

# Keeping Teenagers out of Foster Care:

Do Teen-Specialized Services Make a Difference?



The Center for New York City Affairs is dedicated to advancing innovative public policies that strengthen neighborhoods, support families, and reduce urban poverty.

Our tools include rigorous analysis; journalistic research; candid public dialogue with stakeholders; and strategic planning with government officials, nonprofit practitioners and community residents.

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# Executive Summary

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In 2013, New York City launched an array of programs offering a new and innovative strategy to solve an old and difficult problem: how to keep teenagers out of the City's foster care system.

The programs—known collectively as “teen-specialized preventive services”—see fewer than 900 cases annually, a relatively small slice of the total citywide preventive service system, which served approximately 24,000 kids last year. But they represent a pivotal piece of the City's ongoing child welfare reform agenda: to keep whittling down the number of kids who enter foster care by providing targeted, intensive, “family-centered,” and evidence-based preventive services.

For the majority of its several-decade history, the City's preventive service system followed a standard formula. The Administration for Children's Services (ACS) holds contracts with private social-service agencies (many of which also run foster care programs), where providers refer parents to a mix-and-match of services such as parenting classes and drug treatment, as well as assisting with practical concerns like applying for public housing and benefits. The goal is to get families any help they need to avoid a crisis that might land a child in foster care.

In the best cases, this case-management model (rebranded in recent years as “General Preventive”) offers parents flexibility and the chance to develop long-term relationships with helpful community organizations. But it can also be unwieldy and blunt, sending already stressed families from waiting room to waiting room—sometimes from borough to borough—to sit through classes and therapy sessions that might vary widely in both quality and relevance to the help a parent actually wants.

Teen-specialized preventive services represent a pivotal piece of the City's ongoing child welfare reform agenda: to keep whittling down the number of kids who enter foster care by providing intensive, ‘family-centered,’ evidence-based preventive services.

## Investing in Teen-Specialized Programs

In recent years, ACS has invested in a new generation of preventive service models—far more up-close, intensive (and expensive) than their predecessors. In these new models, providers work with small caseloads of precisely targeted families for several hours each week, often in the families' homes. While there is some case management built into each model, the centerpiece is therapy—both individual and family—designed to change family dynamics and behaviors.

With a few exceptions, the program models lay claim to an “evidence base”: They were developed by social scientists at universities or research institutes, who subjected them to empirical, controlled studies, in which they demonstrated better results than a more standard social work practice. The developers then package and market the programs for replication across the country, complete with training and regular oversight to make sure that providers faithfully emulate the original model.



While ACS-funded providers offer evidence-based programs to families with kids of all ages (including two models designed for infants and toddlers), the teen-specialized programs are the longest standing in the agency's array of next-generation, intensive, therapy-based preventive services. They offer a particular insight into the City's bumpy progress toward a child welfare system that treats families with respect and strives to keep children safe at home.

To develop this report, the Center for New York City Affairs at The New School interviewed families currently and previously involved in teen-specialized preventive services, as well as providers, program model developers, community advocates, and officials at ACS. We observed supervisory staff meetings among teen-specialized providers and reviewed available data about this universe of programs and the people they serve.

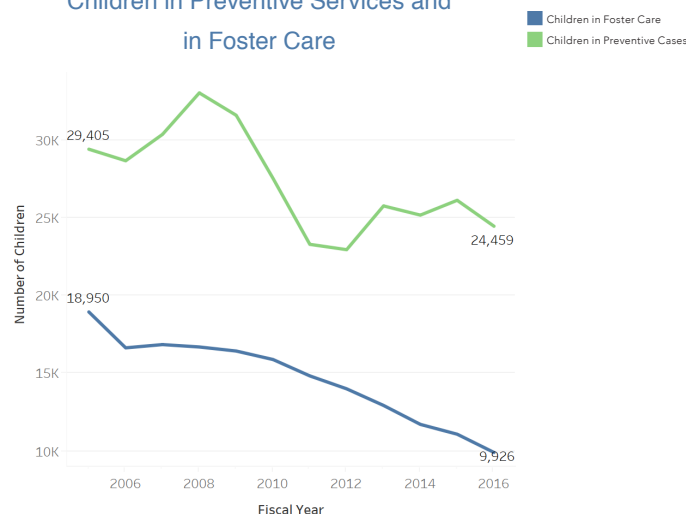
## Strengths of the Programs

We found indisputable strengths: Social workers, while often fresh out of graduate school, receive extensive training and multiple layers of supervision, in which they regularly discuss their cases with more experienced staff, as well as consultants from the models' developers.

Mechanisms are built into the training and methodology of each teen-specialized program that encourage providers to treat families with positivity and respect. It is an explicit piece of providers' job to gain parents' trust and buy-in. They are taught to identify and build on families' strengths, and to work from the presumption that parents in the child welfare system—like almost all parents in the world—want to do right by their kids.

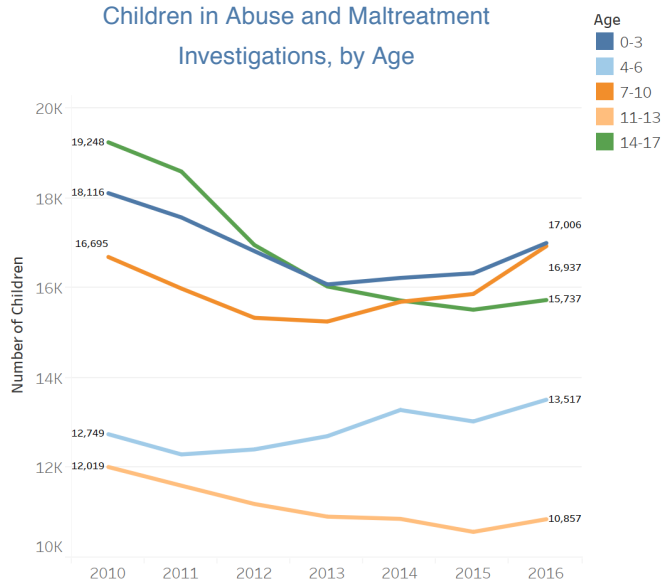
It is also true that, since the introduction of teen-specialized preventive services, the number of teens who enter foster care each year has continued to decline. The foster care census, across all age groups, has been shrinking for more than two decades, from well over 42,000 children in the 1990s—when the City still reeled from a decade of epidemic-level crack addiction and the

