

Too Many Teens

PREVENTING UNNECESSARY OUT-OF-HOME PLACEMENTS

THE ANNIE E. CASEY FOUNDATION



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executive summary

The nation's child welfare and juvenile justice systems were built to address specific issues: abuse, neglect and serious delinquency. But today, too many teens are being placed in these systems for unrelated reasons.

They may land in these public systems because they can't get along with their parents. Or because of the teens' challenging behaviors, such as defying their parents, being truant from school, running away, abusing alcohol and drugs or engaging in risky sexual or other activities that threaten their well-being or safety. These issues are concerning, but too often teens are being removed from their families and homes for behaviors and actions that in many cases would not be illegal if they were adults.¹

To raise awareness of this troubling trend and help identify solutions to it, the Annie E. Casey Foundation's Child Welfare Strategy Group (CWSG) explored why more teens are entering child welfare and juvenile justice systems and why so many of them are experiencing such poor outcomes. The Foundation was surprised by what it found. Many teens simply did not belong in child welfare or juvenile justice placements. They ended up

there because their communities had insufficient alternatives to help families resolve conflicts or address teens' behavioral health issues. CWSG dug deeper to examine not only why teens enter care, but also to identify systems, policies and practices that can meet teens' needs without pushing them into unsuitable placements.

EXPLORING WHAT WORKS

CWSG surveyed states, interviewed experts, performed secondary research and visited communities with promising approaches to meeting teens' conflict- or behavior-related challenges. It also studied the impact of state legislation, funding and evidence-based approaches on jurisdictions' ability to help children ages 12–17 whose behavioral issues were cited as reasons for separating them from their families. This paper provides an overview of CWSG's findings, with details on several effective local solutions that have

had remarkable success working with young people and their families.

DISCOVERING WHAT TEENS NEED

Too many teens are being placed in group settings, whether in child welfare or in juvenile justice systems. These group placements have been shown to be developmentally harmful when used as long-term living situations. What's more, research shows that experimenting with risky behaviors is part of adolescent development. During these challenging years, teens need stronger relationships, access to effective behavioral health services and opportunities for positive growth, not residential group placements. Group placement facilities were not designed with these teens' needs in mind, and evidence indicates that teens who live in such settings often age out without the childhood experiences of safety, permanency and well-being that are the building blocks of successful adulthood. Child-serving agencies should work together to provide teens and their families with a range of programs from crisis intervention and mediation to higher-level, evidence-based services that meet their needs in the most-effective and least-restrictive settings.

KEYS TO SUCCESS

CWSG's research identified common elements of successful approaches to meeting teen's needs and reducing unnecessary out-of-home placements. Agencies improve outcomes for teens when they have:

- **A wide front door.** Systems should be open to families and youth in crisis,

with "crisis" defined by the family and carrying no eligibility criteria other than the youth's age.

- **Timely access to initial screening and assessment.** Families need quick access to services before a crisis becomes too severe.
- **High-quality screening and assessment.** Agencies need experienced staff trained in family engagement who can match youth and families with appropriate services.
- **A range of services.** Most issues that teens are facing can be resolved with low-intensity, low-cost services, such as case management, conflict resolution and referral to community resources. A few teens may require evidence-based practices with a demonstrated ability to reduce or prevent family disruption.
- **Strong, change-focused leaders.** Agency leaders must be able to establish clear goals, guide teen-focused reform efforts, gain buy-in from influencers and emphasize continual improvement.
- **Flexible, sustainable funding.** When possible, jurisdictions should redirect state or local savings from reducing out-of-home placements to help fund community-based prevention services and maximize federal and state funding sources and prevention dollars. Jurisdictions should also work to pool resources from the various child-serving agencies, including child welfare, mental health and juvenile justice.
- **A requirement that families exhaust services before petitioning the court**

to remove a child. State laws and courts should discourage parents from seeking out-of-home placements for a child with behavioral issues.

- **Data collection and analysis.** Agencies need electronic records systems that enable seamless sharing across service providers and agencies. Leaders must be able to monitor progress and outcomes, manage use of services and emphasize continual quality improvement.
- **Community outreach.** Effective teen-focused interventions include community outreach to families and potential referral sources such as schools and police so everyone knows their options and understands where and how to get help.
- **Multisystem collaboration.** Strong collaboration across various child-serving systems enables systems to coordinate, and even pool, their resources to more efficiently and effectively serve families involved with multiple agencies.

While more tests of specific program models are needed, research supports the conclusion that jurisdictions can effectively and safely reduce unnecessary out-of-home placements related to parent-child conflict or challenging youth behavior. By developing and using programs that incorporate the common elements described in this paper, thousands more youth could grow up in families, avoid the trauma of removal and reduce the likelihood of poor life outcomes.

introduction

Although the number of teens in foster care has been slowly declining during the past decade, more than 633,000 children were living in out-of-home placements at some point in 2012. Of these, approximately one-third were teenagers.² While many of these teens aged into adolescence while in care, 70 percent entered care as teens.³

Many teens enter the child welfare system, which was created to protect children from abuse or neglect, because their families find it difficult to manage their behavior. In 2012, “child behavior” was the reason given for 46 percent of youth over age 12 entering the child welfare system. This rate is more than nine times that of children age 12 or under who enter care because of their behavior.⁴

Adolescence is normally a time of risk-taking. Some of these behaviors are part of the normal development process, even though they may be difficult to manage. Challenging behaviors include truancy and other school-related problems, conflict in the home or other relationship issues, running away, drug/alcohol use, risky sexual behaviors or serious threat to the teen’s well-being or safety. Many of these families have not accessed the mental health system or the mental health system has been unable to meet their needs because the parents refuse to be involved in the treatment process.

Unfortunately, child welfare and juvenile justice systems are not particularly well-equipped to help families address the needs of older youth. A substantial proportion of teens end up in group homes and residential treatment centers instead of being placed with relatives or foster families. In 2012, 35.5 percent of 13- to 17-year-olds were placed in group settings, compared with 4 percent of children under age 13.⁵

The practice of sending young people to live long-term in group placements is not supported by adolescent development research, which confirms that disrupted relationships can impede growth at a critical stage in a young person's life.⁶ It is even difficult at times to get the youth back home because the family has settled down comfortably without him or her. Adding to the problem, young people who enter or reenter care as 16- or 17-year-olds are especially vulnerable to aging out of the system without safe, stable and secure family relationships or the skills that prepare them for adulthood. These youth are more likely to:⁷

- drop out of high school,
- have mental and physical health problems;
- be unemployed and have no income;
- experience periods of homelessness;
- rely on public assistance;
- become teen parents; or
- become involved with the criminal justice system and be incarcerated.

Finally, an effective continuum of care includes a range of services, from in-home to residential treatment. The child welfare system must invest in approaches that reduce the need for youth to be placed outside their homes by developing family- and community-based programs that allow more teens to remain with their families even when receiving behavioral health treatment and mediation-type services. When used unnecessarily, group placements are not cost-effective. They cost the state three to five times as much as foster family placements, but often do not provide young people with the social and emotional supports they need to develop the knowledge, daily living skills and relationships that prepare them for adulthood.

what drives teen placements

During the past decade, significant reforms have reduced the number of teens in out-of-home placements. Yet diverting young people with behavior issues from group placements and foster care remains a significant challenge.

Many jurisdictions struggle to establish a continuum of family- and community-based alternatives with varying levels of intensity to match families' diverse needs, and many youth still end up in emergency shelters or group placements when appropriate programs and resources are not readily available.

This chapter presents background on teen entries to public systems, examining:

- current reforms in child welfare and juvenile justice systems;
- an overview of related state laws and policies;
- state-level practice reforms;
- evidence-based programs and practices that address challenging teen behavior and reduce the need for more intensive interventions; and
- funding sources for serving youth and families in crisis.

CHILD WELFARE AND JUVENILE JUSTICE REFORM

During the past decade, the federal government and some states have passed legislation to underscore that youth in the child welfare system need and deserve permanent family relationships.

First, they have expanded efforts to stabilize families to keep children out of the system or to quickly reunite them with their parents if they enter care. In cases where safe reunification is not possible, states have worked to speed the process to terminate parental rights and finalize adoptions.

Second, some jurisdictions have enhanced processes to find extended family members to care for youth; legislative and funding changes have dramatically increased the number of youth in the care of family guardians in many states.⁸

Finally, the Annie E. Casey Foundation has supported several state and local reform efforts to ensure that young people grow up in families, resulting in a dramatic reduction in the number of youths living in and aging out of group and residential facilities.

Similarly, in the field of juvenile justice, Congress passed the Juvenile Justice and Delinquency Prevention Act to prohibit the secure confinement of status offenders (i.e., youth arrested for crimes that would not be illegal if they were adults — primarily truancy, running away, underage drinking and “ungovernables”). As a result, many states and jurisdictions nationwide embarked on efforts to reduce the number of young people in secure confinement by establishing alternative treatments for status offenders.⁹ In addition, many states and jurisdictions have recognized that removing youthful offenders from their homes and families is costly and often counterproductive to public safety and their well-being.

