



Pregnant and Parenting Teen Conferencing:

A Tool to Help Parenting Teens in Foster Care Achieve Better Outcomes for Themselves and Their Children



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I. INTRODUCTION



Becoming a parent, particularly as a youth and even more so as a youth in the foster care system, brings significant challenges, many of which are not easily addressed within the traditional child welfare case planning process. At the same time, however, the teens' hopes and desires for their babies can be a tremendous motivator, helping them to focus on their life trajectory and set goals. Support and intervention at this time is crucial, and have the potential to impact the intergenerational cycle of involvement in the foster care system.

Pregnant and Parenting Teen (PPT) Conferencing is a planning strategy that can be used to identify and address the complex and specialized needs of youth in the foster care system who are parents or who are pregnant and planning to give birth. The conference focuses on the goals of the youth in the context of her¹ role as a parent and tries to connect her with the appropriate services, supports and community network to help her achieve these goals. The purpose of the conference is to build on the strengths of young parents and give them the scaffold and supports they need to grow into their role as parents, successfully transition to independence, and achieve better outcomes for themselves and their children. The New York City Administration on Children is one example of a child welfare system promoting the use of team conferencing for young parents in care.² Los Angeles County also has developed a pregnant and parenting teen conference model to assist parenting and soon-to-be-parenting youth in the child welfare system.

While team conferencing is used in many contexts in child welfare, the team conferencing model as modified for pregnant and parenting foster youth differs in important ways from the model used in other child welfare situations. This document provides background on team conferencing for pregnant and parenting youth, and in particular on the model developed and used in Los Angeles County. The document is intended to provide Institute attendees with the information they need to evaluate whether the Los Angeles model, or certain components of that model, may be suitable for use in their counties.

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- ¹ While team conferencing is helpful for both teen fathers and mothers, most participants are female and this document will use the female gender.
 - ² See Fordham Interdisciplinary Parent Representation Project's *"Guide to Working with Young Parents in Out of Home Care,"* NYC Administration for Children's Services, for discussion of collaborative planning in New York, Appendix I.

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II. Background and History of the Los Angeles Model



The Los Angeles County Inter-Agency Council on Child Abuse & Neglect (ICAN)³ has for many years convened a subcommittee to address the needs of the teen parent population, including young parents living with their families, living in foster care, involved with probation and/or homeless. In 2004, the Los Angeles County Department of Children and Family Services (DCFS), together with several members of ICAN, including the Alliance for Children's Rights⁴, Public Counsel⁵ and the Children's Law Center of California (CLC)⁶, established a workgroup to look specifically at how to better address the needs of pregnant and parenting teens in foster care. These advocates felt strongly that they needed to proactively address issues arising as a result of teen pregnancy and parenting before those issues became crises or resulted in the detention of a teen's baby.

The workgroup recognized that working with parenting teens requires specialized expertise in the issues and challenges parenting teens face, the services and supports they may require, and a deep knowledge of the current community resources available to help meet these needs. The group also recognized that many child welfare case workers and social workers do not have the opportunity to develop this expertise because, while teen pregnancy in foster care is not uncommon, most social workers in DCFS, have one, or at most a few, parenting teen cases a year. With such limited exposure, it is difficult for a social worker to gain expertise and knowledge of both the needs of and resources for this unique population, or to stay apprised of new and changing resources.

The workgroup designed the Los Angeles Pregnant and Parenting Teen (PPT) conference model to address this gap. DCFS already had in place a family team decision-making model for decisions regarding removal, placement and reunification which involved a strengths-based approach that put

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- 3 The Inter-Agency Council on Child Abuse & Neglect (ICAN) was established in 1977 by the Los Angeles County Board of Supervisors as the official county agency to coordinate the development of services for the prevention, identification and treatment of child abuse and neglect. The mandate for much of ICAN's work comes from the ICAN Policy Committee, which includes 32 County, City, State and Federal agency heads as well as UCLA, 5 private sector individuals appointed by the Board of Supervisors and the Children's Planning Council.
 - 4 The Alliance for Children's Rights (ACR) was established in 1992 to protect the rights of impoverished, abused and neglected children and youth. ACR provides free legal services and advocacy, to ensure that children have safe, stable homes, healthcare and the education they need to thrive.
 - 5 Public Counsel (PC) was established in 1970. PC is the public interest law firm of the Los Angeles County and Beverly Hills Bar Associations as well as the Southern California affiliate of the Lawyers' Committee for Civil Rights Under Law.
 - 6 Children's Law Center of California (CLC) was created in 1990 by the Los Angeles Superior Court to serve as appointed counsel for children who have been abused, neglected, or abandoned that come under the protection of the Los Angeles County Juvenile Dependency Court systems. CLC is a non-profit, public interest law firm that provides legal representation for children impacted by abuse and neglect.



family and community at the center of the process. The Los Angeles PPT conference design uses the basic elements from this team decision-making framework, with a few critical differences. Among those key differences:

- 1. The PPT conference is completely independent of other child welfare decision-making and conferencing.*
- 2. It is voluntary and puts the youth at the center and in the driver's seat throughout the process.*
- 3. It requires involvement of an expert in the issues and challenges of teen parenting, with a deep knowledge of current available community resources.*

The developers of the conference model believe their process results in life plans with clear and attainable short- and long-term life goals, better quality resources and more effective referrals, more invested participants, and better implementation and follow-up. The Children's Law Center of California analyzed the PPT conferences by reviewing conference reports and case files, and interviewing the teens involved in the conferences. The analysis concluded that the conferences were effective at meeting the stated goals, including relationship development, progress toward independent living, and referrals for supportive services.⁷

⁷ Children's Law Center, "CLC Analysis of Pregnant and Parenting Teen (PPT) Conferences and Outcomes," Appendix 2.

III. The Los Angeles Parenting Teen Conference Model and Process

The Los Angeles Pregnant and Parenting Teen (PPT) conference process includes five stages:

- 1. Referral and Youth's Acceptance*
- 2. Preparation*
- 3. Conference and Development of an Action Plan*
- 4. Implementation*
- 5. Follow up*

These stages are described in detail below. A graphic description of the process is also included on page 12.

I. Referral and Youth's Acceptance

PPT conferences are offered to parenting youth and youth who are pregnant and have decided to continue their pregnancies. For newly pregnant youth, DCFS policy requires social workers to counsel teens about all their options as soon as the teens disclose their pregnancy. This requires social workers to support the teens' choices, whichever path they choose, including helping them obtain an abortion when that is their choice.⁸ Pregnant youth are not informed about or referred for a PPT conference until they have made the decision to continue a pregnancy.

Pregnant youth may self refer for a PPT conference. They also may be referred by their attorneys, case-carrying social workers, other DCFS workers, court services personnel, family and non-profit advocates, and others. DCFS policy states that any teen continuing a pregnancy as well as all parenting teens under Department supervision should be offered a conference even if there are no identifiable problems in the youth's life. Key participants in the PPT conference process note that once a youth has decided to continue her pregnancy,

DCFS Referral Form

DCFS 174

Click title or see Appendix 3.

⁸ Los Angeles County DCFS Policy 0600-507.10 Revision Date: 12/23/14, found on January 9, 2015 at http://policy.dcfslacounty.gov/Content/Youth_Development_Reprod.htm#PolicyHeaderI_1

it is important to refer her for a conference as early in pregnancy as possible. They suggest that the better the relationship between the teen and the professionals responsible for her case, such as her social worker and legal counsel, the more likely the teen is to disclose her pregnancy to these individuals early and the more likely they will be able to refer her early.

In Los Angeles, the vast majority of participants are young women, even though the process is also available to young men.

If referred, the referring party discusses the conference model with the youth and gauges the youth's interest. If the youth expresses interest, the referring party or the case-carrying social worker completes a referral form (DCFS 174)⁹ and submits that form to the PPT Facilitator at DCFS.

When the **PPT Facilitator** receives a referral, he or she reaches out to the youth to discuss the PPT conference model in more detail and to confirm that the youth wishes to proceed. A core principle of the conference model is that it is voluntary, ensuring the youth's investment in the process, including follow through on action steps. If a referred youth is not interested in a conference, the Facilitator notes this in the youth's case file, advises the referring party and does not proceed further.

If the youth wishes to proceed, the PPT Facilitator then contacts the ICAN¹⁰ Pregnant and Parenting Teen Task Force to have a **Teen Parent Resource Specialist** (TPRS) assigned to the conference.

Currently in Los Angeles, social workers from two private advocacy organizations—the Alliance for Children's Rights and Public Counsel—serve as the TPRS. Additional information about these social workers is available in Appendix 21.

What is a PPT Facilitator?

A Pregnant and Parenting Teen (PPT) Facilitator has expertise in parenting youth issues. The Facilitator manages the conference process, is responsible for documentation, and coordinates between the youth, DCFS, the Teen Parent Resource Specialist and outside agencies. Click [here](#) or see Appendix 10 for a Facilitator "Job Description."

What is a Teen Parent Resource Specialist?

A Teen Parent Resource Specialist (TPRS) has a deep knowledge of the special needs and issues that parenting youth face, as well as the community resources available for them. The TPRS also may have connections with these community agencies that help when coordinating referrals. The TPRS understands how trauma, culture and context may impact parenting and life choices. In Los Angeles, a TPRS is a trained social worker, but that is not a prerequisite. Click [here](#) or see Appendix 9 for a TPRS "Job Description."

⁹ See Appendix 3

¹⁰ See Footnote 3, *infra*, for description of ICAN.

2. Preparation

The preparation stage includes three components: Identifying participants, scheduling and setting the agenda and selecting topics:

i. Identifying Participants to Invite

Once a Teen Parent Resource Specialist is assigned, the Facilitator, DCFS case-carrying social worker and TPRS work with the youth to determine which potential participants to invite to attend the conference. The invitees should include both family and resource supports.

Potential Participant List

For a list of individuals and agencies that Facilitators, youth and Teen Parent Resource Specialists consider inviting to conference, [click here](#) or see Appendix 4.

First, the team asks the youth to identify family members and community support people who could bring information to the meeting about the youth and community resources, as well as provide support to her during the conference and later as she strives to accomplish the action steps agreed to in the meeting. Allowing the youth to invite family and participate in deciding who to invite reinforces the idea that the conference is for the youth and about her personal goals, rather than about the youth and her child welfare case.

With the youth's permission, the team also invites outside agencies currently working with the youth or those who may be able to help the youth work on her identified goals and needs.

ii. Scheduling

The DCFS administrative coordinator who works with the PPT Facilitator then communicates with the team to set a date for the conference. The meeting date is scheduled at least two weeks out so that it is more likely the invitees can attend and so that there is sufficient time for the youth to prepare for the conference. The team attempts to schedule the conference at times convenient for the youth and her support people, such as outside school hours.

The location is chosen to accommodate the youth and her support team. It generally is at a DCFS office or a community-based location, and occasionally at the youth's placement. The Facilitator is responsible for ensuring that identified participants receive invitations to join the conference. The conference is not combined with other team conferencing, which helps reinforce the idea that the conference is about the youth and her goals. It allows the conference to remain youth-centered and youth-driven. It is also more practical because the PPT conference involves different participants and addresses different issues than would other conferences.

iii. Setting the Agenda and Deciding Topics to Address

The Facilitator and Teen Parent Resource Specialist then work with the youth to prepare for the conference. The specialist phones the teen to determine major areas of concern, which may

include educational and employment status; physical, social and emotional well-being; and level of self-sufficiency. The youth is involved in deciding which of these, or other topics, the conference will address. Appendix 5 includes a list of common areas of concern for a pregnant and parenting teen. It can be reviewed with a youth to identify priority issues for discussion. Based on this, the Facilitator, TPRS and youth set an agenda, including purpose and goals for the conference.

Possible Topics

For a list of common areas of concern for pregnant and parenting youth that can be reviewed with the youth and used to decide possible topics for conference, click [here](#) or see Appendix 5.

3. Conference and Development of Goals and Action Plan

The conference typically involves a 1 to 2 hour meeting, managed by the Facilitator. The Facilitator has been specially trained to use a strengths-based team decision-making process.

The meeting begins by reviewing its **purpose**, a summary of the issues previously identified and agreed upon by the youth, the TPRS and Facilitator. Sample topics may include educational planning, birth plans, child care, family law issues, parenting classes or placement stability. Prevention of second pregnancies is always addressed, and specific resources given.

Strengths-Based Decision-Making and Facilitator's Role

DCFS Policy 0070-548.03 describes the process the Facilitator is expected to employ in managing the PPT conference. Click [title](#) or see Appendix 6.

Next, the group discusses the **youth's strengths**. Strengths may include specific areas such as the youth's participation in parenting classes or attendance record at school, as well as more subjective observations such as the cooperative and highly motivated nature of the youth.

The **challenges and needs** of the youth are then discussed. These may be concrete needs, such as a crib and stroller; placement or funding issues, or more long-term challenges, such as finishing high school.

Then the team brainstorms **ideas to address the challenges**. These should be very specific suggestions such as considering child care options, consulting a family law attorney, or contacting specific agencies to plan for the birth.

At this point, the **Teen Parent Resource Specialist** plays a particularly crucial role. The TPRS has knowledge and expertise regarding issues that parenting teens frequently face and knows what questions to ask and issues to explore. The specialist also knows current community resources available to address the youth's needs. Many of these resources speak to needs outside of the usual expertise of a DCFS social worker, such as how to handle tickets for

TPRS Resource and Referral List

For a list of materials developed by the Teen Parent Resource Specialists in Los Angeles that are brought to each conference, click [here](#) or see Appendix 7.

curfew violations, family law issues, resources for immigration advocacy, how to obtain a computer, or how to talk to your baby. The specialist makes sure that referrals are current. In Los Angeles, the TPRS brings a file box of pamphlets and flyers to each conference, to be prepared to provide valuable information and contacts for a range of different issues that may arise.

Then the team develops a **list of goals and a plan for action steps** the youth and others will take to meet these goals and address the challenges.

The Facilitator writes up the meeting in a **report**, which provides a summary of the discussion at the conference, an overview of the youth's situation and a description of the goals and action plan. Action steps are listed with a specific completion date, person responsible for accomplishing the action and contact information as needed. For example, an action step might be for the youth to consult with a family law attorney by a specific date, listed with the legal organization's name and contact information. Each participant is asked to sign the report and is given a copy.

Example of Plan and Report from Los Angeles

For a sample conference plan and meeting notes from Los Angeles, click here or see Appendix 8.

4. Implementation

The action plan includes steps the youth must accomplish and actions steps for others. Action steps for the youth may involve contacting new referrals she has received from the Teen Parent Resource Specialist or engaging in discussions with existing contacts such as parents or doctors. The TPRS seeks to assure that the youth receives “warm referrals” to agencies—that is, that the youth is not just given a list of phone numbers or a stack of brochures, but instead is helped to make real connections through a personal introduction, or is assisted in the self-advocacy process.

Other action steps may obligate other conference participants. For example, they may require the TPRS to look for additional resources or the social worker to update files. The case-carrying social worker may be assigned certain follow-ups, but these are typically actions that the worker would be expected to do as part of the child welfare case plan in any case.

5. Follow-Up

After the Teen Parent Resource Specialist completes assigned tasks, he or she checks back with the youth and other participants to determine the status of implementation and provide further assistance if needed. If the teen needs longer-term advocacy support and the TPRS has capacity, an ongoing relationship may be established. The DCFS Facilitator also follows up on implementation and progress. In some cases, the Facilitator will recommend and arrange for a follow-up conference approximately three months after the first. In many cases, however, the teen will only participate in one conference.

IV. The Los Angeles County PPT Conference Process

REFERRAL AND ACCEPTANCE

- Offered to every male or female, parenting or expecting a child, who is under Department supervision, even if there are no identifiable problems
 - Referrals can be made by youth, attorneys, social workers, family advocates, court personnel etc.
 - Referring party discusses conference with youth to see if youth is interested in learning more
 - Referring party refers youth to **PPT Facilitator** using form DCFS 174
-
- PPT facilitator contacts youth to explain conference in more detail and confirm youth's interest
 - If youth is not interested, facilitator informs referring party and does not proceed
 - If youth is interested, **Teen Parent Resource Specialist (TPRS)** is assigned

PREPARATION

- Conference scheduled at least two weeks out to give time for preparation
- Conference is independent of other child welfare conferences or decision making
- Youth identifies potential participants to invite, with support of facilitator and TPRS
- Facilitator ensures participants are invited
- Youth sets agenda and goals, with support of TPRS

CONFERENCE AND PLAN

- Facilitator runs meeting and takes notes
- Using strengths based family group decision making model, team reviews strengths and needs and then brainstorms ideas
- TPRS brings expertise on local resources and referrals to address needs outside DCFS purview
- Group decides on concrete attainable short and longterm goals and action steps

IMPLEMENTATION

- The TPRS completes assigned tasks and checks back with the youth to assist in follow up
- The TPRS assists with warm hand-offs to ensure referrals are effective

FOLLOW-UP

- The Facilitator follows up with youth to check on progress toward goals and arranges for second conference where necessary

V. Critical Components of the PPT Conference Model with Tools and Questions to Assess and Facilitate Replicability

The PPT conference model borrows many elements from child welfare team decision making, but includes three critical and unique factors:

- It is voluntary, youth-centered and youth-driven,
- It is independent from other child welfare decision making, and
- It includes a teen parent expert.

Key participants¹¹ in the Los Angeles PPT conference and in its development believe these three factors, in conjunction with several components borrowed from the team decision-making model, come together to make the Los Angeles PPT conference model successful. The combined components they identify as important are listed below in no particular hierarchy of importance, and described more fully later in this section:

CRITICAL COMPONENTS OF LOS ANGELES CONFERENCE MODEL

Critical Participants

- Youth
- Teen Parent Resource Specialist
- Trained Facilitator

Process

- Youth-centered and youth-driven decisions at all stages
- Independent from other child welfare decision making and conferencing
 - Strengths-based conference management process
 - Pre-conference preparation time built in
- Concrete, attainable goals and action steps developed
 - Follow up on implementation built in
 - Trauma-informed practice

Important Resources

- Person with deep and comprehensive knowledge of current community resources and referrals

11 Interviews with PPT Facilitator, Hipolito Mendez, DCFS, and Teen Parent Resource Specialists Barbara Facher, Alliance for Children's Rights and Mara Ziegler, Public Counsel. More information about these individuals is available in Appendix 20.



Key participants in the Los Angeles model also believe that a PPT conference model that does not include all of the above elements still could improve outcomes for youth. Indeed, they postulate that where conferencing is not yet possible, outcomes for teen parents in care could be improved by simply having a person who has both experience working with teen parents and expertise in the special needs of parenting youths, meet with pregnant and parenting youths, help them identify their needs, and help them access resources and services.

Using the information and materials that follow, counties considering adopting Pregnant and Parenting Teen conferencing can assess which of the above components may be replicable in their community. In the following pages, each component is described more fully. Each description section also includes tools, examples, and in some cases, questions to prompt discussion about how such components could be adopted, adapted or developed in other counties. Ultimately, each county must make the process work for their county and, most importantly, for their youth.

