Program Annual Report Form:

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Submit the following information on each EBP and data related non-EBP for the outcomes indicated:

Parenting Wisely

Overview: Parenting Wisely (PW) is a parenting skills education system. The PW programs are designed to facilitate the learning of necessary skills for the healthy well-balanced raising of children from age 3 to 18. Proven to reduce problem behaviors and increase communication and family unity, PW offers well documented and tested programs that guarantee results. This program is provided to families involved in service coordination and is six-week class which meets weekly with parenting wisely facilitators and families.

Implementation of this program began in 1st quarter of 2011.

Methods: Parenting classes are provided to groups which met one time per week for a 90-minute session for six (6) weeks.

Measures: Parents complete the Eyberg Child Behavior Inventory and a test of parenting principles and methods as pretest and, after six (6) weeks, as posttest measures. They also complete a rating of their satisfaction with the program.

Population/Sample: Parents who are involved with service coordination. All participants are either court ordered to parenting or are provided parenting classes as a service option.

Descriptives:

Results: This program was just implemented; therefore, there is no data to report.

Discussion: This program was recently implemented and as a result we do not have any data to report.

Limitations: this program may not be utilized for all families if it is determined that another program may better meet their needs. Initial data may reflect a small sample size. We will need to monitor future data to determine if levels vary by staff presenting the program, i.e. education, degree, position.

Conclusions:

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Submit the following information on each EBP and data related non-EBP for the outcomes indicated:

Wraparound

Overview: *Wraparound* is a team-based planning process intended to provide individualized and coordinated family-driven care. *Wraparound* is designed to meet the complex needs of children who are involved with several child and family-serving systems (e.g. mental health, child welfare, juvenile justice, special education, etc.); who are at risk of placement in institutional settings; and who experience emotional, behavioral, or mental health difficulties. The *Wraparound* process requires that families, providers, and key members of the family's social support network collaborate to build a creative plan that responds to the particular needs of the child and family. Team members then implement the plan and continue to meet regularly to monitor progress and make adjustments to the plan as necessary. The team continues its work until members reach a consensus that a formal *Wraparound* process is no longer needed.

The principles of Wraparound are included in initial and ongoing training with staff. It is reinforced in supervision and is used on a daily basis as one of our primary components of family centered practice.

Methods: All workers are trained in wraparound and use the principles of wraparound in their service plans for families.

Measures: We currently do not have measures specific to wraparound. We are planning to use the WFII measures which are listed in the EBP folder.

Population/Sample:

Descriptives:

Results:

Discussion: Initial training has focused on the elements of family centered practice. With the increase of new staff from 150 staff to 450 staff in a short time period our training has focused on family center practice, Signs of Safety, and Solution Focused Interviewing. We are in the process of incorporating the ten core principles of wraparound into our training curriculum.

Limitations: Until recently we did not have adequate infrastructure to implement the fidelity instruments. With the addition of the Quality Management and Training Departments we expect to be able to implement fidelity and evaluation of wraparound during Fiscal Year 2011.

Conclusions:

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Submit the following information on each EBP and data related non-EBP for the outcomes indicated:

Structured Decision Making

Overview: Structured Decision Making is a series of actuarial assessment tools implemented to aid case managers with consistently applying research based criteria to decision making as they determine response priority, immediate threatened harm and the potential risk of future abuse and neglect. Child and family, strengths and needs determine progress toward permanency in an effort to increase validity and reliability of decisions and to strategically target valuable resources where they are needed most. This is a tool used to identify strategies and interventions to mitigate safety risk. Part of this assessment is the use of a tool that provides data that helps inform decisions and can be used for data aggregation to evaluate the efficacy of this approach.

Implementation began in 2nd Quarter of 2010 when trainers were identified and trained. A pilot training was provided 4th Quarter of 2010. Assessment tools were also finalized then as well as the assessment database. Training within KVC will begin during 1st Quarter of 2011.

Methods: The assessment tool is used on a regular basis with families to inform decision making with respect to both safety and permanency.

Measures: The assessment tool is a concrete tool guided by specific directions on how to score each item.

Population/Sample:
Descriptives:
Results:

Discussion: SDM requires that language on our assessment instruments be consistent with the state of Nebraska. The Children's Research Center (CRC) has been working closely with KVC to ensure that the language in all of our training and policies and procedures with respect to SDM are consistent. CRC is also developing our case vignettes so they are consistent with Nebraska practice. In addition, there is an SDM database we must use in order to use this method and this requires various levels of integration within KVC. These conversations have been ongoing and it is expected that the database will be ready in October of 2011. SDM will not allow us to begin collecting data until the database is built and hey have approved.