Children in Preventive Services and in Foster Care



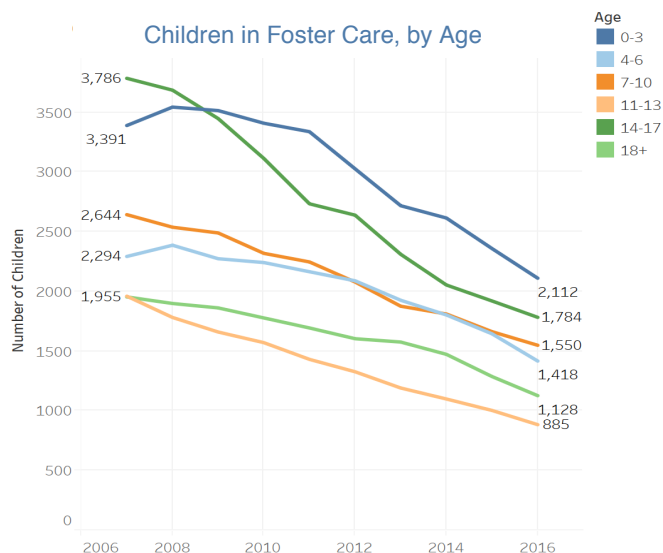
In 2016, close to 2.5 times as many children received ACS-funded preventive services as were in foster care.

Children in Abuse and Maltreatment Investigations, by Age



More than 74,000 NYC children were involved in child abuse and neglect investigations in 2016. Investigations involving teens often start because a school reports absences to the Statewide Central Register (SCR).

Children in Foster Care, by Age



The City's foster care census has dropped precipitously during the last several years.

prevailing wisdom, in child welfare, was that kids were best served by pulling them out of a home at the first sign of trouble—to a record low of under 9,000 this year.

As ACS officials point out, when the system gets smaller—when the bar for removing children is raised—a greater concentration of families with very complicated problems end up in preventive services. A significant reason that foster care entries continue to decline, ACS says, is that the City's new, more intensive preventive service programs help families emerge from serious crisis.

## Challenges

In our research we also saw challenges: Four years into its major investment in teen-specialized programs (which cost the city approximately \$22 million each year), ACS is not transparent about their outcomes. There is some indication that, across age groups, evidence-based models are achieving better results than more traditional preventive services programs. But ACS does not publish (and after many months of requests, did not release) outcomes data for individual models or for teen-specialized programs as a category. This lack of specific data limits what is possible for families, advocates, or the public to know about these taxpayer-funded programs, which impact the lives of extraordinarily vulnerable families.

Individual providers report that they have difficulty retaining the caseworkers and therapists hired to work in the programs, in part because the City's funding is too low to pay competitive salaries. When staff quit, it creates inefficiency for the agencies, which pay for specialized training each time they hire, as well as for the system overall, which serves fewer families when agencies are understaffed.

Staff turnover is also disruptive to parents and kids, who expose intimate pieces of their lives to caseworkers who then disappear, only to be replaced by someone new and—likely—inexperienced.

## Therapy Under Coercion

Like other therapy-centered programs, the teen-specialized models raise bigger questions about how the City reckons with poverty. As in most places, ACS investigations and foster care removals happen almost exclusively in the City's lowest-income, majority black and Latino neighborhoods, where residents are subject to a level of scrutiny that would be unfathomable in richer, whiter places.

Skeptics of the programs ask whether therapy—especially under the inherently coercive conditions of a child welfare case—is an appropriate response to the problems that bring families into the system. There is a clear absurdity, for example, embedded in a City strategy that mandates therapy for a mother whose child is truant from school, but doesn't fund guidance counselors at the underperforming school the child is supposed to attend.

Some supporters of the programs approach the question of coercion from its other side: If the City is convinced of the value of these intensive, evidence-based therapy models—if they really are a valuable service to deeply stressed families—shouldn't they be available before a parent is under threat of losing a child?

In the words of one mother, who lived through six years of chaos and crisis in homeless shelters before ACS charged her with neglect and brought her to Family Court, "Why didn't anybody want to help us before?"



# Please Don't Take Them Away

## The Promise—and Problems—of Delivering Teen-Specialized Services

Annette's life was already crowded with problems when an investigator from the City's Administration for Children's Services (ACS) knocked on her door.

Annette, who asked to be identified by her first name only, had been living in homeless shelters for six years, ever since her husband died and left her to take care of three kids: a now-adult daughter whose memory has been smudged out by lupus; a son, Quenton, 17 years old and on the verge of dropping out of high school when ACS showed up; and a 14-year-old daughter, Latanya, who blocked out the chaos by learning to draw. "Trust me, she'll be famous," Annette says.

The family had shuttled through 13 different shelters in the previous year. "You just get popped up," Annette says. "They come in your room and say, 'Ok you have to be ready [to leave] by 3:00.' You might not know where you're going until you get there."

And Annette had suffered a spine injury, which—combined with the smothering fug of everything bad that had happened to her—left her immobilized much of the time.

The day the ACS worker came, she found Annette's room in disarray, crowded with broken furniture and clothes that

spilled from ripped garbage bags. Annette says the mess was caused by fumigators, but ACS brought her to Family Court, informing the judge not only that Annette's home was unfit for children, but that Latanya had missed more than 90 days of the school year.

"I told the judge, I already lost everything. The last thing I want to do is lose my kids," Annette says. "That's my backbone, that's all I have in this world. Please don't take them away."

He didn't. Instead, the court placed Annette and her children under the ongoing supervision of ACS, which referred them to a newly expanded set of programs designed to help struggling parents with the notoriously harrowing job of raising teenagers.

### Creating Programs for Teens

Adolescents present a particularly tricky set of challenges to the City's preventive service system.

The difficulty, at least in part, is that teens often end up in foster care not just because their parents have problems that lead to neglect or abuse, but because of their own behavior. Historically, about a quarter of kids aged 12 and older who entered care did so as "Persons in Need of Supervision," or

PINS, meaning a parent or guardian had filed a Family Court petition saying the child was out of control.

In the mid-2000s, ACS launched a project to shrink that number by borrowing a strategy from the world of juvenile justice—which, at the time, was engaged in an experiment of its own.

Through much of the previous two decades, New York City had treated juvenile delinquents a lot like their counterparts in the adult criminal system, exporting them from communities in larger and larger numbers to serve longer and longer sentences at institutions far from home.

Toward the end of the 1990s, as the destruction wreaked by mass incarceration became apparent even to mainstream policymakers, juvenile delinquency systems saw a wave of reform—often predicated less on the argument that they replicated a larger injustice, than that they backfired, traumatizing kids, damaging families, and destabilizing already struggling neighborhoods, all of which, perversely, led to more crime.

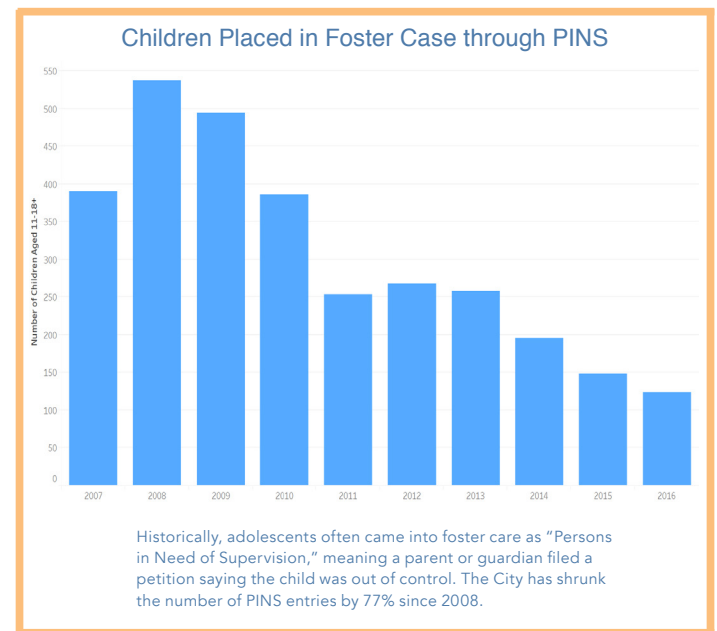
The system began to bend toward a new logic: If adolescents' problems evolved in the ecologies of their homes and communities, then the solution was not to quarantine kids but to change the dynamics of their families.

The City's juvenile justice providers tested an array of new programs. Rather than pulling kids out of their homes, they deployed social workers to go in, spending several hours each week with teenagers' entire families, mediating conflicts, encouraging parents and kids to communicate more effectively, and teaching new parental discipline strategies. The idea was to be intensive and up-close, recreating family interactions in ways that were healthier for children.

The juvenile justice reforms intersected with another trend: the drive to impose a standardized taxonomy on what had, traditionally, been considered the abstract art of social work. With a few exceptions, the new programs qualified as "evidence-based." Each model came with precise requirements and instructions: from the number and qualifications of staff members; to where, how often, and for how much time they met with clients; to what therapists talked about and the language they used.

In New York City, "the early juvenile justice models seemed to be able to do the unthinkable," says Sylvia Rowlands, who directs evidence-based programs at the social service agency New York Foundling and who was one of the first providers to implement the new programs. "They kept kids at home and in the community."

In 2007, the City imported the programs into its foster care system, piloting them with the families of teenagers on the PINS track. The number of kids who entered foster care on a PINS petition dropped each year thereafter, from 540 in 2008 to 124 in 2016.



In 2011, ACS expanded the experiment to teens who came into child welfare because of reported abuse or neglect, rather than through PINS. And two years later the agency doubled down, investing a new \$22 million annually to fund an array of therapeutic, "teen-specialized" preventive service models. (Funding is projected to go up to an estimated \$25.6 million in Fiscal Year 2020.)

### What We Know—And Don't Know—About Teen-Specialized Services

In 2016, teen-specialized programs oversaw 874 cases, distributed among 10 preventive services agencies running 34 teen-specialized sites across the five boroughs.

That's a small piece of the overall preventive service system, which served approximately 24,000 children last year. As a category, however, teen-specialized programs

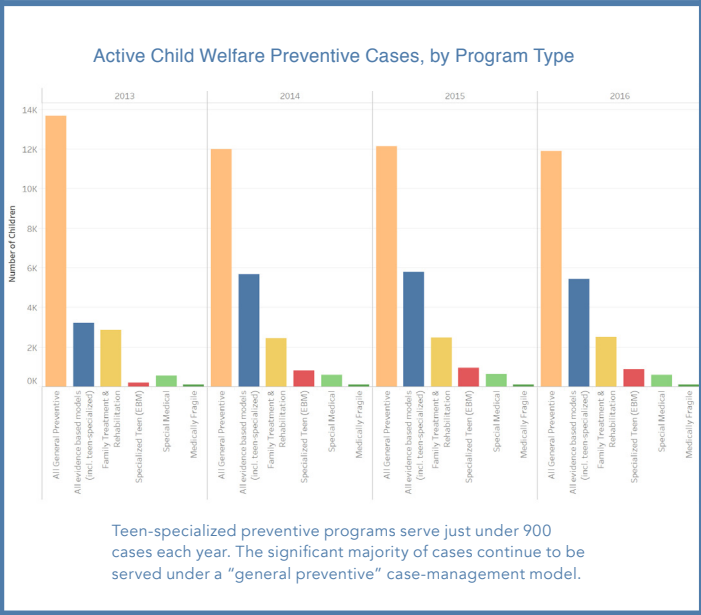


offer a particular insight into ACS’s broader reform agenda: to keep whittling down the number of children who enter foster care by providing intensive, therapeutic, “family-centered,” and evidence-based preventive services.

The City began shrinking its foster care census well over two decades ago, a trend driven by several intersecting factors, including changed priorities at ACS and Family Court. To be sure, some critics believe the system is still too big—that ACS remains far too quick to remove children from the City’s most vulnerable families (see “First, Do No Harm,” page 11).

But it’s also true that when the foster care system shrinks—when the bar for removing children gets raised—a greater number of families with very complicated problems end up in preventive services.

In ACS’s view, the expansion of specialized, targeted preventive programs is a major part of what helps keep those families out of foster care. The agency currently funds 11 models that qualify either as evidence-based or (one step down in the hierarchy of clinical study) “evidence-informed.” (This includes six teen-specialized models and two models designed specifically to work with families of very young children. The remaining three are not age-specific.) Cumulatively, evidence-based programs served more than 5,400 cases last year.

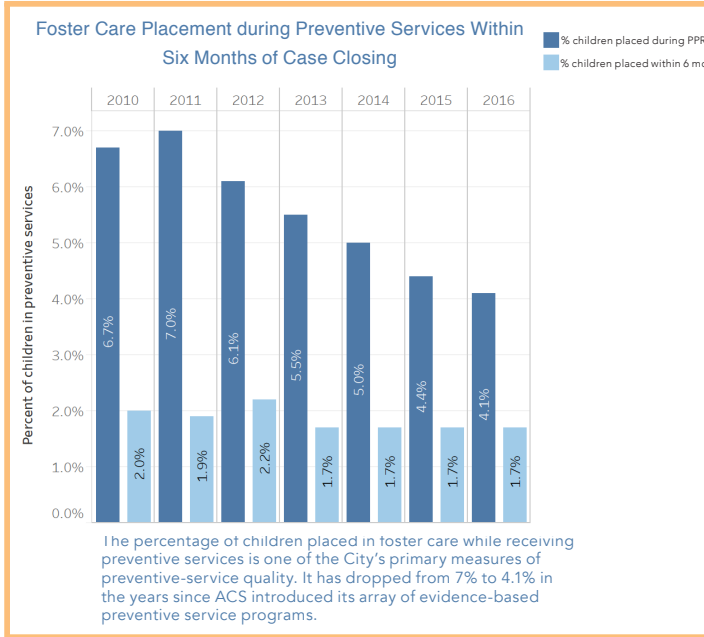


Across the full range of programs, there are preliminary indications that ACS’s investment in evidence-based preventive services is paying off. According to a recent

study conducted by Casey Family Programs (a national child welfare foundation), evidence-based providers reported achieving their treatment goals in 83 percent of cases, compared to 77 percent in more traditional preventive programs serving families deemed to have similarly high levels of risk (based on data from a six-month period in 2016).