Component I: Teen Parent Resource Specialist/Expert

Description:

The workgroup in Los Angeles recognized that working with parenting youth requires (1) individuals with specialized knowledge of the issues and needs parents and soon-to-be parents face, (2) a deep knowledge of community resources to address these needs, and (3) skills in culturally competent, trauma-informed practice.¹²

This individual acts as the Teen Parent Resource Specialist (TPRS). With deep and broad knowledge of the special needs and challenges of parenting youth, she can help the teen identify needs and goals. She can assist the youth in identifying potential participants to invite to a conference, including resource agencies, and during the conference can play a key role in brainstorming solutions and finding resources. This person also can help facilitate referrals and warm handoffs to referral agencies. With expertise in trauma-informed care and cultural competence, a TPRS can help the youth feel safe being honest about her needs, challenges and hopes.

In Los Angeles, this role is played by senior social workers from private non-profit agencies who work regularly with pregnant and parenting teens. While in Los Angeles the experts come from outside the child welfare system, that is not a prerequisite. This expertise may be found in child welfare staff, minors' counsel, or other community agency staff, and also can be fostered and developed. For example, the child welfare agency could assign all pregnant and parenting foster youth to one social worker, and support her with additional training so she can develop expertise.

Do You Have an Expert Available?

TOOLS and RESOURCES

(See Appendices or click titles for tools)

- TPRS "Job Description" (App. 9)
- Cultural Competence (App. 11)
- Trauma & Resilience Toolkit (App. 12)

QUESTIONS for COUNTIES:

1. Is there currently someone within child welfare who meets the TPRS description?
2. Is there an individual or agency with this expertise in the community?
3. If so, would that entity be willing to partner with the child welfare agency? How could that relationship be established?
4. If expertise needs to be developed, is there a social worker, other child welfare staffer, or a staffer at a community based organization, who is willing and interested in developing this expertise and participating in PPT conferences?
5. How can the expertise be developed? Could all teen parent cases be assigned to one person? Are there opportunities for training and support?
6. Are there funding opportunities to support the development of this expertise?

¹² See Appendices 11, 12 and 13 for resources that define cultural competence and trauma informed care.

Component 2: Deep Knowledge of Resources and Referrals for Teen Parents

Description:

In addition to an individual having expertise, it is very important for her to have comprehensive and current knowledge of relevant resources and referrals and, ideally, a relationship with these agencies. This resource “database” or “list” must include referrals that address as many of the common issues that arise for parenting youths as possible, including referrals for free legal services, infant care or parenting classes, educational advocacy, mental health counseling, and health care, as well as resources for housing, childcare and even free or low cost baby equipment. (See Worksheet that identifies common areas of need.) Because the conference is an opportunity to bring together the teen’s important support persons, it also should include resources that can help prepare the youth for a successful transition to self-sufficiency.

The list of resources must remain current. Many agencies change phone numbers or move locations. Others may change client eligibility criteria or put holds on accepting new clients. A resource list is only as valuable as it is current and accurate.

Ideally, your TPRS will develop a relationship with these organizations so that they can provide warm handoffs and even sometimes arrange for priority referrals.

Developing this knowledge also helps identify where there may be gaps in the resources available. Where there are gaps, it may be possible to encourage their development. For example, in counties without home based support, it may be possible to encourage development of a chapter of a national organization such as the Nurse-Family Partnership and other home visitation programs.

Developing Knowledge of Resources Available

TOOLS and RESOURCES:

(See Appendices or click titles for tools)

- Examples of Referral Lists
 - NYC Referral List (App. 1)
 - LA Box Cart List (App. 7)
- List of Common Issues and Resource Needs (App. 5)
- Worksheet to assist in “Developing Your Local Teen Parent Resource and Referral List” (App. 14)

QUESTIONS for COUNTIES:

1. Is there currently a teen parent resource and referral database or list? When was it last updated?
2. If child welfare does not have such a resource, are there community agencies that may have such lists?
3. If the agency needs to develop its own database or list, whose responsibility will it be to develop, maintain, and update it?
4. Once developed, you may identify unmet referral needs. Are there ways to encourage or foster new resources?

Component 3: Youth Centered and Youth Driven

Description:

The Los Angeles conference process is youth driven at every stage of the process.

This means a number of things:

- First, **participation is voluntary**. The youth's voluntary participation in the meeting is crucial to the effectiveness of the conference.
- Second, **youth drive the development of the conference agenda** including decisions about the purpose of the meeting, priorities and the issues to be discussed.
- Third, the **youth identifies participants** they wish to invite, including family and non-related support persons. The Facilitator and TPRS seek the youth's permission when they wish to invite others.
- Fourth, the **youth actively participates in the conference** in brainstorming and making decisions about the goals and action steps.
- Fifth, the **youth signs off on her plan** and is expected to take on many of the action steps and advocate for herself.
- Finally, key participants in the conference process, such as the Facilitator and TPRS, manage the process in a **culturally competent**¹³ and **trauma-informed**¹⁴ way.

New York's child welfare agency also identifies cultural competence as a critical component to team conferencing with young parents in out-of-home care.¹⁵

Creating a Youth Centered Process

TOOLS and RESOURCES:

(See Appendices or click titles for tools)

- Tips for Creating a Youth-Centered Conferencing Process adapted from NYC ACS (App. 15)
- Trauma & Resilience Toolkit (App. 13)
- Cultural Competence (App. 11)
- Complex Trauma Tools and Resources (App. 12)

QUESTIONS for COUNTIES:

1. Does your agency have agency-wide training and resources that address cultural competence and trauma-informed care?
2. Does your agency have staff members who are trained in these areas?
3. Could your agency adapt or include any of the above tools or resources?

13 An individual's life decisions, including her parenting choices, are influenced by culture, race, and her experiences in the community in which she grew up. The individuals assisting the youth with her life planning must check their own biases and strive to understand each youth's context. See Appendix 11.

14 Early experiences of trauma can have long-term impacts on demeanor, decisions, and decision making. Individuals assisting youth must learn how to practice in trauma-informed ways. See Appendices 12 and 13.

15 See "Guide to Working with Young Parents in Out of Home Care," Appendix 1.

Component 4: Independence from Other Child Welfare Decision Making or Conferences

Description:

The Pregnant and Parenting Teen conferences must be independent of other decision making for several reasons. First, the conferences will have very different goals and focus than other child welfare conferences. They are intended to give young parents the scaffold and supports they need to grow into their role as parents and achieve better outcomes for themselves and their children. While some of the issues and goals discussed may overlap with issues and goals in other child welfare case planning, the focus of the PPT conference is the youth and her role as a parent, rather than the youth in the context of her own child welfare case.

Second, by removing child welfare questions from the process, the conferences are less likely to feel adversarial.

This means that participants—the youth and her family members—feel safer being honest and open about challenges and concerns.

Third, participants invited to a PPT conference are likely to be different than those invited to other child welfare conferencing, and it is easier to guarantee a youth-driven and focused process when the conference is separated from other types of decision making.

In Los Angeles, this difference is emphasized by not combining the conference with other meetings, such as transition planning or placement conferences. Indeed, even if detention of the youth's child is under consideration by child welfare, the focus of the PPT conference remains on the youth's goals and strengths rather than detention.

Creating an Independent Process

QUESTIONS for COUNTIES:

1. Does the county have the capacity to establish stand-alone conferences that focus just on pregnant and parenting teens?
2. If the county cannot hold stand-alone meetings, can the conference be added to an already existing system or conference program?
3. If combined with other meetings, how will the facilitator, specialist and/or case worker ensure that participants keep the PPT conference independent of the other process, and as well, keep it youth centered and focused on the youth's goals?



Component 5: Facilitator Trained in Strengths-Based Conference Management

Description:

The PPT Facilitator manages the conference process from referral to conference facilitation to follow up. The Facilitator is trained in strengths-based conference management and has expertise in parenting youth issues. Training and expertise in strengths-based conference management helps ensure that the conferences stay on track, remain youth-focused, and result in concrete attainable goals in which the youths and other participants feel invested.

The Facilitator also documents the conference and coordinates between DCFS, the youth, the TPRS and other participants.

In a large county like Los Angeles, DCFS has been able to create dedicated PPT Facilitator positions and assign trained social workers to the role. One of the current Facilitators served as a supervisor prior to his facilitator role and spent many years as a services worker before that. His managers support his current position. In 2013, one Facilitator managed 150 teen parent conferences for youth under child welfare supervision. Other counties may elect to design their program a bit differently, for example, training one or a few experienced social workers to take on this role as part of a larger scope of duties.

Fostering a Facilitator

TOOLS and RESOURCES:

(See Appendices or click titles for tools)

- What is a strengths-based approach? (App. 15)
- Facilitator "Job Description" (App. 10)
- Sample Case Report and Plan from Los Angeles (App. 8)
- Template for Case Plan (App. 20)

QUESTIONS for COUNTIES:

1. Does your agency currently use strengths-based case management or conferencing?
2. Is there an individual in the agency with expertise in strengths-based management?
3. If expertise needs to be developed, is there a staffer who is willing and interested in developing this expertise?
4. Does your county have the capacity to create a dedicated Facilitator position?
5. If the county cannot create a dedicated Facilitator position, can the county support training for case workers or other staff to take on this role?
6. In what other ways can the county provide support and training opportunities to develop Facilitator expertise?



Component 6: Pre-Conference Preparation

Description:

Conferences are successful when there is adequate preparation. This includes making sure the appropriate and necessary participants are identified and invited to attend, that the purpose and goals of the meeting are clear before the meeting starts, and that there is time to gather necessary background information and seek out resources.

In Los Angeles, conferences include the following preparation:

- The youth works with the Facilitator, the Teen Parent Resource Specialist and the case worker to identify the appropriate participants to invite.
- The meeting is scheduled at least two weeks out to give invitees adequate time to schedule.
- The Facilitator and Teen Parent Resource Specialist then work with the youth to identify what the youth wants to discuss at the meeting and clarify a clear articulative goal and purpose.

These two weeks are also an opportunity to gather background information and identify resources in the youth's community. This lead time is particularly important if the team members need to research resources to address particular or unusual needs of the client or resources in geographic areas with which they are less familiar.

What goes into Pre-Conference Preparation?

TOOLS and RESOURCES:

(See Appendices or click titles for tools)

- Possible Invitee List for review with youth (App. 4)
- Developing an agenda – List of issues to consider with youth when creating agenda (App. 17)



Component 7: Actionable Attainable Goals

Description:

The WorkPlan developed in conference should include goals with clearly articulated action items connected to each goal. The action steps should include sufficient information to act on them.

The WorkPlan should include:

- Completion dates
- Clear identification of person(s) responsible for accomplishing each goal or helping the youth to accomplish the goal
- Specific and up-to-date contact information where appropriate

How to Develop Goals and Action Steps for a PPT Workplan

TOOLS and RESOURCES:

(See Appendices or click titles for tools)

- Tool to help create goals and actions steps, Healthy Teen Network, "A BDI Logic Model for Working with Young Families Resource Kit" (App. 18)
- List of topics for possible review in conference and possible action steps (App. 17)

Component 8: Follow-Up on Implementation

Description:

Even with clearly articulated goals and action steps in the WorkPlan, it is important to have a follow-up mechanism to ensure action items are accomplished on a timely basis. In some cases, the youth may attempt to follow through but run into roadblocks and need assistance connecting with a referral. Others may need reminders. In Los Angeles, the Teen Parent Resource Specialist and the Facilitator both follow up on implementation to ensure the plan is moving forward.

Ensuring Follow-Up Happens

QUESTIONS for COUNTIES:

1. If there is no TPRS connected to the conference, who else can take on the responsibility to ensure participants are following through with action steps? Does this person have the capacity to help connect youths to alternate resources or make warm hand-offs to referral agencies?
2. What follow-up responsibilities will this entail?

VI. Recommendations Regarding Policy and Materials Development

Once a child welfare agency has decided to implement PPT conferencing and has determined the components of PPT conferencing it wishes to employ, the agency must consider what policy and protocols to implement, and must consider what forms, if any, need to be created. Below are some recommendations on documentation and materials the agency may wish to develop. Examples of policy and materials from Los Angeles are also mentioned at the end and included in the Appendix.

I. Mission Statement

The child welfare agency may wish to consider a mission statement for its PPT conferencing program. A mission statement provides a one or two sentence summary of the purpose and methods of a program. A mission statement can help in a few ways. In the first place, the process of developing a mission statement is a valuable way to clarify intentions. The mission statement is also very important when the agency seeks funding or collaborators to assist in efforts to support teen parents. Finally, it helps the program stay true to its goals as it moves forward.

The process of developing the mission statement will require considering many of the same questions that were addressed by the agency in deciding whether to implement the program. Briefly, a mission statement should address the following questions:

- ***The purpose***
- ***The population served***
- ***What service is provided, and***
- ***How the service is provided.***

Idealist.org has posted an article about writing a mission statement on its website:
[http://www.idealists.org/info/Nonprofits/Gov I](http://www.idealists.org/info/Nonprofits/Gov)

2. Policy and Procedure Guidelines and Infrastructure

In order to ensure that the agency's intentions in developing a PPT conference are carried out effectively, the agency policies and procedures should explain the PPT conference process with sufficient detail. Specifically, the policies and procedures should note the individuals responsible for various tasks and describe the tasks with enough detail that the responsible individuals can carry them out effectively.

Policies and procedures should be reviewed frequently. They can be updated to adjust to changing circumstances. For example, if a county decides to concentrate on having one social worker develop expertise in the issues of teen parenting, over time this staff person may take on more roles related to the conference. These changes should be accurately reflected by revisions to the agency's policies and procedures.

The following questions are for child welfare agencies to consider as they develop policies and procedures to document the PPT conference they have chosen to implement. Again, many of these questions will have been addressed in the process of deciding whether to implement a PPT conference.

Policies and Procedures should address agency and agency staff responsibilities:

- ***Who is responsible for publicizing the PPT conference?***
- ***Who is the target population? Which youth should be referred?***
- ***When should referral occur? How does this policy intersect with policies regarding reproductive choice? (see below)***
- ***Who is responsible for referral of youth to the PPT conference?***
- ***Who is responsible for explaining the conference to a youth and obtaining their consent?***
- ***Who is responsible for identifying participants to invite to a conference?***
- ***Who is responsible for inviting participants?***
- ***Who is responsible for preparing the youth?***
- ***How much preparation time should be given before the conference occurs and what does preparation entail?***
- ***Who is responsible for facilitating the conference? What conference management style should be used?***
- ***How will teen parent expertise be brought to the table?***
- ***How will the youth's voice be integrated into the process? How will the youth's voice be heard?***
- ***Who is responsible for developing and for keeping the resources list up to date?***
- ***Who is responsible for writing up the meeting notes and conference plan? In what time frame?***
- ***Who is responsible for follow up and when should it occur?***
- ***When are second conferences appropriate?***
- ***What are your confidentiality and information sharing practices? (see below)***
- ***What outcomes will you track and measure? Who is responsible for this documentation? (see below)***

3. Special Issues to Address in Policy and Procedure

i. Confidentiality and Information Sharing

Some of the challenges faced by pregnant and parenting teens involve sensitive matters such as reproductive and mental health issues. These issues can be discussed and addressed more freely with appropriate procedures in place to protect confidentiality. County child welfare agencies implementing a PPT conference model should consult with county counsel regarding their obligations to protect this information and ensure their policy and procedure guarantee sensitive information is appropriately handled. Here are some questions for counties to consider in developing policies and procedures addressing confidentiality and information sharing:

- *What confidentiality and privacy protections are you obligated to provide? What confidentiality and privacy protections can you provide?*
- *Where will the conference plan and meeting notes be housed? Who will receive copies?*
- *Who will have access to evaluation data?*
- *Who is responsible for explaining these provisions to the youth and other conference participants?*

ii. Data Collection and Evaluation

Tracking of goals for the PPT conference program as a whole, as well as following up on individual conferences, requires collecting data and information that will allow the agency to measure progress towards these goals. Outcome measures for the program will be needed to make adjustments and improvements to the program as implementation is carried out. Outcome measures will also be important to the agency when seeking funding and collaborators. Funders and collaborators will want to see that the program is effective and achieving its stated goals.

Here are some questions for counties to consider in developing policies and procedures addressing data collection and evaluation:

- *What are the goals the agency seeks to measure?*
- *How will the agency measure program-wide outcomes?*
- *Who is responsible for developing evaluation tools?*
- *Where will this data be tracked and who is responsible for doing so?*

iii. Intersection of PPT Conference and Reproductive Health/Pregnant Youth Policies

PPT conferences are designed to address the needs of youth who are parenting or pregnant and planning to give birth. While it is important to refer youths for a PPT conference as early in pregnancy as possible, it also is important to make sure newly pregnant youth are presented with all

their options and feel safe and free to make their own choices. Child welfare should have a policy in place that addresses how to counsel newly pregnant youths about all their options as soon as the teens disclose they are pregnant and that supports their choices. This policy may address referral for a PPT conference once a youth has made the decision to continue a pregnancy.

4. Materials Development

The PPT conference model adopted by a child welfare agency will require development or adaptation of forms to capture information at various stages of the conference process. A procedure for keeping these forms up to date when the process is modified over time is also necessary. Examples of materials from Los Angeles, all available in the appendix, include a referral form and a sample case plan and notes.

5. Supporting Materials

The child welfare agency may wish to develop written and online resources for youth attending the conferences. The list of written materials the Teen Parent Resource Specialists in Los Angeles bring to PPT conferences provides an example of the wide range of topics and materials that may be helpful. (Click [here](#) or see Appendix 7.)

Resources included in the Appendix:

- *Los Angeles DCFS PPT Conference policy, excerpted from Los Angeles County policy 0070-548.03 on Family Centered Conferences/Team Decision Making Meetings (App. 6)*
- *Los Angeles DCFS “FYI” regarding PPT Conferencing (App. 19)*
- *DCFS Referral Form (App. 3)*
- *Template for Case Plan and Notes (App. 20)*

APPENDIX I



Created by the Fordham Interdisciplinary Parent Representation Project*

Guide to Working with Young Parents in Out of Home Care

* Contributors include staff from Advocates for Children, The Bronx Defenders, The Brooklyn Young Mothers' Collective, Center for Family Representation, The Door, Inwood House, Jewish Child Care Association, Lawyers For Children, The Legal Aid Society/Juvenile Rights Practice, Legal Services NYC-Bronx, Legal Services NYC-Brooklyn Family Defense Project, Lehman College Department of Sociology and Social Work, NYC Administration for Children's Services, NYU School of Law Family Defense Clinic, NYS Child Welfare Court Improvement Project.

NYC
Administration for
Children's Services

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Interested in becoming a resource parent for a pregnant or parenting young person?

Call 311 or the Parent Recruitment Hotline at 212-676-WISH (outside of NYC: 877-676-WISH)

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Introduction¹

The *Guide to Working with Young Parents in Out of Home Care* provides information and guidance for working with pregnant and parenting youth that are central to appropriate service delivery and the Family Team Conference practice model. **The focus of this guide is to provide support to young pregnant and parenting youth, helping them as they develop both as individuals and as parents through positive casework interactions.** The *Guide* encourages a strengths-based approach to ensure the safety of both young parents and their children. It offers suggestions for engaging young parents in conferencing and supportive services while highlighting the importance of maintaining a young parent's right to privacy and autonomy, and emphasize comprehensive planning for pregnant young people to promote well being, to minimize the need for court intervention, to ensure placement stability and to help young families move more quickly toward permanency.

The *Guide* is designed to be used primarily by provider agency case planners, but may also be useful to child protective staff, Family Services Unit staff, parent advocates, attorneys and others who work with this vulnerable population.