One such approach is the Juvenile Detention Alternatives Initiative (JDAI), which the Casey Foundation developed. Since its inception in 1992, JDAI has demonstrated that jurisdictions can safely reduce reliance on secure detention. There are 250 JDAI sites in 39 states and Washington, D.C. Those sites have reduced reliance on secure detention, decreased juvenile arrests for serious violent offenses, reduced costs to taxpayers and, in many localities, sparked additional reforms without compromising public safety. Many communities are pursuing efforts to reduce incarceration rates and treat more young people in their communities.¹⁰

STATE LAWS AND POLICIES

When determining how to address the needs of young people struggling with behavioral issues, the complexity and variation in state laws and policies create significant challenges. In particular, these young people and their families may be served through the child welfare, juvenile justice or mental health systems, or some combination of these systems — or they may be denied services by all of them. Policies, procedures and consequences for status offenses — acts that are prohibited for minors — and delinquency are often murky, unclear to all but those most experienced in applying them.¹¹

In many states, status offender statutes have been an “attractive nuisance,” inviting frustrated parents and other adults to deliver youth with challenging behaviors to the courts, where judges often place them in foster care or in expensive residential group placements, which may or may not address their needs. Some states allow parents to voluntarily place their children into foster care. Pennsylvania handles status offenders entirely through the child welfare system. In New York

City, almost a quarter of teens admitted to foster care entered on status offender petitions (“persons in need of supervision”) before reform was passed in the early 2000s.¹² New York and Virginia allow judges to place status offenders in traditional foster care instead of juvenile detention.

In contrast, jurisdictions such as Michigan and Washington, D.C., do not allow courts to place status offenders in foster care, requiring instead that children live in placements operated entirely through the juvenile justice system.¹³ While states cannot generally hold status offenders in secure detention without running afoul of federal legislation, the legislation has not curtailed placements in residential treatment and group homes.

In all states, families who cannot get help for their children often find themselves the subject of abuse and neglect allegations. Some of these families may be appropriate for child welfare intervention, but the circumstances — for example, lockouts by a frustrated parent trying to protect younger siblings from a violent teen — are similar to those of families in the status offender or juvenile delinquency systems in other states.

This variation among states has two major implications. First, patchwork laws and policies make it difficult to determine whether what works in one jurisdiction will achieve equal success in another. Young people who end up in the juvenile justice system in one state may end up in child welfare in another. Second, solutions should engage state and local leaders from different service delivery systems in effective collaborations.

STATE-LEVEL PRACTICE REFORM

Guided by these child welfare and juvenile justice reform efforts, some states across the country have developed policies and programs aimed at diverting youth with challenging behaviors from entering out-of-home placements by increasing access to less restrictive family- and community-based services. Other states have developed practices aimed at preventing youth of all ages from entering foster care. Six state practice reform approaches are described here.

Colorado

Colorado has increased the number of youth and families served by community-based programs and decreased the number of youth who enter foster care. Youth who are at imminent risk of out-of-home placement are eligible for the following core services: home-based intervention, intensive family therapy, life skills, day treatment, sexual abuse treatment, special economic assistance, mental health services, substance abuse treatment, aftercare services and county-designed services, including evidence-based services to adolescents. In FY 2010, more than 15,000 children received at least one core service.

Connecticut

Connecticut operates state-funded family support centers designed to divert status offenders from the courts in its four most populous districts. The centers offer contact within three hours of referral, 24-hour crisis intervention, case management, family mediation, individual and group counseling and group interventions. They also refer families to community-based programs, including respite care and evidence-based programs. A formal Family with Service Needs petition can be filed in juvenile court only if a child's behavior escalates or if the child and family experienced repeated crises while receiving services from the centers.

Florida

Florida has several statewide and local initiatives aimed at increasing access to family- and community-based programs to reduce entries into out-of-home placements in either the child welfare or juvenile justice system. For example, Florida funds 11 nonresidential community-based providers to serve "children in need of services" and their families. Services include case management and crisis intervention as well as individual, group and family therapy. If it is not possible for the child to remain in the home, he or she is admitted to a crisis shelter. In 2010, the Florida network received 22,185 calls for help and served 14,887 youths.

Several counties are also operating civil citation programs that offer services in lieu of an arrest. If the youth completes the service plan, the arrest is never recorded. Upon arrest, the youth and family are screened for mental health and substance abuse problems and receive an assessment to determine service needs. They are referred to community-based organizations for counseling, and Functional Family Therapy (FFT), an evidence-based service, is used extensively.

Miami offers screening, assessment and access to mental health and other community-based services to youths and families in crisis. Most of these youths are out-of-control, defiant, truant and/or violent toward their parents. The unit sends a counselor to conduct an in-home or in-school assessment; a clinical department screens for youth who need more intensive services. Almost all of the youth and families receive individual and family counseling. The unit refers families to community-based providers, and FFT is used extensively. Youths receive weekly calls and monthly, biweekly or weekly home visits based on an assigned risk-level rating.

Illinois

The Illinois Youth Services Bureau provides access to comprehensive community-based services aimed at prevention, diversion and treatment to divert youth from the juvenile justice and child welfare systems. The agency's Comprehensive Community-Based Youth Services program provides 24-hour crisis intervention, temporary shelter and family reunification and preservation counseling; identifies

and closes service gaps; coordinates youth referrals to other services, including education, employment and training; and uses community resources, including local funds and volunteers.

New Jersey

New Jersey operates crisis intervention units in each county to provide early intervention for status offenders and help stabilize family crisis situations on a 24-hour basis, thereby diverting them from the courts. School personnel, families, police and other agencies make referrals based on serious conflict between a parent or guardian and a juvenile regarding behavioral issues. The units' structure and operation vary from county to county, with some units operating through the court and others using public or private agencies. Services may include crisis intervention, assessment and stabilization, short-term family therapy, service coordination and advocacy and referrals to other agencies and services. In extreme cases, the family court may be involved in short-term, out-of-home youth center placement.

Washington

More than 20 years ago, the state of Washington instituted a family reconciliation service system through its child welfare agency to reduce out-of-home placements for families with teens dealing with challenging behavioral problems. The service is primarily a screening and referral system. Workers in local offices take calls directly from families in crisis, and some that are transferred from the child protection hotline. The service works in conjunction with Washington's system of crisis shelters to help teen runaways and others in conflict with their families to return home or to another permanent living arrangement. State officials report that the service has reduced teen entries into foster care, although budget cuts during the past decade have significantly reduced the program's size. Families must seek these services as a prerequisite to filing a "child in need of services" petition with the courts.

EVIDENCE-BASED PROGRAMS AND PRACTICES

Often, communities need a continuum of programs, practices and services to help teens and their families. This may include a variety of preventive options, some intensive clinical services and, for the few who need it, access to effective, more intensive treatment programs, including, infrequently, residential treatment.

Some of the options available to communities and agencies are supported by rigorous evaluation, including clinical trials. Well-established examples include Multisystemic Therapy (MST) and Functional Family Therapy (FFT). MST and FFT focus on helping teens with complex behavioral issues and have been implemented in numerous jurisdictions nationwide. MST, for example, has been shown to reduce out-of-home placements for serious juvenile offenders by 47 percent to 64 percent.¹⁴ FFT results show a high program completion rate, a

reduction in recidivism and a cost benefit to taxpayers.¹⁵ Both programs are listed on Blueprints for Healthy Youth Development (<http://www.blueprintsprograms.com/>), an online resource that public systems and communities can use to identify cost-effective programs that have been shown to benefit children and youth.

Other examples of available evidence-based programs are High-Fidelity Wraparound¹⁶ and Homebuilders.¹⁷ Wraparound approaches have been used in multiple jurisdictions, with quite a few implementing rigorous High-Fidelity Wraparound models to serve troubled teens and their families. Homebuilders serves all ages and is being used in several states however, the program's initial focus was on teens and approximately half of the families currently being served are raising teens with behavioral challenges. Multidimensional Family Therapy,¹⁸ Brief Strategic Family Therapy¹⁹ and various other treatments — all based on cognitive-behavioral approaches — have encouraging evidence of success.

Information on these and other treatment programs that serve challenging teens and their families is readily available through several web-based clearinghouses that describe and rate programs based on their efficacy (see: Evidence-Based Program Databases on page 13). The federal Substance Abuse and Mental Health Services Administration (SAMHSA) has also published a series of booklets to guide communities and families in selecting and implementing mental health evidence-based practices that work in addressing disruptive behavior disorders.²⁰

Researchers are working to identify common elements of programs that have proven effective at preventing out-of-home placements across child welfare, juvenile justice and mental health settings. A review of evidence-based programs described above suggests that such programs have common components, including that each:²¹

- is intensive in nature, often involving several contacts per week, at least initially, between provider and family;
- includes some form of 24/7 support for families during the intervention;
- provides the majority of their services in home or in the community;
- includes a significant focus on the family, particularly on empowering parents to manage and guide their children's challenges more effectively, and on improving communication within the family;
- draws on family and youth strengths as protective factors;
- works with families to more effectively address their interactions with the multiple systems, such as schools and courts, that may affect youth and family success;
- seeks to help families take better advantage of natural supports, such as extended family and the community;

- provides individualized treatment toward specific key outcomes set in conjunction with the youth and family and based on a structured set of principles, tools and/or curriculum;
- are intended as a short-term intervention, most with specified lengths of service of approximately three to four months;
- includes significant staff training and supervision/monitoring components to ensure model fidelity and quality assurance;
- keeps caseloads small; and
- fits generally into a cognitive-behavioral theoretical framework.

All of the treatments described in this section, other than High-Fidelity Wraparound, require substantial training and ongoing supervision. Most involve significant start-up expenses and an investment in carefully trained and supervised treatment professionals carrying small caseloads. Cost estimates range from \$3,200 to \$7,200 or more per participant family depending on many factors, including location. Research has shown many such programs to be highly cost effective if implemented well and targeted toward the appropriate high-need populations.²²

Although a number of jurisdictions are using evidence-based programs to serve challenging teens and their families, slots tend to be limited, resulting in long waiting lists with only a small percentage of eligible youth and families able to use them. Even when the evidence of a program's impact is strong, the costs associated with many evidence-based treatments can create barriers to their use. While local treatment programs may include similar program elements and appear to achieve positive results, they may not have been subjected to rigorous testing or measurement. But failure to undertake rigorous random clinical trial testing should not deter jurisdictions from supporting programs that appear effective; less rigorous evaluation processes can be used to ensure that programs have positive results. However, we should be clear that the vast majority of youth do not need these high-cost evidence-based interventions, and their needs can be successfully addressed with less intensive strategies.

FUNDING SOURCES

Programs serving youth and families in crisis often rely on multiple sources of funding. Because these young people interact with the juvenile justice, child welfare and mental health systems, all of these systems offer potential sources of support for initiatives aimed at preventing out-of-home placements.

Funding sources include the federal Social Services Block Grant, Temporary Assistance for Needy Families (TANF) and state and federal resources appropriated for family preservation. Some states, such as New York, also encourage local prevention efforts by reimbursing the counties 63 percent of those

costs. In Virginia, Comprehensive Services Act funds support local expenditures for community-based services at a higher rate than expenditures for foster care or group placements.

In the juvenile justice system, state funds generally are used for probation services, incarceration and other institutional placements. Some initiatives have redirected funds from out-of-home placements to preventive, community-based services, effectively reducing out-of-home placements.

In Ohio, Reasonable and Equitable Community and Local Alternatives to the Incarceration of Minors (RECLAIM) encourages juvenile courts to meet the needs of offending or at-risk youth within the community. By allocating funds to the courts and having them “pay” for incarcerating youth on a per diem basis out of that allocation, or purchasing community-based services as an alternative, they are able to serve more youth by focusing on community services than by incarcerating them. Similarly, efforts to safely divert youth to community-based services have shown results in Alabama. After analysis demonstrated that the majority of youth in custody were not violent or serious offenders, the state devised reforms that decreased admissions and used the savings to improve community-based interventions for the state’s youth.²³

Medicaid funds more than half of public mental health expenditures through the states. Tapping into the Medicaid system to fund community-based treatment for youth can be challenging, but some state Medicaid agencies have been more open to innovative new service models.²⁴ SAMHSA funds, such as system-of-care grants, have supplied start-up funding in some jurisdictions.

In addition, federal Runaway and Homeless Youth Act funds, and accompanying state or private philanthropic dollars, support crisis intervention in conjunction with runaway shelters and respite care. The nonprofit organizations administering these programs usually operate independently of the other child-serving systems so that youth are not wary of using them, but their target populations overlap substantially. Diverting funds used in a duplicative or overlapping manner, or from less effective to more effective services, allows agencies to create an array of services that better meets the needs of youth and families.

Successful initiatives often blend or braid funding from several agencies to support new programs and services. In Maryland, for example, opportunity compacts created a mechanism to use foundation funding as start-up funds to divert youth who unnecessarily entered placement into a community-based prevention program; placement program savings were then committed to sustain and expand the program. These types of investment strategies suggest that programs may be able to pay for themselves if an initiative reduces out-of-home placements.

Evidence-Based Program Databases

- Blueprints for Violence Prevention
www.colorado.edu/cspv/blueprints/index.html
- National Registry of Evidence-Based Programs and Practices, published by the federal Substance Abuse and Mental Health Services Administration
www.nrepp.samhsa.gov
- California Evidence-Based Clearinghouse for Child Welfare
www.cebc4cw.org

model jurisdictions

Four communities doing innovative and exciting work diverting teens with behavior problems from out-of-home care are highlighted here. This chapter includes details on approaches to working with teens and their families now in use in:

- ▶ **New York City**, which have significantly reduced out-of-home placements for status offenders by taking a systematic approach to serving them in the community;
- ▶ **Erie County, New York**, which has developed a cross-systems planning process involving its probation, mental health and social services departments;
- ▶ **Mecklenburg County, North Carolina**, which has developed a collaborative approach to community mental health to support families involved in the child welfare system; and
- ▶ **Wayne County, Michigan**, which has instituted a public/private partnership focused on treating youth at home rather than in institutional settings whenever possible.

Please note: Unless otherwise indicated, charts include data supplied by each jurisdiction.

NEW YORK CITY

Total population: 8.175 million

Population 18 and under: 22 percent

Race/ethnicity: Two-thirds of the population is African American, Hispanic or other minorities

Poverty: One-fifth of the population was living below the poverty level in 2009

History of Reform

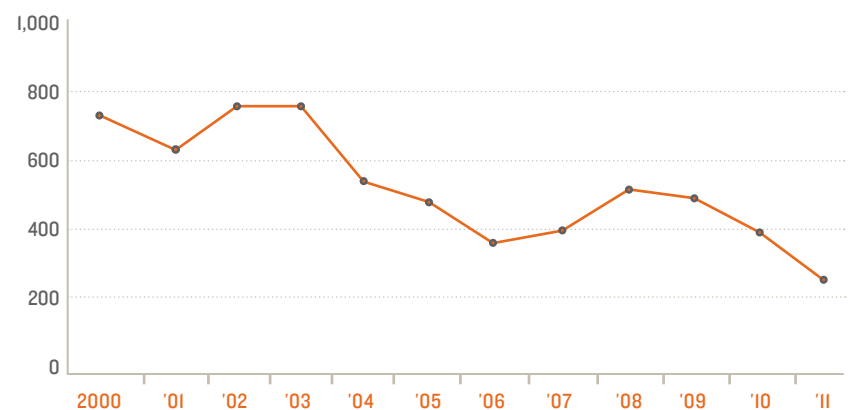
New York State has a long history of allowing parents to file Persons in Need of Supervision (PINS) petitions when a child is alleged to be truant, incorrigible or a runaway. In New York City, such petitions frequently resulted in foster care placements in group homes. During the past decade, statutory changes motivated jurisdictions to launch prevention efforts by requiring parents to try available prevention programs before being able to file PINS petitions.

In late 2002, New York City established its Family Assessment Program (FAP), to reduce petitions and placements into foster care by serving families more effectively in the community. Housed within the Administration for Children's Services (ACS), the program has achieved the following results: Between 2002 and 2006, placements into foster care resulting from parental petitions decreased more than 50 percent, from 751 to 367. When admissions began to increase again in 2007, ACS instituted changes to more quickly screen, assess and connect families with services. Placements resulting from petitions dropped to 265 in 2011, a reduction of more than 60 percent from pre-FAP levels. ACS administrators attribute these declines primarily to FAP.

Access to Services

FAP is available to all families residing in the city, although parents seeking to file petitions to remove a child from home are the most typical applicants; most of the children served are teens. Typical presenting problems include truancy and other school-related problems, runaways, conflict in the home or other relational issues, drug/alcohol use and sexually risky behaviors. Families are referred by the courts, schools, police and a wide variety of other sources to one of five FAP offices, which are in each of the city's five boroughs (Manhattan, Brooklyn, Queens, the Bronx and Staten

PINS Placements for Youth 12-17



Island), near family court. All services are voluntary, but parents must exhaust FAP services before filing a petition. Families are excluded from FAP services if they are receiving services elsewhere within the child welfare or probation systems.

FAP offices are open during normal business hours and are staffed by licensed social workers who immediately meet with families. They meet with the child and parents separately and screen families using an instrument created by ACS. Low-risk families are given brief information and advocacy or are referred to appropriate neighborhood-based services; sometimes this process functions as a family mediation session as well.

High-risk families are given a more thorough assessment, using a tool adapted by ACS from various standardized tools. Using this tool, clinicians gather information about the families' strengths and needs, and are expected to use their clinical judgment and extensive training on service options to match families to the most appropriate services. Families are then referred to one of four types of service, for which FAP contracts with private providers in each of the five boroughs. Families with an acute substance abuse or mental health crisis at intake are referred to hospital emergency rooms, as FAP cannot accommodate them.

Families deemed eligible for additional services receive an immediate referral (generally within 24 hours). Providers must contact the families within 24 hours and initiate services within five calendar days, although providers normally begin services within two days.

Services

In 2011, 53 FAP specialists saw more than 8,000 families. Thirty-six percent of these families received information and advocacy and an additional 27 percent received referrals to other organizations, primarily neighborhood-based services. Ten percent received Level 1 Crisis Stabilization — the least intensive level of service — and 12 percent received more intensive, evidence-based services. The chart on the next page summarizes the service delivery data for all families served by FAP during its first full year of operation.