Limitations:

Conclusions: Data provided on this approach will be used to evaluate our success in safely keeping children in the home and being able to return children home in a timely manner if they were removed. Data will also identify our success in preventing re-entries into the system.

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Submit the following information on each EBP and data related non-EBP for the outcomes indicated:

Signs of Safety

Overview: This is a conceptual framework that structures case discussion and review. It is completed jointly with professionals, family members and supports during the first team meeting post referral and updated at all team meetings. KVC's use of this framework has proven its effectiveness, not only to us, but to families and other stakeholders such as area judges. It is viewed as a simple yet comprehensive guide map that keeps all team members entirely focused on addressing the safety and risk concerns that resulted in state involvement, clearly defines family strengths as well as tasks to be addressed and provides ongoing, visual feedback on progress made: all on one page.

All staff have been tried in the Signs of Safety Approach through an initial 4-hour training. Signs of Safety is our primary assessment tool and is used in interactions with families and the assessment tool is used at all family team meetings.

Methods: 100% of newly referred families are assessed using the Signs of Safety approach.

Measures: Going forward we will be looking at the data provided on this assessment tool to identify trends and patterns with respect to barriers families are reporting. This will help us to identify service gaps that can be addressed.

Population/Sample: This approach is used with all of our families.

Descriptives:

Results:

Discussion: Although all of our services use the Signs of Safety approach, we have not begun to look at data trends using this approach due to the unexpected transitions we have experienced during that last ten (10) months. As we move forward we will be looking at this data more critically.

Limitations: Currently the assessment does not lend itself to entering the data in a concrete format as there is no data collection method for the data other than N-FOCUS. Therefore, any evaluation efforts will encompass manual data coding and entry before we can assess trends. We have identified and received feedback from DHHS indicating that this tool may not work well with juvenile offenders and their families.

Conclusions:

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Trauma Systems Therapy (TST)

Overview:

TST is utilized mainly in children who have experienced a traumatic stress in their lives. This EBP focuses on the child who is not able to regulate their emotional states and is in an environment that is not capable of helping said child. The focus is to help the child gain control over emotions and behavior by enhancing their own capacity to regulate their own emotions. Implementation of this approach began during 4th Quarter 2010.

Implementation:

- Phase 1
  - Outpatient clinicians are familiarizing themselves with the TST approach prior to receive onsite training with Dr. Saxe. Outpatient Clinicians read the book "Collaborative Treatment of Traumatized Children and Teens: the Trauma Systems Therapy Approach" (2009) authored by Glenn Saxe, Heidi Ellis, and Julie Kaplow. The book consists of 17 chapter and three (3) major sections: 10 Foundations; 2) Getting Started; and 3) Doing Trauma Systems Therapy. The book was read over a 4-week period and was supplemented by a weekly two-hour web-based training and conference call between KVC's content expert and therapists. This conference call was an extensive discussion and review of the chapters read. Phase 1 was completed during 4th Quarter of 010.
- Phase 2
  - September 2010 – 2-hour refresher discussion will be scheduled
  - November 2010 – 2-day onsite training with Dr. Saxe
- Phase 3
  - December 2010 - weekly consultation calls will begin with Dr. Saxe to finalize implementation of TST assessments, treatment planning, and consultation format

Methods:

Measures:

Population/Sample:

Descriptives:

Results:

Discussion: This program is in the process of being implemented and as a result we do not have any data to report.

Limitations:

Conclusions:

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Strengthening Families Program (SFP)

Overview:

SFP is a family skills training program designed to increase resilience and reduce risk factors for behavioral, emotional, academic, and social problems in children 3 to 17 years old. This program has been utilized and implemented in many community settings, such as family or youth services agencies, schools, drug treatment centers, community mental health centers, housing projects, homeless shelters, churches, recreation centers and drug courts.

KVC has not begun implementing this program. Current plans are to begin the implementation in 4th Quarter of 2011.

Methods:

Measures:

Population/Sample:

Descriptives:

Results:

Discussion:

Limitations:

Conclusions:

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Submit the following information on each EBP and data related non-EBP for the outcomes indicated:

Aggression Replacement Training

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

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

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

This program has not been implemented. Staff that were identified as trainers in this area are no longer with the agency.

Methods:
Measures:
Population/Sample:
Descriptives:
Results:
Discussion:
Limitations:
Conclusions: