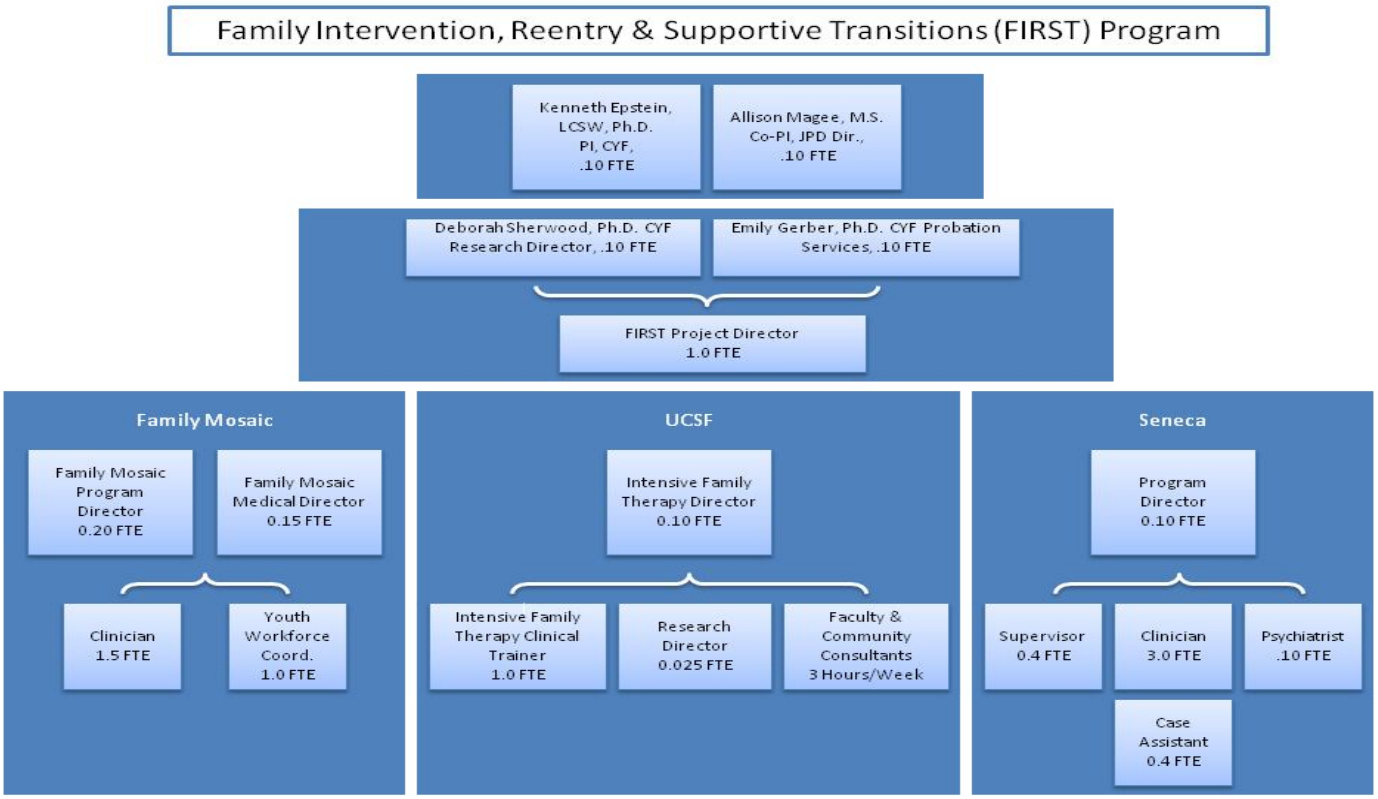
In order to maximize a significant investment of resources and to ensure that FIRST continues beyond the project period, we have embedded sustainability into the FIRST program design and implementation plan in several ways: 1) leveraging the well-established JCRU program as a foundation for family-focused reentry services, 2) partnering with local experts (UCSF YAFC) makes continued training and coaching feasible and affordable, 3) building capacity to deliver services by training existing JCRU and CYF supervisors and clinicians, and identifying blended cash match (local share of Medicaid, MHSA State Funding, and County General Fund to support and extend services, and 4) manualizing FIRST so that services are portable and replicable.