Level 1 Crisis Stabilization is not an evidence-based practice. FAP contracts with service providers who design their own programs for this short-term (up to 60 days) service. The Children's Aid Society (CAS) serves three of the five boroughs and its services are loosely based on crisis intervention theory and various family mediation techniques with general casework support.

FAP offers a continuum of services ranging from crisis stabilization to an array of evidence-based programs, which includes Functional Family Therapy (FFT), Multidimensional Family Therapy (MFT), Multisystemic Therapy (MST) and

Multidimensional Treatment Foster Care (MTFC). Services are provided for a fixed period of time and the FAP administration monitors service capacity to prevent wait lists for services.

Although FAP is limited to youth who enter the system through PINS applications, in December 2011 ACS began offering FAP’s evidence-based treatment services to teens at risk of entering foster care as a result of abuse and neglect investigations. During 2012, specially trained teen and family specialists began attending child safety conferences for teens on a limited basis to assess eligibility for FFT or MST and to facilitate referrals as appropriate.

In 2013, ACS implemented new preventive programs available to teens through the Division of Child Protection when they are conducting an investigation of abuse and neglect.

Funding

ACS funds FAP by effectively “borrowing” internally from foster care funds within ACS. Because ACS is a large agency with a record of successful reforms, it has been able to develop a reinvestment strategy that reallocates expected savings from child welfare, particularly institutional placements, to fund prevention efforts. In 2013, contracted FAP children’s services, FAP staff and overhead expenses for the five borough offices were estimated to cost just under \$6 million. The FAP budget for FY 2014 was cut to just under \$12 million in part because Level 1 Crisis Stabilization was underused, so some of the spots were cut.

In addition, New York State reimburses counties for roughly two-thirds of all prevention efforts, which means counties fund only one-third of the cost of all prevention efforts. FAP services are not funded by Medicaid; ACS has no plans to pursue Medicaid funding.

Challenges

FAP is developing a data collection system, which means it is not yet possible to measure post-discharge recidivism into the juvenile justice or child welfare systems or to determine the subsequent path of FAP participants even within the FAP system. The most significant indicator of success has been the dramatic drop in placements by petition since the program’s inception.

NYC Family Assistance Program Services 2011²⁵

SERVICE TYPE	SERVICES DELIVERED
Level 1 Crisis Stabilization	801
Level 2 FFT	504
Level 2a MFT	230
Level 3 MST	228
Level 4 MTFC	15
Totals Levels 2 through 4	986
Totals All Levels 1 through 4	1,787
Information and Advocacy	2,875
Referrals to Other Services	2,194
Total Families Seen	8,006

FAP Level 1 Crisis Stabilization is not based on a clear treatment model, nor is there a uniform curriculum or staffing requirements. The providers have strong local connections and anecdotally are achieving good results, but program evaluation is not possible without better data.

ACS' ability to accommodate youth with significant mental health needs through FAP has been limited by the lack of collaboration with the mental health system, unless the youth is eligible for one of the evidence-based program services. New York City also has not pursued Medicaid funding for FAP services because of the capitated nature of New York's Medicaid program. This lack of collaboration also can lead to duplicated services or confusion for families dealing with multiple agencies.

New York City's size allows for economies of scale that other jurisdictions may find hard to replicate. For example, the city contracts for a significant range of evidence-based practices, enabling workers to match families with services best designed to meet their particular needs. Initial training and supervision costs could make such a strategy prohibitively expensive in smaller jurisdictions. On the other hand, FAP operates each borough's operation independently, and each is the size of a moderate-sized city.

ERIE COUNTY, NEW YORK

Total population: 919,000

Population 18 and under: 20 percent

Race/ethnicity: Roughly 22 percent of the population is African American, Hispanic or other minorities

Poverty: Approximately 14 percent of the population was living below the poverty level in 2009

History of Reform

In 2002, New York State promoted county reforms to children's services, which mandated local responsibilities for changes in state laws governing petitions for children's removal from home and the implementation of a federal Medicaid waiver for youth at risk of out-of-home placement due to severe emotional disturbances.

Erie County, which includes the city of Buffalo, responded by implementing a cross-systems planning process involving its probation, mental health and social services departments. This planning process emphasized collaboration across departments to improve service coordination and effectively use resources to achieve better outcomes for at-risk children; it culminated in a six-year SAMHSA grant to establish a community-based system of care, focused on severely emotionally disturbed children. This system of care includes a continuum of evidence-based and local promising practices, supported by system-of-care values and local practice reforms affecting points of entry into the system.²⁶

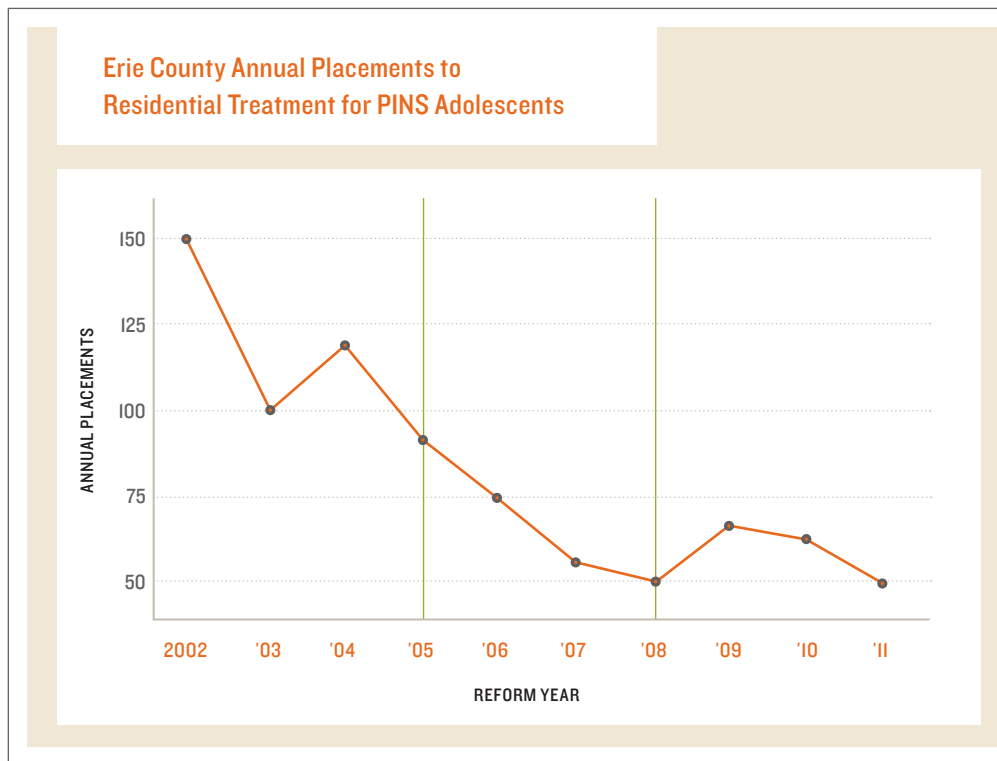
In 2005, Erie County experienced a severe fiscal crisis that resulted in a state-imposed fiscal control board and required the agency to develop a five-year projected budget with significant spending reductions. The approved plan, which was championed by reform leaders, included the projected savings from reductions in children’s institutional care and a commitment to reinvest a portion of savings in the development of community-based services. During the next several years, system-of-care development was further supported by additional state and local initiatives increasing the efficacy of PINS diversion, targeting detention reform and implementing changes to practice within the family courts through a model court initiative. As a result of reform, Erie County has reduced petitions to family court by more than half and cut the number of PINS youth placed annually in residential treatment by more than two-thirds.

Moreover, between 2002 and 2009, secure juvenile placements decreased to 355 children with 5,500 days of care from 881 children with 15,000 days of care. Non-secure placements decreased to 369 children with 4,300 days of care from 941 with 16,000 days of care. In 2011, Erie County estimated it saved almost \$12 million through reduced use of out-of-home bed days.

Access to Services

Erie County’s system of care is notable for its expansiveness in serving families in crisis and for the level of coordination between departments. The Department of Social Services (DSS) leads diversion efforts through a Memorandum of Understanding (MOU) with the mental health agency and juvenile probation. The mental health agency has clinical oversight for the Family Services Team intake and the formal diversion services. The Family Services Team intake center, located in the Social Services building, is open to all families and youth in crisis for immediate service during normal business hours; it is staffed by DSS (child welfare) caseworkers, youth probation officers and mental health practitioners.