While there are many references to young mothers² throughout the document, we recognize the importance of engaging young fathers, as appropriate, in planning and caring for their children. The *Guide* includes a section entitled "Involving Fathers" and lists some resources for fathers in the Appendix.

Other family members or members of a young parent's support network may also be instrumental in supporting the young parent from childhood or adolescence into adulthood. While many young parents and their children reside in group settings, it is generally preferable for young parents to reside in family settings. Family settings may be foster homes but may also be homes of close family or friends that young parents and their children are released to or directly placed in by the Family Court. The term "resource parent" appears in this *Guide* in place of "foster parent."

Case planners and others working with pregnant or parenting young people should also be mindful that lesbian, gay, and bisexual young people experience higher rates of pregnancy than their heterosexual peers.³ It should not be assumed that a young person identifies as heterosexual simply because he or she is pregnant or parenting. As with all casework practice,⁴ services provided to pregnant or parenting lesbian, gay, bisexual, transgender or questioning (LGBTQ) young people should be designed to address their particular needs as parents, and should be provided in a culturally competent manner.

The *Guide* should be read in its entirety and used as both a training tool and a reference guide as it includes a variety of resources that may be useful in individual cases.

- 1 This *Guide to Working with Young Parents in Out of Home Care* was created by members of the Fordham Interdisciplinary Parent Representation Project, a working group of parent and child advocates, foster care providers and community-based organizations with invaluable insight provided by young parents in foster care. Contributions from NYC Children's Services helped ensure the *Guide's* accuracy and consistency with Children's Services policies and procedures.
- 2 Throughout this document, the terms "youth," "young mother," "young parent," "minor parent" and "young person" appear interchangeably. All are intended to refer to a young person who is in foster care and is either pregnant or parenting, including, where appropriate, young fathers in care.
- 3 A number of population-based surveys of youth in Canada and the U.S. in the past two decades have documented higher rates of teen pregnancy involvement among sexual minority youth compared to heterosexual peers, often 2 to 10 times higher (Blake et al., 2001; Saewyc, Bearinger, Blum & Resnick, 1999; Saewyc, Pettingell, & Skay, 2004). 2008 SIECCAN, The Sex Information and Education Council of Canada
- 4 Promoting a Safe and Respectful Environment for Lesbian, Gay, Bisexual, Transgender and Questioning (LGBTQ) Youth and Their Families Involved in the Child Welfare System, NYC Administration for Children's Services Policy #2011/5,

IMPLICATIONS OF CULTURE AND RACE

The ways in which culture and race affect teenage pregnancy are complex and dynamic, yet each play an important role in defining the characteristics and specific needs of pregnant and parenting youth. Unraveling the impact of these two forces can be challenging in terms of understanding the broader social factors that play out in response to public policy decisions and practices. Policy makers, practitioners and the community must see, hear and understand culture and racial experiences in a historical context that impact the health and lives of young parents in out of home care to achieve positive outcomes on their behalf.

Culture and race are directly associated with access to services, opportunities and lifestyle choices for young parents in out of home care. Child welfare workers, practitioners and program administrators should be aware of and be responsive to the influence of family, community and religious beliefs, cultural norms, language and communication styles, and intergenerational patterns on each young parent, including young fathers. In striving for cultural competency it will be necessary for child welfare staff, practitioners and program administrators to continually challenge cultural and racial stereotypes and biases that can potentially undermine positive casework relationships.

This is an excerpt from a longer document. For the complete document, go to Fordham Interdisciplinary Parent Representation Project, Guide to Working with Young Parents in Out of Home Care, NYC:Administration for Children's Services, available at: http://www.nyc.gov/html/acs/downloads/pdf/a_Guide%20to%20Working%20with%20Young%20Parents_LR.pdf

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APPENDIX 2

CLC Analysis of Pregnant and Parenting Teen (PPT) Conferences and Outcomes

In coordination with the Department of Children and Family Services in Los Angeles, CLC has reviewed and analyzed a sample of PPT Conference reports and documentation in an effort to assess the effectiveness of this recently instituted process. This was completed as part of a grant project in collaboration with the Los Angeles Juvenile Dependency Court and the National Council of Juvenile and Family Court Judges. It was generously funded by the National Campaign to Prevent Teen and Unplanned Pregnancy.

Introduction

Pregnant and parenting teens living in foster care confront unique challenges that require specialized resources, supports and services to help them parent their young children successfully and move toward independence. Providing an individualized conference to a teen in foster care who is pregnant or parenting can be an effective mechanism to address potential problems before those problems reach crisis level. The most innovative aspect of the PPT Conference (as it is now known in Los Angeles) – which distinguishes it from other group decision-making conferences conducted by the child welfare agency – is the required involvement of a specialist who, independent of the child welfare agency or the court system, brings knowledge and expertise regarding the issues and available resources for this population. The below analysis supports our belief that this independent expertise maximizes the ultimate effectiveness of the conferences, and thus the number of positive outcomes for the teens involved.

Individualized PPT Conferences help build support networks, both formal and informal, for pregnant and parenting teens involved in the child welfare and other court systems. Bringing together individuals who can help assure that these vulnerable youth have stable placements, prenatal care, access to appropriate child development information, and early intervention services – and that they are able to remain in school – can profoundly affect the future of teens in foster care and their young children. The conferences can also address other potential obstacles to success, including but not limited to additional pregnancies, custody and child support, childcare, and health and mental health issues.

These conferences first provide an initial needs assessment and identification of services, followed by continued communication with the teen that is crucial to ensuring that she/he is actually linked to the services and that more effective resources are identified if needed.

Analysis – Our Process

CLC's analysis of the conferences included review of the DCFS-produced post-conference report, as well as in-depth case file review of approximately 50 attorney case files to assess the case plan after the conferences, whether court orders reflect the conference discussions/decisions, and then later whether services were provided to meet the established conference goals. CLC also surveyed the teens who were the subjects of the PPT Conferences regarding their impressions of the effectiveness of the conference. In order to attain the maximum level of cooperation and engagement by the youth surveyed, whenever possible, the surveys were conducted in person by a CLC Peer Advocate (former foster youth). When in-person discussion was not possible, interviews were conducted by phone.

The goals identified during PPT conferences ranged from enrolling the youth in school, to finding placement for the youth and baby, and to prenatal healthcare for the youth. Following is a breakdown of each of the identified goals and how frequently the goals were met.

Analysis - Results

Analysis of the Pregnant and Parenting Teen Conferences ultimately identified 39 total case reviews that were eligible for consideration (a number of the cases were deemed ineligible for reasons such as the teen's case had already closed or the youth could not currently be located). CLC utilized 13 categories of goals set during the team meetings and a total of 142 individual goals in our analysis. Participants included 38 females and one male foster youth.

- *Teen/Team Communication*

Only 3.5% of the goals identified were related to communication between the teen and other team members, including the attorney. These goals were met 60% of the time, were not met 20% of the time, and 20% were rendered moot. Examples: *client will get in touch with her attorney; client will maintain contact with her CSW; client will call her attorney and introduce herself.*

- *Development of Teen as a Parent*

14.7% of the total goals fell into this category. Of those, 52% were met and 14% were not met. 4.7% were rendered moot. Also, 15% of participants experienced additional positive outcomes in this category. Examples: *DCFS Wraparound will follow up with parenting class referrals for client by 6/17/11; foster parent and PGM will assist youth to obtain a copy of baby's birth certificate and social security card; youth will enroll in the Children's Institute parenting program (NATEEN).*

- *Personal Development*

Just 8.4% of goals were related to the teen's personal development. These goals were met 66.6% of the time, not met 16.6% of the time, and 5.1% of participants experienced additional positive outcomes in this category. Examples: *DCFS Social Worker will refer youth to DMH; once replaced, youth will participate in individual counseling; PPT Facilitator will obtain information as to a mentoring program in Fontana for client.*

- *Relationship Development*

Only 5.6% of the total goals fell into this category. However, these goals were met 87.5% of the time and not met 12.5% of the time. (No goals were rendered moot.) Examples: *[Therapist] will provide family therapy starting next week; youth will make every possible effort to call her foster parents and let them know of her whereabouts when she will be home late; youth's mother and father to visit with youth and baby on Sundays at 8:50 am.*

- *Housing/Placement (for teen or teen's child)*

10.5% of the total goals fell into this category. These goals were met 78% of the time and not met 7% of the time. Fifteen percent of goals in this category were rendered moot. Examples: *CSW and ICAN Resource Specialist to follow up with current caretaker of youth with Whole Family Foster Home information by [specified date]; DCFS Social Worker will request (baby's father) and his family to live scan; DCFS Social Worker will continue to search for appropriate placement.*

- *Progress Toward Independent Living*

This category represented 12% of the total goals. These goals were met 73% of the time, and not met 6.6% of the time. A total of 5.1% of participants experienced additional positive outcomes in this category (no goals were rendered moot.) Examples: *Youth and DCFS Social Worker will consider transitional housing and AB-12 Supervised Independent Living Plan; DCFS CSW will update youth's TILP; FFA Social Worker will search for appropriate community service for minor (as part of TILP).*

- *Referrals for Supportive Services*

This category represented 15% of the total identified goals. These goals were met 72% of the time and rendered moot 27% of the time (no goals were unmet). Examples: *PPT Facilitator will contact resource specialist to refer minor to Adolescent Family Life Program; ICAN Resource Specialist will provide youth with information on the Teen LA program for issues of custody of youth's children; resource specialist will consult with BHS as to in-home inpatient program, substance abuse program.*

- *Receipt of Support Services*

8% of goals fell into this category. These goals were met 33% of the time, not met 25% of the time, and 16% were rendered moot. Also, 7.6% of participants experienced additional positive outcomes in this category. Examples: *DCFS Social Worker will consult youth's case with County Counsel regarding reunification with her daughter; provide youth and youth's mother with share responsibility (SRP) referral to CSW (CSW to inform family about the plan when baby is born); youth will continue participating in Wraparound.*

- *Education*

Education represented 15% of the total goals. These goals were met 50% of the time, not met 36% of the time, and 9% were rendered moot. Also, 2.5% of participants experienced additional positive outcomes in this category. Examples: *DCFS Social Worker will refer minor to Educational Liaison to assist her to be on track to graduate; youth will receive a comprehensive educational assessment and assistance in her overall educational goals; youth will continue to attend school and participate in case plan activities.*

- *Health Care*

This category represented 5.6% of the total goals. These goals were met 87.5% of the time, and 12.5% were rendered moot (no goals were unmet). Examples: *DCFS Social Worker will follow up with minor's attorney to obtain signed medical form to proceed with youth's foot surgery; youth to continue attending prenatal care services and to change medical care provider by [specified date]; foster mother will continue to assist youth in scheduling and transportation to and from medical appointments.*

- *Employment*

This category represented 2.8% of the total goals. These goals were met 75% of the time; 25% of these goals were not met. Examples: *CSW will call Work Source Center and register youth for job leads; facilitator will obtain information as to DCFS job training for foster youth; youth will contact Archdiocesan Youth Employment for job leads.*

- *Childcare*

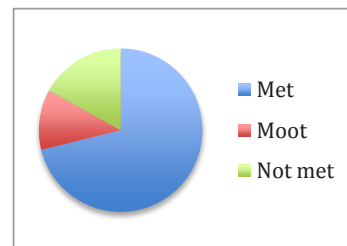
This category represented 4% of the total goals. These goals were met 66% of the time, not met 12.5% of the time, and 12.5% were rendered moot. Examples: *Child care has been initiated by DCFS on LA Cell and DCFS Child Care; facilitator will fax completed Early Head Start Referral to El Nido Family Centers Manchester Office; by [specified date], facilitator will search for subsidized child care options in 90001 and 90808 ZIP codes.*

- *Reproductive Health Information*

This category represented 0.7% of the total goals. These goals were met 100% of the time. Examples: *Planned Parenthood has been discussed and information provided to youth and her foster mother; Resource Specialist will provide youth with the phone number to Planned Parenthood closer to her home, once provided with her new address; on [specified date], youth will make an OB/GYN doctor appointment to obtain birth control.*

Summary of Results

Overall, of the 142 identified goals, **71% were met, 16.9% were not met, and 11.9% of the goals were rendered moot as circumstances within the case changed over time.** Also, of the 39 participants, **33% experienced positive outcomes¹ beyond those goals identified during their conferences.** These positive results demonstrate the effectiveness of the PPT Conference and its utility in ensuring that pregnant and parenting teens receive the support they need.



¹ Additional positive outcomes are those outcomes that were documented and beneficial to the youth but not explicitly identified in the PPT conference. For example, the goal may have been for a resource specialist to provide the youth with information about individual counseling; the additional positive outcome documented in the case file may have been that the youth actually attended counseling.

APPENDIX 3

COUNTY OF LOS ANGELES

DEPARTMENT OF CHILDREN AND FAMILY SERVICES

Family Centered Referral Form

CSW:

1. Complete page 1 of the DCFS 174 Family Centered Referral Form.
2. Complete pages 1 and 2 of the DCFS 174 form for Resource Management Process (RMP), Wraparound (Tier I and II) and all Department of Mental Health referrals.
3. Submit to SCSW for signature.
4. After receiving SCSW signature:
 - Submit to Team Decision-Making (TDM) Scheduler to request a conference,
 - Place pages 1 and 2 of DCFS 174 in CSAT in-box for DMH only referrals along with the 179-MH and 179 PHI (Parent Consent for MH Treatment/Release of Info) or a copy of minute order, and the positive MHST.

CSW instructions following the TDM:

1. When the child (ren)/family are referred for services, attach the TDM Safety/Action Plan to DCFS 174 form, along with additional pertinent information, and provide copies to both the service provider and the caregiver.
2. Attach the pertinent referral paperwork for the service recommended during the TDM to the DCFS 174 packet and submit according to the instructions below.
3. Add additional information to page 2 (the DMH Co-located Programs form) of DCFS 174.
4. File a copy of the DCFS 174 form and the attached TDM Safety/Action Plan in the case file.
5. Schedule a first visit (icebreaker) if the child is removed from the home.
6. Schedule a 30-day Permanency Planning Conference, if needed.

FGDM/TDM Facilitators:

1. Complete pages 3 and 4 of the DCFS 174 at the conclusion of any TDM/Family Group Decision-Making (FGDM) meeting.
2. Complete the Safety/Action Plan and attach a copy to the DCFS 174.
3. Distribute copies to all the parties that participated in the TDM/FGDM.
4. If the representative for a DCFS Specialized Service is not present and a box for that service is checked, please forward a copy of the DCFS 174 and Safety/ Action Plan to the appropriate liaison staff assigned to your Regional Office.

Reminder:

Wraparound Tier I referral:

Referrals can **only** come through the RMP.

Wraparound Tier II referral If referring directly to the DCFS Wraparound liaison without a TDM or RMP: submit the DCFS 174 with the referral packet (include consent forms and Wraparound Agency Child and Family Enrollment Agreement document without parent/caregiver signature) to DCFS Wraparound liaison.

SLS/MAT Coordinator

For a referral for mental health services, attach DCFS 179-MH and 179 PHI, or minute order, CIMH/MHST and benefits establishment status and submit to the DMH co-located staff.

Family Centered Referral Form

Is it a CFT

☐ Yes ☐ NoSecurity Needed? ☐ Yes ☐ NoHas the family had a conference before? ☐ Yes ☐ No

Requested Meeting Date and Time _____

Date of Referral	Case Name	Referral/State No. /	Court # (if applicable)
CSW	CSW Cell	Office	SDM Attached <input type="checkbox"/> Yes <input type="checkbox"/> N/A
	Office Phone		
SCSW	SCSW Phone	CIMH/MHST Included <input type="checkbox"/> Yes <input type="checkbox"/> No	SDM Risk Level <input type="checkbox"/> Low <input type="checkbox"/> Moderate
Primary Language of Conference	Service Component <input type="checkbox"/> ER <input type="checkbox"/> Voluntary <input type="checkbox"/> Court	Domestic Violence <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> High <input type="checkbox"/> Very High/Intensive
			<input type="checkbox"/> SDM Not Available
Referral Only: <input type="checkbox"/> TIER II Wrap <input type="checkbox"/> DMH Referral		Ethnicity of Birth Parents	

Primary Purpose/Concerns for the Conference (Check One):		Concerns of Family/Child	
<input type="checkbox"/> 1. Potential Removal from Home or Going Back Home (TDM)		<input type="checkbox"/> Domestic Violence	<input type="checkbox"/> Mental Health
<input type="checkbox"/> 2. Potential Placement Move (Not RCL), (TDM)		<input type="checkbox"/> Educational/Tutoring	<input type="checkbox"/> Permanency-
<input type="checkbox"/> 3. Potential Placement move to RCL or move out of RCL (RMP)		<input type="checkbox"/> Youth Transitional	<input type="checkbox"/> Sexual Abuse
<input type="checkbox"/> 4. Perm./Case Plan (PPC)		<input type="checkbox"/> Health Services	<input type="checkbox"/> Substance Abuse
<input type="checkbox"/> 5. Transition Planning (T-Conf.)		<input type="checkbox"/> Housing	<input type="checkbox"/> Probation
<input type="checkbox"/> 6. Pregnant or Parenting Teen Conference (PPT)		<input type="checkbox"/> Physical Abuse	<input type="checkbox"/> Other (specify):
Comments:			

Child Information (please indicate if attending)

Child's Name	DOB/Gender	Current Placement	Is Child Detained?	Detention Date	Medi-Cal	Medi-Cal Provider
	/		<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No	
	/		<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No	
	/		<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No	
	/		<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No	
	/		<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No	

Caregiver Information

Name	Address	Phone Number	Relationship	Willing participant?
				<input type="checkbox"/> Yes <input type="checkbox"/> No
				<input type="checkbox"/> Yes <input type="checkbox"/> No

School Name	Location	Phone Number

Family/ Extended Family, Community Support, Service Providers to be invited (include providers already involved):

Name	Address	Phone Number	Relationship	Willing participant?
				<input type="checkbox"/> Yes <input type="checkbox"/> No
				<input type="checkbox"/> Yes <input type="checkbox"/> No

Service Providers, DCFS Staff/Resources to be invited

<input type="checkbox"/> Voluntary Services	<input type="checkbox"/> PHN	<input type="checkbox"/> RUM	<input type="checkbox"/> Adoptions/P3	<input type="checkbox"/> Wrap/SOC
<input type="checkbox"/> Parenting	<input type="checkbox"/> DMH	<input type="checkbox"/> YDS	<input type="checkbox"/> Education Liaison	<input type="checkbox"/> Service Provider/Caregiver
<input type="checkbox"/> Drug/Alcohol	<input type="checkbox"/> Counseling	<input type="checkbox"/> Domestic Violence		
<input type="checkbox"/> Probation	<input type="checkbox"/> DPSS	<input type="checkbox"/> Family Preservation	<input type="checkbox"/> Other	

SCSW'S Signature (required) _____ Date: _____

Page 2 must be completed by CSW.