The Casey study also found that families receiving preventive services in evidence-based programs were less likely to be involved in a new investigation in which ACS found evidence of neglect or abuse. Specifically, during a three-month period of 2015, these indicated reports occurred among 10 percent of “high-risk” families and nine percent of “low-risk” families in evidence-based programs, compared to 22 percent of “high risk” families and 10 percent of “low-risk” families enrolled in other preventive service programs.

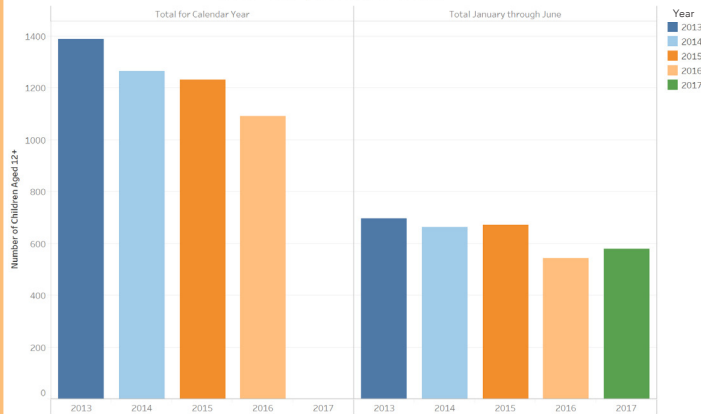
According to data from ACS, the agency has also seen a continued drop in the proportion of children placed in foster care during their enrollment in preventive service programs overall, from 7 percent in 2011 to 4.1 percent in 2016.



However, the City does not publish data comparing preventive service programs on a regular basis. And after several months of requests made to inform this policy brief, ACS did not release outcomes measures for individual program models, or for teen-specialized programs as a group. This lack of specific data limits what is possible for families, advocates, or the public to know about these

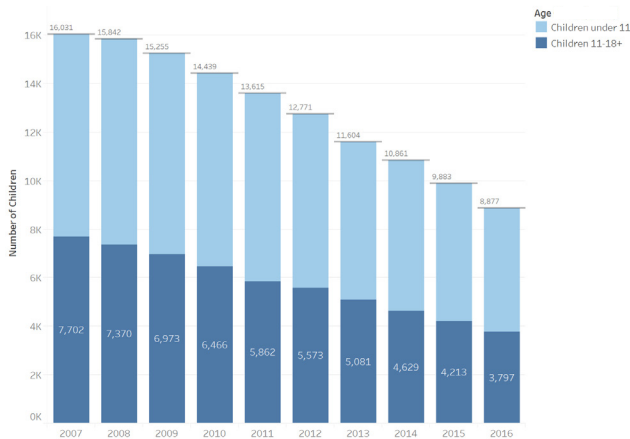


## Adolescents Placed in Foster Care



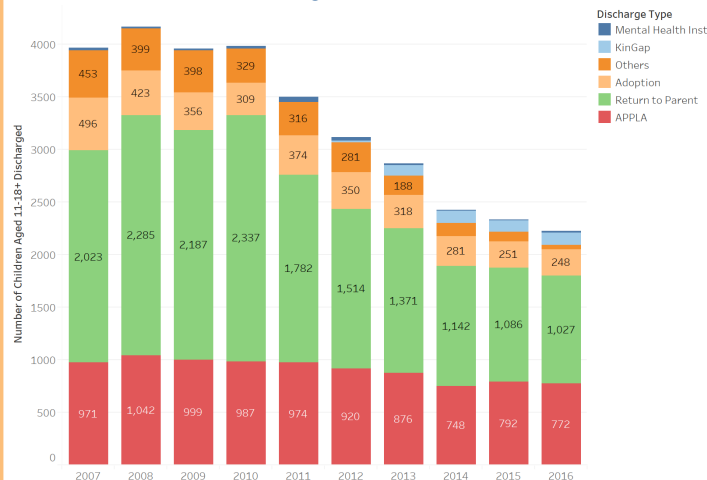
Between 2013 and 2016, the number of children aged 12 and older placed in New York City foster care dropped from 1,388 to 1,092.

## Proportion of Adolescents in Foster Care



In the past 10 years, the number of adolescents in foster care has dropped slightly more steeply (50%) than the total number of children in care (45%).

## Where Adolescents go After Foster Care



While the total number of adolescents who leave foster care each year has dropped precipitously over the past decade, the number who “age out” without being returned to a parent or adopted has fallen by just 20%.

taxpayer-funded programs for very vulnerable families. ACS officials do point to the fact that, across the board, preventive programs serving teens seem to be accomplishing their foundational goal: The number of teenagers entering New York City foster care (as with the number of kids overall) continues to fall, from close to 1,400 in 2013, when the agency implemented its full spread of teen-specialized programs, to fewer than 1,100 last year. “You can’t attribute that success to any one program,” says Andrew White, the deputy commissioner for policy and planning at ACS. “But we know that more intensive preventive services are an important piece.”

White says that ACS has begun an in-depth assessment of its full range of evidence-based preventive service programs, and that preliminary results will likely be available in a year. Meanwhile, providers work directly with the developers of each model to make sure services look as much as possible like the program that was originally tested in clinical trials. The developers train new staff members, offer regular “skill booster” sessions, and provide ongoing supervision via program consultants—in some cases, as frequently as once a week—to ensure faithful replication of the original model.

The result, White says, is a level of quality that can be hard to find outside the ACS system.

“There’s no shortage of families in New York City that are struggling to find the mental health or behavioral health care they need,” White says. “Through this work, we’re able to provide something truly supportive and meaningful for families experiencing tragic challenges: teenagers who’ve experienced deeply traumatic events, who are using drugs that undermine their education and family life. Our job is to help them overcome those challenges with high-quality, intensive supports—and with services they don’t have to pay for.”

