New Hampshire
Division for Children, Youth and Families

Adequacy and Enhancement Assessment
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II. INTRODUCTION

A. DHHS/DCYF Current Landscape and Transformation

The Department of Health and Human Services and Division for Children, Youth and Families (DHHS/DCYF) have a deep commitment to creating a child and family centered continuum of services and supports that ensure the safety, health and well-being of children, youth, and their families. Leadership from DHHS/DCYF have led and are leading major reforms of their child and family serving systems. Initiatives have included implementation of a practice model (Safety ~ Permanency ~ Wellbeing), Solution Based Casework, Better Together Parent Partner program, the FAST Forward Wraparound program (which is now a part of the Bureau of Children’s Behavioral Health), training on trauma informed care across the system (in partnership with Dartmouth College), and ongoing continuous improvements efforts related to the Child and Family Service Reviews. There has also been an emphasis on developing competencies with Juvenile Probation and Parole Officers (JPPOs) around transition and permanency planning who can then provide expertise to local offices; there are five of these dedicated positions in five district offices. JPPOs are also being trained as facilitators in restorative practices.

DHHS/DCYF are implementing the recommendations from the Quality Assurance Review completed by the Center for the Support of Families completed in December 2016, which is feeding a larger vision for transformation and integration across DHHS including child welfare and juvenile justice. To help facilitate that vision, DHHS recently re-organized to create a more holistic, multi-generational, and integrated approach for individuals, families, and children receiving services. The reorganization streamlines and integrates divisions in order to identify and intervene earlier with families and individuals experiencing challenges, creating a system of “every door is the right door”, and working collaboratively to create multi-generation solutions. Under the new structure are: an integrated Division of Behavioral Health which brings mental health and substance use disorders services for both adults and children together, a single Division for Long Term Supports and Services that includes services for individuals with disabilities, the elderly and veterans, and a new Division of Economic & Housing Stability. The new infrastructure emphasizes rapid and holistic engagement with integrated, targeted supports and services to prevent deeper involvement and interventions whenever possible and appropriate.

DHHS is establishing cross-departmental integration teams, focused on early childhood and multi-system involved families, to try and understand what barriers are getting in the way of responding quickly and most effectively to individual and family needs to inform and improve policies, practices and funding/budget development.

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1 Restorative justice practices respond to crime by: identifying and taking steps to repair harm, involving all stakeholders, and transforming the traditional relationship between communities and their governments in responding to crime.
Challenges

- The Administration for Children and Families (ACF), Children’s Bureau, is federally required to conduct a Child and Family Service Review (CFSR), which are periodic reviews of state child welfare systems to achieve the following goals:
  - Ensure conformity with federal child welfare requirements
  - Determine what is happening to children and families engaged in child welfare services
  - Assist states in helping children and families achieve positive outcomes

All states are subject to these reviews and, to date, there have been three (3) rounds of CFSRs. In 2010, New Hampshire’s (CFSR) results showed significant improvement over the 2003 results. Preliminary feedback from the 2018 review is that there will be declines across most of the areas assessed. Since 2010, budget constraints have limited the number, quality, and accessibility of preventive and early intervention services and supports available to children, youth, and families and rate freezes have placed further pressure on the social services sector. As some

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examples, a number of residential programs closed between 2006 and 2017 due to declining referrals and constrained rates. When the Fostering Connections to Success and Increasing Adoptions Act of 2008 (FCSIAA) was passed, states were afforded the opportunity to extend foster care services up to age 21, but due to budget constraints, New Hampshire did not implement that option. New Hampshire has also been hit hard by the opioid crisis with the second highest rate of overdose deaths per capita\(^3\). The number of children being placed in out of home care has been increasing for several years, after previous declines. Figure 2 below provides a brief overview of significant events that have occurred at DCYF since 2006.

<table>
<thead>
<tr>
<th>Year</th>
<th>Events</th>
</tr>
</thead>
<tbody>
<tr>
<td>2007</td>
<td>Rates frozen from 2008 – July 2017, Revisions to CHINS statute</td>
</tr>
<tr>
<td>2008</td>
<td>DCYF enacts practice model including CPS and then JJS</td>
</tr>
<tr>
<td>2009</td>
<td>Passage of Fostering Connections to Success and Increasing Adoptions Act (FCSIAA)</td>
</tr>
<tr>
<td>2010</td>
<td>CPS and JJ incentive funds eliminated, Solution-Based Casework training to field staff initiated</td>
</tr>
<tr>
<td>2011</td>
<td>CPS no longer provides voluntary services due to significant funding reduction, Revisions to CHINS statute</td>
</tr>
<tr>
<td>2012</td>
<td>Bridge project to assess trauma, Parent Partner program began</td>
</tr>
<tr>
<td>2013</td>
<td>SAVRY risk assessment instrument initiated for Juvenile Justice field staff</td>
</tr>
<tr>
<td>2014</td>
<td>Partner with Dartmouth Trauma Institute, Revisions to CHINS statute</td>
</tr>
<tr>
<td>2015</td>
<td>FAST Forward program began, NHIA implemented</td>
</tr>
<tr>
<td>2016</td>
<td>JJS increased age of majority from 17 to 18 years of age</td>
</tr>
<tr>
<td>2017</td>
<td>Enhanced assessment required for opioid use, CSF report released</td>
</tr>
</tbody>
</table>

Figure 2. DCYF Historical Overview – abbreviations in the above chart include: Child Protection Services (CPS), Juvenile Justice Services (JJS), Child Welfare (CW), Child and Family Service Reviews (CFSR), New Hampshire Integrated Assessment (NHIA), Children in Need of Services (CHINS), Structured Assessment of Violence Risk in Youth (SAVRY), Center for Support of Families (CSF)
Moving Forward

As DHHS moves their current system transformation forward, they seek to answer the questions, "How can DCYF and its partners work together to build a highly effective continuum of services and supports that is aligned to the needs of New Hampshire’s children and their families? What is missing from the continuum that could be added to better meet the needs of the population?" DHHS/DCYF envisions a system where children, youth, and their families are connected to streamlined services and supports that meet their unique needs, no matter the door through which they first seek assistance.

Strong and nurturing families are at the core of productive communities. A child welfare/ juvenile justice system that provides timely, preventative, effective, and integrated services and supports will be a system capable of reducing the number of children and families involved in these systems, lowering costs, improving outcomes, and improving the economic vitality of the state. No single state agency, program or system can achieve these goals and address the needs of children, youth, and families alone.

Children, youth, and families involved in the child welfare or juvenile justice system may have a broad range of needs, including poverty and economic instability, difficulty in school, housing instability and homelessness, involvement in the criminal justice system, developmental and intellectual disabilities, substance use disorders, and mental and physical health issues\(^4\). DCYF is aided by and dependent on numerous partners and stakeholders, such as the legislature which makes laws and appropriates funds, the courts which interpret laws, and other interdependent stakeholders such as schools, family resource centers, healthcare, transportation, housing, community mental health centers and human services community based organizations. These various partners and stakeholders can be referred to as the “human services ecosystem”. The practices, policies, rules, requirements, regulations, and finances of these intersecting partners and stakeholders must be aligned to create a system that produces the desired results and outcomes and is cost effective. This report assesses how the ecosystem, as described above, can be both strengthened and more fully integrated and aligned to achieve better outcomes for the children, youth, and families of New Hampshire. This report also builds on the alternative placement capacity report that DHHS submitted to the legislature in September 2017 related to youth who may be released or diverted from the Sununu Youth Services Center (“SYSC”) under HB517, to provide a deeper analysis into how community based services and placement capacity can be further enhanced for this population. This desired future state is clearly within reach; the state of New Hampshire can build upon its many strengths, innovations and current and past initiatives.

