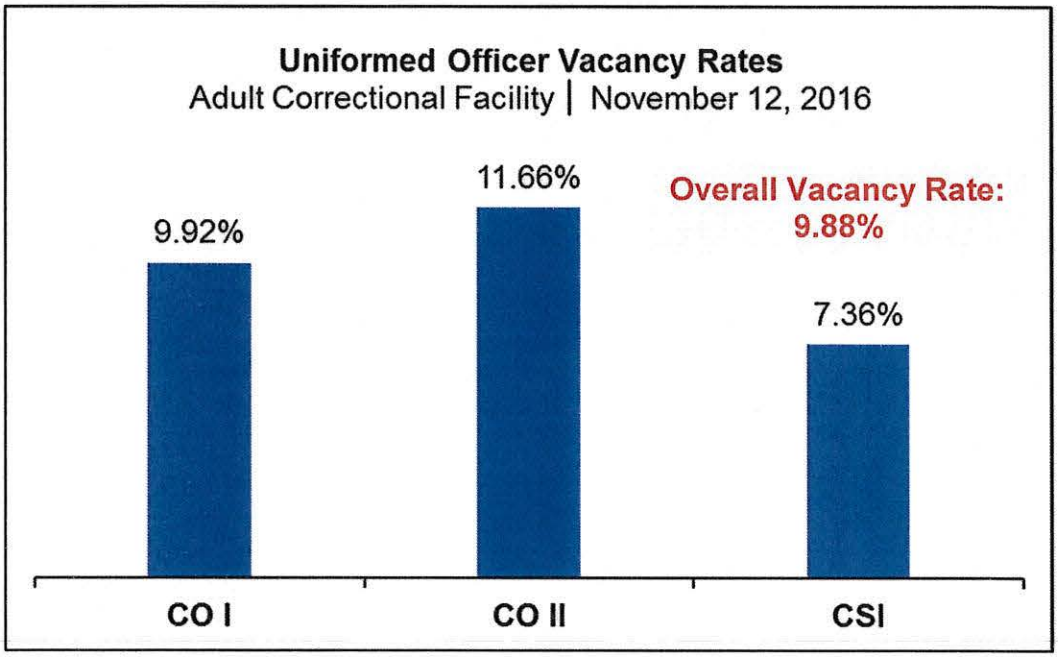
714 S.W. Jackson St., Suite 300
Topeka, KS 66603

Kansas
Department of Corrections

Phone: (785) 296-3317
Fax: (785) 296-0014
kdocpub@doc.ks.gov
doc.ks.gov

Joe Norwood, Secretary

Sam Brownback, Governor



Vacancy Rates by Facility

CO I	Vacancies	TOTAL CO I FTE	%
ECF	13	69	18.84%
EDCF	28	240	11.67%
HCF	14	212	6.60%
LCF	36	308	11.69%
LCMHF	9	83	10.84%
NCF	5	83	6.02%
TCF	1	67	1.49%
WCF	6	66	9.09%
TOTAL	112	1128	9.92%

CO II	Vacancies	TOTAL CO II FTE	%
ECF	1	49	2.04%
EDCF	1	35	2.86%
HCF	13	82	15.85%
LCF	17	81	20.99%
LCMHF	2	15	13.33%
NCF	8	59	13.56%
TCF	6	74	8.11%
WCF	2	34	5.88%
TOTAL	50	429	11.66%

CSI	Vacancies	TOTAL CSI FTE	%
ECF	3	29	10.34%
EDCF	4	62	6.45%
HCF	2	49	4.08%
LCF	9	90	10.00%
LCMHF	1	19	5.26%
NCF	3	35	8.57%
TCF	2	26	7.69%
WCF	0	16	0.00%
TOTAL	24	326	7.36%

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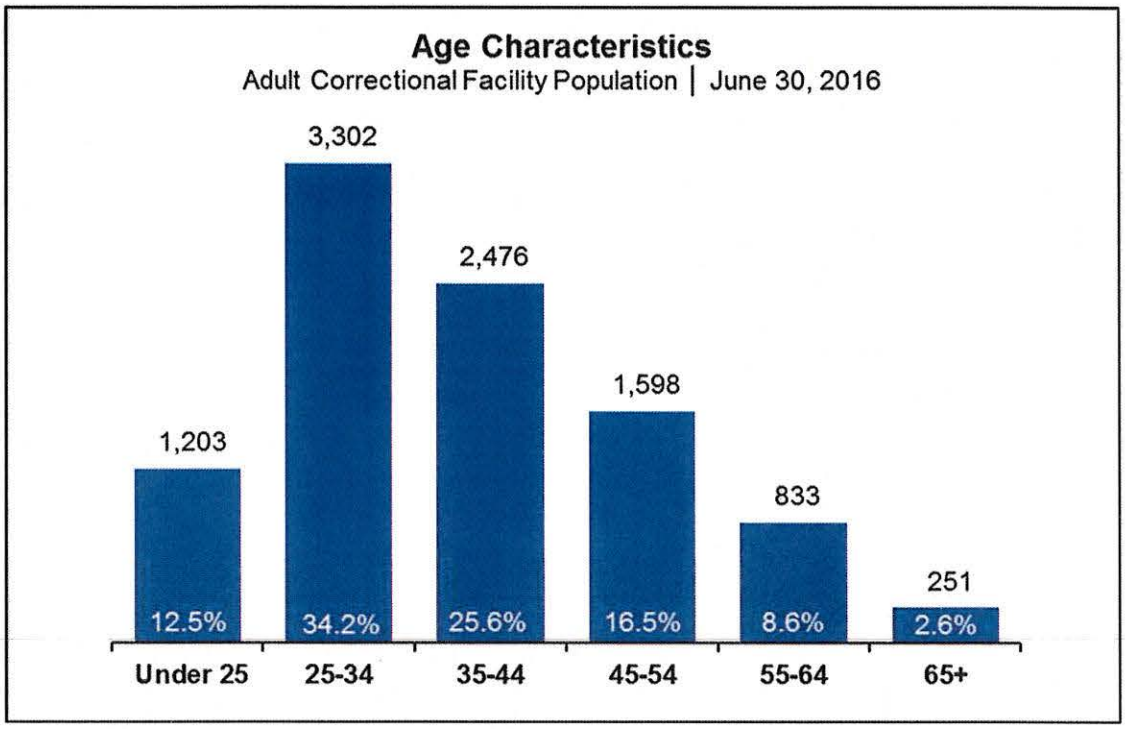

Age Characteristics
Adult Correctional Facility Population | June 30, 2016

	TOTAL	EDCF	ECF	HCF	LCF	LCMHF	NCF	TCF	WCF*	LSSH**	CONTRACT JAIL
(Yrs.)											
Under 25	1,203	216	137	257	287	36	81	90	76	2	21
25-34	3,302	499	322	656	763	124	275	353	265	7	38
35-44	2,476	314	226	476	622	130	256	212	204	14	22
45-54	1,598	222	137	304	440	81	138	116	145	9	6
55-64	833	191	73	138	226	36	45	38	75	8	3
65+	251	104	7	31	66	12	8	6	15	2	-
Total	9,663	1,546	902	1,862	2,404	419	803	815	780	42	90
Avg. Age	38	40	37	37	39	40	38	36	39		

*Winfield includes Wichita Work Release. ** LSSH = Larned State Security Hospital.

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Additions to Behavioral Health Staffing

Location	Addition	Type
El Dorado (January 2017)	4.0	MA/MSW behavioral health professionals
Lansing (FY 2016)	2.0	MA/MSW behavioral health professionals
	1.0	Activity Therapist
	2.0	Certified Medication Assistant
	1.0	Psych Advanced Practitioner Registered Nurse
Systemwide Additions (FY 2015)	22.0	Master's Level Psychologists
	11.0	Activity Therapists
	1.0	Forensic Psychologist

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KDOC Division of Juvenile Services

JCF Education Outcome Measures:

In FY12, a total of 355 post-secondary hours were earned by youth in our Juvenile Correctional Facilities (JCFs). In FY16, the total was 1458, representing over a 310% increase from FY12. During that same time the decrease in JCF population was 33%.

Girls have continued to have access to and earn post-secondary hours and receive vocational certifications in proportion to their population size. This wasn't the case in 2011. In fact, in 2011 there were NO post-secondary hours earned by any youth at the Kansas Juvenile Correctional Complex (KJCC). Now, due to the collaborative partnership with Washburn Tech, our youth have the ability to access national certification courses.

The credit hours at KJCC came from NCCER Core classes, Certified Production Technology, and Electrical Technology. In addition, 221 National Certifications were awarded in FY16 (190 to males and 31 to females). National Certifications are from passing Manufacturing Skills Standards Council (MSSC), National Center for Construction Education and Research (NCCER), or OSHA national tests. Finally, 20 WIT Program Certificates were awarded (16 to males and 4 to females). The Program Certificates are for completing all courses with a grade of "C" or higher in the Certified Production Technician, Building Technology, Plumbing Technology, or Electrical Technology programs. These students completed the same programs that are offered on WIT's main campus. The credit hours at LJCF were earned via Barton Community College.

JCF Safety Outcome Measures:

Each month the JCFs report incidents of fights, batteries, and other safety measures. Given that the JCF population has declined over the last 2 fiscal years by roughly 26%, we would expect to see a drop in these events at a similar rate. We are happy to report that when looking at JCF totals from FY16 as compared to FY14, each item (batteries of staff, youth, and fights) have decreased at a higher rate than the population decline. For instance, youth fights have been reduced by 58%; youth batteries with serious injuries have been reduced by 100%; and there has been a 42.4% in youth batteries with less than serious injury. Staff safety issues are also much improved. We will continue to work to improve, but these numbers speak to the increased quality of programming, staff training, facility culture and the dedication and professionalism of the JCF staff.

JCF Program Outcome Measures:

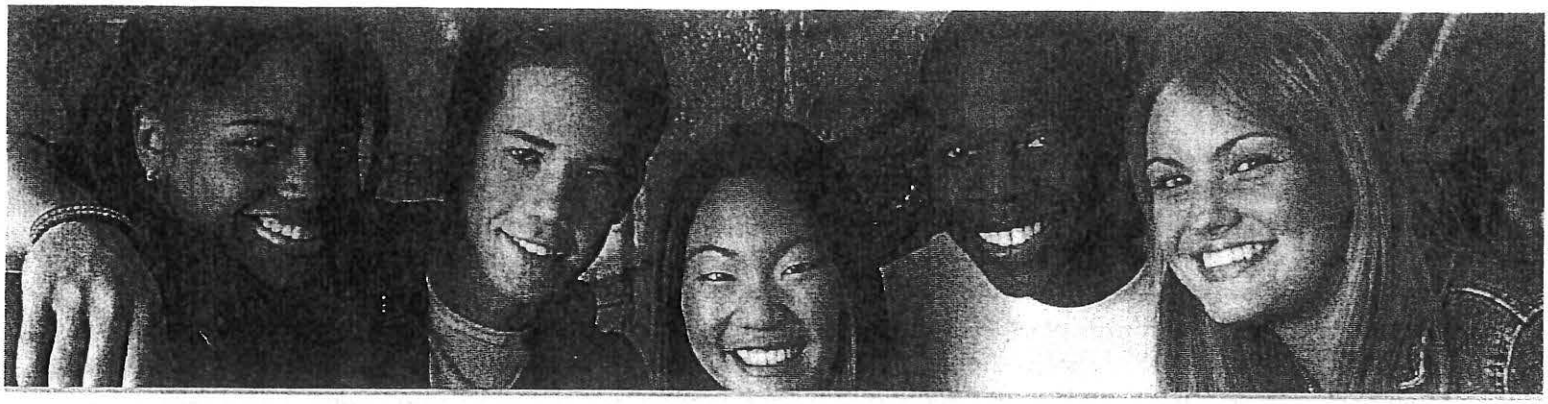
Our FY16 JCF program completions are similarly improved from FY15. Overall, there was an increase in all completions of programs (181 completions in substance abuse versus 172 in FY15; 90 completions in Aggression Replacement Training, ART© versus 79 in FY15; and 57 sex offender treatment completions versus 46 in FY15). The exception is that there were ten fewer completions in Thinking4 a Change from last year's numbers (97 in FY15 versus 87 in FY16). The number of youth who successfully completed each program (with the exception of ART©) increased from FY15 to FY16. The increase in program participation is especially impressive considering the JCF population decreased over 15% from FY15 to FY16 (average 272 in FY15 versus 230.6 in FY16).