## Low Salaries and High Turnover

Individual providers of the programs generally concur, saying the small caseloads and intensive training that come with teen-specialized programs allow them to provide the kind of real and meaningful support that can get lost in less intensive models.

But providers also commonly identify two major obstacles to delivering teen-specialized models as they were originally designed: Funding for preventive service programs is too low and—largely as a result—staff turnover is too high. Citywide, as many as 35 to 40 percent of preventive service workers leave their jobs each year, according to data compiled by the Council of Family and Child Care Agencies (COFFCA), which represents nearly all of New York City’s preventive service providers.

In part, that’s inherent to the nature of a high-stress, high-stakes job. “The work is hard, the model comes with high expectations. It’s easy to feel overworked and underappreciated, like you’re out there by yourself,” one teen-specialized provider told us. “At one point, we were having people leave every two or three months.”

But it’s also true that underfunded programs underpay their staff. The average starting salary for a bachelor’s degree-level preventive caseworker in New York City is just over \$36,000, says Sophie Charles, director of preventive services policy and practice at COFFCA, while

master’s-level preventive workers start at between \$42,000 and \$45,000. Social workers with the same levels of education can get jobs at hospitals, or working directly for the City’s health department, for an additional \$12,000 to \$20,000 per year, plus good benefits, Charles says.

In testimony to the New York State Assembly, COFCCA’s executive director, Jim Purcell, explained the impact of staff turnover on families: “Since there is no funding to have replacement workers available and trained when a caseworker leaves their position... their cases are ‘picked up’ by the remaining workers on the team. They maintain the basic functions until a replacement worker is hired. So for one-third of our families, they will now have had at least three workers.

“If this were my family,” he added, “and I suspect if it were your family, this would not be acceptable.”

The City increased its total preventive services budget from \$245 million in Fiscal Year 2017 to \$313 million in the current fiscal year, which will cover cost-of-living adjustments for City-employed preventive service workers, as well as increases for staff employed by nonprofits working under City contracts. The budget also provides for an expansion of slots and bolstered training and support at ACS. But the additional funding will not come close to raising the nonprofit salaries to those offered by City agencies.

### A “Life Raft” for a Floundering Family

Annette, the mother in the homeless shelter, didn’t see any of the operational problems of the preventive service system. Instead she saw a group of people who, she quickly came to believe, were willing to do whatever it took to help her family.

ACS referred Annette to the most intensive model in its array of teen-specialized preventive services: Multisystemic Therapy for Child Abuse and Neglect, or MST-CAN.

The model was developed in South Carolina in the early 1990s, as an adaptation of one of the original, evidence-based juvenile justice programs.

In New York City, MST-CAN programs accept families with issues deemed by ACS to be particularly severe or complex. Either there’s been a confirmed case of abuse

#### EMPTY SLOTS?

Vacant staff positions can mean that programs are underutilized. ACS does not release point-in-time utilization data, but program providers told us they frequently lack the staffing to take on their full allotment of clients.

ACS points out that because teen-specialized programs are designed to work with families for less than a year, they gain efficiency by serving more than one family per contracted slot. In 2016, the ratio of newly opened cases to contracted slots ranged from 1.54 among providers offering the most utilized teen-specialized model (a now-closed program called the Boys Town model) to .79 among programs offering the most underutilized model (a high-intensity model called Trauma Systems Therapy). The cumulative ratio of cases opened per contracted slot, for all of ACS’s teen-specialized programs, was 1.09. In 2016, these programs oversaw approximately 900 cases overall.

or neglect in the previous six months, putting a teen at risk of being removed from home, or the family has an extensive repeat history of ACS involvement. Parents who end up in MST-CAN often have their own experiences of childhood abuse or adult domestic violence. About two-thirds have diagnosable mental health or substance abuse problems, says Sarah Alvi, the director of the MST-CAN program at New York Foundling, which ended up with Annette's case.

Once a family is in the program, a therapist or case worker visits them at home between three and five times each week and is on-call to answer the phone and respond to emergencies 24 hours a day.

The first goal is to set up a safety plan: Are there prescription drugs in the home where kids can get to them? Weapons? Particular times when a parent might drink and become aggressive? What should happen if a teen threatens to hurt himself?

Because providers see families so regularly and up-close, they're sometimes able to convince ACS to let children stay home under circumstances that might otherwise be considered too dangerous, says Dr. Cynthia Swenson, who developed MST-CAN and oversees its dissemination. If a parent is in treatment for addiction, for example, her therapist will work with her to find a back-up adult who can look after the kids, just in case she relapses, Swenson says. Then, "we can say to the case worker, 'The child doesn't need to leave the home. Instead, the parent will go somewhere and get clean. We have it all worked out.'"

The workers' next job is to convince parents that—even though they're working with ACS—they genuinely want the family to succeed and stay together.

With Annette, case workers started by helping her solve practical problems: They went with her to an Access-A-Ride evaluation, where she qualified for door-to-door transportation. They got her a walker with a built-in seat, so she could be more mobile on her own. They helped her son get a license to work in construction.

Annette says she was surprised by how quickly she stopped caring that this help had been sent by ACS. After years of tangling with City systems (homeless shelters, school administrators, benefits counselors) this was the

first time she felt like someone genuinely wanted to see her family do well. "Not only were they helping us but their hearts were in it," Annette says. "They actually treated us like human beings. So of course we didn't mind welcoming them and working with them."

Creating that perception is part of MST-CAN's training and methodology. When teams discuss their cases, there is much reliance on variations of the word "alignment." Team members check to make sure they are "aligned" with one another's decisions. They discuss strategies to "align" "mom" or "dad" (who are addressed according to their family roles rather than their names, even in-person) with the goals of treatment. They work to avoid "disaligning" family members by coming off as directive or judgmental.

The language is revealing, in that it serves as a kind of intellectual positioning system for therapists and case workers, mapping their thinking according to the worldview of the program: Even in the inherently coercive context of a child welfare case, it is their job to get willingness and buy-in from families.

“They actually treated us like human beings.”

"I've been in institutions where everyone in the agency is bashing families. It's almost fun to talk negatively about this parent," says Swenson. "We don't do that and don't allow that. We want to make sure the therapist can focus on the positive and think of a parent as a human being who has been through extraordinarily difficult circumstances and has extraordinary strengths."

Once a relationship has been established, providers move to the behavior-change phase. As with most evidence-based therapies, the idea is not to dredge the subconscious, but to take an almost mechanical approach, breaking down family members' choices and interactions into their component parts and reconfiguring them to produce better outcomes.

In MST-CAN, the primary behavior-change tool is something called a FIT diagram—a kind of psychological network graph designed to identify "target behaviors" and their potential causes (or "drivers") until a factor is discovered that seems both possible and important to change.