B. Specific Project Goals

This report aims to accomplish two main goals:

1. **Adequacy Assessment**: On September 13\(^{th}\) 2017, DCYF provided an assessment of the system from the perspective of DCYF. Over the next four months DCYF created additional placement capacity through two contract procurements as well as additional certified beds in existing programs to meet the demands of HB 517. The Department engaged this project team to understand how community based services and placement capacity can be further enhanced for the population of youth affected by HB 517.

2. **Child Welfare and Juvenile Justice Services Review**: The project team was asked to review the adequacy and alignment of the current ecosystem of interdependent partners and stakeholders to ensure a comprehensive, child and family centered system that is more preventative, responsive, and effective for all children, youth, and families involved with the child welfare and/or juvenile justice system.

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DHHS engaged Public Consulting Group (PCG), the Alliance for Strong Families and Communities (the Alliance), and the American Public Human Services Association (APHSA) to complete this report.

III. METHODOLOGY

Data for the assessment were collected through the following major sources:

- Internal DCYF data and materials including data on the child welfare and juvenile justice populations
- Internal and external stakeholder meetings and focus groups
- A review of recent legislation, pertinent to the findings and recommendations of this report

The team also researched other state systems of care to inform the recommendations and implementation plan. This information is included in the Implementation Plan section of the report.

A. Data and Materials Review

PCG worked closely with several DCYF staff to gather pertinent data and materials for this assessment. Reports were obtained through PCG’s secure File Transfer Protocol (FTP) server from Bridges, DCYF’s Statewide Automated Child Welfare Information System (SACWIS), and CourtStream, DCYF’s web-based residential management system designed specifically for the Sununu Youth Services Center (SYSC). Our review consisted of a wide variety of data and documents, including but not limited to the following, to obtain a comprehensive understanding of the children, youth, and families currently served by DCYF and the array of services provided.

- Statutes, regulations and policies that govern child, youth, and family services in New Hampshire
- Data collected and shared with the HB 517 Advisory Board
  - Residential Treatment Census
  - SYSC data
  - Parole data
- Annual Progress and Service Report (APSR), 2018
- RSA 135-F: System of Care for Children’s Behavioral Health, Year 2 Report, 2017
- DCYF service array
- Case data on all child welfare/juvenile justice cases opened, including case types, demographic information, placement history, DCYF service history, etc., 2014 – 2017
- Child protection removals, 2010 – 2017
- New Hampshire Integrated Assessment (NHIA) data, 2013 – 2017
- SYSC youth meeting criteria to be released as of 1/1/2018
- SYSC admission data, 2014 - 2017
- Arrest demographics, 2016
- Disproportionate minority contact data, 2014 - 2016
B. Stakeholder Engagement, Interviews, and Focus Groups

A broad range of participants were engaged to provide insight and recommendations. The table below provides more details about the types of stakeholders who were engaged.

**Table 1: Stakeholder Engagement**

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<tr>
<th>Type of Engagement</th>
<th>Participants</th>
<th>Date</th>
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<tbody>
<tr>
<td>Kickoff Meetings</td>
<td>• DCYF Staff and Directors&lt;br&gt;• DHHS Directors and Commissioner&lt;br&gt;• External Stakeholders including representatives from:&lt;br&gt;  • law enforcement agencies&lt;br&gt;  • courts&lt;br&gt;  • school districts&lt;br&gt;  • mental health services&lt;br&gt;  • community based service providers&lt;br&gt;  • advocacy groups</td>
<td>January 25 and 26, 2018</td>
</tr>
<tr>
<td>Focus Groups</td>
<td>• Parents&lt;br&gt;• Youth&lt;br&gt;• Providers</td>
<td>January 25, 2018</td>
</tr>
<tr>
<td>Interviews</td>
<td>• Director of Operations at SYSC</td>
<td>February 5, 2018</td>
</tr>
<tr>
<td>Focus Groups/Interviews</td>
<td>Personnel from:&lt;br&gt;  • SYSC&lt;br&gt;  • Bureau of Developmental Services and a representative of the Area Agency&lt;br&gt;  • New Hampshire Hospital&lt;br&gt;  • Office of Health Equity and Disproportionate Minority Contact&lt;br&gt;  • Family Resource Centers&lt;br&gt;  • Fast Forward wraparound program&lt;br&gt;  • Bureau of Children’s Behavioral Health&lt;br&gt;  • Child Protection Staff&lt;br&gt;  • DHHS Directors</td>
<td>February 14, 2018</td>
</tr>
<tr>
<td>Focus Groups/Interviews</td>
<td>• Child Protection Intake staff&lt;br&gt;  • Field Administrators and Bureau Chief&lt;br&gt;  • Juvenile Probation and Parole Officers (JPPOs)&lt;br&gt;  • Special Medical Services - Children with special health care needs.</td>
<td>February 15, 2018</td>
</tr>
<tr>
<td>Interview</td>
<td>• Bureau of Organizational Learning and Quality Improvement (BOLQI)</td>
<td>February 16, 2018</td>
</tr>
<tr>
<td>Interview</td>
<td>• Procurement and Support Services</td>
<td>February 21, 2018</td>
</tr>
<tr>
<td>Interview</td>
<td>• Director of Advocacy, Child and Family Services&lt;br&gt;• Policy Director, Disability Rights Center&lt;br&gt;• Judge</td>
<td>February 23, 2018</td>
</tr>
<tr>
<td>Interview</td>
<td>• Judge&lt;br&gt;• Judge&lt;br&gt;• Dartmouth-Hitchcock and DCYF Trauma Partners</td>
<td>February 26, 2018</td>
</tr>
<tr>
<td>Interview</td>
<td>• Representative from Juvenile Justice Statewide Advisory Group (SAG)</td>
<td>March 2, 2018</td>
</tr>
<tr>
<td>Type of Engagement</td>
<td>Participants</td>
<td>Date</td>
</tr>
<tr>
<td>-------------------</td>
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| Focus Group       | • New Hampshire School Administrators Association  
                      • New Hampshire Special Education Administrators  
                      • Superintendent, Principal, Director of Students Services from local school districts | March 6, 2018 |
| Interview         | • Judge                                                                      | March 9, 2018 |
| Interview         | • Medicaid Director                                                          | March 15, 2018 |
| Interview         | • Managed Care Organization                                                  | March 16, 2018 |
| Interview         | • Circuit Court Administrator  
                      • Juvenile Detention Alternatives Initiative (JDAI) Coordinator         | March 23, 2018 |
| Interview         | • State Representative                                                      | April 2, 2018  |
| Interview         | • State Representative                                                      | April 3, 2018  |
| Interview         | • Advisory Board Member                                                     | April 24, 2018 |

C. Relevant Legislation

**Description of HB 517**

The New Hampshire state legislature enacted HB517 in June 2017, which allows for the release and diversion of certain youth from SYSC. Specifically, the legislation stated that:

- **Secure Detention:**
  - Secure detention shall not be ordered for delinquency charges which may not form the basis for commitment under RSA 169-B:19, I(j).

- **Dispositional Hearing:**
  - A minor committed to the youth development center for the remainder of minority may be placed at any facility certified by the commissioner of the department of health and human services for the commitment of minors. The commissioner of the department of health and human services shall be responsible for notifying the court, within 5 business days, of any such placement and of any subsequent changes in placement made within 60 days of the original placement.

- **Dispositions and Case Closure in Certain Cases:**
  - The court shall close all cases other than those involving serious violent offenses no later than 2 years after the date of adjudication. This section shall not apply if, with the assistance of counsel, the minor consents to continued jurisdiction.

- **Youth Development Center Releases and Discharges:**
  - The board shall release any child committed to its care for a delinquency adjudication based on an offense other than a violent crime as defined in RSA 169-B:35-a no later than 6 months from the date of the child's commitment pursuant to RSA 169-B:19, I(j), unless the board determines that continued commitment is necessary in order to protect the safety of the child or the community, and in such case declines to release the child. Such release shall occur no later than 3 months from the date of the child's commitment if the offense would be a misdemeanor if committed by an adult. If the board declines to release a child pursuant to this paragraph, it shall provide written notice to the child of his or her right to seek review of the board's decision, of his or her right to the assistance of counsel during the review process, and of the procedure the child may follow to initiate
such a review. If the board declines to release a child pursuant to this paragraph, it shall consider the child for release no later than 2 months after its initial decision, and every 2 months thereafter until the child is released.

- The department shall review, on a quarterly basis, the case of every child committed to SYSC who is not a serious violent offender to determine if the child can safely be placed outside SYSC. The department shall petition the court to modify the disposition of those cases in which a safe placement outside of the SYSC is possible.

- **Alternative Placement Capacity for Youth:**
  - The commissioner shall evaluate the adequacy of the service system and ensure that sufficient alternative placement capacity is in place for those children who are not serious violent offenders who prior to this act would have been placed at the SYSC.
  - On or before September 1, 2017, a plan for development of such capacity for minors who are not serious violent offenders shall be provided to the fiscal committee of the general court, and the plan shall be updated on a monthly basis until it is fully implemented. The plan shall provide for an increase in the state's capacity for placement in Medicaid-eligible settings of no fewer than 35 minors. The increase in capacity for minors who are not serious violent offenders shall be implemented no later than January 1, 2018, and include a rate structure which supports the staffing ratios and other resources necessary for the safe and effective treatment of such children in residential and other treatment settings.

**Other Legislation**

During the course of this engagement, several laws that change current practices were initiated and passed, in part due to the efforts of DHHS leadership and stakeholders, including members of the executive and legislative branches to address some longstanding issues and challenges. Below is a list of the bills with their relevant provisions.

**SB 592:**
- Funds additional staff at DCYF and foster parent reimbursement rates;
- Provides funds for DCYF to provide voluntary services to children, youth, and families without a finding of abuse or neglect;
- Waives the requirement that parents pay for voluntary services under the Child Protection Act;
- Establishes a drug court study; and
- Funds additional home visiting services, child care services, and parental assistance programs.

**HB 1103:**
- Removes the state's right of recovery for the cost of voluntary services provided to children and families in cases that are deemed "unfounded but with reasonable concern." The bill states that in such cases, any services provided by the Department of Health and Human Services may be paid from available Temporary Assistance to Needy Families (TANF) funds.

**SB 590:**
- Designates funding for the developmental disabilities wait list;
- Extends the reporting date for the 10-year plan for mental health services from July 2018 to October 15, 2018;
- Directs the department of health and human services to increase behavioral health services by establishing either a behavioral health crisis treatment center in an area with high rates of admissions to and discharges from New Hampshire hospital or a mobile crisis team; and
- Requires DHHS to utilize existing appropriations provide supported housing to enable individuals with serious mental illness to attain and maintain integrated, affordable, supported housing.
HB 1743:
- Creates a legislative committee to conduct a study of the current and future use of Sununu Youth Services Center.

SB 313:
- Establishes the Granite Advantage Program for individuals with incomes up to 138% of the federal poverty level. Coverage will be offered via Medicaid managed care organizations (MCO) rather than through the federal insurance marketplace; and
- Requires workforce participation to receive Medicaid benefits

IV. ADEQUACY AND ENHANCEMENT ASSESSMENT

On September 13th, 2017 DHHS submitted an adequacy assessment completed by DCYF. DCYF also created a plan for the development of alternative placement capacity youth who may be diverted or released from SYSC as a result of HB517. Through this engagement, the Department seeks a deeper analysis into how community based services and placement capacity can be further enhanced for this population.

A. Overview of Youth at SYSC

Juvenile Justice Services (JJS) is responsible for providing supervision and rehabilitative services to youth adjudicated under state law as delinquent or as Children In Need of Services (CHINS). According to SYSC Eligibility Guidelines, SYSC is the most restrictive DCYF placement option for juveniles and is used only as a last resort. Only serious and/or chronic juvenile offenders are to be placed at SYSC, and only if no less restrictive alternative is feasible. At SYSC there exists two (2) placement services; SYSC – Committed and SYSC – Detained with different placement rates. SYSC – Committed is for youth who have been adjudicated and committed via dispositional order and are delinquent, whereas SYSC – Detained is solely for youth with pre-adjudication through pre-disposition status.

As the most restrictive DCYF placement option, there are several reasons juveniles may be detained or committed to SYSC, such as:

- **Community Safety:** The youth is a risk to themselves or the community at large and placement is necessary to keep the youth and community safe.
- **Volatile Behavior:** The youth exhibits volatile behavior and placement is necessary to begin treatment and rehabilitative services.
- **Risk Level of Absconding:** The youth has a frequent history of absconding, or running away from home or other placements.

Table 2 below represents SYSC admission and release data, including the number of juveniles admitted to SYSC, number of juveniles committed and detained, total percent of commitments and detentions, average length of stay, percent of admissions for violent and non-violent offenses and number of juveniles released from SYSC each year. Note that Bridges IDs were not verified for all individuals with a CourtStream ID number until 2017. Therefore, 2014 data was not included for violent and non-violent offenses due to the inability to distinguish individual youth.
Table 2: SYSC Admissions and Release

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<tbody>
<tr>
<td><strong>Total Number of Admissions</strong></td>
<td>265</td>
<td>343</td>
<td>283</td>
<td>311</td>
<td>299</td>
<td>329</td>
</tr>
<tr>
<td><strong>Total Number of Individual Admissions</strong></td>
<td>201</td>
<td>269</td>
<td>229</td>
<td>231</td>
<td>231</td>
<td>250</td>
</tr>
<tr>
<td><strong>Annual Percent Change of Individual Admissions</strong></td>
<td>(25%)</td>
<td>17%</td>
<td>(.1%)</td>
<td>0%</td>
<td>(8%)</td>
<td>-</td>
</tr>
<tr>
<td><strong>Total Number of Individual Admissions (age 17-18)</strong></td>
<td>88</td>
<td>100</td>
<td>57</td>
<td>19</td>
<td>20</td>
<td>21</td>
</tr>
<tr>
<td><strong>Percent of Individual Admissions (age 17-18)</strong></td>
<td>44%</td>
<td>37%</td>
<td>25%</td>
<td>8%</td>
<td>9%</td>
<td>8%</td>
</tr>
<tr>
<td><strong>Number of Individual Commitments¹</strong></td>
<td>71</td>
<td>88</td>
<td>79</td>
<td>84</td>
<td>84</td>
<td>81</td>
</tr>
<tr>
<td><strong>Number of Individual Detentions</strong></td>
<td>130</td>
<td>181</td>
<td>150</td>
<td>147</td>
<td>147</td>
<td>169</td>
</tr>
<tr>
<td><strong>Total Percentage of Commitments</strong></td>
<td>35%</td>
<td>33%</td>
<td>34%</td>
<td>36%</td>
<td>32%</td>
<td>30%</td>
</tr>
<tr>
<td><strong>Total Percentage of Detentions</strong></td>
<td>65%</td>
<td>67%</td>
<td>66%</td>
<td>64%</td>
<td>68%</td>
<td>70%</td>
</tr>
<tr>
<td><strong>Number of Juveniles Released from Commitment</strong></td>
<td>94</td>
<td>80</td>
<td>62</td>
<td>92</td>
<td>73</td>
<td>73</td>
</tr>
<tr>
<td><strong>Percent Admissions for Violent Offenses</strong></td>
<td>58%</td>
<td>59%</td>
<td>51%</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td><strong>Percent Admissions for Non-Violent Offenses</strong></td>
<td>40%</td>
<td>41%</td>
<td>47%</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td><strong>Average Length of Stay – Committed Releases (days)</strong></td>
<td>181</td>
<td>162</td>
<td>148</td>
<td>174</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td><strong>Average Length of Stay – Detained Releases (days)</strong></td>
<td>20</td>
<td>22</td>
<td>19</td>
<td>18</td>
<td>-</td>
<td>-</td>
</tr>
</tbody>
</table>

1 Individuals can be counted as Committed and Detained in same year.

The data above shows a rather consistent picture of juveniles admitted to SYSC over the past six years (2012 – 2017), although 2017 was the lowest year for admissions. The average number of admissions to SYSC over this timeframe was 305, with a higher percentage increase in 2016 and a dramatic decrease from 2016 to 2017. Total admissions accounts for all admissions; including re-admissions for the same youth; the data is not unduplicated. Of the juveniles admitted to SYSC, approximately 35% are committed to serve their sentence and 65% are detained awaiting adjudication. The number of juveniles released from commitment has fluctuated over the years ranging from a low of 63 in 2015 to 94 in 2017, which can be contributed to a couple of legislative initiatives. In 2014, the juvenile justice system age of majority was raised from 17 to 18 years of age. SYSC admitted, on average, 20 individuals aged 17-18 between 2012 – 2014 and, on average, 82 individuals aged 17-18 between 2015 – 2017. It is interesting to note that even though the number of individuals aged 17-18 increased significantly during this period, the overall individual admissions did not grow at the same percent. The average length of stay is tracked by release cohorts for committed and detained releases and has also fluctuated over the years due to the same legislative initiatives.

For this analysis, the number of violent and non-violent offenses were reviewed. Note the offense presented to SYSC as justification for admission to the facility is documented in CourtStream as a free text field and there does not exist a uniform reporting method for offense type. All of the charges entered into this field were compared against the violent crime list in New Hampshire statute, 169-B:35-a. The most common violent offense was simple assault or assault, followed by aggravated assault and armed robbery. The most common type of non-violent offense was criminal mischief (destruction of property), followed by disorderly conduct, theft and possession of marijuana. The data consistently show that approximately 60% of admissions are typically for violent offenses and 40% are for non-violent offenses.

Absconding also is a driver of placement at SYSC due to the significant risk of harm associated with this behavior. In 2017 there were 161 absconding episodes, involving 115 individual youth under Court ordered supervision through juvenile justice services or child protection services. Of those 115 youth, 43 were female and 72 were male. So far in 2018 (January – June), there have been 118 episodes of youth who have absconded, involving 74 individual youth. Of those 74 youth, 26 were female and 48 were male. These incidents do not all result in placement at SYSC. DCYF has developed a process in managing and tracking the absconding youth and are in the process of training all staff on human trafficking to help better identify children or youth who may be exposed to this harm due to their absconding behavior, but seeks to do more to prevent the behavior from occurring in the first place.
To gain perspective on how New Hampshire compares to other states in terms of the juvenile correctional population, the project team researched state level commitment and detention rate data for the nation and for New Hampshire. The most recent data from the Office of Juvenile Justice and Delinquency Prevention (OJJDP) was released in 2017 with data from 2015. New Hampshire’s commitment rate is the seventh lowest in the country and the detention rate is the third lowest in the country, behind Maine and Rhode Island, respectively.\(^5\)

A variety of data was analyzed to better understand the population of youth meeting the criteria to be released from SYSC. Table 3 below provides a snapshot of these youth committed to SYSC as of January 1, 2018. Basic demographic information was removed from the table to maintain anonymity. As of January 1, 2018, there were 12 youth meeting this criteria in commitment. Ten of the 12 youth had been at SYSC less than 1 year, and 2 longer than one year. 73% were male and 27% were female with an average age of 16. Since January 1, 2018, nine (9) youth have been released either through court order, released to parole, or aged out. The last column of the table provides information about the number of prior services received from DCYF, however it does not include services provided by other sources such as Medicaid or private insurance.

Table 3: SYSC Youth Meeting Criteria to be Released

<table>
<thead>
<tr>
<th>Youth</th>
<th>Length of Stay (Days)</th>
<th>SAVRY Risk Rating(^2)</th>
<th>Identified Disability</th>
<th>Number of Delinquent Petitions(^3)</th>
<th>Number of Prior Placements (Non-secure)</th>
<th>Number of Prior Placements (Secure)</th>
<th>Number of Prior Services Provided by DCYF(^4)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Less than 6 mos(^1)</td>
<td>M</td>
<td>Y</td>
<td>1</td>
<td>5</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>2</td>
<td>Less than 6 mos</td>
<td>H</td>
<td>N</td>
<td>2</td>
<td>6</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>3</td>
<td>Less than 6 mos(^1)</td>
<td>H</td>
<td>N</td>
<td>4</td>
<td>8</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>4</td>
<td>Less than 6 mos(^1)</td>
<td>M</td>
<td>Y</td>
<td>3</td>
<td>12</td>
<td>3</td>
<td>2</td>
</tr>
<tr>
<td>5</td>
<td>Less than 6 mos(^1)</td>
<td>M</td>
<td>N</td>
<td>8</td>
<td>5</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>6</td>
<td>Less than 6 mos</td>
<td>M</td>
<td>Y</td>
<td>5</td>
<td>8</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>7</td>
<td>Less than 6 mos</td>
<td>M</td>
<td>Y</td>
<td>10</td>
<td>10</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td>8</td>
<td>Less than 6 mos(^1)</td>
<td>H</td>
<td>Y</td>
<td>2</td>
<td>8</td>
<td>3</td>
<td>2</td>
</tr>
<tr>
<td>9</td>
<td>6 months to 1 year</td>
<td>M</td>
<td>N</td>
<td>6</td>
<td>5</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>10</td>
<td>6 months to 1 year</td>
<td>M</td>
<td>Y</td>
<td>10</td>
<td>3</td>
<td>0</td>
<td>4</td>
</tr>
<tr>
<td>11</td>
<td>6 months to 1 year(^1)</td>
<td>M</td>
<td>N</td>
<td>1</td>
<td>6</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td>12</td>
<td>6 months to 1 year(^1)</td>
<td>H</td>
<td>N</td>
<td>1</td>
<td>1</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>13</td>
<td>6 months to 1 year(^1)</td>
<td>M</td>
<td>Y</td>
<td>6</td>
<td>7</td>
<td>2</td>
<td>8</td>
</tr>
<tr>
<td>14</td>
<td>More than 1 year</td>
<td>H</td>
<td>Y</td>
<td>6</td>
<td>3</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>15</td>
<td>More than 2 years(^1)</td>
<td>H</td>
<td>Y</td>
<td>10</td>
<td>4</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

\(^1\) Released from SYSC as of 1/1/18, \(^2\) Most recent SAVRY rating, \(^3\) Includes all prior delinquent petitions for both felonies and misdemeanors, \(^4\) ISO-In-Home, Groups/Clinics, Therapeutic Day Treatment, Home-Based Therapeutic, Family Support Services

In 2013, DCYF’s Bureau of Field Services Juvenile Justice staff partnered with the National Youth Screening and Assistance Project (NYSAP) to implement the Structured Assessment of Violence Risk in Youth (SAVRY) for juvenile probation. The SAVRY is completed by the juvenile probation/parole officer (JPPO) within 30 days post adjudication and again six (6) months post-adjudication. There is no risk or needs assessment completed pre-

adjudication. The SAVRY measures whether the youth is at relatively low, moderate or high risk for engaging in violence or general delinquency, it does not measure the needs principle of the Risk-Needs-Responsivity model like some other assessment tools. For the current youth meeting criteria for release from SYSC, their most recent SAVRY risk assessment scores range from moderate to high. 58% of youth have a SAVRY score of moderate and 42% have a score of high. In addition to risk assessment scores, identified disability diagnoses were reviewed and 67% have an identified disability, with “emotional disability” as the most prominent disability type.

Dispositional authority over services and placement usually rests with the judge overseeing the case. In several other states that have evolved their juvenile justice systems, JPPOs utilize risk and needs assessments and other tools, such as dispositional matrices designed to provide evidence-based recommendations about the most appropriate supervision and placement needs at the time of disposition. These types of tools are utilized by juvenile probation to provide recommendations to judicial officers who provide oversight and ask the necessary, appropriate questions to ensure the consistent application of the tools. In other states that have evolved their juvenile justice systems, over time, confidence in the system has been developed, and courts have transferred more authority to the system of care.

In addition to demographic and behavioral characteristics, petitions filed and prior services and placements were also reviewed. All of the youth meeting criteria for release from SYSC had previous petitions filed with the juvenile court and three (3) of these youths had 10 prior petitions, however this does not mean that each petition resulted in adjudication. Prior placement activity is also high for these youth, with 67% having prior placements within either the child welfare or juvenile justice systems, such as foster homes, residential treatment, or secure detention placements. A closer review of the placement information revealed that most of these youths, 67%, also had prior commitments at SYSC. Finally, prior therapeutic and community-based services were reviewed in order to understand the services these youths had received in their past. These services included: Individual Service Options (ISO) In-Home, Groups/Clinics, Therapeutic Day Treatment Services, Home-Based Therapeutic Services, and Family Support Services. 33% of these youths had no prior therapeutic or community-based services in their service history and 83% had three (3) or less prior services. This does not reflect services which may have been accessed outside of DCYF through Medicaid, private insurance, or other sources.

Community-Based Services
Most of the youth in Table 3 had at least one prior secure placement but few prior therapeutic, home-based or community-based services provided by DCYF, which suggests that these youths may not have been referred to the appropriate services to meet their individual needs or the services are limited for this population to serve them in the community, or both.

In addition to the data analysis, SYSC provided a deeper review of youth meeting criteria for release at SYSC, reviewing case files to determine the key issues and challenges they have faced in their past and the types of services and placements they have received. There is a history of substance abuse, family violence, and absconding behavior (youth and family) in all of the youth. Additionally, a significant percentage are gang-involved with a history of school disruption. Many case files did not indicate that any services were accessed prior to DCYF involvement. In some cases, families have accessed individual counseling and youth received additional services through their Individualized Education Program (IEP), but no significant services were provided until JJS became involved. It is possible that the case files may not have complete data documenting services that were provided by entities other than DCYF prior to DCYF involvement. 62% of the youth at SYSC have an active IEP and a significant number of youth at SYSC have a history of truancy and are behind with their academic functioning and credit.

There have been attempts to conduct a formal recidivism study of SYSC youth, however, due to legislative changes the characteristics of the sample population change which has made a study difficult to complete. SYSC does track the type of petition for each of the committed youth. For instance, in 2016, 40% of commitments were from youth

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6 The need principle would be aimed at assessing and treating needs associated with criminal behavior such as drug dependence and psychosocial functioning.
on administrative release or parole and in 2017 the percent of commitments from youth on administrative release or parole increased to 50%. A formal recidivism study would help to identify specific root causes of recidivism.

B. Findings

- SYSC is generally utilized as a placement of last resort on the continuum of services when there is an elevated risk of harm or safety to the youth and/or the community.

- More could be done to prevent placement at SYSC and to hasten the release of youth who are committed:
  - The depth and breadth of services available and accessible to youth involved in the juvenile justice system and SYSC is not sufficient, especially mental health and substance use services. Due to long waiting periods for mental health services, youths being released from SYSC may not be linked to needed mental health services and often re-offend.
  - Under HB517, additional beds were made available and residential and other service rates were better aligned to the costs of caring for these youth, but there are still challenges finding the right treatment program for the right child at the right time. Residential treatment providers had not had a rate increase since 2008, but were provided a 5% increase in 2017 and another increase in January 2018, however, these increases were still not enough to help offset costs incurred. Six (6) beds for females have not been implemented due to system and programmatic challenges, including staffing challenges. No additional community-based services were implemented that may divert youth prior to placement.
  - Services and placements are not consistently, appropriately matched to the individual needs of each child, youth, and family.
  - The requirement around “least restrictive, most appropriate” is sometimes interpreted to try the least restrictive option first even if it is not the most appropriate service for the child, youth, and family. This approach results in higher costs as children, youth, and families “fail their way up” to the appropriate service or placement resulting in longer length of stays.
  - Multiple CHINS law changes over the past decade have limited the types of children and youth who can be served under the law and the types of services that can be provided, making it harder to match youth and families with services.

- Cases are currently adjudicated without information from a validated risk assessment tool which captures risk and protective factors. The Structured Assessment of Violence Risk in Youth (SAVRY) assessment tool is completed post adjudication by the probation officer. Also, SAVRY focuses only on risk, unlike other more comprehensive risk assessment tools.⁷

- There is a lack of performance and outcome data to help guide referrals to services and a lack of evidence based practices.

C. Recommendations

Below are some short-term steps that can be taken to improve the system’s capacity to serve youth who may be diverted or released from SYSC as a result of HB517. However, the remainder of this report, which pertains to all children and youth involved with the child welfare and juvenile justice systems, also applies to this population. The recommendations at the end of this report would have a significant impact on this population by diverting more youth from high-end services whenever possible and hastening release and/or exit from more restrictive settings to

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⁷ More comprehensive risk assessment tools include but are not limited to the Child and Adolescent Needs Survey (CANS), the Multi-Dimensional Youth Assessment (MDYA) 360, the Treatment Outcome Package (TOP), or possibly tools listed in the research and best practices section of the document.
less restrictive settings. Therefore, the items below are intended to be short-term actions that can help mitigate the current system gaps while longer-term transformation is underway.

- Consider ways to re-allocate funds into greater bed capacity and diversion programs and/or to create incentives and capacity for providers to adapt their programs to better meet the needs of these children, youth, and families. Funds that may be leveraged include:
  - Funds currently utilized for out of state placements
  - Funds that were allocated for the 6-bed female residential program that was not implemented
  - Parental assistance funds included in SB 592

Examples of how the funds could be utilized include: additional beds for hard to place youth, more diversion programs, and/or expanding the current FAST Forward program to serve more youth, including youth with complex needs. The Division could also look at ways to more strategically purchase services to incentivize providers to create solutions for this population and divert placement at SYSC and/or expedite their release. This would require working in partnership with key providers, but could include developing case rates or "capacity" based rates for certain programs, along with performance metrics.

- Implement a strengths-based assessment tool, like the Child and Adolescent Needs Survey (CANS) used in New Jersey, Massachusetts, California, and Connecticut for assessment, case planning, treatment planning, and disposition/adjudication so that the individualized needs of each child and his/her family can be adequately assessed and appropriate services and supports can be provided as soon as possible.