In 2011, nearly 1,000 families visited the center. When families and youth arrive, they are screened by DSS staff using a tool that measures a youth’s functional capacity in four areas: interpersonal relations,

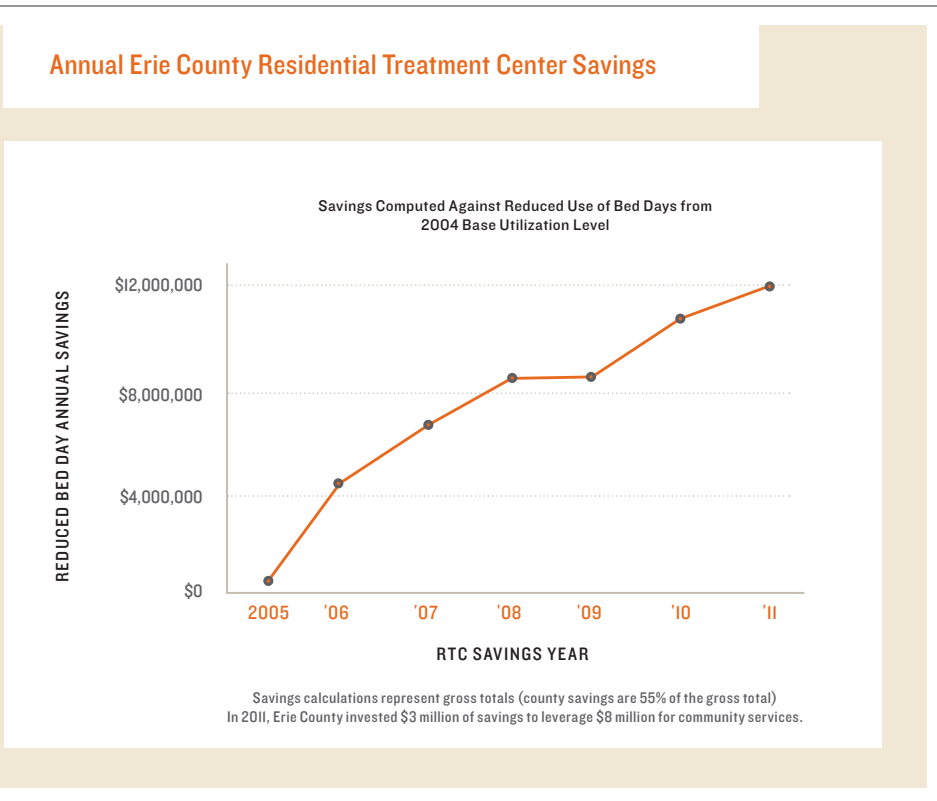


psychopathology, school and/or work and use of leisure time. Of the families who visited the center in 2011, about 20 percent left with information or community referrals, and only 7 percent left with an authorization for a warrant for a runaway.²⁷ The remaining nearly three-fourths of the families were referred to services based on the results of the screening.

Services

During the course of the initiative, Erie County has increased its total annual spending on community-based services from \$4.55 million in 2005 to \$16.44 million in 2012, which means the system can now offer community-based services

to approximately 1,373 youth and families at any point in time (up from 331 slots in 2005). If the assessment indicates moderate to high risk of deeper-end placement, families are linked to a probation officer, while also being overseen clinically by mental health staff. The probation officer explores the family's needs and makes referrals to appropriate community-based service providers. Providers have two to three business days from the time of referral to meet with the families in their home, where they determine both the progress of families during treatment and success across different providers. Service options include FFT, MST, Multisystemic Therapy/Substance Abuse, best practice alcohol and substance abuse outpatient treatment and Family Voices Network (FVN), a provider of High-Fidelity Wraparound care (see table).



FVN is the largest of the system's intensive service options and provides comprehensive, coordinated, individualized, culturally competent and cost-effective community-based services that support youth and their families to keep them in their homes and communities. The program is intended for youth who are experiencing serious emotional, behavioral and/or social challenges. These are youth with a history of or risk of hospitalization or out-of-home placement, multisystem involvement or needs, substantial functional impairments and/or psychiatric symptoms and an unsuccessful history of interventions. Care coordination services are planned and delivered with a family-driven, strength-based focus using the wraparound process, which creates collaboration between

Erie County Expands Access to Community-Based Services

In 2005, the county spent \$4.55 million to help 331 children.

SERVICE OPTIONS	2012 FUNDING	2012 SERVICE SLOTS
NYS Home and Community Waiver	\$ 3,529,500	78
Blended System of Care Full Flex Wraparound	\$ 6,973,620	372
Supported Care Coordination/ Flex Supports	\$ 485,000	60
Multisystemic Therapy	\$ 750,000	60
Functional Family Therapy	\$ 310,000	56
Urgent Access Intensive In Home	\$ 672,226	60
Community Connections In Home	\$ 750,000	80
Intensive Community Monitoring	\$ 300,000	40
Family Keys PINS Intervention	\$ 375,000	80
Alcohol/Substance Abuse EBPs	\$ 661,775	50
Mobile Crisis Outreach	\$ 730,000	12
Enhanced Psychiatric Services Demonstration	\$ 75,000	25
Youth Advocacy	\$ 175,000	125
Family Resource Center	\$ 210,000	100
Family Support/ Family Advocacy	\$ 445,000	175
Total	\$ 16,442,121	1,373

Blended (Braided) Funding Supporting 2012 Annual System of Care Budget Costs

FUNDING SOURCE	2012 FUNDING
NYS Home and Community Medicaid Waiver	\$ 3,529,500
DSS Mandated Preventive Services	\$ 7,495,935
NYS FFFS Grant (Including TANF)	\$ 2,646,091
NYS Office of Mental Health State Aid	\$ 3,682,395
Total Annual SOC Budgeted Costs	\$ 17,353,921 (includes approximately \$900K of administrative infrastructure)

the youth, their families and a team they select.

All families also have access to the county-funded Families’ Child Advocate Network, which provides support, information and services to families raising children with emotional, behavioral and social disabilities. Upon request, the network matches parents in crisis with culturally competent advocates — parents who have experienced similar challenges and can help families navigate and understand the various systems. Families or providers can also request a youth advocate in conjunction with other services.

Based on the achievements of the system-of-care reform initiative to date, Erie County’s DSS and mental health agencies began to identify specific opportunities to apply system-of-care principles and management practices to the traditional child protection system, starting with improvements in the effectiveness of contracted community-based services for foster care prevention. The initial focus is on ensuring that those services achieve positive outcomes within targeted time frames.

Data Collection and Analysis

To ensure that youth are receiving effective services, Erie County maintains an online electronic records system that all providers can access and use to support treatment services and facilitate outcome measurement and effective contract management. Using this system in the early years of the reform, Erie County noted variability across service providers in fidelity to practice models and achievement of outcomes, even when the agencies used the same evidence-based practices. Moreover, even though the reforms increased service capacity, there were often waiting lists and long enrollment periods for services.

To address these issues, the county partnered with community providers to create and fund Community Connections of New York (CCNY). CCNY collects and analyzes data and provides program evaluation, training and mentoring services, utilization management and “practice to outcome” quality improvement technology for all private providers participating in the system of care. Through its partnership with CCNY, Erie County uses data to ensure timely access to services and to

continuously monitor and improve service quality and outcomes. With CCNY's help, Erie focuses on matching youths to the right services for the right length of time.

Funding

As shown in the chart, Erie County blends funds from four primary sources: Medicaid, mandated preventive state funds, TANF and mental health.

Challenges

Erie measures post-discharge entries into the juvenile justice or foster care systems for the youth served at the time of discharge from the system of care, but is not tracking post-discharge recidivism (e.g., after six months). However, the pre- and post-reform data on out-of-home placements that participants attribute directly to reform efforts are compelling. Erie County is working to improve its capacity to measure longer-term outcomes.

While Erie can demonstrate a significant reduction in out-of-home PINS placements, youth who are not diverted through the PINS system still can end up being placed in foster care on PINS petitions. While foster care placements based on petitions have dropped along with other out-of-home placements, data establishing the extent of the decline are not available.

Erie's system of care is not being fully used to support the work of child protection workers assisting families who enter through the child protective services hotline. If an abuse/neglect investigation results in a conclusion that foster care prevention services are needed, the social services agency provides separately for those services, even for cases that otherwise resemble those of young people with behavioral problems. The DSS prevention services caseload of 1,500+ may well include teens with significant behavioral issues contributing to their agency involvement, and these teens could still enter foster care without ever being offered help through the impressive system of care Erie has developed. DSS' child protective services system does not participate in the system of care as thoroughly as PINS, mental health and juvenile justice do, although DSS voluntary placement cases are routed through the system, starting with the Family Services Team intake. Erie County leaders anticipate that they can address this by extending system-of-care principles and a similar service delivery system to DSS preventive service contracts.

WAYNE COUNTY, MICHIGAN

Total population: 1.8 million

Population 18 and under: 25 percent

Race/ethnicity: Half of the population is African American, Hispanic or other minorities

Poverty: 24 percent of the population was living below the poverty level in 2009

History of Reform

Wayne County's juvenile justice system has undergone drastic changes during the past 12 years. It began when the county, which includes the city of Detroit, entered an agreement to take over responsibility from the state for all juvenile justice services, including prevention, probation services and out-of-home placements for high-risk offenders. Previously, more than 2,000 youth were incarcerated daily in state training facilities or other institutional placements; the local detention population was larger than 500 youth per day in crowded facilities. Under Michigan law, status offenders are served through the juvenile justice system rather than through child welfare; before reform efforts began, as many as 40 percent of young people placed in institutions were status offenders. Juvenile recidivism was estimated between 38 and 56 percent.

In 1999, the new county management instituted a public/private partnership focused on treating youth at home rather than in institutional settings whenever possible. The changes have included adopting detention policies, such as screening pre-adjudication to detain only those who are safety or flight risks; speeding up court dates; and using forms of home detention and electronic monitoring. But much of the success can be attributed to effectively aligning responsibility and authority for delinquent youths and status offenders in a single governmental entity, enabling financial and programmatic decision making to be in line with clear outcome goals set by the county, as well as a change in focus to home-based treatment services.