Plan for Project Dissemination and Replication

It will be the intent of SF FIRST to make contributions to the field, by researching and disseminating information on the efficacy of family-focused reentry work. Information about the impact of our project

will be disseminated through presentations at conferences and publication of the findings of our efficacy studies. We have already presented two concept papers about reflecting teams at the American Family Therapy Academy meetings in 2012 and 2013.. and anticipate presenting the results of our studies at other national meetings. Manuscripts detailing our findings will be targeted for publication in peer-reviewed journals in the fields of family therapy and clinical neuroscience such as *Human Systems* or *Family Process*, as well as traditional journals like the *New England Journal of Medicine.* We would also like to publish the results of our research in publications whose target audiences include lay people such as: local newspapers; national organization (i.e., NAMI) websites; and mainstream magazines.

D. CAPABILITIES AND CAPACITIES



Key Implementing Agencies

Community Behavioral Health Services—Child, Youth and Family System of Care (CYF SOC): CYF SOC provides culturally competent, family-centered, outcomes-based mental health services to San Francisco children, youth, and their families. This includes direct mental health services to approximately 4,900 children and youth, as well as prevention and early intervention services to an additional 5,000 children and youth in schools, child care sites, and homeless shelters each year. Services are delivered through a vast network of community mental health programs, clinics, agencies, private psychiatrists, psychologists, and therapists. Mental health services are available to San Francisco children and youth who receive Medi-Cal benefits and those with limited or no resources for their mental health needs. Community Behavioral Health Services—Child, Youth and Family System of Care is under the City and County of San Francisco Department of Public Health, Community Programs Division.

Dr. Emily Gerber oversees access to a continuum of community-based care for probation-involved youth. The continuum of services, which are portable and delivered at home, in school and in the community, includes integrated substance abuse and mental health outpatient services, the Intensive Community Supervision and Clinical Services program, Juvenile Wellness Court Case Management, Multisystemic Therapy, Wraparound, and Youth Workforce Assessment and Referral. CYF SOC services are accessed through AIIM (Assess, Identify Needs, Integrate Information, and Match to Services) Higher, a collaborative juvenile justice-behavioral health assessment and aftercare planning unit located at the SF Juvenile Justice Center. CYF SOC has extensive experience managing grants, contracts, federal awards, and local funding streams. Dr. Gerber and CYF SOC manage millions of dollars of subawards, and have partnered with UCSF, Probation, and Seneca on collaborative programs. CYF SOC is

under the City's Department of Public Health department and subject to oversight by the Mayor and City and County Administrator.

San Francisco Juvenile Probation Department (SFJPD): The mission of SFJPD is to: serve the needs of youth and families brought to its attention with care and compassion, identify and respond to the individual risks and needs presented by each youth; engage fiscally sound and culturally competent strategies that promote the best interests of the youth; provide victims with opportunities for restoration; identify and utilize the least restrictive interventions and placements that do not compromise public safety; hold youth accountable for their actions while providing them with opportunities and assisting them to develop new skills and competencies; and contribute to the overall quality of life for the citizens of San Francisco within the sound framework of public safety as outlined in the Welfare & Institutions Code. SFJPD supervises youth who are alleged and have been found to be beyond their parents' control, runaway, or truant, as well as those who have been found to have committed law violations. SFJPD operates Juvenile Hall, the short-term detention facility for youth in custody awaiting hearings or placement, as well as Log Cabin Ranch, the post adjudication facility for delinquent male juveniles. The agency's Private Placement Unit supervises youth removed from their homes by the Court and placed in foster homes, group homes and residential treatment programs primarily in California as well as Nevada, Colorado and Pennsylvania. SFJPD is involved in several ongoing systems change efforts that bear directly on the challenges and opportunities described in this proposal. It is one of five City agencies that serve on the Task Force on Residential Treatment for Youth in Foster Care.

Young Adult and Family Center, University of California, San Francisco: The Young Adult and Family Center (YAFC) is dedicated to innovation in the creation and delivery of clinical

services, clinical training, clinical research, health education, and outreach for the benefit of adolescents with mental illness, and their families. Dr. Kim Norman leads this effort, working with a multidisciplinary and interdepartmental collaboration of psychiatrists, psychologists, social workers, pediatricians, scientists, public health officials, and philanthropists to improve the mental health of adolescents in all communities in the San Francisco Bay Area and beyond. The YAFC is among the first academically-based psychiatry programs in the nation dedicated to advancing the understanding and care of an important subset of adolescents (transition-aged youth ages 16–24) with mental illness. Clinical care in the YAFC is provided primarily within the clinical services at Langley Porter Psychiatric Institute and includes:

- Intensive Family Therapy Program: provides intensive crisis intervention and stabilization to families. Designed to help those who are suicidal or engaged in self-injurious behavior, substance abuse, delinquency, or unsafe sexual activity to remain at home while receiving necessary treatment, the program treats the whole family.
- Dialectical Behavior Therapy Program: Combining group, individual, and family therapy, this is an evidence-based treatment program for adolescents at risk for suicide, self-injurious behaviors, eating disorders, substance abuse, and unsafe sexual activity. The offerings include a parent skills course and a multi-family therapy group.
- Adolescent Assessment Clinic: provides comprehensive multidisciplinary assessments for more than 80 adolescents each year.
- Coping with Depression and Anxiety Program: provides cognitive behavioral therapy services for adolescents and young adults with depression and/or anxiety disorders.