- Identify potential risk factors and interventions to reduce absconding, as it is one of the key reasons why youth are placed at SYSC.

- Consistent with HB 1743, which seeks to review the current and future use of SYSC, engage representatives from state agencies, SYSC, advocacy organizations, families and other stakeholders to consider the future of SYSC as it relates to the larger system of care, and whether the current facility, or parts of it, should be further re-purposed given vacancy rates and other needs in the system. The study should take place in coordination with the implementation of the larger recommendations at the end of this report.
  - Consider alternative models for secure detention and commitment, given what is feasible in New Hampshire.
  - Consider how the funds that currently support SYSC could be better leveraged to match and draw down additional federal dollars, particularly for diversion programs or programs that support successful release from SYSC.

- Conduct a formal recidivism study with a university partner to better understand the characteristics of youth who recidivate and potential root causes. The study will help DCYF develop an action plan to address recidivism.
V. CHILD WELFARE AND JUVENILE JUSTICE SERVICES REVIEW

A. Overview of all Children and Youth Involved in the Child Welfare and/or Juvenile Justice System

The estimated population of New Hampshire in 2016 was approximately 1.33 million people, and approximately 19.5%, or 260,285, were children or youth under age 18 (US Census Bureau, 2017). To understand the entire population of children under the purview of DCYF, we analyzed all delinquency, abuse and neglect and CHINS cases in New Hampshire over the past four (4) years, 2014 – 2017. A total of 18,264 individuals were served. The project team was provided with their entire case history data, which totaled 31,744 cases categorized into 18 different case types. Of those 31,744 cases, 20% were open cases with no case closure date (N=6,486). A total of 15,285 cases were opened from 2014 – 2017 with 33% still open with no case closure date (N=4,995).

YOUTH INVOLVED IN THE JUVENILE JUSTICE SYSTEM

Table 4 below represents the summary of the delinquency cases during this time (N=4,444). The majority of delinquency cases in New Hampshire involved males with an average age of 14. According to the most recent SAVRY risk ratings, most youth rated either low or moderate risk for engaging in violence or general delinquency, whereas only 12% rated as high risk. 12% of the total juveniles had an identified disability. In terms of prior detention and services, only 1% (N=45) of juveniles had previous detention placements at SYSC and 11% (N=511) received prior therapeutic and community-based services (this does not include services that may have been accessed outside of DCYF, such as Medicaid funded services). Furthermore, 9% (N=393) of juveniles had a prior case of abuse/neglect at some point in their history.

Table 4: Total Delinquency Cases 2014 – 2017 (N=4,444)

<table>
<thead>
<tr>
<th>Gender</th>
<th>Average Age</th>
<th>SAVRY Risk Rating</th>
<th>Percent of Juveniles with an Identified Disability</th>
<th>Percent of Juveniles with Prior Detention Commitments</th>
<th>Percent of Juveniles with a Prior Abuse/Neglect Case</th>
<th>Percentage of Juveniles with Prior Services Provided by DCYF¹</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male (61%)</td>
<td>14</td>
<td>Low (43%) Moderate (45%) High (12%)</td>
<td>12%</td>
<td>1%</td>
<td>9%</td>
<td>11%</td>
</tr>
<tr>
<td>Female (39%)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

¹ISO-In-Home, Groups/Clinics, Therapeutic Day Treatment, Home-Based Therapeutic, Family Support Services

We also reviewed juvenile arrest information from 2016 to better understand the types of offenses committed by youth which may or may not result in a commitment to SYSC. Table 5 below represents the number of arrests for offenses committed by juveniles in 2016. In 2016, there were 3,754 arrests for offenses committed by juveniles. Most of juvenile offenses are committed by Caucasian males from the ages of 14 – 17 for property, financial and other crimes. While violent offenses are the lowest, simple assault constitutes 76% of the total violent offenses, and 14% of all offenses. Drug and narcotic violations constitute 49% of the substance use offenses and 17% of total offenses. These offenses are also recorded by county, with Rockingham (30%), Hillsborough (29%), Strafford (10%) and Merrimack (9%) the top 4 counties where these offenses occurred in 2016, respectively.
Table 5: Total Juvenile Arrests, 2016 (N=3,754)

<table>
<thead>
<tr>
<th>Gender</th>
<th>Age</th>
<th>Race</th>
<th>Violent Offenses (N=664)</th>
<th>Substance Use Offenses (N=1,315)</th>
<th>Property, Financial Offenses (N=1,775)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male (70%) Female (30%)</td>
<td>14 (9%)</td>
<td>15 (16%) 16 (27%) 17 (39%)</td>
<td>Caucasian (85%) Hispanic (8%) African American (5%)</td>
<td>Simple Assault (76%) Intimidation (11%) Aggravated Assault (6%)</td>
<td>Drug/Narcotics (49%) Liquor Laws (30%) Drunkenness (18%)</td>
</tr>
</tbody>
</table>

Lastly, in Table 6 below we reviewed three (3) years of Disproportionate Minority Contact (DMC) data for the juvenile justice population from 2014 – 2016 and the Relative Rate Index (RRI). RRI is the method used by OJJDP to measure the over or under-representation of minority youth in the juvenile justice system, in comparison to white youth. According to OJJDP, in the first step, the rate for a particular racial group of youth at a particular decision point in the juvenile justice system is calculated by taking the number of youth at that point and dividing it by (a) the number of youth in that racial/ethnic group in the general population (if the decision point is arrest); or (b) dividing it by the number of youth in that racial/ethnic group at the previous decision point (for any decision point besides arrest). New Hampshire calculates RRI using method (b). In the next step, the rate for the group is divided by the rate for the white population of youth. If the value is larger than 1, it indicates the group is overrepresented compared to white youth. If the value is less than 1, it indicates that the group is underrepresented compared to white youth.

Table 6: Disproportionate Minority Contact (DMC) Data, 2014 – 2016

<table>
<thead>
<tr>
<th>DMC Data (Age 10 – 17)</th>
<th>2014</th>
<th>2015</th>
<th>2016</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Youth</td>
<td>130,544</td>
<td>128,628</td>
<td>126,462</td>
</tr>
<tr>
<td>White Youth</td>
<td>116,785</td>
<td>114,713</td>
<td>112,281</td>
</tr>
<tr>
<td>Minority Youth</td>
<td>13,759</td>
<td>13,915</td>
<td>14,181</td>
</tr>
<tr>
<td>Percent of Minorities to White Youth</td>
<td>12%</td>
<td>12%</td>
<td>13%</td>
</tr>
<tr>
<td>Percent of Minority Arrests (Step 1)</td>
<td>12%</td>
<td>13%</td>
<td>15%</td>
</tr>
<tr>
<td>Relative Rate Index (Step 1)</td>
<td>1.20</td>
<td>1.26</td>
<td>1.41</td>
</tr>
<tr>
<td>Percent of Minority Cases Resulting in Confinement (Step 9)</td>
<td>25%</td>
<td>27%</td>
<td>41%</td>
</tr>
<tr>
<td>Relative Rate Index (Step 9)</td>
<td>1.24</td>
<td>1.45</td>
<td>2.08</td>
</tr>
</tbody>
</table>

1 Statistically significant results

The number of total youth has steadily decreased from 2014 – 2016, but the RRI in 2016 was statistically significant at 2.08. For example, in 2016 all minorities ages 10 - 17 were approximately 13% of the total white population, but 41% of those committed were minorities. A review of DMC data reported by each of the 10 counties in New Hampshire further provided clarification into the statewide data. Of the 10 counties, four (4) counties showed minority over-representation in confinement; Hillsborough, Merrimack, Rockingham and Grafton. For example, in 2016, Hillsborough county minority youth were approximately 22% of the total white population, but accounted for

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Disproportionate Minority Contact (DMC)
The data below shows New Hampshire has an over-representation of minorities in confinement; specifically within certain geographical areas.
63% of those committed. The number of counties with a DMC issues is low, but these counties encompass the high population areas of the state. A root causes analysis could help determine the drivers of the issues to be remedied.

CHILDREN IN NEED OF SERVICES (CHINS)

The CHINS statute in New Hampshire, RSA 169-D, has changed several times over the past 10 years, including the population of youth served and the types of placements and services available to this population.

Under the current CHINS statute, RSA 169-D, a child in need of services is defined as a child:

- Who is subject to compulsory school attendance, and who is habitually, willfully, and without good and sufficient cause truant from school;
- Who habitually runs away from home, or who repeatedly disregards the reasonable and lawful commands of his or her parents, guardian, or custodian and places himself or herself or others in unsafe circumstances;
- Who has exhibited willful repeated or habitual conduct constituting offenses which would be violations under the criminal code of this state if committed by an adult or, if committed by a person 16 years of age or older, would be violations under the motor vehicle code of this state; or
- With a diagnosis of severe emotional, cognitive, or other mental health issues who engages in aggressive, fire setting, or sexualized behaviors that pose a danger to the child or others and who is otherwise unable or ineligible to receive services under RSA 169-B or RSA 169-C; and
- Is expressly found to be in need of care, guidance, counseling, discipline, supervision, treatment, or rehabilitation.

In 2007, status offenders were able to receive services through DCYF, including placement in a residential facility or group home. In 2010, the CHINS statute was changed removing status offenses, which removed the ability for DCYF to provide services to this population.

In 2013, the CHINS statute re-instituted status offenses, but limited interventions to home-based interventions and supervised probation; placement is not allowed. Currently, JPPOs are treating and supervising, Mental Health CHINS (D2 CHINS), the population defined in statute with a diagnosis of severe emotional, cognitive, or other mental health issues for whom placement is allowed, although these children and youth would be more appropriately served by other systems (such as mental health). The current CHINS statute prohibits a CHINS finding due to a child’s special needs and the parental ability to meet those needs.

Of the 18,264 cases over the past 4 years which we reviewed, there was a total of 254 “CHINS” cases open and a total of 225 “CHINS Without Court” cases open from data gathered through Bridges and CourtStream. CHINS Without Court are those voluntary cases, which are not under a court order. Services can be provided but the state can seek reimbursement from the parents for the services.

CHILDREN AND YOUTH INVOLVED IN THE CHILD WELFARE SYSTEM

Table 7 below represents the summary of the abuse and neglect cases over the past four (4) years (N=4,669). The cases are generally evenly split between males and females with the average age of the child at 9 years old. 13% of the children have an identified disability, which is just slightly higher than the delinquency population, and 16% of children had received prior therapeutic and/or community-based services through DCYF. 19% of the population over this timeframe had a prior case of abuse or neglect at some point in their history.
Table 7: Total Abuse and Neglect Cases, 2014 – 2017 (N=4,669)

<table>
<thead>
<tr>
<th>Gender</th>
<th>Average Age</th>
<th>Percentage of Children with an Identified Disability</th>
<th>Percentage of Children with Prior Abuse &amp; Neglect Cases</th>
<th>Percentage of Children with Prior Services Provided by DCYF</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male (52%) Female (48%)</td>
<td>9</td>
<td>13%</td>
<td>19%</td>
<td>16%</td>
</tr>
</tbody>
</table>

ISO-In-Home, Groups/Clinics, Therapeutic Day Treatment, Home-Based Therapeutic, Family Support Services

Table 8 below represents the number of child protection removals over the past four (4) years by age group (N=1,976). The number of removals for all age groups has significantly risen from 2014 – 2017. The percent change from 2014 – 2017 is well over 100% for each age group, other than Age 15+. This data suggests the substance abuse problem in New Hampshire has increased over time and the number of removals due to substance abuse continues to rapidly increase.

Table 8: Total Child Protection Removals, 2014 – 2017 (N=1,976)

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Age 0 – 2</td>
<td>253</td>
<td>228</td>
<td>148</td>
<td>118</td>
<td>114%</td>
</tr>
<tr>
<td>Age 3 – 5</td>
<td>158</td>
<td>109</td>
<td>98</td>
<td>59</td>
<td>167%</td>
</tr>
<tr>
<td>Age 6 – 8</td>
<td>95</td>
<td>79</td>
<td>52</td>
<td>42</td>
<td>126%</td>
</tr>
<tr>
<td>Age 9 – 11</td>
<td>67</td>
<td>54</td>
<td>51</td>
<td>26</td>
<td>158%</td>
</tr>
<tr>
<td>Age 12 – 14</td>
<td>68</td>
<td>46</td>
<td>44</td>
<td>25</td>
<td>172%</td>
</tr>
<tr>
<td>Age 15+</td>
<td>47</td>
<td>31</td>
<td>36</td>
<td>42</td>
<td>12%</td>
</tr>
<tr>
<td>TOTAL</td>
<td>688</td>
<td>547</td>
<td>429</td>
<td>312</td>
<td>-</td>
</tr>
</tbody>
</table>

Percent of children removed with allegations of substance abuse, drug abuse, or poisoning/noxious gases in assessment: 53% (N=365), 60% (N=329), 48% (N=208), 44% (N=137), 166%

Percent of children born “drug-exposed” at time of referral and allegation founded: 7% (N=49), 5% (N=28), 5% (N=22), 4% (N=14), 250%

Percent of children removed from their home where substance abuse was a risk factor at time of referral: 67% (N=461), 52% (N=286), 62% (N=266), 59% (N=185), 149%

In addition to the abuse and neglect case data, we also analyzed New Hampshire Integrated Assessment (NHIA) tool information from 2014 – 2017. The NHIA is DCYF’s primary strategy to ensure that accurate, timely, and ongoing safety and risk assessment tools are utilized statewide in child protection to guide case decisions and engage families in a meaningful way. Assessment social workers are required to conduct an assessment of child safety, which is documented in the NHIA, within 24 hours of the first contact. NHIA data was provided from 2013 – 2017 consisting of 15,786 assessments for 5,562 individuals. The assessment data was sorted by DHHS District Office, for a total of 11 offices for comparison purposes. The following variables were compared; educational achievement, child and youth development, delinquent behavior, emotional and behavioral adjustment, family relationships, physical health and disability, social

NHIA Assessments

The majority response for each district office’s substance abuse variable was “no use/experimentation.” This data suggests either the tool may not accurately depict the population served, or the tool is not being used to fidelity, or both.
relationships, and substance abuse. After a detailed review and analysis, we found the NHIA data to be of little value in determining the strengths and needs of children and families across the state. In comparing the results of assessments across offices, there were little to no variances in the variables. For instance, for all district offices the majority response for each variable was either “satisfactory”, “adequate”, or “good”.

Transitional Age Youth

New Hampshire has not chosen to not extend foster care under the Fostering Connections to Success and Increasing Adoptions Act (FCSIAA) of 2008 beyond the age of 18. DCYF will allow young adults to stay in the care of the division until they are 18 years old and/or graduate high school. Numerous studies have shown poor outcomes for young adults who age out of foster care and as a result, many states have extended foster care services up to age 21 to give young adults more time to develop skills and transition to independence more successfully. Each district office has one adolescent worker that works solely with youth prior to transitioning out of care to help prepare them for the future. DCYF also provides aftercare services for youth age 18-21 formerly in out-of-home placement in their pursuit of education, employment, housing and wellbeing goals through federal programs such as the John H. Chafee Foster Care Independence Program (CFCIP) and Chafee Educational and Training Voucher Program (ETV).