Since the initiative began, state training school commitments have been reduced to fewer than 10; placements in residential group facilities through the juvenile justice system are down from pre-reform levels of 2,000 a day to 650 a day; and detention populations are at 150 a day — collectively a 65 percent reduction. The recidivism rate for adjudicated offenders is 17.8 percent, and the recidivism rate for youth in Correct Course, a diversion program for first-time offenders, is about 10 percent.

Access to Services

Private entities provide all juvenile justice services (including status offender services) through contracts with the county's Department of Children and Family Services.²⁸ The Juvenile Assessment Center (JAC), a private entity, assesses all adjudicated youth (including adjudicated status offenders) and assigns them to an initial security level and to a care management organization (CMO) in their neighborhood. The initial assessment also includes a drug and alcohol screening, as well as additional psychological and substance abuse clinical assessments as needed. The CMOs provide some services directly and refer youths to other services as needed. Functional improvements are measured quarterly and at case closing to measure youths' progress. CMOs have wide discretion in case planning, while the county measures performance on key outcome indicators.

Starting in 2007, Wayne County added a diversion option, called Correct Course, for first-time offenders with status offenses and low-level delinquency charges. Dedicated prosecutors screen cases for referral at the first court appearance. Youth who are deemed to be amenable to and appropriate for services are offered the opportunity to comply with services in exchange for dismissal of the charges. Participation is voluntary. If the youth accepts, he/she is given a self-administered computerized assessment completed by both the youth and a caregiver that is designed to identify challenges in the home, school and community. A sample is also taken for drug and alcohol analysis. Based on these results, and additional evaluations if indicated, the JAC staff determine goals with the youth and family and refer them to a Youth Assistance Program in their neighborhood for approximately three to six months of services and/or to more intensive mental health treatment as needed.

Standardized assessments for diversion cases and for adjudicated offenders support efforts at effective treatment and performance-based management.

Services

Community-based services have expanded to serve thousands of youth. Correct Course serves more than 800 youth per year. A variant of the Correct Course model, First Contact, has recently been expanded to include police referrals as well as self-referrals, though the numbers of these remain small. These families can be seen at the JAC site during business and evening hours. The JAC refers families to community-based agencies for follow-up services. These cases do not touch the formal justice system.

Funding

Wayne County has succeeded in funding community-based services as part of its juvenile justice services reform effort largely through reductions in spending on residential placements. Once-skyrocketing and -increasing juvenile justice costs decreased by 2 percent, to \$131.7 million in 2005, during the first five years of reform, as the increase in spending on community-based services was more than offset by reductions in out-of-home placement costs. The juvenile justice system is tightly coordinated with the local community mental health (CMH) system, which has also undergone a major outcomes-oriented reformation, through which juvenile offenders with serious mental health needs are identified and connected to treatment. CMH is accessing Medicaid to pay for assessment and treatment services and funds mental health assessments and other services provided by the JAC as well.

Challenges

Child welfare, administered at the state level, is focused on the demands of a 2008 consent decree and has not participated in this process. Because the child welfare agency is not responsible for serving status offenders, reforms in juvenile justice

and child welfare have proceeded largely independently, even though both systems deal with the same teens with the same behavioral issues.²⁹ This may limit the usefulness of Wayne County's model in states where status offenders frequently end up in foster care, although many of the lessons learned in Wayne County remain relevant.

The service system described here is in significant ways dependent on prosecutors, who make key decisions such as screening which cases are offered diversion services. This is consistent with and perhaps necessary for Wayne County's juvenile justice goals, but it is different from a system of accessible, quick screening and assessment by trained professionals.

Wayne County also serves thousands of youth annually through its prevention services programs, but those services operate independently of the JAC and Correct Course and were not part of the review.

MECKLENBURG COUNTY, NORTH CAROLINA

Total population: 919,628. Notably, the jurisdiction has grown rapidly, increasing 32 percent in population from 2000 to 2010

Population 18 and under: 25 percent

Race/ethnicity: 49 percent of the population is African American, Hispanic or other minorities

Poverty: Approximately 12.5 percent of the population was living below the poverty level in 2009

History of Reform

North Carolina has a state-supervised, locally administered child welfare system that has implemented several major reform initiatives relevant to youth at risk of entering out-of-home placements during the past decade. In 2003, the state began a statewide effort to reform its child protection system through development of a Multiple Response System (MRS). MRS began in 10 counties, including Mecklenburg County, which includes the city of Charlotte. MRS was extended statewide in 2006. The reform focuses on several key strategies, including:

- a family-strengths-based, structured intake process;
- a two-track alternative response to abuse and neglect allegations, with many families routed to a non-adversarial assessment and service delivery track instead of the traditional investigatory track; and
- the use of child and family team meetings for both in-home and foster care cases, to bring together all the resources of the family, community and public agencies to work cooperatively toward desired outcomes for children and families.

Local jurisdictions had substantial discretion in implementing this statewide

reform effort, and Mecklenburg opted to use the family assessment track to the maximum extent allowable by law. Fully 80 to 90 percent of screened-in allegations of abuse and neglect in Mecklenburg are handled through the family assessment track.

In 2005, Mecklenburg County received a SAMHSA system-of-care grant, contributing to the state's quarter-century focus and leadership on implementing reforms. The grant emphasized collaboration across the mental health, child welfare, juvenile justice and education systems to provide services to children ages 10 to 21 with serious emotional disturbances and their families. Mecklenburg also participated in a contemporaneous statewide grant from the federal Children's Bureau of the Administration for Children and Families to extend system-of-care principles to child welfare. Those principles include an emphasis on interagency collaboration, individualized strengths-based care, youth and family involvement, cultural competence, community-based services and accountability.³⁰ The state also has been engaged in extensive reform of its mental health system. The reforms have used Medicaid and state mental health resources to build community-based services, with an emphasis on evidence-based and promising treatment practices instead of institutional care wherever possible.

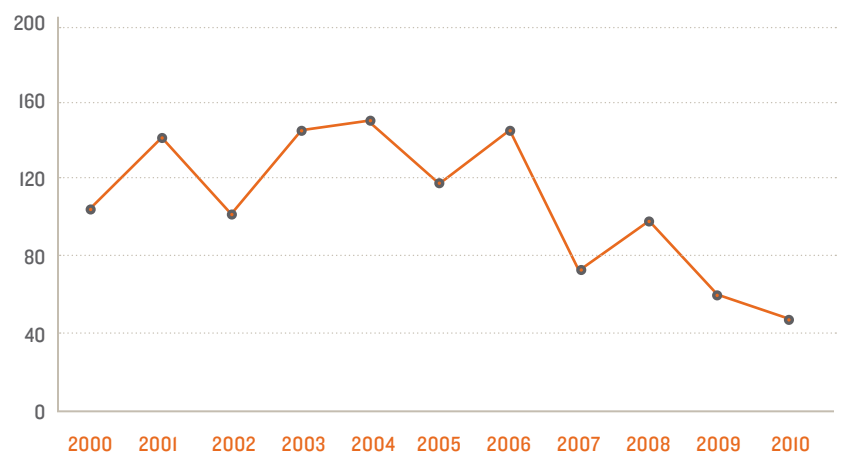
In Mecklenburg, teen out-of-home placements have dropped dramatically during the past decade, even as the child population increased by 33 percent from 2000 to 2010.³¹

While it is hard to compare entry data among states, by any measure Mecklenburg's overall rate of entries into foster care — 1.24 per 1,000 children in FY 2010 — is one of the lowest in the country, and well below the comparable national average of 3 per 1,000 children.³² North Carolina's MRS and system-of-care efforts have been widely and favorably evaluated by independent evaluators on a variety of criteria.³³

Access to Services

Mecklenburg uses system-of-care principles to guide the way it does business throughout all of its child-serving agencies. Child and Family Teams are used as the primary case planning tool throughout the provision

Entries to Foster Care in Mecklenburg County, 13-to 17-year-olds



of mental health and child welfare services, and to some extent in juvenile justice and education. Children involved in multiple systems have a “one-child-one-plan” document that unifies the work across all involved agencies, which the team updates monthly.

Mental health services, with an emphasis on evidence-based treatment programs, are widely available to all Mecklenburg residents. Services are accessed initially through MeckLink, a 24/7 call center that links families to an array of more than 80 private provider agencies. Families who contact MeckLink are connected immediately with a service provider, who initiates a Child and Family Team to coordinate with the family and other agencies as needed. Services are available regardless of ability to pay, funded by private insurance where available and otherwise by Medicaid and state mental health funds. Service capacity is sufficient to meet the need; community leaders report that waiting lists and delays in obtaining services are not an issue.

Children with more severe needs are enrolled through their providers in MeckCares, the formal system of care for youth with serious emotional disturbances. Juvenile justice workers and child protection workers also use MeckLink to connect families with appropriate mental health services. A wide variety of mental health treatments is available through MeckLink and MeckCares, including multiple evidence-based and promising options such as MST, MTFC, cognitive behavioral therapy/trauma focused, wraparound, parent child interaction therapy and FFT.