Take, for example, an excessive use of corporal punishment. For one parent, a primary driver might be a lack of alternative discipline strategies, which could be resolved by trying a new system of rewards and consequences. For another, it might be anxiety, which could be treated with cognitive-behavioral therapy. Or poor problem-solving skills, which would merit yet another set of charts to identify a remediable root cause.

For Annette, behavior change began with meeting daily challenges—walking down the hall, or to the corner. “They wanted to motivate me and let me see that I could help myself,” she says.

Her case worker convinced her that, even though she couldn’t physically get to Latanya’s school, she could still do the job of a parent in making her daughter’s education happen. The team helped her set up regular conference calls with Latanya’s guidance counselor and teachers.

And the team’s therapist worked with everyone in the family on cognitive-behavioral strategies. “We had anger issues,” Annette says. “They taught us, if you feel like you’re talking about something and it’s making you sad, you move on to the next channel, move on to something positive. So now, if I’m thinking about somebody who did me wrong, I’m not gonna sit there and dwell on the story. I flip the channel.

“Once you get stronger,” Annette says, “where you don’t have the tears and bad thoughts, you start to realize, this is not about them, this is about you and your family and how you can become better.”

At her most recent case conference, Annette’s ACS worker told her that her case would be closed at her next court hearing. “I was crying,” Annette says. “I was so thankful. The Foundling to me was like a life raft, like you’re in the middle of the ocean and you can’t swim and somebody throws a life raft and you grab it and they save your life. I can’t describe it better than that.”

Annette’s only question is why things had to get so bad. Couldn’t someone have knocked on her door before she was in danger of losing her children? “We’ve been in the shelters for so long,” she says. “But it’s like nobody cared about us before.”



# First, Do No Harm:

## When Do Interventions Go Awry?

Three of Alicia's\* four children were grown when ACS made its way into her home.

In the 10 years since her husband had moved out, she'd supported the family on her own, working as a home health aide six days a week to keep the roof of a Harlem apartment over their heads.

The middle two kids seemed safely on their way to adulthood, enrolled in college and working part-time jobs. But the eldest daughter had been slipping into trouble since she was a teenager. Now 27, she was living in Alicia's apartment with a 6-year-old son of her own, and what started as a drinking problem had devolved into a decreasingly deniable addiction to crack.

The youngest son, now 16, appeared headed in an equally wayward direction. By the time ACS called, he had been regularly skipping school for a year. "My mom did the best she could," says Marie, one of Alicia's middle children. "She even walked him to school in the morning, but he would find his way out the back door."

The school made a report to the State child abuse hotline, and Alicia found herself under investigation for educational neglect.



In many ways, it was an ideal case for teen-specialized preventive services, which often start with a report from a truant kid's school. ACS investigates and—as with Alicia's son—finds more problems: He was staying out late, disobeying his mother, and hanging out with neighbors the family saw as trouble.

From providers' perspective, the idea is that intensive, in-home family therapy can right whatever dynamic has gone wrong between parents and kids before it further destabilizes the home and puts the teenager (or any younger siblings) at risk.

But the programs also have their critics—in part because skeptics see a fundamental disconnect between the problems that bring families into child welfare and the solutions being offered.

As in most places, ACS investigations and foster care removals happen almost exclusively in the city's lowest-income, majority black and Latino neighborhoods, where residents are subject to a level of scrutiny that would be unfathomable in richer, whiter places.

Poverty is a factor in the vast majority of cases brought against parents in Family Court—either directly, because a parent is charged with providing dilapidated housing or inadequate supervision, or indirectly, via the varied and circuitous routes through which life can become impossible when people are grindingly poor.

Sending families to therapy doesn't fix poverty, says Joyce McMillan, the director of programming at the Child Welfare Organizing Project, which advocates for the rights of parents in the system.

Instead, it implies that there is something pathologically wrong with poor people: The problem is not that you are working impossible hours, or stressed to your maximum capacity because you can't pay rent, or that your kid is being undereducated, bullied, or systematically ignored at an inadequate neighborhood school. The problem is *you*.

## Sending families to therapy doesn't fix poverty.

Even where therapy might be useful, McMillan argues, it's wrongheaded to expect that people will benefit under the coercive conditions inherent in any interaction involving ACS.

In the neighborhoods where ACS operates, McMillan says, families don't see preventive service programs as real

\* Names have been changed

help—or even as better-researched improvements on the options of the past—but as yet another surveillance arm of the agency that threatens to take their kids.

“The work on yourself, you’re just going through the motions because they’re holding your child up over your head like a piece of steak.”

ACS recently announced funding for a series of “community partnership programs,” which will aim to support neighborhood-based support systems for families, including storefront-style community resource “hubs.” It remains to be seen whether these programs will eventually be able to connect parents with teen-specialized or other evidence-based preventive programs.

Regardless, McMillan says, the plan doesn’t go nearly far enough. If the City truly wanted to help struggling families, she argues, it would divorce preventive services altogether from the agency that operates foster care. “It becomes real when you ask a family what they need and provide that.”



When Alicia’s family was first referred to teen-specialized preventive services, she hoped that the program would help.

She arranged to miss work one afternoon each week, when a social worker would come to her home to talk with her and her teenaged son about their problems. At the worker’s suggestion, she tried new discipline strategies, like taking away his phone when he missed curfew.

Soon, however, the teenager began skipping the therapy sessions. He always found a way to get the phone back, and he continued to skip school. “It didn’t change anything. He wasn’t interested,” Marie says. Alicia’s missed time at work became more of a burden.

And then the social worker turned her attention to Alicia’s 6-year-old grandson—the one whose mother was sinking deeper into addiction.

From the family’s point of view, the boy was okay. He had his grandmother, aunt, and uncles to make sure he was well taken care of, Marie says. They took him to school when his mother didn’t get out of bed. They bought him everything he needed and never left him unsupervised.

But a caseworker told Alicia that she needed to formalize the situation, not only by filing for custody of her grandson in court but also by putting the boy’s mother—her own eldest daughter—out of the home. Otherwise, the caseworker warned, he might end up being placed in foster care with strangers.

**“The work on yourself, you’re just going through the motions because they’re holding your child up over your head like a piece of steak.”**

There were court dates and more missed work. There was also new animosity between Alicia, who never wanted to see her own child homeless, and the little boy’s mom, who blamed the family for collaborating with ACS in putting her out of the home. Now, the 6-year-old can only see his mother during supervised visits at the foster care agency that has taken charge of his case.

“If anything, he’s worse off,” Marie says. “He loves his mother to death.”

Some, to be sure, would say the system worked exactly as it should: A report of educational neglect tipped off ACS that more serious problems existed in a home. Because a teen preventive worker saw the family up-close, she was able to identify a problem involving a younger child, whom the City has now stepped in to protect.

But to Marie, it’s as if the unwieldy bundle of her family had been held together by a frayed string, which ACS came and cut.

# Teen-Specialized Preventive Service Models

Specialized to teens in **all** program locations:

Model Name	Capacity	Target Population
Trauma Systems Therapy (TST)	56	Youth with serious conduct problems including violence and criminal behaviors
Masters-level therapists meet with families in their homes two to four times each week to provide psychotherapy. Emotional or behavioral problems are understood as “dysregulation” due to trauma triggers. The program also provides legal advocacy.		
Functional Family Therapy (FFT)	285	Youth with serious conduct problems including violence and criminal behaviors
Masters-level social workers meet with families weekly, in-home, to teach new skills to address behavior and connect families with community resources.		
Multisystemic Therapy—Substance Abuse (MST-SA)	160	Youth using substances
Masters-level therapists meet with families in their homes two to four times each week to work on parenting skills and to provide family and cognitive-behavioral therapy and substance abuse treatment.		
Multisystemic Therapy—Child Abuse & Neglect (MST-CAN)	160	Youth with recent or imminent indicated abuse or neglect cases
Masters-level therapists and caseworkers visit families three to five times per week, in-home, to provide case management, safety planning, substance abuse and PTSD treatment, anger management, and family therapy.		

Specialized to teens in **some** program locations:

Brief Strategic Family Therapy (BSFTA)	96	Youth with recent or imminent indicated abuse or neglect cases
Masters-level therapists meet with families in their homes for at least 90 minutes each week, with the goals of improving family interactions, restoring parental leadership and involvement, and reducing drug use and delinquency.		
Family Functional Therapy—Child Welfare (FFT-CW)	1165	Youth with little engagement with or acceptance of services
Bachelors-level “interventions” (in low-risk cases) or masters-level therapists (in high-risk cases) meet with families at least weekly, in their homes, to provide case management and/or family therapy.		

# Recommendations

## Fulfilling the Promise of a Work in Progress

Teen-specialized preventive service programs embody a crucial component of the City's ongoing child welfare reform agenda: keeping ever-more complex subgroups of families out of foster care by providing researched, quality-controlled, intensive, precisely targeted, and therapeutic services.

The programs have inarguable strengths—most notably their methodological commitments to approaching families with respect and to building trust between parents and providers. But the City can take steps to improve and stabilize the programs, and to apply their best attributes to a wider range of struggling New York City families.

### 1. ACS should release outcomes data for teen-specialized program models.

The agency tracks several key outcomes measures for preventive service programs, including: the proportion of families who experience a new incident of abuse or neglect, during or within six months of receiving services; the proportion of children who are removed to foster care; and the proportion of closed cases in which the goals set for families were met.

ACS reports that these outcomes have improved, across its array of preventive service programs, in the years since the agency introduced its more intensive, evidence-based services. (For example, the percentage of closed preventive cases in which a child entered foster care while receiving services fell from 7 in 2011 to 4.1 in 2016.) But the agency does not publish and would not provide outcomes data for individual programs, or for teen-specialized programs overall.

These programs are significantly more expensive than traditional, “general preventive” services and are designed to impact extremely vulnerable families. In the interest of transparency, ACS should make outcomes data available to families, communities, advocates, and the public.

### 2. The City should further increase preventive service workers' salaries, with the goal of decreasing turnover among those who work with families.

According to the Council of Family and Child Caring Agencies, which represents nearly all ACS-contracted preventive service providers, turnover among preventive service staff is as high as 35 to 40 percent each year. This instability creates inefficiency for provider agencies, which must pay for intensive and expensive training for each new hire, and for the system as a whole, which loses capacity when programs are understaffed. It also causes disruption for families, who are expected to open up their homes and reveal intimate details of their lives to social workers who may be replaced multiple times during a family's involvement in preventive services. And it undermines providers' ability to faithfully replicate evidence-based program models.

In its current budget, ACS allocates funds to increase support for preventive services workers—including cost-of-living pay increases for staff at contracted agencies. These are important wage gains but will not make salaries at contracted nonprofit providers competitive with those offered to social workers at hospitals or City agencies.



Evidence-based preventive programs work with extremely vulnerable families in high-stakes circumstances, and they depend on providers' ability to develop relationships and build trust. They must be funded adequately to hire and retain a strong and stable workforce.

### 3. The City should offer evidence-based services to families in crisis without the stigma and coercion inherent to an ACS case.

If, in fact, New York City's teen-specialized preventive service programs are achieving the kinds of positive outcomes that many of the models' developers demonstrated during their original, empirical testing, then they should be available to struggling families through multiple entry points, under lower stakes and less inherently coercive circumstances than involvement with the child welfare system.

The programs come with many positive characteristics: They incorporate extensively researched social work practices, executed by providers with small caseloads, specialized training, and intensive supervision. Each model trains providers in a family-positive perspective, in which they identify parents' strengths and work to support healthy family preservation. This kind of assistance might fill significant gaps in the City's behavioral health care system.

While it is, technically, possible to access preventive services voluntarily, the current system requires a parent to enter the frame of child welfare, acknowledging that a child is at risk of abuse or neglect at home. ACS recently announced funding for a series of "community partnership programs," which will aim to support neighborhood-based support systems for families. This is a meaningful step toward more voluntary, "primary" prevention, but it remains to be seen whether families will trust these services—or whether they will be able to connect parents with teen-specialized or other evidence based preventive programs.

The City should go further, making it possible for struggling families to be referred directly to the programs from the multiple places where they come into contact with City systems: homeless shelters, benefits offices, Head Start programs, school guidance offices, and so on. Many of the providers offering these programs are trusted multi-service organizations that have many potential ways to engage appropriate families without ACS involvement.

# WATCHING THE NUMBERS

A six-year statistical survey monitoring New York City's child welfare system

November 2017

## PROTECTIVE SERVICES

	FY12	FY13	FY14	FY15	FY16	FY17	TREND
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<b>REPORTS OF ABUSE AND NEGLECT:</b>	63,521	59,675	61,798	60,841	62,639	67,387	
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There was a significant jump in state hotline reports in FY17.

<b>PERCENTAGE OF REPORTS SUBSTANTIATED:</b>	39.6	39.8	39.5	38.7	36.1	40.4	
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Substantiated reports spiked in FY17 to a level higher than in any of the previous six years.

<b>PENDING RATE:</b>	3.9	4.4	5.2	5.2	5.5	6.2	
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The monthly average of new cases per child protective worker has continued to rise.

<b>AVERAGE CHILD PROTECTIVE CASELOAD:</b>	8.7	8.2	9.8	10.5	10.6	12.4	
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The influx of children into the system in FY17 has led to significantly higher caseloads for caseworkers.

<b>ACS SUPERVISION ORDERED BY FAMILY COURT (PREVIOUS CALENDAR YEAR):</b>	5,180	5,009	5,712	6,158	6,427	7,490	
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The total number of court-ordered supervisions as an outcome of Article 10 filings continues to rise.

<b>CHILD FATALITIES IN CASES KNOWN TO ACS (PREVIOUS CALENDAR YEAR):</b>	43	50	44	58	43	56	
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The number of child fatalities jumped by 13 over the previous year; this includes deaths from natural causes.

## PREVENTIVE SERVICES

<b>FAMILIES RECEIVING ACS-CONTRACTED PREVENTIVE SERVICES (ANNUAL, CUMULATIVE):</b>	19,172	20,853	21,039	22,280	22,147	20,322	
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The number of families in preventive programs dropped sharply in FY17 after rising slowly and steadily over several years.

<b>NUMBER OF CHILDREN IN PREVENTIVE CASES (ACTIVE, JUNE):</b>	22,952	25,762	25,172	26,123	24,459	24,680	
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The number of children in preventive cases in June 2017 was similar to the previous year.

<b>PREVENTIVE CASES IN EVIDENCE-BASED SERVICES (PREVIOUS CALENDAR YEAR):</b>	665	754	3,231	5,695	5,780	5,422	
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Evidence-based preventive services have greatly expanded since their introduction, representing about 28% of all preventive cases in FY17.

<b>PERCENTAGE OF PREVENTIVE CASES REFERRED BY ACS:</b>	72.0	72.0	68.1	72.0	74.6	77.8	
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The majority of cases in preventive services continue to be referred by ACS Child Protective Services.

<b>FOSTER CARE PLACEMENT DURING PREVENTIVE SERVICES (%) (PREVIOUS CALENDAR YEAR):</b>	7.0	6.1	5.5	5.0	4.4	4.1	
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The percentage of preventive cases in which a child is placed in foster care is trending downward.

## FOSTER CARE SERVICES

<b>NUMBER OF CHILDREN ADMITTED TO FOSTER CARE:</b>	5,698	4,779	4,501	4,233	3,695	4,177	
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After a long trend of decreases, there was an increase in FY17.

<b>NUMBER OF CHILDREN DISCHARGED FROM FOSTER CARE:</b>	6,453	5,416	4,969	4,250	4,421	3,655	
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The number of children discharged from care in FY17 dropped by 17% from the previous year's number.

<b>TOTAL AVERAGE FOSTER CARE POPULATION:</b>	13,820	12,958	11,750	11,098	9,926	8,960	
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Despite the increase in admitted children and decrease in children discharged, the number of children in foster care was at a record low.

<b>MEDIAN LENGTH OF STAY FOR CHILDREN BEFORE RETURN TO PARENTS (MONTHS):</b>	5.5	6.8	7.5	6.6	7.7	NA	
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Children entering foster care for the first time returned home in slightly under 8 months in FY16.

<b>PERCENTAGE OF CHILDREN WITH REUNIFICATION GOAL (PREVIOUS CALENDAR YEAR):</b>	52.1	49.1	48.5	50.0	49.8	52.6	
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About half of the children in foster care at any point in time are expected to return home.

<b>PERCENTAGE OF SEPARATED SIBLINGS (PREVIOUS CALENDAR YEAR):</b>	47.1	44.7	44.7	45.6	42.4	41.3	
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About 59% of siblings in foster care lived together in the most recent year.

<b>RECIDIVISM RATE (%) (PREVIOUS CALENDAR YEAR):</b>	13.6	13.1	13.0	11.6	10.7	11.6	
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The percentage of children returning to foster care within two years of discharge increased slightly after a long decline.

<b>PERCENTAGE OF FOSTER CHILDREN IN KINSHIP CARE:</b>	35.0	34.4	33.5	32.8	32.5	30.8	
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The recent decline in kinship care likely reflects the introduction of KinGap, which allows permanent placement with relatives without adoption.

<b>PERCENTAGE OF FOSTER PLACEMENTS IN BOROUGH OF ORIGIN:</b>	57.9	60.7	61.6	62.4	63.2	62.1	
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This number includes residential care as well as foster boarding homes.

<b>PERCENTAGE OF FOSTER PLACEMENTS IN CONTIGUOUS COMMUNITY DISTRICTS:</b>	33.5	33.4	33.3	36.9	36.3	36.5	
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The number of children placed in foster homes close to home was over one-third of the system in FY17.

## ADOPTION SERVICES

<b>PERCENTAGE OF CHILDREN WITH ADOPTION AS A GOAL (PREVIOUS CALENDAR YEAR):</b>	30.7	32.4	31.5	29.8	29.8	28.0	
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The percentage of children in care with a goal of adoption was the lowest it has been in eight years.

<b>NUMBER OF FINALIZED ADOPTIONS:</b>	1,295	1,310	1,101	1,004	1,052	899	
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The number of adoptions in FY17 is lower, but is consistent with the previous two years in representing a quarter of children discharged from foster care.

<b>AVERAGE TIME TO COMPLETE ADOPTIONS (YEARS):</b>	3.1	3.1	2.9	2.7	NA	NA	
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This is the time it takes to finalize once a child is considered appropriate for adoption.

All numbers above reported in NYC fiscal years unless otherwise indicated. Sources: NYC Mayor's Management Reports, NY State Office of Children and Family Services Monitoring and Analysis Profiles, NYC Administration for Children's Services Updates, and data requests.

# Related Works



## Reform or Relapse? Kid's Medicaid Mental Health Service Hang in the Balance

After five years of planning and negotiation, New York State's departments of health, mental health, and substance abuse had come up with a plan to overhaul their outdated, overburdened system of mental health services for low-income kids.

## ACS in Overdrive: Since the Death of Harlem 6-Year-Old, Are Fewer Families Getting the Help They Need?

After a series of widely publicized child deaths in 2016, New York City's child welfare system continues to struggle under a glut of new cases.

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### ACS IN OVERDRIVE:

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## Adrift in NYC: Family Homelessness and the Struggle to Stay Together

As family homelessness in New York City continues to climb and the City fights to open 90 new shelters, a new report by the Center for New York City Affairs at the New School offers insight into how family shelters are missing opportunities to avert a hidden but common catastrophe of homelessness: families breaking apart.

## What's Needed for '3-K for All' and Child Care Centers to Work and Play Well Together?

In late April, Mayor Bill de Blasio announced two new plans that could determine the future of the country's largest child care system for poor and low-income families.



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URBAN MATTERS

JANUARY 11, 2017