- Eating Disorder Program: a collaboration with UCSF Adolescent Medicine, and provides assessment and treatment to young people 10-24 with Anorexia, Bulimia, Eating Disorders NOS, and other eating-related disorders.

Seneca Family of Agencies: Seneca was founded in 1985 as a California nonprofit agency to provide unconditional care and treatment for youth and families struggling with the most challenging needs and circumstances. Since its inception, Seneca has dedicated itself to providing family-driven, culturally competent and strengths-based treatment for youth diagnosed with severe emotional disturbances. One of the primary strengths of this application is Seneca's strong history of successfully engaging and serving the juvenile justice population. The agency has significant experience serving juvenile justice involved youth and their families, including seven years providing Multisystemic Therapy (MST), as well as other manualized evidence-based treatments such as Functional Family Therapy. The agency has a strong collaborative partnership with SFJPD, providing trainings for its staff, Wraparound services for families with justice-involved youth, and comprehensive assessment and community linkages. **Project Staff Roles and Responsibilities**

The FIRST program is collaboration between Child, Youth, and Family System of Care, Juvenile Probation Department, UCSF, and Seneca Family of Agencies. Each partner will have distinct roles working with youth and families, continuously from placement through reentry and termination of probation. Team members will include:

<u>FIRST Project Director (1.0 FTE):</u> The Program Director (PD) manages the grant-related daily activities and deliverables of the development, implementation and evaluation of all the components of this multi-site intensive family therapy program, ensure seamless coordination between JCRU reentry activities and FIRST, convene and participate in weekly planning and

operations meetings to review progress and address challenge, facilitate monthly cross-agency leadership and oversight meetings to support attainment of the project objectives.

Seneca & FMP Teams

Program Director (.10 FTE): Provide general oversight for FIRST team, supervise the FIRST supervisor, and participate in leadership and oversight meeting to support attainment of the project objectives.

Supervisor (.4 FTE): provide program supervision and case supervision to clinicians and direct services staff in the FIRST program. The Supervisor ensures that services are delivered with fidelity to comprehensively address the needs of participating youth and family.

Clinicians (3.0 FTE): provide direct services to youth and families which include: engaging youth referred through JCRU probation department in the process of transitioning from placement and their families, facilitating intensive family therapy and multifamily groups therapy, maintenance of case records and progress notes, ongoing training and consultation with UCSF Clinical Supervisor-Trainer.

Medical Director (.20 FTE) and Psychiatrist (.10 FTE): Complete initial and ongoing evaluations of clients to determine medication and treatment needs, prescribe and monitor medications, provide consultation and education to treatment staff regarding medication use as part of the treatment regimen.

Youth Workforce Coordinator (1.0 FTE): collaborate with JCRU to conduct occupational assessment and assist FIRST youth in identifying interests, strengths, and needed skills,

Case Assistant (.4 FTE): maintain client charts with a focus on the quality assurance of the program and to support the administrative functioning of the program.

UCSF Team

Intensive Family Therapy Director (.10 FTE): Provide general oversight of project, adapt models to client population and community-based work, supervise supervisor/trainer, develop didactic trainings, deliver didactic trainings (with supervisor/trainer)

Clinical Supervisor-Trainer (1.0 FTE): The Clinical Supervisor-Trainer will implement training and supervision/consultation, serve as liaison between field staff and IFT/clinical director, provide didactic trainings (with clinical director), provide ongoing supervision, weekly meetings, case reviews, etc., provide on-call support as needed and oversee faculty & community consultants.

Research Director (.025 FTE): Support co-development of evaluation tools, obtain CHR approval for any human subjects research, develop research study protocols, oversee ongoing research, train SF FIRST staff as needed in implementation of research protocols

Faculty and Community Consultants (3 hours/week): Faculty consultants to participate in and coach reflecting teams, faculty consultants to train and support community consultant reflecting team members, community consultants to participate in reflecting teams