Families who come to the attention of the Division of Youth and Family Services (YFS) child protection hotline are screened to determine if there is a qualifying allegation of abuse or neglect. A strengths-based approach with the family begins from the first contact with the hotline, which sets the stage for cooperation between the agency and family throughout the process. If the matter is screened out, the family is referred for voluntary services to MeckLink or other community resources as appropriate. If the matter is screened in, most cases other than sexual abuse, serious physical abuse or severe neglect are routed to the family assessment track; most teen-related issues go to the assessment track. A YFS worker assigned within one of five districts meets with the family and determines if services are needed or recommended. If services are needed and the family refuses, the matter can be transferred to the investigatory track, but this option is rarely needed. Child and Family Teams are used to plan for in-home services and meet frequently to adjust and monitor the plan.

A local Community Collaborative composed of leaders of all the relevant agencies along with local judges, parents, youths and community representatives meets

on a monthly basis to oversee the system of care. Among other responsibilities, the collaborative identifies service gaps, addresses barriers to the work of the Child and Family Teams and ensures interagency training. Workers throughout the participating agencies (covering mental health, child welfare, juvenile justice and to some extent education) as well as private providers participating in MeckLink undergo rigorous, unified training on system-of-care principles and implementation. System-of-care principles guide work throughout the participating agencies, not just within the more specific MeckCares program for severely emotionally disturbed children.

Parent Voice, funded originally by the SAMHSA grant and now supported with local dollars, provides additional support to families navigating their way through the Mecklenburg system of care. This organization is staffed by parents who have experienced the system with their own family challenges. It provides an orientation to the system of care and one-on-one consultation and advocacy as needed along with support groups for youths and parents. It plays a crucial role in ensuring family involvement throughout the system.

While it is difficult to attribute these results specifically to one or another of the overlapping reform efforts, local leaders emphasize the strengths-based, nonadversarial approach to working with families, and the degree of both systemic and case-specific collaboration among agencies. The ready availability of community-based mental health services is also considered a key ingredient in Mecklenburg's success.

Funding

As an example of the effective collaboration among agencies, local leaders described how they responded to recent state budget cuts that affected a program called FACET, which funded child welfare workers to collaborate with court staff and families to find alternatives to out-of-home placements for juveniles with delinquency issues. As that program's capacity declined sharply, agency leaders created another option: a multidisciplinary team that seeks alternatives for youths who are otherwise heading to out-of-home placements within child welfare or juvenile justice. The Council on Children's Rights, a local nonprofit and lead agency on the team, provides court-appointed legal counsel to juveniles in child welfare and delinquency matters (and voluntary assistance to youths who are the subject of "undisciplined"³⁴ petitions). Children's Rights attorneys meet weekly with representatives from child welfare, juvenile probation and mental health services to staff the challenging cases. Each agency contributes staff time as needed; the multidisciplinary team has no independent funding. The team has been in place for only a few months, but local leaders report impressive results so far, with almost none of the cases reviewed ending up in group placements.

The depth and strength of the collaboration among the three key agencies is remarkable. This has resulted in fewer entries into care from all the typical entry points — juvenile justice, mental health and child protection — with ongoing work to address school issues. While there is no statutory gatekeeping method to prevent “undisciplined” juveniles from entering custody unnecessarily, the judges support the system-of-care approach and encourage alternatives to group placements whenever possible for all children.

Challenges

Perhaps due to the wide availability of community-based mental health services, some local leaders contend that the system tends to over-diagnose children in care with mental health issues.

Local leaders maintain that they have insufficient control over the quality of treatment programming. State agencies set minimum licensing standards that emphasize evidence-based treatment approaches, and the county has a system of star ratings to guide parents’ selection of a provider. But these government agencies are not able to match parents to providers or direct resources to the most effective providers because parents may select any providers within the MeckLink network.

Teens are considered adults at 16 within North Carolina’s criminal justice system, even though they remain legally children for other purposes (including child welfare). This is a major impediment to continuing to provide them with effective treatment services after they age out of juvenile court.

findings and analysis

Based on our research, CWSG identified four common practice elements and six systemic factors that were common to the promising sites we visited.

The four common practice elements include agencies having:

1. A WIDE FRONT DOOR. What constitutes problem behavior and a crisis is different for every family, and many systems offer help only to individuals with severe mental health problems or those who are eligible for Medicaid. To reach families when they are amenable to help, the system should be open to all families and youths in crisis, with crisis defined by the family and no eligibility criteria other than the age of the youth. Inevitably communities may offer more than one path to families dealing with teen behavioral problems, and it may not be feasible or wise to merge different agencies with varying missions and statutory mandates. However, the most successful systems have coordinated services to eliminate delays and duplication and ensure that preventive services are available to families and teens seeking help on their own. While this wide level of access to services may seem to invite an unmanageable number of youths and families into the system, this has not proven to be the case in the model sites visited. Moreover, offering support to families before their crises escalate has proven to be cost-effective by reducing the need for more intensive, expensive services and out-of-home placements later on.

2. TIMELY ACCESS TO INITIAL SCREENING AND ASSESSMENT. If families are forced to wait weeks or months for services, they have often either lost their motivation or the crisis has become so severe that intervention is not as likely to succeed. Many of the successful programs we visited operate within normal business hours, so an around-the-clock intake system may not be necessary as long as families are seen promptly and can quickly access services. Of course, an immediate crisis response service benefits any community, and a number of jurisdictions have some services that operates at all times.

3. HIGH-QUALITY SCREENING AND ASSESSMENT. Experienced staff knowledgeable about available services and trained in family engagement techniques speak with the youth and the parent or guardian. This initial screening and assessment serves as an informal mediation session and may be all the family wants or needs. Data in Erie and New York City confirm that many families' interaction with the child welfare system consists entirely of this first contact. The effectiveness of this initial interaction depends in large part on the quality of the screening and assessment personnel and how well they are trained and supported to address families' needs.

Second, the workers who handle the screening and assessment are the critical gatekeepers who match youths and their families to appropriate services, ensuring that the most intensive services are reserved for those who need them.

Finally, the screening and assessment process should include individual consultations with youths by professionals trained to identify and address serious neglect and abuse, because some youth who appear to be runaways or "ungovernables" may be victims of sexual abuse or other serious abuse or neglect.

4. A RANGE OF HIGH-QUALITY SERVICES. Systems should offer an array of services of varying levels of intensity. Sufficient capacity should be available so that families who need services can access a range of effective promising and evidence-based options without delay. The programs being used most often are relatively intensive programs, including Functional Family Therapy, Multisystemic Therapy and High-Fidelity Wraparound. In some jurisdictions, evidence-based programs are being offered to a significant number of high-risk families.

Jurisdictions have found it harder to find evidence-based treatments to serve the greater portion of families who need a lower level of intervention. The Family Keys program operated by Southwest Keys in Erie is one potential candidate for a more rigorously structured program with data collection that might be a useful model.

All of these services are most successful when they are matched to children's developmental and behavioral needs, and when families are promptly connected to services through referral mechanisms. Services should focus on helping parents meet their children's needs through natural support, family- and community-based support networks as well as formal services. They also should be accessible and convenient to families, including in-home, after-hours and weekend options.

The six common systemic factors included agencies having:

- 1. STRONG INTERNAL CHAMPIONS FOR CHANGE.** Leaders must understand the importance of establishing clear goals, guiding reform efforts, working to gain buy-in from influencers and emphasizing continual improvement.
- 2. A REQUIREMENT THAT FAMILIES MUST EXHAUST AVAILABLE SERVICES BEFORE PETITIONING THE COURT TO REMOVE A CHILD.** State laws should discourage parents from seeking out-of-home placements for a child with behavioral issues. In New York, services are voluntary but state law requires families to exhaust available services before they can petition the court to remove a child from his or her home. Mecklenburg and Wayne counties have no comparable gatekeeping statutes, but local judges and prosecutors strongly support the focus on community-based services and effectively serve a gatekeeping function.
- 3. DATA COLLECTION AND ANALYSIS.** Wayne and Erie counties use cloud-based electronic records systems that allow for seamless data sharing across various service providers and agencies. Erie County’s system enables leaders to monitor process and outcomes, manage use of services and emphasize continual quality improvement.
- 4. COMMUNITY OUTREACH.** Systems must reach families before they are too frustrated to benefit from the help offered or too fed up to accept any service that allows the youth to remain at home. Effective interventions need to include community outreach to families and potential referral sources such as schools and police so that they are aware that help is available and know how to access it.
- 5. MULTISYSTEMIC COLLABORATION.** Systems that coordinate and even pool their resources can more effectively and efficiently serve families involved with multiple agencies. In New York City, the juvenile justice and child welfare systems were merged within the Administration for Children’s Services in early 2010. Erie County’s mental health staff supervise juvenile justice and child welfare staff participating in the system, and Wayne County has achieved a high degree of coordination between juvenile justice and mental health services. In Mecklenburg, both case planning and systemic leadership are closely coordinated across the juvenile justice, child welfare and mental health systems. This may be easier to do in a county-administered child welfare system with considerable local control, such as in New York and North Carolina.