Functional Family Therapy:

http://fftllc.com/about-fft-training/clinical-model.html
http://www.crimesolutions.gov/ProgramDetails.aspx?ID=122

Oversight Committee Membership:

Membership of oversight committee can be viewed via the following link:
http://www.doc.ks.gov/juvenile-services/committee/members-of-the-juvenile-justice-oversight-committee/view



IN THIS SECTION

Clinical Model

FFT is a short-term, high quality intervention program with an average of 12 to 14 sessions over three to five months. FFT works primarily with 11- to 18-year-old youth who have been referred for behavioral or emotional problems by the juvenile justice, mental health, school or child welfare systems. Services are conducted in both clinic and home settings, and can also be provided schools, child welfare facilities, probation and parole offices/aftercare systems and mental health facilities.

FFT is a strength-based model built on a foundation of acceptance and respect. At its core is a focus on assessment and intervention to address risk and protective factors within and outside of the family that impact the adolescent and his or her adaptive development.

FFT consists of five major components: engagement, motivation, relational assessment, behavior change and generalization. Each of these components has its own goals, focus and intervention strategies and techniques.

Engagement

The goals of this phase involve enhancing family members' perceptions of therapist responsiveness and credibility. Therapists work hard to demonstrate a sincere desire to listen, help, respect and "match" to family members in a way that is sensitive and respectful of individual, family and cultural beliefs, perspectives and values. The therapist's focus is on immediate responsiveness to family needs and maintaining a strength-based relational focus. Activities include high availability, telephone outreach, appropriate language and dress, contact with as many family members as possible, "matching" and a respectful attitude.

Motivation

The goals of this phase include creating a positive motivational context by decreasing family hostility, conflict and blame, increasing hope and building balanced alliances with family members. Therapists work to change the meaning of family relationships by emphasizing possible hopeful alternatives, maintaining a nonjudgmental approach and conveying acceptance and sensitivity to diversity. The therapist's focus is on the relationship process, separating blame from responsibility while remaining strength-based. Activities include the interruption of highly negative interaction patterns, changing meaning through a strength-based relational focus, pointing process, sequencing and reframing of the themes by validating negative impact of behavior

while introducing possible benign/ noble (but misguided) motives for behavior. The introduction of themes and sequences that imply a positive future are important activities of this phase.

Relational Assessment

The goal of this phase is to identify the patterns of interaction within the family to understand the relational "functions" or interpersonal payoffs for individual family members' behaviors. The therapist focuses on eliciting and analyzing information pertaining to relational processes, and assess each dyad in the family using perception and understanding of relational processes. The focus is directed to intrafamily and extrafamily context and capacities (e.g., values, attributions, functions, interaction patterns, sources of resistance, resources and limitations). Therapist activities involve observation, questioning, inferences regarding the functions of negative behaviors, and switching from an individual problem focus to a relational perspective. This sets the stage for planning in Behavior change and Generalization, where all interventions are matched to the families' relational functions.

Behavior Change

The goal of this phase is to reduce or eliminate referral problems by improving family functioning and individual skill development. Behavior Change often includes formal behavior change strategies that specifically address relevant family processes, individual skills or clinical domains (such as depression, truancy, substance use). Skills such as structuring, teaching, organizing and understanding behavioral assessment are required. Therapists focus on communication training, using technical aids, assigning tasks, and training in conflict resolution. Techniques and strategies often include evidence-based cognitive-behavioral strategies for addressing family functioning and referral problems. Phase activities are focused on modeling and prompting positive behavior, providing directives and information, developing creative programs to change behavior, all while remaining sensitive to family member abilities and interpersonal needs.

Generalization Phase

The primary goals in this phase are to extend the improvements made during Behavior Change into multiple areas and to plan for future challenges. This often involves extending positive family functioning into new situations or systems, planning for relapse prevention, and incorporating community systems into the treatment process (such as teachers, Probation Officers). Skills include a multisystemic/systems understanding and the ability to establish links, maintain energy, and provide outreach into community systems. The primary focus is on relationships between family members and multiple community systems. Generalization activities involve knowing the community, developing and maintain contacts, initiating clinical linkages, creating relapse prevention plans, and helping the family develop independence.

1251 Northwest Elford Drive

Seattle, Washington, 98177

P: (206) 369-5894

EMAIL US (MAILTO:HOLLY@FFTLLC.COM) (http://www.facebook.com/FunctionalFamilyTherapyInc/)

(https://twitter.com/FFT_LLC)

Clinical Service System Login (https://www.fftcss.com/)

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Oct 2016

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OVERSIGHT
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