DMH Co-located Programs*(Please use a separate copy of this page for each identified child)***Conference Decision Regarding Child**

(Name)

Primary Language of Child

Primary Language of Caregiver

Please indicate if the child(ren) is currently enrolled or being referred to the following programs:

☐ FP☐ Wrap Tier II☐ MAT Case☐ D-RateLead
Agency:**BEHAVIORAL PROBLEMS AND MENTAL HEALTH SYMPTOMS (Check all that apply and provide a description):**☐ Anxious/Nervous☐ Irritable/Mood Swings☐ Sexualized Behavior☐ Hyperactive/Impulsive/Inattentive☐ Substance Abuse☐ Aggressive/Violent☐ Delinquent/Defiant☐ History of Suicidal/Self-Harming☐ Sad/Depressed☐ Eating Disorder☐ Odd Thoughts☐ Current Suicidal/Self-Harming☐ Seeing/Hearing Things

Comments to be added by CSW:

FUNCTIONAL IMPAIRMENTS IN (Check all that apply and provide a description):☐ Health☐ School☐ Work☐ Safety☐ Placement Stability☐ Development (Delay/MR)☐ Social/Peer/Family☐ Living Skills

Comments to be added by CSW:

Additional Information:

Current Therapist: _____ Phone: _____ Clinic: _____

Psychiatrist: _____ Phone: _____

Medications: _____

History of Psychiatric Hospitalizations: ☐ Yes ☐ NoSchool: _____ Grade: _____ Special Education/IEP: ☐ Yes ☐ No**----- BELOW FOR DMH STAFF USE ONLY -----**

Date Referral Received: _____ Case Open Date: _____ Case Closed Date: _____

Child/Youth's MIS#: _____

Service Provided:

☐ TDM☐ Consultation☐ Crisis-Intervention☐ Face to Face Assessment☐ RMP☐ Brief Therapy☐ Case Management☐ Direct Linkage

Referred to:

☐ Wraparound☐ TBS☐ Regular EPSDT Outpatient☐ FSP☐ Family Preservation☐ SFC Basic☐ Intensive In-Home Services (Specify: ☐ CCSP ☐ MST ☐ MTFC ☐ ITFC)☐ Other (Agency/Program): _____

(Contact Person): _____

Phone: _____

DMH Staff Assigned: _____

Phone: _____

☐ No Action Taken

Reason: _____

Family Centered Referral Form

Conference Location		Conference Facilitator	Conference Date	Start Time	End Time
Type of Conference: <input type="checkbox"/> A. Imminent Risk of Placement <input type="checkbox"/> G. PPC <input type="checkbox"/> B. Emergency Placement <input type="checkbox"/> H. Transitional Conf. <input type="checkbox"/> C. Placement Move <input type="checkbox"/> I. PPT <input type="checkbox"/> D. RMP <input type="checkbox"/> E. Exit from Placement <input type="checkbox"/> F. DCFS Case Plan/Update			Reason Conference Cancelled: <input type="checkbox"/> CSW's request <input type="checkbox"/> Family's request <input type="checkbox"/> Reason for conference no longer valid <input type="checkbox"/> Child/family referred to more appropriate services <input type="checkbox"/> Child not available <input type="checkbox"/> Family No-Show		
Did anyone leave meeting? <input type="checkbox"/> Yes <input type="checkbox"/> No			If yes, why?		
Is it a CFT <input type="checkbox"/> Yes <input type="checkbox"/> No					

Caregivers:		M	F	DCFS Staff:	
<input type="checkbox"/> Birth Parent(s)	#	_____	_____	<input type="checkbox"/> Emergency Response CSW	# _____
<input type="checkbox"/> Adoptive Parent(s)	#	_____	_____	<input type="checkbox"/> Generic (FM/FR/PP) CSW	# _____
<input type="checkbox"/> Relative Caregiver(s)	#	_____	_____	<input type="checkbox"/> DI	# _____
<input type="checkbox"/> Non-Related Extended Family Member(s)	#	_____	_____	<input type="checkbox"/> Worker on Companion Case	# _____
<input type="checkbox"/> County Foster Parent(s)	#	_____	_____	<input type="checkbox"/> YDS/Aftercare Workers	# _____
<input type="checkbox"/> FFA Foster Parent(s)	#	_____	_____	<input type="checkbox"/> Adoption CSW	# _____
<input type="checkbox"/> Caregiver Partner(s)	#	_____	_____	<input type="checkbox"/> SCSW	# _____
<input type="checkbox"/> Guardian(s)	#	_____	_____	<input type="checkbox"/> Family Preservation Staff	# _____
* Is the caregiver or parent a victim of DV or SA? * Is the caregiver or parent a victim of DV or SA offender?				<input type="checkbox"/> Yes <input type="checkbox"/> No	# _____
				<input type="checkbox"/> Yes <input type="checkbox"/> No	# _____
Children/Youth:					
<input type="checkbox"/> Children/Youth	#	_____		<input type="checkbox"/> Other Strength Based Program Staff	# _____
<input type="checkbox"/> Child Victim	#	_____		<input type="checkbox"/> Public Health Nurse	# _____
<input type="checkbox"/> Child Offender	#	_____		<input type="checkbox"/> RUM Liaison	# _____
				<input type="checkbox"/> Educational Consultant	# _____
				<input type="checkbox"/> P3 CSW	# _____
				<input type="checkbox"/> Other (specify)	# _____
Family Members and other interested individual					
<input type="checkbox"/> Maternal Relative(s)	#	_____		Service Providers:	
<input type="checkbox"/> Paternal Relative(s)	#	_____		<input type="checkbox"/> Alcohol / Drug Staff	# _____
<input type="checkbox"/> Friend(s)	#	_____		<input type="checkbox"/> DPSS Staff	# _____
<input type="checkbox"/> Interested Individual(s)	#	_____		<input type="checkbox"/> Domestic Violence Staff	# _____
<input type="checkbox"/> Adult Sibling	#	_____		<input type="checkbox"/> Educational/Tutoring Staff	# _____
Neighborhood/Community Representatives:				<input type="checkbox"/> FFA Social Worker	# _____
<input type="checkbox"/> Community Representative(s)	#	_____		<input type="checkbox"/> Medical Staff	# _____
<input type="checkbox"/> School Staff	#	_____		<input type="checkbox"/> Mental Health Staff	# _____
<input type="checkbox"/> Parent Advocate	#	_____		<input type="checkbox"/> Group Home Staff	# _____
Facilitators Present				<input type="checkbox"/> Regional Center Staff	# _____
				<input type="checkbox"/> Sexual Abuse Staff	# _____
Other:				<input type="checkbox"/> Probation	# _____
<input type="checkbox"/> Guardian Ad Litem	#	_____		<input type="checkbox"/> Family Preservation	# _____
<input type="checkbox"/> Attorney	#	_____		<input type="checkbox"/> Wraparound	# _____
<input type="checkbox"/> CASA Advocate	#	_____		<input type="checkbox"/> Cultural Broker	# _____
<input type="checkbox"/> CLC Investigator	#	_____		<input type="checkbox"/> Parents in Partnership (PIP)	# _____
<input type="checkbox"/> Other (specify):	#	_____		<input type="checkbox"/> Other (specify):	# _____

Page 3 through 4 must be completed by Facilitator and returned to the CSW within 24 hours after conference.

Family Centered Referral Form

(Please use a separate copy of this page for each identified child)

Conference Decision Regarding Child _____		
(Name)		
A: Imminent risk of placement <input type="checkbox"/> Child stays home/ voluntary contract <input type="checkbox"/> Child stays home/court involvement <input type="checkbox"/> Voluntary placement <input type="checkbox"/> Court placement <input type="checkbox"/> Referral closed/ no DCFS involvement	C: Placement Move/ D: RMP <input type="checkbox"/> Change to less restrictive placement <input type="checkbox"/> Maintain child in present placement <input type="checkbox"/> Change to same level placement <input type="checkbox"/> Change to more restrictive placement <input type="checkbox"/> Exit from Group Home	F: DCFS Case Plan/ Update <input type="checkbox"/> DCFS Case Plan developed <input type="checkbox"/> DCFS Case Plan not developed <input type="checkbox"/> Case Closed (Voluntary) <input type="checkbox"/> Case Closed (Court)
B: Emergency Placement <input type="checkbox"/> Return child home/ voluntary contract (VFM) <input type="checkbox"/> Return child home/ court involvement (FM) <input type="checkbox"/> Continue voluntary placement <input type="checkbox"/> Continue court placement <input type="checkbox"/> Child returns home/ no DCFS involvement	E: Exit from Placement <input type="checkbox"/> Reunification <input type="checkbox"/> Adoption <input type="checkbox"/> Guardianship <input type="checkbox"/> Youth Transition <input type="checkbox"/> Terminate Jurisdiction	G: Permanency Placement Plan <input type="checkbox"/> Reunification <input type="checkbox"/> Adoption <input type="checkbox"/> Guardianship <input type="checkbox"/> Youth Transition
Released to non-offending parent Conference Decision Deferred		
H: Youth Transition Plan <input type="checkbox"/> Education <input type="checkbox"/> Housing <input type="checkbox"/> Work <input type="checkbox"/> Mentor		

Reason for ARA Review/Consultation.

- | | |
|--|---|
| <input type="checkbox"/> Unable to Reach Consensus
<input type="checkbox"/> Facilitator's Request
<input type="checkbox"/> Approval Required | <input type="checkbox"/> 0-59 Months Remaining or Returning Home
<input type="checkbox"/> 0-59 Months More Restrictive Placement
<input type="checkbox"/> 0-59 Months Termination of Jurisdiction |
|--|---|

When conference decision is to change child's placement, please check new placement recommendation.

- | | | | |
|--|--|--|--|
| <input type="checkbox"/> Small Family Home
<input type="checkbox"/> Foster Family Home
<input type="checkbox"/> FFA
<input type="checkbox"/> D-Rate Foster Care | <input type="checkbox"/> Court Specified
<input type="checkbox"/> Medical Facility
<input type="checkbox"/> Tribe Specified Home
<input type="checkbox"/> MTFC/ITFC | <input type="checkbox"/> Relative Home
<input type="checkbox"/> Non Relative Family Member
<input type="checkbox"/> Guardian Home
<input type="checkbox"/> THPP | <input type="checkbox"/> Emergency Shelter Care
<input type="checkbox"/> Group Home
(specify RCL level): _____ |
|--|--|--|--|

DCFS Specialized Services Recommended for the CHILD/FAMILY:

- | | | | |
|--|--|--|---|
| <input type="checkbox"/> Family Preservation
<input type="checkbox"/> DPSS Linkages
<input type="checkbox"/> DHS/HUB | <input type="checkbox"/> Wraparound
<input type="checkbox"/> Kinship
<input type="checkbox"/> Child Care | <input type="checkbox"/> Mentoring
<input type="checkbox"/> ITFC
<input type="checkbox"/> Residential Based Services | <input type="checkbox"/> Youth Development Services
<input type="checkbox"/> Education Consultant
<input type="checkbox"/> Other (specify): _____ |
|--|--|--|---|

Mental Health/ Counseling Services Recommended for the CHILD/FAMILY:

- | | | | |
|---|--|--|--|
| Community based agency (DMH and non DMH) | | | |
| <input type="checkbox"/> Dom. Violence Treatment
<input type="checkbox"/> Sexual Abuse Treatment
<input type="checkbox"/> Substance Abuse Treatment | <input type="checkbox"/> DMH
<input type="checkbox"/> MAT Assessment
<input type="checkbox"/> AB 3632 referral | <input type="checkbox"/> D-rate unit
<input type="checkbox"/> TBS | <input type="checkbox"/> CAPIT (1733/ Child Abuse Prevention)
<input type="checkbox"/> Other (specify): _____ |
| <input type="checkbox"/> DMH Mental Health Co-located staff (If checked, complete page 2) | | | |

Intensive Mental Health Services

- | | | |
|--|--|---|
| <input type="checkbox"/> Multi Systemic Therapy (MST)
<input type="checkbox"/> WRAP | <input type="checkbox"/> Comp Child Services Program (CCSP)
<input type="checkbox"/> Intensive Home-Based Services (IHBS) | <input type="checkbox"/> MTFC
<input type="checkbox"/> FSP
<input type="checkbox"/> Other |
|--|--|---|

Other Community Services for the CHILD/FAMILY:

	Family	Child		Family	Child
Counseling/Mental Health Services	<input type="checkbox"/>	<input type="checkbox"/>	Educational Services	<input type="checkbox"/>	<input type="checkbox"/>
Substance Abuse Treatment	<input type="checkbox"/>	<input type="checkbox"/>	Medical Services	<input type="checkbox"/>	<input type="checkbox"/>
Housing Services	<input type="checkbox"/>	<input type="checkbox"/>	Regional Center Services	<input type="checkbox"/>	<input type="checkbox"/>
Domestic Violence	<input type="checkbox"/>	<input type="checkbox"/>	Sexual Abuse Treatment	<input type="checkbox"/>	<input type="checkbox"/>
Parenting Classes	<input type="checkbox"/>	<input type="checkbox"/>	Other (specify):	<input type="checkbox"/>	<input type="checkbox"/>

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APPENDIX 4

Los Angeles PPT Conference – Possible Invitee Checklist

The youth, in consultation with fellow attendees the Facilitator and Teen Parent Resource Specialist (TPRS), should consider whether any of the following individuals or agencies should also be invited to attend the youth's PPT conference:

Child Welfare Supports		
	<i>P3 worker</i>	A social worker specifically assigned to help DCSF CSW and youth address issue of finding permanent placement for older foster youth (ages 12-18).
	<i>Educational Consultant</i>	Staying in school (and understanding their rights to remain in school) is a big challenge for many pregnant and parenting teens. The educational consultant can help identify options and strategies for continuing with education.
	<i>Independent Living Program (ILP) Coordinator</i>	Planning for independent living after foster care is a challenge for almost all foster children, and even more complicated for pregnant and parenting teens.
	<i>Public Health Nurse (PHN)</i>	For children with medical or developmental concerns.
	<i>Youth Development Specialist</i>	Identifies assistance available through DCSF program to assist transition-age youth in education, employment, life skills and housing.
Community and Specialist Supports		
	<i>Department of Mental Health</i>	Can provide support and information regarding resources and services.
	<i>Child Advocate</i>	Representative from a child advocacy agency can provide expertise, referrals, follow-up and support for the youth.
	<i>Home Visitation</i>	Representative from a home visitation program, such as Nurse Family Partnership.
	<i>Department of Public Social Services</i>	Helps to navigate eligibility for different forms of public assistance.

Based on Los Angeles DCFS Policy 0070-548.03 | Revision Date: 07/01/14, available at http://policy.dcfslacounty.gov/Content/Family_Centered_Conferen.htm#PPT

Family and Community Support Systems		
	<i>Father/mother of teen's baby</i>	May play an important role in the youth's life and may serve as an advocate and support for the youth. He/she also can help the youth accomplish his or her goals.
	<i>Foster Caregivers</i>	Provide information and support for the youth.
	<i>Family members</i>	Provide information on strengths and needs of child and family and can be a resource.
	<i>Non-related extended family members or community representative</i>	May serve as advocates for and represent the youth's community as part of a neighborhood, faith, ethnicity or other connection. They also can be a resource and help connect the youth to a community network.
	<i>Significant friend</i>	Plays an important role in the youth's life and may serve as an advocate and support for the youth. He or she also can help the youth accomplish his or her goals.

Based on Los Angeles DCFS Policy 0070-548.03 | Revision Date: 07/01/14, available at http://policy.dcfs.lacounty.gov/Content/Family_Centered_Conferen.htm#PPT

APPENDIX 5

Common Issues and Resource Needs: subjects to review and discuss with youth as possible topics for conference

1. Pregnancy, Birth and Postpartum Related Services
 - a. Prenatal Care
 - b. Planning for childbirth (labor, delivery and postpartum)
 - c. Breastfeeding support
 - d. Medical home visiting programs, such as Nurse Family Partnership
 - e. Sexual health services, including STI/HIV education and services
 - f. Family planning and secondary pregnancy prevention
2. Parenting Supports
 - a. Infant care classes
 - b. Parenting programs for parenting skills, appropriate discipline and nurturing behavior
 - c. Mentoring
 - d. Young father programs
 - e. Adolescent family life programs
 - f. Regional center for help with children with disabilities
3. Health, Counseling and Mental Health Providers
 - a. Counseling, including developing healthy relationships with partner, peers and family
 - b. Domestic violence and assault
 - c. Alcohol and other drugs
 - d. Pediatrics and general medicine
4. Education
 - a. CalSAFE
 - b. Local district teen parent schools
 - c. Local schools affiliated with group homes
 - d. AFLP (CalLearn)
 - e. Childcare
 - f. Tutoring
 - g. GED programs
 - h. High school graduation
 - i. Special education
 - j. Post-secondary education
 - k. Vocational training

(Continued over)

Adapted from “Working with Pregnant & Parenting Teens Tip Sheet”, U.S. Department of Health and Human Services, Family and Youth Bureau, available at <http://www.acf.hhs.gov/programs/fysb/resource/pregnant-parenting-teens-tips>

5. Free or Low-Cost Legal Services
 - a. Immigration
 - b. Family law, including child support, child custody, paternity and guardianship
 - c. Domestic violence, including restraining orders
 - d. Criminal law, including sealing a juvenile record
 - e. Tickets
 - f. Consumer
 - g. Health care and consent
6. Transition to Independent Living
 - a. Housing
 - b. Job training
 - c. Computer
 - d. Transportation
 - e. TILP
 - f. Financial literacy
7. Benefits
 - a. Foster care funding, including the infant supplement
 - b. Public benefits, including WIC, CalFresh, MediCal and other health coverage
 - c. Infant and baby supplies (diapers, cribs, carseats, etc.)

Adapted from “Working with Pregnant & Parenting Teens Tip Sheet”, U.S. Department of Health and Human Services, Family and Youth Bureau, available at <http://www.acf.hhs.gov/programs/fysb/resource/pregnant-parenting-teens-tips>

APPENDIX 6

Family Centered Conferences/Team Decision Making (TDM) Meetings

L.A. DCFS Policy 0070-548.03 | Revision Date: 07/01/14¹

Overview

This policy guide provides guidelines on Team Decision Making (TDM) Meetings, Resource Management Process (RMP) TDM's, Permanency Planning Conferences (PPC), and Pregnant and Parenting Teen (PPT) Meetings. The policy guide outlines participation, attendance and documentation responsibilities for these meetings.

This policy guide was updated from the 08/25/10 version, as part of the Policy Redesign, in accordance with the DCFS Strategic Plan.

Team Decision Making (TDM) Meetings

Team Decision Making (TDM) is a process that uses a multidisciplinary assessment and team approach to work with children and their families. TDM allows DCFS staff, parents, family members, youth, community members, caregivers, and service providers to collaborate in the decision making process regarding a child's removal, placement, or reunification.

The goal of a TDM meeting is to reach consensus on a decision regarding placement and/or to make a Safety/Action Plan, to protect the child and preserve or reunify the family. In this case, consensus means that each participant can support the plan made by the team; it may not necessarily mean that each participant fully agrees with everything.

....[cut for length. Please see full policy].

Pregnant and Parenting Teen (PPT) Conferences

Pregnant and Parenting Teen (PPT) conferences are held for any pregnant or parenting teen under DCFS' supervision (including potential and recent fathers). This is a youth-centered approach to identify and discuss issues related to pregnancy and the early stages of child-rearing. It also aims to break intergenerational cycles.

The goals of the PPT are to:

- Aid in placement stability and support for the teen parent and baby
- Connect teen parents to prenatal care and birth plans
- Engage and promote the support and involvement of the maternal and paternal family network
- Assess educational status and needs and the development of an education plan
- Refer teen parents to parenting education and mentoring programs
- Encourage family planning
- Direct the individual to family law referrals
- Link the teen parent to DPSS or other Service Resources (if applicable)
- Provide independent living/transition planning information and resources

Participation by the pregnant or parenting youth is voluntary. The PPT uses the Family Group Decision Making (FGDM) model. Though placement issues may be addressed in a PPT, placements decisions are not necessarily made during a PPT.