The Center for Juvenile Justice Reform at Georgetown University has developed a helpful practice model for collaboration between juvenile justice and child welfare agencies regarding “crossover” youth who are involved in both those systems. Many of the recommendations embedded in the practice model apply more broadly to cross-agency collaborations for child-serving agencies.³⁵

Unfortunately, cross-agency collaboration is challenging to achieve. Even in jurisdictions that have made progress, there were opportunities for better coordination. Child protective service workers are often still serving families in crisis without the benefit of full collaboration with other systems. And even where jurisdictions have worked hard to coordinate their efforts across agencies, schools and services for homeless and runaway youth often operate independently of other initiatives.

6. FLEXIBLE, SUSTAINABLE FUNDING SOURCES. New York City and Erie County both use an internal reinvestment strategy that redirects savings from reductions in out-of-home placements to community prevention. They also benefited from structures that allowed them to leverage state funds to help pay for prevention efforts. In Mecklenburg, local leadership continually adjusts to take advantage of various funding opportunities, including North Carolina's generous but ever-changing use of Medicaid to fund community-based mental health services. The New York jurisdictions, in particular, have recognized that documenting their cost-effectiveness and proving their impact on core government functions are crucial to sustainability and to avoiding funding cuts they might otherwise have faced. Creating a data collection process that allows an agency to measure return on investment can be especially helpful to ensuring sustained funding.

conclusion

While additional testing of specific program models is necessary, research and analysis support the conclusion that jurisdictions can effectively reduce unnecessary out-of-home placements resulting from youth behavioral problems using programs that incorporate the key elements described in this paper.

While none of these models is perfect, Erie County and New York City are particularly strong examples of systems that are effectively reducing the entry of status offenders into foster care, although they are still working to extend the approach to child protection cases. Wayne County is achieving similar success reducing the entry of status offenders into juvenile justice placements. Mecklenburg County likewise has developed a strong system-of-care collaboration among all three child-serving agencies and committed to family engagement, especially through differential response, for those entering through the child welfare system, along with its ample Medicaid-funded children's mental health services.

The experiences of these jurisdictions demonstrate the potential to prevent the removal of young people from their homes, where they risk losing connections with their families and aging out of care without the skills needed to become productive adults. If similar programs were adopted nationally, thousands more youths could grow up in their families, avoiding the trauma of removal and reducing the potential for poor life outcomes.

ENDNOTES

1. These behaviors and actions are often called status offenses because they relate to a teen's "status" as a minor.
2. Wildfire Associates unpublished analysis of AFCARS 2012 data.
3. Ibid.
4. Ibid.; For this analysis, AFCARS categories of "child behavior," "child alcohol use" and "child drug abuse" are combined. Note that AFCARS categories for removal reasons are not mutually exclusive, so a removal may be counted in more than one category.
5. Ibid.; Based on point-in-time data as of Sept. 30, 2012.
6. Jim Casey Youth Opportunities Initiative. (2011). *The adolescent brain: New research and its implications for young people transitioning from foster care*. St. Louis, MO: Author. Retrieved from www.jimcaseyouth.org
7. Casey Family Programs. (2008). *Improving outcomes for older youth in foster care*. Seattle, WA: Author.
8. The Annie E. Casey Foundation. (2012). *KIDS COUNT policy report – Stepping up for kids: What government and communities should do to support kinship families*. Baltimore, MD: Author. Retrieved from www.aecf.org/kinship
9. The Office of Juvenile Justice and Delinquency Prevention maintains a useful online Deinstitutionalization of Status Offenders Best Practices Database cataloging these efforts at www.juvenilejustice-tta.org/resources/dso/about-dso
10. Mendel, R., & The Annie E. Casey Foundation. (2011). *No place for kids: The case for reducing juvenile incarceration*. Baltimore, MD: The Annie E. Casey Foundation. Retrieved from www.aecf.org/noplacforkids
11. Because of these complexities, surveying the variations in state law on status offenders is fraught with difficulty. National surveys are useful in understanding the range of variation but must be used with caution in analyzing relevant law in any given state. See Kendall, J. (2007). *Families in need of critical assistance: Legislation and policy aiding youth who engage in noncriminal misbehavior*. Chicago, IL: ABA Center on Children and the Law; National Law Center on Homelessness & Poverty and the National Network for Youth. (2003). *Alone without a home: A state-by-state survey of laws affecting unaccompanied youth*. Washington, DC: Authors. Retrieved from www.nlchp.org
12. In 2002, "Person in Need of Supervision" (PINS) youth made up 23.5 percent of foster care placements of 12- to 17-year-olds. See NYC Administration for Children's Services Chart on p. 15.
13. Technically some of these placements may be considered foster care pursuant to state law and for federal statistical purposes, but in such states they are managed entirely within the juvenile justice agency, with no child welfare agency involvement.
14. Retrieved from <http://mstservices.com/proven-results/proven-results>
15. Retrieved from <http://blueprintsprograms.com/factSheet.php?pid=0a57cb53ba59c46fc4b692527a38a87c78d84028>
16. National Wraparound Initiative: www.nwi.pdx.edu/
17. Homebuilders Program, Institute for Family Development: www.institutefamily.org/
18. Multidimensional Family Therapy: www.mdft.org/
19. Brief Strategic Family Therapy: www.bsft.org/
20. Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services. (2011). *Interventions for disruptive behavior disorders evidence-based practices KIT*. Rockville, MD: Author. Retrieved from <http://store.samhsa.gov/product/Interventions-for-Disruptive-Behavior-Disorders-Evidence-Based-Practices-EBP-KIT/SMI11-4634CD-DVD-Based-Practices-EBP-KIT/SMI11-4634CD-DVD>
21. Barth, R. (2010-2013). *Work in progress: Common elements of child & family services*. Funded by Center for Medicaid Services 1915 Waiver to Innovations Institute at the University of Maryland. This work is not limited to prevention programs serving older youth exclusively.
22. Cost estimates and cost-benefit analyses for MST, FFT and Homebuilders among others can be found in Lee, S., Aos, S., Drake, E., Pennucci, A., Miller, M., & Anderson, L. (2012). *Return on investment: Evidence-based options to improve statewide outcomes, April 2012 (Document No. I2-04-I201)*. Olympia: Washington State Institute for Public Policy. Retrieved from www.wsipp.wa.gov/rptfiles/I2-04-I201.pdf
23. The Annie E. Casey Foundation. (2011, May). *Smaller, smarter and more strategic: Juvenile justice reform in Alabama*. Baltimore, MD: Author. Retrieved from http://dys.alabama.gov/pdf_other/Grants/Grant%20Forms/JJ_Reform_AL_%20Report_Caseyftn/Alabama%20engagement%20write-up%20FINAL%205_11_11.pdf
24. Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services. (2011). *Interventions for disruptive behavior disorders evidence-based practices KIT. Implementation Considerations* (pp. 7 et seq.). Rockville, MD: Author. Retrieved from <http://store.samhsa.gov/product/Interventions-for-Disruptive-Behavior-Disorders-Evidence-Based-Practices-EBP-KIT/SMI11-4634CD-DVD-Based-Practices-EBP-KIT/SMI11-4634CD-DVD>
25. Chart compiled by authors based on ACS FAP Administration data. Total services do not match total families seen because some families withdrew, refused services or were connected to services within other ACS divisions.
26. Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services. (2011). *Interventions for disruptive behavior disorders evidence-based practices KIT*. Rockville, MD: Author. Retrieved from <http://store.samhsa.gov/product/Interventions-for-Disruptive-Behavior-Disorders-Evidence-Based-Practices-EBP-KIT/SMI11-4634CD-DVD-Based-Practices-EBP-KIT/SMI11-4634CD-DVD>
27. Runaways are generally referred for services through the system of care once picked up on a warrant.
28. Retrieved from <http://quickfacts.census.gov/qfd/states/26/26163.html>
29. Technically the juvenile justice system could use foster care placements within its own system for status offenders and delinquents, but in Wayne County this option is used no more than a half-dozen times per year. This has been true for many decades, even before the reforms we have described.
30. Further information on the six guiding principles of systems of care, along with additional resources on systems of care implementation within child welfare, is available at www.childwelfare.gov/topics/management/reform/soc/
31. The Annie E. Casey Foundation KIDS COUNT Data Center: www.datacenter.kidscount.org/
32. Mecklenburg data from the Jordan Institute for Families (retrieved from www.ssw.unc.edu/ma/). National data from the Annie E. Casey Foundation's KIDS COUNT Data Center. Retrieved from www.datacenter.kidscount.org
33. The Center for Child and Family Policy at Duke University has evaluated North Carolina's MRS reform. See, for example, Multiple Response System Evaluation Report to N.C. Division of Social Services: Review of Juvenile Petitions (June 30, 2011), www.ncdhhs.gov/dss/mrs/docs/MRS%20Report%202011.pdf, and Multiple Response System Evaluation Report (June 2006), www.childandfamilypolicy.duke.edu/pdfs/pubpres/MRS_FinalReport-06.pdf Mecklenburg's system-of-care effort has been evaluated as part of national evaluations; see, for example, National Technical Assistance and Evaluation Center for Systems of Care's System of Care Implementation Case Studies (November 2010), www.childwelfare.gov/management/reform/soc/communicate/initiative/evalreports/reports/ImplementationCaseStudies.pdf
34. North Carolina's version of children-in-need-of-supervision (2001). N.C. Gen. Stat. Sections 7B-1501, 2502.
35. Retrieved from <http://cjjr.georgetown.edu/pm/practicemodel.html>



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