1 Available at http://policy.dcfs.lacounty.gov/Content/Family_Centered_Conferen.htm#PPT

The PPT also allows for a comprehensive review of the following:

- Pregnant/Parenting youth's educational status
- Pregnant/Parenting youth's employment status
- Pregnant/Parenting youth's social and emotional well being
- Pregnant/Parenting youth's level of self-sufficiency

PROCEDURE

Before the Team Decision Making (TDM) Meeting

CSW Responsibilities

1. Consult with SCSW regarding the TDM. If it is determined that a TDM is appropriate, discuss with SCSW possible meeting participants and times for meetings.
2. Provide the parent/guardian and youth (if developmentally appropriate) with a TDM brochure. Explain the purpose of the TDM, the role of each participant, the process (including the option to invite family or other support persons to the meeting).
 - a. Ask the family if they are engaged with any service providers that should be invited to the meeting.
 - i. If applicable, obtain the provider's names and phone numbers
 - b. If appropriate, ask the family if there are any restraining orders or domestic violence concerns that warrant two separate TDMs.
 - c. Ask the family if any individuals participating in the TDM require translation services.
 - i. If someone does require translation services, notify the TDM Facilitator.
3. Inform the family of the individuals who are expected to be invited/present at the TDM Meeting.
 - Ask the family if they have any concerns about the individuals expected to attend and try to address these concerns prior to the TDM Meeting.
4. Determine three possible times for the TDM Meeting to be held; taking into consideration the parent/guardian's work, school and child care commitments.
5. Obtain the date and time for the TDM Meeting from the TDM Scheduler.
 - When the date and time of the TDM is confirmed, confirm this with the birth/adoptive parents or guardians and/or care providers.
6. Complete the [DCFS 174](#), Family-Centered Referral and Services form and place it in the TDM Request box at the Facilitator's desk.
 - Because of the time-sensitive nature, contact the Facilitator by telephone/ e-mail regarding the pending TDM.
 - If necessary, the TDM Scheduler or Facilitator can assist the CSW in completing the "Family-Centered Referral and Services" form either in person or by telephone.
7. If a child has an attorney, [notify the attorney](#) of the TDM Meeting using the [DCFS 5402](#) – Notice to Child's Attorney Re: Child's Case Status.
 - Notification is not intended to ask the attorney to attend. Consult with the County Counsel if there is a specific request by the youth/family member or a Court order for the Attorney and/or attorney's designated representative to participate.

- Complete the Structured Decision-Making (SDM) tool appropriate for the type of TDM to be held.

Type of TDM	Type of SDM
Initial TDM with an emergency removal	<ul style="list-style-type: none"> SDM Safety and Risk Assessment
Initial TDM where child is at imminent risk of removal	<ul style="list-style-type: none"> SDM Safety Assessment Risk Assessment SDM Safety Plan
Replacement TDM	<ul style="list-style-type: none"> SDM Reunification Assessment (if consideration is being given to returning the child to their family)
Reunification TDM	<ul style="list-style-type: none"> SDM Reunification Assessment

- Ensure that the purple folder is forwarded to the PHN if there are health issues to be addressed.

SCSW Responsibilities

- Monitor, direct and support the CSW to arrange for a TDM prior to any placement decision and ensure that the TDM takes place within the required timeframes.
- Sign the [DCFS 174](#), Family-Centered Referral and Services form, ensure that the applicable SDM is completed before the TDM, and that it is attached to the DCFS 174.

TDM Scheduler Responsibilities

- Assist the referring CSW in preparing for the TDM meeting by making the TDM meeting arrangements.
- Reserve time slots each day based on the needs of the individual office and as determined by the office Assistant Regional Administrator (ARA) who directly manages the TDM facilitator(s).
- Assist in contacting and inviting community partners currently and not currently involved with the family to the TDM meeting.

During the Team Decision Making (TDM) Meeting

TDM Facilitator Responsibilities

- Greet the family and meeting participants.
- Before meeting participants are seated, ask the parents and child if they object to having community partners attend and participate in the meeting.
 - Parents, the child and their supports are invited to sit first, followed by the rest of the team.
- Ask the meeting participants to sign the meeting attendance form.
- Begin the meeting by explaining the purpose of the meeting and reviewing the meeting “Ground Rules” and “Straight Talk”.
- Explain confidentiality, confidentiality limitations, and have all participants sign the “Understanding of Confidentiality” statement.
 - The Confidentiality form shall be signed by all participants including DCFS Staff.

- All information shared in a TDM meeting is considered confidential, with the following exceptions: Information discussed directly related to the final decision, including the date of the TDM and participants in attendance. These can be disclosed in court proceedings or used for Case Planning Purposes.
- 6. Encourage direct, respectful discussion, focused on the purpose for the meeting and why all have been gathered.
- 7. Ensure the TDM Action Plan is completed, obtaining each participant's signature. Give a copy to each participant before they leave.
 - The TDM Facilitator shall ensure that all plan options are discussed and that all members understand the plan prior to signing the document.

Case-Carrying CSW Responsibilities

1. Present a summary of the situation discussing risk as well as the outcome of the investigation (disposition of allegations).
 - Be sensitive to the potential reactions of the family and youth when presenting the summary.
2. If DCFS services are identified as needed during the TDM, provide the [Family-Centered Referral and Services](#) form and the Safety/Action Plan to the appropriate service representative.
3. If parent(s) no show(s):
 - If parents are scheduled to participate in a TDM meeting, and do not arrive on time nor call, the TDM Facilitator is to wait a minimum of 15 minutes before beginning the meeting without the parents.
 - If the parents have called and stated they are running late and will be there within 30 minutes of the original time slot, then the other TDM participants are to wait for the parents to arrive before beginning the meeting.
 - If the parent has called and will be delayed longer than 30 minutes from the original time slot and their late arrival will not conflict with previously scheduled TDMs or DCFS staff's other commitments (e.g., scheduled home calls, etc.), the participants will wait for the parent's arrival.
 - If the parents will be over 30 minutes late and this conflicts with previously scheduled TDM's or DCFS staff's other commitments (e.g., scheduled home calls, etc.) then the TDM meeting goes ahead and a placement decision and Safety/Action Plan are made.
 - If a parent arrives after the TDM meeting participants have left, the CSW will review the placement decision and Safety/Action Plan with the parent(s) and document the parent(s) response. The CSW will also document in the Contact Notebook the parents' stated reason for not showing up for the meeting.

After the Team Decision Making (TDM) Meeting

CSW Responsibilities

1. [Update the case plan](#), as needed, to reflect the Safety/Action Plan.
2. Document the TDM contact in the Contact Notebook in CWS/CMS.
 - It is not necessary to include the strengths, concerns and safety/action plan from the TDM meeting in the [documentation](#) as this information is documented by the TDM Facilitator.
3. Incorporate the following elements of the Safety/Action Plan into the Court Report:
 - a. List each issue, the goal and the planned intervention(s) to reach the goal.
 - b. List who will take, what action, when and where.

- c. Complete all Safety/Action Plan tasks assigned to the CSW within the time-frames specified, and monitor follow-through in open cases.
 - d. Ensure all referrals for services are made
4. If the child requires placement or replacement, follow existing procedures for [placing or replacing a child](#).
 - If a decision is reached through the TDM for a change in placement, unless the immediate safety of a youth is at risk, do not move the youth until:
 - A placement suitable to meet the youth's needs has been identified
 - The youth has an opportunity to gather his or her belongings in a humane way and say goodbye to the appropriate people
 - An appropriate school has been arranged (including transportation to the school of origin, as appropriate)
 - Appropriate in-home supports have been arranged
 5. As applicable, follow departmental policy and procedures regarding CSWs' required notification of and [communications](#) with the child's attorney.
 6. File a copy of the Family-Centered Referral and Services, [DCFS 174](#).
 7. Referral and Services form and Safety/Action Plan in the child's TDM folder.
 8. File the "TDM Safety/Action Plan" completed by the TDM Facilitator in the Green TDM within three business days.

SCSW Responsibilities

1. Verify with the CSW, that the Safety/Action Plan developed at the TDM meeting is incorporated into the Case Plan and the Court Report.
2. Ensure that the Safety/Action Plan is attached to the [Family-Centered Referral and Services](#) form and that any services requested are secured.
3. Ensure that the CSW gives the Service Provider(s) all necessary information to provide required services.

TDM Facilitator Responsibilities

1. Enter required TDM data/information into the TDM data base application.
2. Within 10 business days from the TDM meeting, document the TDM meeting (i.e. the participants, strengths, concerns and the Safety/Action Plan) in the CSW/CMS Contact Notebook.
 - If Community Partners are not among the participants, [document](#) your efforts to invite them.

Resources Management Process (RMP) Team Decision Making (TDM) Meetings

ER CSW/Case-carrying CSW Responsibilities

1. Complete the [DCFS 174](#), Family Centered Referral and Services Form.
2. Submit the DCFS 174 to TDM Scheduler.

3. Provide access to the case so the RMP staff or DMH clinician can complete the CANS.
 - If a 7-day Notice/Intent to Discharge is given, the CSW will immediately complete the DCFS 174 and the RMP TDM shall be scheduled within 5 business days, or earlier if a potential placement disruption is anticipated.
4. Once the DCFS 174 is submitted to the TDM Scheduler, follow all other TDM procedures set forth in this policy.
5. If the RMP TDM results in the decision to have the child placed in a group home, with the RMP Designated staff's assistance, fax placements packets to the recommended group home placements.
 - Once the placement is decided, the CSW will follow the existing guidelines in initiating the placement process.
6. [Notify](#) the youth's attorney of the pending replacement.
7. Complete all Safety/Action Plan tasks within the timeframes specified.
8. Update case plan, as needed, to reflect the Safety/Action Plan.
9. Document the TDM in the Contact Notebook in CWS/CMS.

SCSW Responsibilities

1. Review the [DCFS 174](#). If approved, sign the DCFS 174. If not approved, return the DCFS 174 to the CSW for corrective action.
2. Ensure that child is not placed in residential care (excluding emergencies) without going through the RMP TDM.
 - For children that are placed in residential care during a crisis, ensure that a RMP TDM is held within 5 business days of the child's placement.
3. Support the CSW in making timely referrals to the RMP TDM.
4. Attend the RMP TDM.
5. Once the placement decision is made, follow existing procedures for placing or replacing a child.
6. Sign the closure report created by RMP staff to show agreement with results of safety/action plan recommendations and outcomes.

TDM Facilitator/Scheduler Responsibilities

1. Immediately notify the RMP Designated staff and DMH clinician that an RMP TDM has been requested and provide both with a copy of the [DCFS 174](#).
 - The RMP Designated staff and DMH clinician require a minimum of three (3) business days advance notice to complete the CANS and other documents necessary for an RMP TDM.
2. Ensure RMP Designated staff and DMH clinician participation.
3. Inform RMP Designated staff, DMH, and Wraparound Liaisons of the date, time, and location of the meeting within 24 hours of the RMP/TDM being scheduled.
4. Conduct the RMP TDM process.

RMP Designated Staff Responsibilities

1. Within 24 hours, initiate contact with DMH clinician in efforts to collaboratively complete the CANS before the RMP TDM.
2. Prior to the meeting, review the case documentation, discuss the case with the caseworker and/or supervisor, obtain an updated list of resources and complete the CANS, along with the DMH clinician.
3. Use the [DCFS 174](#), Family Centered Referral and Services Form to request the RMP TDM.
4. During the RMP TDM, discuss the findings of the CANS in relation to the youth's need for appropriate services and/or recommended level of placement. If the recommendation is group home placement, present the list of available vacancies in-group homes in the family's community that best meets the needs of the youth.
5. After the RMP TDM, RMP Designated staff will be the lead in following up on DCFS services only.
 - a. Advise your SCSW within 24 hours to assign you as a secondary on youth's case.
6. Follow up with case-carrying CSW to ensure the youth has been placed in the recommended placement.
7. Complete the RMP Exit/Summary Report, up to 2 months after the RMP, and submit to SCSW, stating the safety/action plan linkages were successful.
 - The summary report needs to be signed by CSW, SCSW, RMP Designated staff, RMP SCSW and the DMH clinician.
 - The RMP Designated staff is the lead in completing this form and obtaining the necessary signatures.
8. If the case cannot be closed due to ongoing difficulties, a staffing will be scheduled to resolve the conflict in order for secondary assignment of RMP Designated staff can be end dated.
9. Work with the DMH clinician regarding ongoing quality assurance and outcome tracking after the RMP TDM is completed.

RMP Supervisor Responsibilities

1. Assign RMP Designated staff as secondary on designated case.

DMH Clinician Responsibilities

1. Coordinate with RMP Designated staff to review the case and come up with recommendations for appropriate placement and/or services.
2. Assist RMP Designated staff to complete CANS.
3. Provide clinical expertise during the RMP TDM.
4. Participate in developing the safety/action plan.
5. After the RMP TDM, provide mental health case management support to the CSW by problem solving and finding additional resources, as needed.
6. Provide Clinical Feedback report after 2 months to your DMH supervisor stating the safety/action plan linkages outcomes.

7. Forward the Clinical Feedback report to the RMP Designated staff to incorporate it into the RMP Exit/Summary Report.

DCFS Wraparound Liaison Responsibilities

1. Upon notification of an RMP TDM date, the DCFS Wraparound Liaison will contact the DCFS Wrap Tracker Liaison in the destination Service Planning Area (SPA) and determine if there is a Wraparound/SOC slot available.
 - If there is a slot available, the Tracker Liaison will reserve a DCFS slot for the upcoming RMP.
2. Research the case, and print out copies of the most recent Wrap and the most recent Status Review, a Minute Order from court authorizing treatment, and the Placement History to bring to the RMP.
3. Advise the RMP Designated staff of WRAP/SOC slot availability.
4. Prepare a set of Consent forms and a complete LAW Enrollment Agreement (except for the caregiver and agency signature) for the RMP.
 - If needed, a follow up staffing can be called by anyone attending the original meeting. If there is no follow up meeting needed within 6 months of the original meeting, then a Permanency Planning Conference will be scheduled as a follow up meeting.

Permanency Planning Conferences

CSW Responsibilities

1. Collaborate with SCSW and PPC TDM Facilitator regarding the youth and permanency.
2. Complete the [DCFS 174](#), Family Centered Referral and Services Form and submit to the PPC TDM Facilitator.
3. Ensure that the PPC TDM is scheduled around the youth's availability.
4. Meet with the youth for preparation and identify who the youth wants present at the PPC.
5. Follow all other TDM procedures.
6. Complete all Safety/Action Plan tasks assigned to the CSW within the timeframes specified.
7. Update case plan, as needed, to reflect the Safety/Action Plan.
8. Document the TDM in the Contact Notebook in CWS/CMS.

SCSW Responsibilities

1. Review the [DCFS 174](#). If approved, sign the DCFS 174. If not approved, return the DCFS 174 to the CSW for corrective action.
2. Attend the PPC TDM.

PPC TDM Facilitator Responsibilities

1. Develop a monthly list of youth who meet the criteria within your assigned office.
2. Collaborate with CSW and SCSW regarding youth and permanency.
3. Ensure that the PPC TDM is scheduled around the youth's availability.
 - When possible, the PPC TDM Facilitator will schedule the PPC at the youth's placement.

4. Ensure attendance of additional DCFS staff when appropriate, which may include Adoption and Permanency Resources Division (APRD) staff, Permanency Workers (P3), Education Consultant, service providers, Youth Development Services (YDS) staff, child/youth's therapist, Kinship Support/ASFA, RMP Designated staff (if the PPC may result in a placement move and Wraparound Liaison).
5. Conduct the PPC TDM.
6. Conduct follow-up PPC TDM every 6 months thereafter, until legal permanency for youth has been identified and all barriers have been eliminated.
 - Only under exceptional circumstances (e. g. for children with special health care needs requiring continued placement in Intermediate Care Facility for the Developmentally Delayed and Handicapped (ICFDDH), Intermediate Care Facility for the Developmentally Delayed (ICFDD), Intermediate Care Facility for the Developmentally Delayed with Nursing Care (ICFDDN) and Sub-acute Facilities) that the PPC TDM participants may determine if an exception to the 6 month follow up TDMs may be granted and when the next appropriate follow up PPC TDM shall be held.

Pregnant and Parenting Teen (PPT) Conferences

CSW Responsibilities:

1. Prior to submitting the referral ([DCFS 174](#)), to the PPT Facilitator, the following must be completed:
 - a. CSW has discussed the PPT Conference with the youth and is assured that the youth is in agreement with participating.
 - b. The CSW is open to accepting the family's plan if the plan addresses the Department's concerns and keeps the children safe.
 - c. The CSW has asked the youth to identify individuals she/he wants to participate in the PPT Conference.
2. After the PPT, complete all tasks located on the PPT Plan within the specified timeframes.
3. Update the case plan, as needed, to reflect the Family's Plan.
4. Document the PPT in the Contact Notebook.

SCSW Responsibilities

1. Review the DCFS 174. If approved, sign the [DCFS 174](#). If not approved, return the DCFS 174 to the CSW for corrective action.
2. Attend the PPT.

PPT FGDM Facilitator Responsibilities

1. Contact and coordinate with the Interagency County on Child Abuse & Neglect (ICAN) Resource Specialist.
 - For assistance in determining who is the ICAN Resource Specialist for the office, contact (626) 455-4585.
2. Work with the CSW, ICAN Resource Specialist, and the youth to determine the PPT Conference participants.
 - Potential participants to consider:
 - DCFS – P3 Worker, Educational Consultant, RMP Designated staff, Wrap-around Liaison, PHN, and YDS coordinator, DPSS Linkages
 - Community Supports – DMH Systems Navigator, Therapist, School Representative, child advocate, etc.

- Support Systems: Father, Family members, Non-related extended family members, caregiver, and significant friend (maternal and paternal).
3. Prior to the start of the PPT, ensure that all participants sign the Family Group Decision Making (FGDM) Sign-In Sheet. This form will also include a statement regarding the confidentiality of the meeting.
 4. Complete the notes and plans from the PPT and ensure that each participant receives a hard copy of the PPT Plan.

APPROVALS

SCSW Approval

- DCFS 174; SDM tools
- Safety Action Plan
- DCFS 280, Initial Case Plan/Case Plan Update and Detention Report (as applicable)
- RMP Exit/Summary Report

ARA Approval

- Safety Action Plan, when required
- DCFS 280 and/or Initial Case Plan/Case Plan Update, when required
- RMP Exit/Summary Report

RMP SCSW and DMH Clinician

- RMP Exit/Summary Report

HELPFUL LINKS

Forms

CWS/CMS

DCFS 174, Family Centered Referral and Services Form
 Detention Report
 Jurisdictional/Dispositional Hearing Report
 Status Review Hearing Report

LA Kids

[TDM Safety/Action Plan](#)
[DCFS 174](#), Family Centered Referral and Services Form
[DCFS 280](#), Technical Assistance Action Request
[DCFS 5402](#), Notice to Child's/NMD's Attorney Re: Case Status
[Family Visitation Planning Tool](#)

Hard Copy

Child and Adolescent Needs and Strengths (CANS)

Referenced Policy Guides

[0080-502.10](#), Case Plans

[0100-510.50](#), Placing Children Six Years of Age or Younger in Congregate Care

[0100-510.61](#), Placement Responsibilities

[0300-506.05](#), Communication with Attorneys, County Counsel, and Non-DCFS Staff

[0400-503.10](#), Contact Requirements and Exceptions

[0400-504.00](#), Family Visitation

[0600-515.11](#), Psychiatric Residential Treatment Placements through the Interagency Placement Screening Committee

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APPENDIX 7

Los Angeles PPT Conference TPRS “Box” List

<ul style="list-style-type: none">• Consultation Agreement• Brief Service Agreement• Conference Check List• AB 167/216 Grad Requirements• Before You Go• Birth Control Guide• Birth Control Guide (Spanish)• CalFresh• CalWorks• College Tips• DACA• Developmental Milestones• You and Baby• 0-3• 0-5• DOULA• Education• GED Plus Program Requirements• Get the Truth about Teen Dating and Domestic Violence• Grad Plan• Healthcare & Consent• I Foster• ILP• Legal Issues for Teen Families• My Life My Right	<ul style="list-style-type: none">• NFP• PPT Clinic Referral• Project Fatherhood• Regional Center Basics• Regional Center Referrals• Monitoring Child’s Development (Regional Center)• Sealing Your Juvenile Record• Share Living Agreement Template• Shared Responsibility Plan Instructions• SILP Readiness Assessment• Special Education• Talk to Your Baby• Tap Cards• TILP• Whole Family Foster Home• WIC
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Directory and materials developed by Public Counsel and Alliance for Children’s Rights. For more information on their contents, contact Public Counsel or the Alliance

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APPENDIX 8

Notes and Plans for Pregnant and Parenting Teen Family Group Decision Making Meeting

Case Name:

Case Number: 9999999

Court Case Number: CK####

Teen Mother's Name: Youth

Date of Meeting: 04/22/2013

Location of Meeting: DCFS Belvedere Office
5835 S. Eastern Ave.
Commerce, CA 90040

Facilitator: Hipolito Mendez

Participants: Youth – teen mother
– DCFS Social Worker
– mother
– I-CAN PPT Resource Specialist
– DCFS Supervisor
– Therapist
– St. Anne's Case Manager

Purpose of Meeting: The purpose of this meeting was to identify and discuss Youth's needs in regards to pregnancy, early child rearing, child care, education and baby's needs. The purpose of the meeting was also to provide support and services to foster child safety.

Family Strengths:

- Youth has a healthy pregnancy.
- Youth is participating in Nurse Family Partnership.
- Youth completed parenting classes and continues to participate.
- Youth is cooperative.
- Youth has great interaction and bonding with her son.
- Youth attends to her sons needs before her own.
- Youth communicates positively with staff and peers at St. Annes.
- Youth has already discussed her reproductive health with her doctor.
- Youth is very motivated.

Challenges/ Needs:

- Youth wants to remain in St. Annes.
- Youth needs a double stroller.
- Youth needs child care for baby while she is in the hospital giving birth.

Ideas:

- Youth to consider having a Family Law consultation from LA Center for Law & Justice's Teen LA Program.
- Youth to consider placing her name on the wait list for child care through the Referral and Resource center.
- Youth to consider continued services at the Parenting Teen Clinic at LAC-USC.
- St. Annes to consider providing child care during the day for baby while Youth is in the hospital giving birth.
- SCSW to consider discussing St. Annes contractual responsibility to provide child care for baby while Youth is hospitalized.
- Olive Crest will be explored as an alternative placement through their Safe Families for Children program.
- Youths mother will be considered as a child care provider for baby.

Plan:

1. By 08/09/13, St. Anne's will explore the possibility of providing child care for Baby during the day at the EOC, while Youth is in the hospital.
2. By 8/09/13, DCFS will discuss child care plan of Baby with Youth's mother.
3. By 9/23/2013, Youth will call LA Center For Law & Justice's Teen LA Program at (323) 980-3500 for a free Family Law consultation.
4. By 10/04/2013, Youth will discuss long-term birth control with her doctor at the Parenting Teen Clinic at LAC-USC.

Discussion and General Overview:

Youth has a 9 month old son and is currently 8 months pregnant. Youth reported that the fathers are not involved. Youth stated that the father of her unborn baby is incarcerated. Regarding the father of her unborn baby, Youth reports that she does not having any contact with him. Currently, Youth and her son live at St. Anne's group home. While at St. Anne's Youth receives child care, formula, diapers, bottles and other baby basics. Youth's son is not a dependent of the court and has no open case with DCFS. Youth's next court hearing is on 8/09/2013.

PPT Team discussed Youth's education situation and needs. She attends New Village Charter School but due to attendance issues is not performing well. Her school counselor indicates that when youth attends school, she does stay on task and works well on projects. Youth admitted that her poor attendance is due to her pregnancy. Youth averages about 2 to 3 school absences per week. Youth has discussed independent study as a possibility with her school advisor. This may be further explored while she is on maternity leave.

PPT Team discussed Youth's up coming court hearing and any plans regarding reunification or continued placement at St. Anne's. Youth was very clear that although she hopes to one day live with her family, at this time she feels that remaining at St. Anne's would be best plan for her and her children. Youth stated that she feels that

she needs the structure and the resources available to her at St. Anne's. Youth stated that she does not want to overwhelm her mother. The CSW stated that the recommendation for the next hearing would be to terminate family reunification and that Youth remain placed at St. Anne's.

I-CAN PPT Resource Specialist asked if any of the fathers were or would be named on the birth certificates. Youth denied that Baby's father was on the birth certificate and indicated that she would not name father on the birth certificate at this current pregnancy. I-CAN PPT Resource Specialist informed Youth that if the father's were not on the birth certificate they would not have parental rights over the children. The I-CAN PPT Resource Specialist further informed Youth that if the fathers want parental rights over the children, the fathers would have to file a petition at Family Law court. I-CAN PPT Resource Specialist discussed potential services for family law through the LA Center for Law and Justice. I-CAN PPT Resource Specialist explained that LA Center For Law & Justice's Teen LA Program provides free Family Law consultations and services for teen parents until they are 24 years old. Youth indicated that she would consider contacting the LA Center for Law and Justice.

The PPT Team asked Youth what assistance she needed regarding her child and or her pregnancy. Youth stated that St. Anne's provides her with child care (while at school), formula, diapers, bottles and other baby basics. Youth stated that she needed assistance with a double stroller. Everything else she indicated that either had or will receive from St. Anne's. Although STOP funds was discussed as a potential option, the case carrying SCSW indicated that she would prefer to submit a referral to the Children's Trust Fund. This would allow STOP funds to be available for Youth's mother, potentially for rental assistance.

The PPT Team discussed family planning and Youth's reproductive health. Youth stated that she already discussed this with Dr. Rios from the LAC-USC Parenting Teen Clinic. Youth stated that she plans to use an IUD as her birth control. She indicated that she will further discuss this with her OBGYN at her appointment 6 weeks after the birth of her daughter.

The PPT Team discussed the plan Youth had set up once she is ready to give birth. Youth stated that she has continued to receive prenatal services at the Parenting Teen Clinic at LAC-USC and she plans on delivering at LAC-USC. Youth was concerned with the care of her child Baby while she is hospitalized. Youth stated that St. Anne's will not allow her to leave her son at St. Anne's while in the hospital giving to her daughter. Further because Youth's mother was not reunifying with Youth, she would not be an option to allow Baby to stay with her while Youth is in the hospital. St. Anne's staff indicated that in the past they have relied on residents' family to take care of the children, while they were hospitalized. St. Anne's staff made it clear that it is against their rules to allow the child to stay at St. Anne's while the mother was not at the placement. The case carrying SCSW and the PPT Team discussed why there was not protocol set up for these emergencies. Further, it was discussed that St. Anne's may contractually be responsible to provide child care for the baby while Youth was hospitalized.

The PPT Team continued to discuss the conditions that Youth's mother could be a child care option. The team discussed the possibility of Youth asking one of her friends at St. Anne's to babysit her son while in the hospital. Youth stated that she trusted no one but her mother. Youth stated that she did not want her son to go to foster care. The PPT Team discussed the placement options for Baby. In order to place Baby in a foster home a case would need to be opened for Baby. A referral must be reported and an allegation must be substantiated. Because Youth has not neglected or abused her child the Department was reluctant to go this route. The option of Olivecrest's Safe Families for Children was proposed. This option is available for families that are high risk but do not have an open DCFS case or alternative response services.

The case carrying SCSW indicated that she would discuss the matter with her ARA. She indicated that her ARA was previously assigned to Out of Home Care and is very knowledgeable regarding placement contracts. She indicated that he may be able to verify what child care option, regarding the baby and St. Anne's responsibility to provide child care while Youth is hospitalized. The plan for the baby was to examine what resources St. Anne's could provide to assist with child care, such as providing day care during the day. Additionally, Youth's mother would also be considered as a child care option if St. Anne's provides child care assistance during the day. Also Olivecrest will be explored as an option for Baby through their Safe Families for Children program.

Finally, on further review of the legal file the case carrying SCSW indicated that Youth's mother would be a child care option for Baby. She indicated that although Youth was not reunifying with the mother, it was not due to Youth's mother's non-compliance with court ordered services, it was due to Youth decision to remain placed at St. Anne's. Youth's mother has unmonitored visits with Youth and the baby is not a dependent so there were no visitation orders in place for Youth's mother and the baby. The plan for the baby's care during Youth's hospitalization will be to allow Youth's mother to babysit the baby at night and St. Anne's EOC will provide child care during the day. St. Anne's staff indicated that they still needed approval from their director. The case carrying SCSW stated that if St. Anne's is unable to provide child care, Youth's mother would be allowed to provide child care for Baby while Youth was hospitalized.

On April 22nd, 2014 PPT Conference Facilitator provided (via e-mail) PPT Team with PPT service providers inclusive of home visitation programs: (list of providers inserted here)

Report Completed by: Hipolito Mendez
Date Report Completed: April 22nd, 2013

APPENDIX 9

Teen Parent Resource Specialist (TPRS): Job Description

Qualifications:

- Knowledge of issues and challenges that pregnant and parenting teens often face.
- Knowledge of current resources available in community to address common challenges.
- Maintains current connections with resources and organizations available in community to support pregnant and parenting teens.
- Understands how culture and race can impact access to services, opportunities, and family and parenting choices.
- Aware of and responsive to the influence of family, community and religious beliefs, cultural norms, language and communication styles, and intergenerational patterns on young parents.
- Understands impact of trauma, and uses a trauma-informed lens in all interactions with the teen, and helps others in the teen's support system to do the same.

Job Duties:

- Together with PPT conference facilitator and case worker, helps teens prepare for conference. Works with youth to identify possible participants to invite, review possible topics to develop priorities and goals to develop agenda, and identify resources and professionals who may be able to support youth.
- Once agenda is developed, finds resources that may be necessary or helpful before the conference.
- Participates in conference and brings knowledge of issues and resources to discussion.
- Follows up on action steps from PPT conference to ensure that participants are following through in a timely manner.
- Helps connect teen with alternative resources or referrals when needed.
- Helps teens advocate for themselves.

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APPENDIX 10

PPT Facilitator: Job Description

Qualifications:

- Trained in strengths-based case management.
- Understanding of challenges faced by pregnant and parenting teens.
- Knowledge of resources available in community for pregnant and parenting teens.

Job Duties in Los Angeles:¹

- Contacts and coordinates with the Inter-Agency Council on Child Abuse & Neglect (ICAN) Resource Specialist.
- Work with the CSW, ICAN Resource Specialist, Teen Parent Resource Specialist and the youth to determine the PPT conference participants.
- Prior to the start of the conference, ensures that all participants sign the Family Group Decision Making (FGDM) Sign-In Sheet. This form will also include a statement regarding the confidentiality of the meeting.
- Models respectful interaction with the family, staff and other participants, creating an inclusive meeting environment.
- Reviews the DCFS 174 prior to the conference, and invites appropriate community partners.
- Manages the PPT conference meeting, and supports DCFS' best practices and procedures ensuring that:
 - Adequate translation services are provided to all participants.
 - Youth and family have a clear understanding of the services being offered and choices being made prior to agreeing to and signing the plan.
 - Family history is presented in a manner that is sensitive to the feelings and potential reactions of participants, particularly to avoid unnecessary shame on the part of the youth and/or family.
 - Conversation is focused on issues relevant to the meeting and in keeping with the strength-based framework.
 - All options available to the youth and/or family are presented in a non-biased manner.
- Ensures that everyone is heard and that “professionals” use language everyone understands (e.g. avoiding the use of acronyms).

(Continued over)

1 Job Duties excerpted from Los Angeles DCFS Policy 0070-548.03 | Revision Date: 07/01/14, available at http://policy.dcfs.lacounty.gov/Content/Family_Centered_Conferen.htm#PPT

- Develops a consensus among the participants by: finding common ground amid diverse interests and opinions, focusing on family strengths, negotiating services, and developing Action Plans to support teen in healthy pregnancy and parenting.
- Records meeting information and decisions on the Action Plan, obtains each participant's signature, and gives a copy to each participant before they leave, making sure everyone has a clear understanding of the Action Steps (including responsible parties and target dates).
- Collects and enters PPT conference data/information into the database application.
- Documents the PPT conference meeting (i.e. the participants, strengths, concerns and the Action Plan) in CSW/CMS Contact Notebook.
- Complete the notes and plans from the conference and ensures that each participant receives a hard copy.

APPENDIX I I

Defining Cultural Competency¹

The Child Welfare League of America defines cultural competency as "the ability of individuals and systems to respond respectfully and effectively to people of all cultures, classes, races, ethnic backgrounds, sexual orientations, and faiths or religions in a manner that recognizes, affirms, and values the worth of individuals, families, tribes, and communities, and protects and preserves the dignity of each" (Child Welfare League of America, 2001, Cultural Competence Defined). A definition of cultural competency in public child welfare should also consider age, especially concerning youth transitioning out of the child welfare system. A context of cultural competency means a commitment to re-evaluate the exclusive, adult-centered culture of child welfare agencies at minimum and an active agenda for empowerment and inclusion of youth at best (National Child Welfare Resource Centers, 2007).

Cultural and linguistic competence suggests more than just language proficiency, but a commitment to incorporate the cultural knowledge into policy and practice. Language is a crucial aspect of culture and a primary vehicle for transmitting knowledge, beliefs, attitudes, and social expectations. Consequently, social service systems committed to cultural competency should consider linguistic and literacy issues in developing a comprehensive strategy. The National Center for Cultural Competence (n.d.) explains that to become culturally competent, organizations must have:

A defined set of values and principles and demonstrate behaviors, attitudes, policies, and structures that enable them to work effectively cross-culturally;

The capacity to value diversity, conduct self-assessment, manage the dynamics of differences, acquire and institutionalize cultural knowledge, and adapt to diversity and the cultural contexts of the communities they serve; and

Incorporate the above in all aspects of policy-making, administration, practice, and service delivery, and systematically involve consumers, key stakeholders, and communities.

Cultural competence is a developmental process that evolves over time rather than being a static, one-time achievement (Cross, Bazron, Dennis, & Isaacs, 1989; McPhatter, 1997). Cross et al. described the process of becoming culturally competent as a continuum ranging from cultural destructiveness, cultural incapacity, cultural blindness to the ultimate goal of cultural proficiency.¹ This cultural competence continuum takes into account the continuous organizational changes in child welfare agencies, as well as contextual changes affecting the communities served by child welfare systems, making cultural proficiency a desired goal in an effort to improve outcomes. Though knowledge about and research on cultural and linguistic competency are expanding and calls for change are increasing, considerable variability remains in system responses to effectively serving culturally and ethnically diverse populations (McPhatter & Ganaway, 2003).

"Cultural competency means being aware of your own cultural beliefs and values and how these may be different from other cultures—including being able to learn about and honor the different cultures of those you work with."

-Agency Staff Member

¹ For more information, see the Cultural Competence Continuum ([Word](#) - 73 KB) by the National Center for Cultural Competence. [back](#)

¹ U.S. Dept. of Health and Human Services, Child Welfare Information Gateway, "Defining Cultural Competency," <https://www.childwelfare.gov/pubs/acloserlook/culturalcompetency/culturalcompetency2/>

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APPENDIX 12

National Child Traumatic Stress Network, “Complex Trauma”
available at <http://www.nctsn.org/trauma-types/complex-trauma/resources>

General Information on Complex Trauma

Many children with complex trauma histories suffer a variety of traumatic events, such as physical and sexual abuse, witnessing domestic and community violence, separation from family members, and revictimization by others. Complex trauma can have devastating effects on a child’s physiology, emotions, ability to think, learn, and concentrate, impulse control, self-image, and relationships with others. Across the life span, complex trauma is linked to a wide range of problems, including addiction, chronic physical conditions, depression and anxiety, self-harming behaviors, and other psychiatric disorders.

Beyond the consequences for the child and family, these problems carry high costs for society. For example, a child who cannot learn may grow up to be an adult who cannot hold a job. A child with chronic physical problems may grow up to be a chronically ill adult. A child who grows up learning to hate herself may become an adult with an eating disorder or substance addiction.

Children whose families and homes do not provide consistent safety, comfort, and protection may develop ways of coping that allow them to survive and function day-to-day. For instance, they may be overly sensitive to the moods of others, always watching to figure out what the adults around them are feeling and how they will behave. They may withhold their own emotions from others, never letting them see when they are afraid, sad, or angry. These kinds of learned adaptations make sense when physical and/or emotional threats are ever-present. As a child grows up and encounters situations and relationships that are safe, these adaptations are no longer helpful, and may in fact be counterproductive and interfere with the capacity to live, love, and be loved.

Complex Trauma Resources¹

Complex Trauma Fact Sheets

Complex Trauma: Facts for Service Providers Working with Homeless Youth and Young Adults (2014) (PDF)

Offers information on how to support teens and young adults who are homeless and may have experienced multiple traumas.

Complex Trauma: Facts for Shelter Staff Working with Homeless Children and Families (2014) (PDF)

Guides shelter staff in how best to support the homeless children and families with whom they work.

Complex Trauma: Facts for Caregivers (2014) (PDF)

Helps parents and caregivers recognize the signs and symptoms of complex trauma and offers recommendations on how to help children heal.

Complex Trauma: Facts for Educators (2014) (PDF)

Explains the ways complex trauma may affect learning and offers recommendations for educators to support students and take care of themselves.

Additional Resources

Complex Trauma Speaker Series

Featuring experts from the NCTSN, this series includes presentations on the neurobiology of complex trauma, assessment and treatment planning, and a wide range of evidence-based interventions. All presentations are available for free through the NCTSN Learning Center for Child and Adolescent Trauma, and continuing education credits are available.

¹ Excerpted from National Child Traumatic Stress Network, at, <http://www.nctsn.org/trauma-types/complex-trauma/resources>

Polyvictimization and Complex Trauma: Understanding Special Populations, Enhancing Multidisciplinary

LEARN

Responses to Polyvictimization

This webinar series, a collaborative effort between the OVC National Action Partnership on Polyvictimization and the NCTSN Complex Trauma Workgroup and Complex Trauma Treatment Network, focuses on complex trauma and polyvictimization as they affect a wide range of populations and offers useful tools to a broad range of professionals, including educators, mental health workers, law enforcement, judicial personnel, and child welfare workers.

ORDER

Complex Trauma in Children and Adolescents (2003) (PDF)

The original white paper on this topic developed by the NCTSN Complex Trauma Task Force.

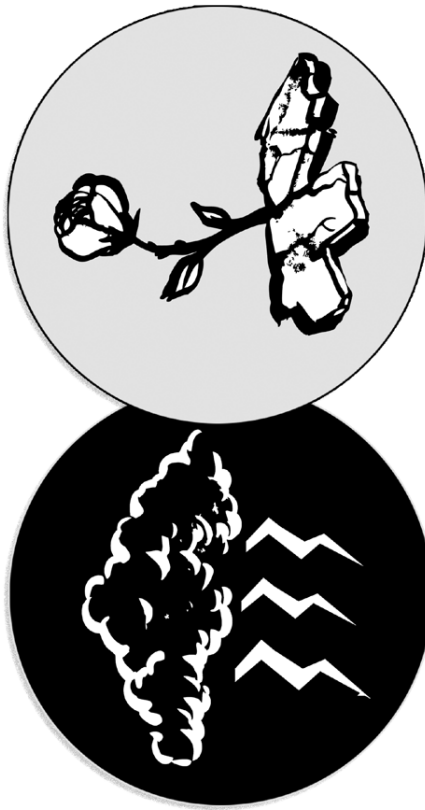
Complex Trauma in Children and Adolescents (2007) (PDF)

This article appeared in the winter 2007 issue of the journal Focal Point. It is an adaptation and update of the Network white paper listed above. Click here to access the article. Focal Point is a publication of the Research and Training Center on Family Support and Children's Mental Health.

Complex Trauma in the NCTSN (PDF)

Results of an NCTSN survey on complex trauma exposure, outcomes, and treatment approaches for impacted children and their families who received intervention and/or comprehensive assessment services in 2002.

TRAUMA & RESILIENCE



AN ADOLESCENT PROVIDER TOOLKIT

ADOLESCENT HEALTH WORKING GROUP



THE ADOLESCENT HEALTH WORKING GROUP (AHWG)

History: The AHWG was formed in 1996 by a group of adolescent health providers and advocates concerned about the lack of age-appropriate health services for young people in the city of San Francisco.

Vision: All youth have unimpeded access to high quality, culturally competent, youth friendly health services.

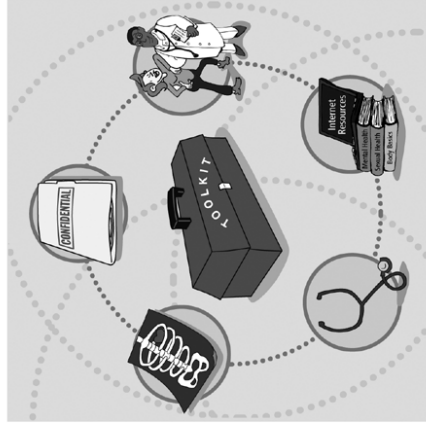
Mission: Support and strengthen the network of providers working to improve adolescent health.

Core Functions:

- 1) Develop tools and trainings that increase providers' capacity to effectively serve youth/young adults.
- 2) Advocate for policies that increase access to care and utilization of youth/young adult services.
- 3) Convene stakeholders and coordinate linkages across systems to improve information sharing, networking, and referrals for youth/young adult services.

Fiscal Sponsor: The AHWG is a project of the Tides Center.

Additional Info: www.ahwg.net



THE AHWG ADOLESCENT PROVIDER TOOLKIT SERIES

The toolkit consists of five modules:

1. Adolescent Health 101 (2003)
2. Body Basics (2004)
3. Understanding Minor Consent and Confidentiality in CA (2003, 2010)
4. Behavioral Health (2007)
5. Sexual Health (2010)
6. Trauma & Resilience (2013)

Designed for busy providers, each module addresses a complexity of issues through accessible, user-friendly resources including screening and assessment tools, evidence based best practices and promising approaches, and health education handouts for youth/young adults and parents/caregivers. The toolkit series, developed locally, has been distributed and utilized by providers nation wide. Accompanying training has also been developed and delivered locally and regionally to health plans, community clinics, and educators.

For more information on AHWG resources, training, and events, please visit:

www.ahwg.net



TRAUMA & RESILIENCE

Trauma & Resilience, the sixth module of the AHWG Adolescent Provider Toolkit Series, was created in response to a continued demand among providers for resources focused on the intersections of health and violence.

The Trauma & Resilience toolkit module is designed to:

1) Encourage paradigm shifts from:

- Trauma to resilience
- Deficits to assets
- Oppression to empowerment
- Individuals to systems

2) Increase communication and collaboration among different service sectors and systems of care including: health, education, juvenile justice, workforce development, human services, housing, and youth/young adult development programs.

The Trauma & Resilience toolkit module is designed for:

- All levels of youth/young adult service providers, from front line staff, to clinicians, to administrators.

Youth Handouts

- Handouts specifically designed for youth/young adults are starred and underlined in the Table of Contents.
- Youth handouts may also be useful with parents/caregivers and community members, as deemed appropriate by providers, and in conjunction with supportive services.
- Youth handouts are intended to enhance communication, education, and support for youth/young adults, parents/caregivers, and community members, NOT replace it.

Capacity Building

The AHWG recognizes that this work is dependent on the involvement of providers, youth/young adults, and parents/caregivers across all sectors and systems. As a result, the AHWG will continue to focus its efforts on capacity building among health providers to meet the unique needs of youth and young adults, in addition to assisting with the development of supports for providers across other sectors and systems. Please contact the AHWG to inquire about possible collaboration opportunities. Current contact info can be accessed at www.ahwg.net

Suggested Citation

St. Andrews, Alicia (2013). Trauma & Resilience: An Adolescent Provider Toolkit. San Francisco, CA: Adolescent Health Working Group, San Francisco.

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ACKNOWLEDGEMENTS

The Adolescent Health Working Group would like to thank the following organizations and individuals for their generous contributions of time, energy, expertise, and financial support. This work could not have been completed without you!

PARTICIPATING ORGANIZATIONS

- ACEs Too High/ACEs Connection
- Applied Mindfulness
- Center for Youth Wellness
- Community Response Network
- Edgewood Center for Children and Families
- Global Resiliency Outreach Work
- Hollywood Homeless Youth Partnership
- Institute for Safe Families
- Instituto Familiar de la Raza
- Peace For Tarpon, Tarpon Springs Florida
- Resilience Trumps ACEs, Children's Resilience Initiative
- Richmond Area Multi-Services
- San Francisco Department of Children, Youth, and Their Families, Violence Prevention and Intervention Unit
- San Francisco Department of Public Health: Adult Systems of Care; Child and Adolescent Sexual Abuse Resource Center; Child, Youth, and Family System of Care; Community Behavioral Health Services; Community Health Programs for Youth; Crisis Response Services; Environmental Health; Public Safety; Transitional Age Youth
- TAY Research, Advocacy, Policy, & Practice
- Transitional Age Youth San Francisco
- University of California San Francisco: Community Partnership Resource Center; Division of Adolescent and Young Adult Medicine; Family and Community Medicine Residency Program's Community Oriented Primary Care; UCSF Healthy Environment and Response to Trauma in Schools (HEARTS), Child and Adolescent Services; Wrap Around Project, Department of Surgery
- Youth Justice Institute

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Adolescent Provider Toolkit

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FINANCIAL SUPPORTERS/FISCAL SPONSOR

San Francisco Department of Public Health
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Tides Center

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Special thanks goes to the following individuals for their critical and unwavering encouragement, guidance, contributions, and support:

Joyce Dorado, UCSF Healthy Environment and Response to Trauma in Schools (HEARTS), University of California San Francisco
Gena Castro-Rodriguez, Youth Justice Institute
Susana Osorno-Crandall, Center For Youth Wellness
Marlo Simmons, Mental Health Services Act, Community Behavioral Health Services, San Francisco Department of Public Health

Dedicated to:

Jeff & Lyla St. Andrews

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▲ **FOR YOUTH:** Youth handouts specifically designed for youth/young adults are starred and underlined. Youth handouts may also be useful with parents/caregivers and community members, as deemed appropriate by providers, and in conjunction with supportive services. Youth handouts are intended to enhance communication, education, and support for youth/young adults, parents/caregivers, and community members, NOT replace it.

This is an excerpt from a longer document. For the complete document, go to *Trauma & Resilience: An Adolescent Provider Toolkit*, Adolescent Health Working Group: San Francisco, available at: <https://rodriguezgsarah.files.wordpress.com/2013/05/traumaresbooklet-web.pdf>

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APPENDIX I4

What are the services and resources in your county available to teen parents in foster care in the following areas?

1. Pregnancy, Birth and Postpartum Related Services
 - a. Family planning and sexual health services
 - b. Prenatal care
 - c. Planning for childbirth (labor, delivery and postpartum)
 - d. Breastfeeding support
 - e. Medical home visiting programs, such as Nurse Family Partnership
2. Parenting Supports
 - a. Infant care classes
 - b. Parenting programs
 - c. Mentoring
 - d. Young father programs
 - e. Adolescent family life programs
3. Health, Counseling and Mental Health Providers
 - a. Counseling
 - b. Domestic violence and assault
 - c. AOD
 - d. Pediatrics and general medicine
4. Education
 - a. CalSAFE
 - b. Local district teen parent schools
 - c. Local schools affiliated with group homes
 - d. AFLP (CalLearn)
 - e. Childcare
 - f. Tutoring
 - g. GED programs
 - h. Special education
5. Free or Low-Cost Legal Services
 - a. Immigration
 - b. Family law, including child support, child custody, paternity and guardianship
 - c. Violence, including restraining orders
 - d. Criminal
 - e. Tickets
 - f. Consumer

(Continued over)

6. Transitional Living

- a. Housing
- b. Job training
- c. Computer
- d. Transportation
- e. TILP

7. Benefits

- a. Foster care funding, including the infant supplement
- b. Public benefits, including WIC, CalFresh, MediCal and other health coverage
- c. Infant and baby supplies (diapers, cribs, carseats, etc.)

APPENDIX 15

Tips for Maximizing a Young Person's Participation in Conferences¹

- Listen to the young parent. Make sure that her voice is central and that she is treated respectfully as a full participant in the conference
- Respect the young parent's right to confidentiality, privacy and familial decision making. Discuss only relevant information during conferences.
- Ask the young person who she wants to invite. Is there a former resource parent? A friend or family member? A boyfriend? Is there a therapist, teacher, or other service provider who may provide feedback and input about the young person's needs and the availability of appropriate services?
- Is there a resource who can temporarily provide babysitting or respite for the young parent while she attends the conference?
- Help her to reach her supports to notify them of the time and location of the conference and confirm whether or not they can attend.
- Are there community based service providers who would be willing to come to the meeting and meet the young person face-to-face for the purpose of planning additional support that the young person may need?
- Notify the lawyers for the youth of any upcoming conferences as soon as a conference is scheduled.
- Discuss with the young person whether to include the expecting or parenting youth's parents.
- Efforts should be made to include the father and paternal relatives when possible.

¹ Adapted from "Tips for Maximizing a Young Person's Participation in Conferences" in Fordham Interdisciplinary Parent Representation Project's "Guide to Working with Young Parents in Out of Home Care," NYC Administration for Children's Services, at 8.

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APPENDIX 16

An Individualized, Strengths-Based Approach in Public Child Welfare Driven Systems of Care

Author(s): National Technical Assistance and Evaluation Center for Systems of Care.
Year Published: 2008

Defining an Individualized, Strengths-Based Approach

An individualized, strengths-based approach refers to policies, practice methods, and strategies that identify and draw upon the strengths of children, families, and communities. Strengths-based practice involves a shift from a deficit approach, which emphasizes problems and pathology, to a positive partnership with the family. The approach acknowledges each child and family's unique set of strengths and challenges, and engages the family as a partner in developing and implementing the service plan. Formal and informal services and supports are used to create service plans based on specific needs and strengths, rather than fitting families into pre-existing service plans. An individualized, strengths-based assessment focuses on the complex interplay of risks and strengths among individual family members, the family as a unit, and the broader neighborhood and environment. The individualized, strengths-based approach is an overall philosophical view supported by policies and standards that encompasses a range of concrete practices of child welfare caseworkers and other service providers at various points from the time the child and family enter the system to when they leave (see Figure 1).

Historically, child welfare systems (and other human services) emphasized efficient provision of services with little attention to family systems and approached clients from a deficit model. Traditional practices, focusing on what was wrong with the child or the family, resulted in a child welfare system that was punitive and stigmatizing in its approach and often produced passive and resistant responses from clients (Waldfoegel, 2000). Beginning in the early 1980s, strengths-based case management was first implemented in community mental health centers (Brun & Rapp, 2001) and since then has been implemented in many other health and social service settings.

A review of the literature suggests at least three pathways by which strengths-based practices benefit clients: 1) by influencing the extent of clients' engagement in program services; 2) by increasing family efficacy and empowerment; and 3) by enhancing families' relationship-building capacity and social support networks (Green, McAllister, & Tarte, 2004).

Although there is limited research on the effects of an individualized, strengths-based approach on child and family outcomes for the population of child welfare clients, prior studies of other service recipients (e.g., early intervention, mental health, elderly services) have found that a family-centered, strengths-based approach is associated with increased service engagement (Green et al., 2004; Shireman, 1998), increased parenting competency (Green et al., 2004; Whitley, 1999), and enhanced interaction among family members (Green et al., 2004; Huebner, Jones, Miller, Custer, & Critchfield, 2006).

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APPENDIX 17

PPT Conference Preparation: Preparing an Agenda and Goals

The youth, in consultation with PPT Facilitator and TPRS, should consider whether any of the following issues or areas should be addressed during the youth's PPT conference:

Self-Sufficiency	
	High school graduation/GED completion
	Post-secondary education
	Vocational training
	Employment at livable wage
	Transition to independent living
	Housing
	Financial literacy
Health	
	Prenatal care
	Support network during pregnancy
	Healthy birth/Birth plan
	Breastfeeding support
	Reduce STIs/HIV
	Subsequent pregnancy prevention (should be discussed with all participants)
	Counseling, including developing healthy relationships with partner, peers and family
	Domestic violence and assault
	Pediatrics and general medicine
Successful and Engaged Parenting and Attachment	
	Develop engaged parenting skills to increase appropriate discipline, nurturing behavior, and children who are well cared for
	Infant care classes
	Parenting programs for parenting skills
	Mentoring, including young father programs
	Adolescent family life programs

(Continued over)

Healthy Relationships	
	Increase healthy relationships between partners, peers and family
Benefits	
	Medical insurance
	Foster care funding, including infant supplement
	Infant and baby supplies (diapers, cribs, car seats, etc.)
Legal Services Needs	
	Immigration
	Family law
	Domestic violence
	Consumer
	Criminal

The Health Teen Network's Behavior-Determinant-Intervention (BDI) Logic Model for Working with Young Families may be used to identify interventions to reach goals.

The model is available at
http://www.healthyteennetwork.org/sites/default/files/BDI_Logic_Model.PDF

APPENDIX 18

Making a Difference . . .

Healthy Teen Network



A BDI Logic Model for Working with Young Families Resource Kit

leadership,
education,
training, resources,
advocacy,
information and
support



Healthy Teen Network

MAKING A DIFFERENCE IN THE LIVES
OF TEENS AND YOUNG FAMILIES

A BDI Logic Model for Working with Young Families Resource Kit

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ABOUT HEALTHY TEEN NETWORK

Healthy Teen Network (HTN) is a national membership organization that provides resources and services to professionals working in the field of adolescent reproductive health—specifically teen pregnancy prevention, teen pregnancy, and teen parenting. Healthy Teen Network believes youth can make responsible decisions about sexuality, pregnancy, and parenting when they have complete and accurate information, resources, and support that are culturally relevant and appropriate to their age, gender, and developmental stage.

ACKNOWLEDGEMENTS

We would like to extend our most heartfelt thanks and appreciation to the professionals who helped to develop this logic model. Healthy Teen Network staff members Mary Martha Wilson, Janet Max, and Gina Desiderio formed an advisory committee with Healthy Teen Network members Marilyn Colby-Rivkin, Minnesota Organization on Adolescent Pregnancy, Prevention, and Parenting (MOAPPP), Sue Cupito, YWCA of Greensboro, North Carolina; Kathy Putnam, Adolescent Pregnancy Prevention Coalition of North Carolina (APPCNC); and Wanda Spann-Roddy, Health and Hospital Corporation of Marion County, Indiana. Additionally, Healthy Teen Network put out a call to the field to solicit logic models. We could not have developed this logic model without the expertise and support of these direct service providers and experienced professionals.

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www.HealthyTeenNetwork.org

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A BDI Logic Model for Working with Young Families Resource Kit

BACKGROUND INFORMATION

In response to a need voiced by professionals working with young families, Healthy Teen Network designed a Behavior-Determinant-Intervention (BDI) Logic Model for Working with Young Families in collaboration with various professionals in the field.

To develop this logic model, Healthy Teen Network formed an advisory committee of experienced professionals working in the field of young families. In preparation, the advisory committee reviewed relevant research, including

- Outcome research conducted by the Center for Assessment and Policy Development¹
- Risk and protective factor research conducted by Douglas Kirby and Gina Lepore²
- Parent-child connectedness research BDI Logic Model developed by Steve Bean and Lori Roller³
- Program evaluation research conducted by Lorraine Klerman⁴
- Supportive housing research conducted by Janet Max and Pat Paluzzi^{5, 6}

By reviewing the relevant research, examining various logic models collected from the field, and meeting with the advisory committee, Healthy Teen Network developed a BDI Logic Model for Working with Young Families. The first version of this logic model was presented in a workshop at the Healthy Teen Network annual conference in Baltimore, Maryland in November, 2007. Workshop participants reviewed the logic model and, over the course of the next nine months, submitted suggestions for revising the logic model via a survey, resulting in a second version of the logic model (below).

It should be noted that this logic model is a general example of a BDI Logic Model that includes a comprehensive range of outcomes for working with young families. Not all programs working with young families will be as comprehensive; a focused-approach on selected outcomes may prove to be more effective and efficient given available resources as well as other services offered in the community. Also, this logic model is not meant to be an exhaustive list of all the determinants and relevant intervention activities; rather this logic model identifies what our committee has identified as the most relevant determinants and intervention activities.

Furthermore, while using a logic model is indeed a science-based approach (defined below), it cannot be affirmed that the intervention activities listed here are proven to be effective. Again, the primary prevention field is further along than the young families field in the rigorous evaluation of programs. Thus, at this time, we cannot provide a list of relevant science-based (or evidence-based) programs for working with young families. However, it is Healthy Teen Network's hope that the development of this BDI Logic Model provides professionals with another tool to aid them in the provision of services, as well as in the continued improvement and evaluation of these services.

RESOURCES

Healthy Teen Network
www.healthyteennetwork.org

Center for Assessment and
Policy Development
www.capd.org

Chapin Hall Center for Children
at the University of Chicago
www.chapinhall.org/

Children's Law Center of Los
Angeles
www.clcla.org/facts_teens.htm

Child Welfare League of
America
[http://www.cwla.org/programs/fo
stercare/sexualityfcyouth.htm](http://www.cwla.org/programs/fo
stercare/sexualityfcyouth.htm)

ETR Associates
www.etr.org/recapp

National Campaign to Prevent
Teen and Unplanned
Pregnancy
www.thenationalcampaign.org

National Resource Center for
Family-Centered Practice and
Permanency Planning,
[www.hunter.cuny.edu/socwork/
nrcfcpp/info_services/pregnant-
and-parenting-teens.html](http://www.hunter.cuny.edu/socwork/
nrcfcpp/info_services/pregnant-
and-parenting-teens.html)

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www.HealthyTeenNetwork.org

GOALS FOR WORKING WITH YOUNG FAMILIES

When working in the primary prevention field, the program goal is more straightforward—the sole focus of the program is usually to reduce teen pregnancy, STIs, and/or HIV. However, when working with young families, while one of many goals is usually preventing (or delaying) subsequent pregnancies and reducing STIs/HIV, this is usually or often times not the sole focus of the program.



Based on research from the Center for Assessment and Policy Development, a comprehensive program for young families would incorporate the following goals:

- Self-Sufficiency Outcomes for Young Mothers and Fathers
 - Increase high school graduation/GED completion
 - Increase completion of post-secondary education, vocational training, and/or employment at a livable wage
 - Increase self reliance and transition to independent living
 - Reduce/delay subsequent pregnancies
 - Reduce STIs/HIV
- Developmental Outcomes for Children of Young Mothers and Fathers
 - Increase healthy births
 - Increase age-appropriate physical, emotional, cognitive, and social development (and readiness for school success)
 - Increase appropriate discipline, nurturing behavior, and children who are well cared for
- Outcomes for Young Families
 - Increase healthy relationships between partner(s), peers, and family

Clearly, this list of goals extends far beyond the prevention of pregnancy, STIs, and HIV/AIDS; consequently, young families programs often have a wider focus of than primary prevention programs.

ABOUT SCIENCE-BASED APPROACHES

In 2002, CDC's Division of Reproductive Health (DRH) funded the national project, Promoting Science-Based Approaches in teen pregnancy, HIV and STI prevention with the goal to decrease teen pregnancy, STI, and HIV rates by increasing the use of research-proven practices and programs, or what we call "science-based approaches." As part of this project, national and state grantees worked together for over a year with CDC DRH staff to identify important science-based approaches (or practices) that should be integrated into the work of adolescent reproductive health practitioners. After reviewing adolescent pregnancy, HIV, and STI programs and initiatives that demonstrated effectiveness, the group identified the following science-based approaches that would become the focus of our project:

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www.HealthyTeenNetwork.org

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A BDI Logic Model for Working with Young Families Resource Kit

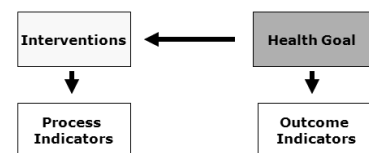
SCIENCE-BASED APPROACHES

1. *ASSESS* the priority population using social science research
2. Use health education & behavior *THEORY* to design intervention activities
3. Use *LOGIC MODELS* to design intervention activities, especially the Behavior-Determinant-Intervention (BDI) Logic Model
4. Use what works best: *SCIENCE-BASED PROGRAMS* and *PROMISING PROGRAMS*
5. Make strategic *ADAPTATIONS* to science-based programs
6. Conduct process & outcome *EVALUATION*

These science-based approaches are not exclusive to primary pregnancy, STI, or HIV prevention—they are methodical, strategic, and purposeful ways to plan for effective programs. The BDI Logic Model was originally designed for the primary prevention field; it was a clear progression to develop a BDI Logic Model for Working with Young Families.

ABOUT THE BDI LOGIC MODEL

Program developers use logic models to strategically, purposefully, and scientifically identify the causal pathways between goals and interventions. Logic models also point to the outcome and process indicators to be measured and evaluated.



Although there are many examples of program logic models, the Behavior-Determinant-Intervention (BDI) Logic Model was designed specifically for the adolescent reproductive health field by Douglas Kirby, PhD. There are many easily accessible resources available to learn more about how to use the BDI Logic Model, including a free online course available through ETR Associates.

A thorough needs and resource assessment guides the process of creating a BDI Logic Model—which is also a science-based approach. Uniquely, the BDI Logic Model focuses first on the goal or intended outcomes, in order to make sure that the intervention activities are strategically and purposefully designed to reach the goal or outcomes. Second, the BDI Logic Model focuses on the sexual risk-taking behavior(s) of the individual—something practitioners can influence within the context of programs. The third focus is on determinants, or risk and protective factors, that influence decisions and choices about sexual risk-taking behaviors. Lastly, the BDI Logic Model focuses on the specific intervention strategy, or set of intervention activities, that impact selected determinants that influence behaviors. It may seem counter-intuitive to create a logic model starting with the

4 STEPS TO COMPLETE A BDI LOGIC MODEL

1. **Step One:** Establish a *GOAL*.
2. **Step Two:** Identify and select important *BEHAVIORS* that need to be changed.
3. **Step Three:** Identify and select *DETERMINANTS* of each of the behaviors selected.
4. **Step Four:** Design *INTERVENTION* activities to change each of the selected determinants.

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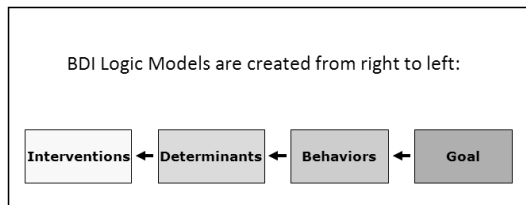
If you use material from Healthy Teen Network, the following acknowledgement must be included:
Grateful acknowledgement is made to Healthy Teen Network for the use of the following materials: [insert here].

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www.HealthyTeenNetwork.org

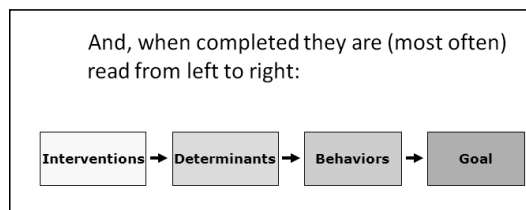
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A BDI Logic Model for Working with Young Families Resource Kit

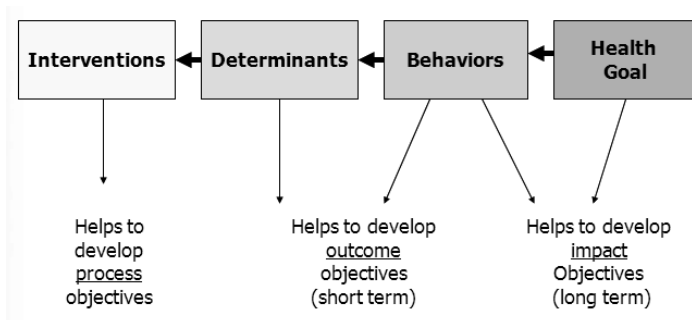
goal; often times, we are much more familiar with the intervention activities. However, BDI Logic Models are created from right to left in order to be more strategic and purposeful in designing or selecting an intervention that will be effective at reaching the program goal.



Once completed, BDI Logic Models may be read from left to right, if the desired focus is the intervention.



In a BDI Logic Model, the evaluation plan is set up because the goal and behaviors help to develop impact objectives. Impact objectives are long-term—greater than one year—changes in the program participants. The behaviors and determinants help to develop outcome objectives. Outcome objectives are short-term—less than one year—changes in the program participants. The interventions help to develop process objectives. Process objectives measure how the program was implemented and general participant satisfaction (such as number of staff trainings, number of youth attending program, number of materials distributed, etc.).



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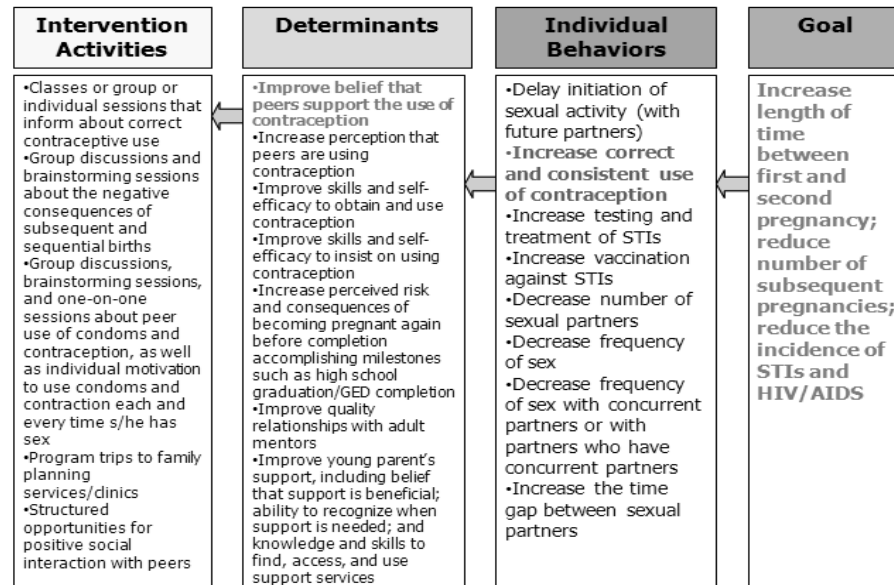
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A BDI Logic Model for Working with Young Families Resource Kit

A sample thread of a BDI Logic Model:



POTENTIAL USES FOR THE FIELD

Healthy Teen Network anticipates that this logic model may serve as an example for professionals providing services for young families. Logic models have two main purposes:

1. Based on assessment data, logic models may be used as a program planning, designing, and/or selection tool to identify the program goal, priority population, key behaviors, key determinants, and the range of intervention activities.
2. Logic models point to the program impact, outcome, and process objectives, thus setting up the program's evaluation plan.

Professionals working with young families may choose to use this sample logic model to guide in the program planning, design, and/or selection of services for young families. This logic model may be used as the foundation for a program and then modified based on that program's priority population, behaviors, determinants, and intervention activities. Modifying this logic model to fit one's own program will also then help to set up the evaluation plan for that program. By using the logic model as a science-based approach, programs may be more strategic, more purposeful, and ultimately, more effective.

POTENTIAL USES

1. Plan
2. Design
3. Select
4. Adapt
5. Improve
6. Evaluate
7. Fund

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This is an excerpt from a longer document. For the complete document, go to Healthy Teen Network, *A BDI Logic Model for Working with Young Families Resource Kit*, available at:

http://www.healthyteennetwork.org/sites/default/files/BDI_Logic_Model.PDF

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APPENDIX 19

Los Angeles County FYI Issue 10-80 December 15, 2010
"Pregnant and Parenting Teen (PPT) Conference Utilizing the Family Group Decision Making (FGDM) Model"

F O R Y O U R I N F O R M A T I O N

Issue 10-80

Date: 12/15/10

PREGNANT AND PARENTING TEEN (PPT) CONFERENCE UTILIZING THE FAMILY GROUP DECISION MAKING (FGDM) Model

The purpose of this FYI is to remind staff that the Pregnant and Parenting Teen (PPT) conference still exists. Please refer to Procedural Guide 0070-548.03, Family Centered Conferences/Team Decision Making (TDM) Meetings, for further details. The release of this FYI cancels FYI 09-30(REV), Family Group Decision Making (FGDM) for Pregnant and Parenting Teens (PPT), dated 08/10/09.

The Pregnant and Parenting Teen (PPT) Conference utilizing the Family Group Decision Making (FGDM) Model is a proactive tool, intended to identify and discuss issues related to pregnancy and early stages of child rearing. Its long term goal is to assist in breaking intergenerational cycles of children being brought into the child protection system. PPT Conferences utilizing the FGDM Model assist the youth with planning for healthy parenting, identifying appropriate resources and services, and preparing for a successful transition to independence.

The PPT Conference utilizing the FGDM Model is a family conferencing process used as a social work tool that provides for the voluntary creation and design of a life plan by and for a family and its' members. The PPT Conference Facilitator, the teen and their support network, will work collaboratively to craft initial plans that are both attainable and meet the highest standards for achieving the goals of safety, permanency and well-being. The plans will subsequently be shared with the professionals to ensure implementation and follow-up. In order to identify and access appropriate resources and services for each youth, the PPT Conference Facilitator will consult with a designee of the Inter-Agency Council on Child Abuse and Neglect (ICAN) Pregnant and Parenting Teen Task Force and invite them to participate in the PPT conference. If acceptable to the youth, the ICAN designee (a Teen Parent Resource Specialist) may be involved in some aspects of preparing the family for the meeting and in providing ongoing support subsequent to the meeting.



If you have any questions regarding this release please e-mail your question to:

Policy@dcfs.lacounty.gov

Clerical Handbook: <http://lacdcfs.org/Policy/Hndbook%20Clerical/Default.htm>

Eligibility Handbook: <http://lacdcfs.org/Policy/Hndbook%20FCE/TableofContents.htm>

Child Welfare Services Handbook: <http://lacdcfs.org/Policy/Hndbook%20CWS/default.htm>

FYI's: <http://lacdcfs.org/Policy/FYI/TOCFYI.htm>

The PPT Conference utilizing the FGDM Model can assist with:

- Ensuring placement stability and support for the pregnant and parenting teen and baby;
- Utilization of Whole Family Foster Home when appropriate;
- Educational status and needs;
- Pre-natal care and birth plans, including the role of father;
- Creating a care plan for the newborn;
- Family Planning;
- Parenting education and mentoring for minor mother and father;
- Family law referrals;
- Extended paternal and maternal family relationships and involvement; and,
- Identifying and engaging family and community support persons to assist the mother and father to take part in the services and develop as parents.

In order to engage the family as fully as possible in the planning process, PPT conferences emphasize the practice of fully preparing for the meeting. Towards this end, a designee of the ICAN Pregnant and Parenting Teen Task Force, with the agreement of the youth, will contact the youth prior to the conference in order to prepare for the specific issues and concerns the youth would like to address.

Youth may be referred for a PPT Conference by their attorneys, regional children social workers, emergency response workers, adoption workers, hot line workers, court services personnel and family advocates.

The referring party will discuss the PPT Conference with the youth and determine if the youth wishes to participate or learn more about PPT Conference. Participation in a PPT Conference is **voluntary**. If the youth wishes to have a PPT Conference, then the CSW will complete the **DCFS 174, Family Centered Referral and Services Form**.

The conferences are arranged by the Service Bureau PPT Facilitator once:

The PPT Facilitator explains in more detail what to expect and confirms that youth is in agreement. If youth is not in agreement, this is noted and the referring party is advised.

- It is confirmed that the youth is in agreement with participating in the PPT Conference;
- The CSW has given the Service Bureau PPT Facilitator some days and times that are available for the conference;
- A designee of the ICAN Pregnant and Parenting Teen Task Force (a Teen Parent Resource Specialist) has been identified as available to attend the conference.

The referral form may be:

- E-mailed to Maria D. Rodriguez at rodrimo@dcfs.lacounty.gov
- Faxed to Maria D. Rodriguez at (213) 738-6483

To schedule a PPT Conference, the following steps are to be implemented:

1. The case-carrying CSW refers the family to the PPT Facilitator who serves their office using the DCFS 174, Family Centered Referral and Services Form;
2. The case-carrying CSW introduces the PPT Conference to the youth and informs the youth to expect contact from the PPT facilitator;
3. A designee of the ICAN Pregnant and Parenting Teen Task Force partners with the PPT Facilitator in preparing the youth and family for the meeting and explains PPT Conference more fully to the youth and present its benefits;
4. The youth's attorney is notified so that he/she can assist in encouraging the youth to participate. At this time, youth's attorney is not allowed to participate in the PPT Conference. Notification to the youth's attorney of the pending PPT Conference must occur within 72 hours of the conference date. See Procedural Guide 0300-506.08 Communications with a Child's Attorney, for instructions;
5. The PPT Facilitator and a designee of the ICAN Pregnant and Parenting Teen Task Force will work with the case-carrying CSW and his/her SCSW, the teen, and all other participants to schedule a conference.

Any pregnant or parenting teen under the Department's supervision, potential and recent teen fathers as well as mothers, would benefit from being referred to this program, even if no problems have been identified.

CSWs should utilize this valuable resource to serve our youth.

CSWs are also encouraged to review the following Procedural Guides and FYIs:

- 0600-507.10, Youth Development & Reproductive Health
- 0100-510.40, Teen Parents in Foster Care
- FYI 07-40, Reproductive Health & Parenting Resources in LA County
- FYI 8-19, Referring Caregivers for Whole Family Foster Home Certification

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APPENDIX 20

Parenting Teen Family Decision-Making Meeting: Case Plan and Notes

Case Name:	
Case Number:	
Court Case Number:	
Teen Parent's Name:	
Date of Meeting:	
Location of Meeting:	
Facilitator:	
Participants:	

Purpose of Meeting:

--

Discussion:

1. Family Strengths:

2. Challenges and Needs:

3. Brainstorming Ideas:

Plan/Goals:

1.
2.
3.
4.

Signed by: (list all participants)

Teen Parent

Date

Facilitator

Teen Parent Resource Specialist

Discussion and General Overview:**Follow-up Notes:**

Report Completed by:	
Date Report Completed:	

APPENDIX 2I

Biographies of Key Participants in Los Angeles PPT Conference interviewed for this report

PPT Facilitator

Hipolito Mendez, MSW, *Los Angeles Department of Children and Family Services*

Hipolito Mendez has worked for the Los Angeles County Department of Children and Family Services (DCFS) for the last 12 years. He began his career with DCFS as a Children's Social Worker Trainee. He has worked as a case-carrying Children's Social Worker, a Dependency Investigator, and a Supervising Children's Social Worker. He currently facilitates the Pregnant and Parenting Teen (PPT) Conferences for DCFS.

Teen Parent Resource Specialists (TPRS) in Los Angeles

Barbara Facher, MSW, *The Alliance for Children's Rights*

Barbara Facher is a Social Worker at the Alliance for Children's Rights. Ms. Facher works on issues specific to pregnant and parenting teens living in foster care, and collaborates with public and private agencies to improve and expand services for this population. She co-chairs the Inter-Agency Council on Child Abuse & Neglect (ICAN) Task Force on Pregnant and Parenting Teens. She also focuses on health care issues for children in foster care to ensure youth have access to health and mental health care, and other critical supports and services.

Mara Ziegler, LCSW, *Public Counsel, Children's Rights Project*

Mara Ziegler is a Senior Social Worker on Public Counsel's Children's Rights Project (CRP). The multi-disciplinary CRP staff works as a team to advocate for the rights of children, youth and families. Ms. Ziegler pursues options for resolving clients' problems which may include: securing an attorney to represent the child, advocating for services on behalf of the child, providing support and guidance to the client and their caregivers, participating in relevant community groups and coalitions, and taking part in legislative advocacy and policy development. She also writes materials for the Project and provides outreach and training to clients, service providers, child advocates, attorneys and others on a variety of issues related to Children's Rights. Areas of specialization for Ms. Ziegler include empowering and advocating for pregnant and parenting teens, helping clients to access government benefits and programs, and working with youth transitioning out of the Dependency system.

Prior to joining Public Counsel in 1989, Mara had extensive experience in providing group and individual therapy to children who had been abused and worked with high school students on issues of date rape and physical and sexual abuse. Currently, she is also an Associate Professor at the University of Southern California in the School of Social Work teaching several classes including Social Work Practice with Individuals, Families and Groups, Working with Adolescents: Practice, Systems and Advocacy and Social Work Practice with Transition Age Youth.

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