In a recent National Youth in Transition Database (NYTD) survey, 38% (11) of youth reported experiencing homelessness within the past two years. Currently, there are only a few providers in New Hampshire that offer transitional living programs which provide supportive housing, life skills training and other support services to youth 18 to 21 who are homeless or transitioning out of foster care.

B. Community Based Service Capacity

Community-based services in New Hampshire are covered and paid by both public and private entities. DCYF pays for a variety of community-based, therapeutic services to children, youth, and families involved with the child welfare and juvenile justice systems.

Table 9 below shows the array of community-based services provided by DCYF from 2014 - 2017. There is a total of 24 services and 748 different organizations and individuals that have been paid by DCYF to provide these services. 21 of these providers are located out of state; Massachusetts (N=12), Vermont (N=5), Maine (N=2), Missouri (N=1), North Carolina (N=1).

<table>
<thead>
<tr>
<th>Community-Based Services</th>
<th>Number of Providers</th>
<th>Number of District Office Locations</th>
<th>District Office</th>
</tr>
</thead>
<tbody>
<tr>
<td>Accompanied Transportation</td>
<td>4</td>
<td>3</td>
<td>Laconia, Manchester, Seacoast</td>
</tr>
<tr>
<td>Alcohol/Drug Group Outpatient Counseling</td>
<td>33</td>
<td>9</td>
<td>Laconia, Conway, Keene, Littleton, Manchester, Concord, Seacoast, Claremont, Southern</td>
</tr>
<tr>
<td>Alcohol/Drug Group Individual Counseling</td>
<td>50</td>
<td>10</td>
<td>Laconia, Conway, Keene, Littleton, Manchester, Rochester, Concord, Seacoast, Claremont, Southern</td>
</tr>
<tr>
<td>Community-Based Services</td>
<td>Number of Providers</td>
<td>Number of District Office Locations</td>
<td>District Office</td>
</tr>
<tr>
<td>------------------------------------------</td>
<td>---------------------</td>
<td>-------------------------------------</td>
<td>--------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Attorney</td>
<td>98</td>
<td>11</td>
<td>Berlin, Claremont, Concord, Conway, Keene, Laconia, Littleton, Manchester, Rochester, Seacoast, Southern</td>
</tr>
<tr>
<td>Child Health Support</td>
<td>12</td>
<td>7</td>
<td>Berlin, Claremont, Concord, Conway, Manchester, Seacoast, Southern</td>
</tr>
<tr>
<td>Clinics/Groups</td>
<td>13</td>
<td>6</td>
<td>Berlin, Concord, Conway, Littleton, Manchester, Southern</td>
</tr>
<tr>
<td>Dental</td>
<td>7</td>
<td>4</td>
<td>Berlin, Concord, Laconia, Manchester</td>
</tr>
<tr>
<td>Diagnostic Evaluation</td>
<td>74</td>
<td>11</td>
<td>Berlin, Claremont, Concord, Conway, Keene, Laconia, Littleton, Manchester, Rochester, Seacoast, Southern</td>
</tr>
<tr>
<td>Educational Trans or Parent/Child Visit</td>
<td>5</td>
<td>4</td>
<td>Concord, Keene, Manchester, Rochester</td>
</tr>
<tr>
<td>Family Counseling</td>
<td>110</td>
<td>11</td>
<td>Berlin, Claremont, Concord, Conway, Keene, Laconia, Littleton, Manchester, Rochester, Seacoast, Southern</td>
</tr>
<tr>
<td>Group Outpatient Counseling</td>
<td>82</td>
<td>11</td>
<td>Berlin, Claremont, Conway, Keene, Laconia, Littleton, Manchester, Rochester, Seacoast, Southern</td>
</tr>
<tr>
<td>Guardian ad Litem</td>
<td>33</td>
<td>11</td>
<td>Berlin, Claremont, Conway, Keene, Laconia, Littleton, Manchester, Rochester, Seacoast, Southern</td>
</tr>
<tr>
<td>Home Based Therapeutic Services</td>
<td>15</td>
<td>7</td>
<td>Claremont, Concord, Conway, Littleton, Manchester, Rochester, Seacoast, Southern</td>
</tr>
<tr>
<td>Hospitals</td>
<td>6</td>
<td>4</td>
<td>Concord, Keene, Manchester, Seacoast</td>
</tr>
<tr>
<td>Individual Outpatient Counseling</td>
<td>132</td>
<td>11</td>
<td>Berlin, Claremont, Concord, Conway, Keene, Laconia, Littleton, Manchester, Rochester, Seacoast, Southern</td>
</tr>
<tr>
<td>Inpatient Psychiatric</td>
<td>2</td>
<td>2</td>
<td>Concord, Keene</td>
</tr>
<tr>
<td>Interpreter Services</td>
<td>2</td>
<td>2</td>
<td>Concord, Seacoast</td>
</tr>
<tr>
<td>ISO In-Home</td>
<td>13</td>
<td>6</td>
<td>Concord, Conway, Littleton, Manchester, Seacoast, Southern</td>
</tr>
<tr>
<td>Medical and Psychological Evaluation</td>
<td>14</td>
<td>8</td>
<td>Concord, Keene, Laconia, Littleton, Manchester, Rochester, Seacoast, Southern</td>
</tr>
<tr>
<td>Community-Based Services</td>
<td>Number of Providers</td>
<td>Number of District Office Locations</td>
<td>District Office</td>
</tr>
<tr>
<td>----------------------------------</td>
<td>--------------------</td>
<td>-----------------------------------</td>
<td>--------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Out of Home 1 on 1 Aide</td>
<td>21</td>
<td>6</td>
<td>Concord, Conway, Littleton, Manchester, Rochester, Seacoast,</td>
</tr>
<tr>
<td>Outreach and Tracking</td>
<td>4</td>
<td>2</td>
<td>Manchester, Seacoast</td>
</tr>
<tr>
<td>Pharmacy</td>
<td>2</td>
<td>2</td>
<td>Concord, Littleton</td>
</tr>
<tr>
<td>Physician’s Services</td>
<td>5</td>
<td>4</td>
<td>Berlin, Concord, Manchester, Seacoast</td>
</tr>
<tr>
<td>Public Transportation</td>
<td>1</td>
<td>1</td>
<td>Littleton</td>
</tr>
<tr>
<td>Secure Transportation</td>
<td>11</td>
<td>11</td>
<td>Berlin, Claremont, Concord, Conway, Keene, Laconia, Littleton, Manchester, Rochester, Seacoast, Southern</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>748</strong></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

The location information in the chart above represents the number of DCYF district offices in which the providers’ physical locations reside (different divisions within DHHS have different district office delineations). Providers may be physically located in one district, but may serve multiple districts. Many of the services have providers located in five (5) or more districts. Three of the most utilized DCYF paid services are Home-Based Therapeutic Services, Child Health Support and Individual Service Option:

- **Home-Based Therapeutic Services (HBTS)** is defined as in-home interventions for identified child, youth, and family issues to prevent future problems within the family, to strengthen and support the family, to prevent placement of a child, to assist with family reunification, or to intervene when crisis situations arise. Currently, there are 17 agencies across the state providing HBTS services.

- **Child Health Support (CHS)** Services is defined as in-home support for children and families through the provision of supportive counseling, health assessment, health education, behavioral health management, referral to resources, coordination of services, and other supports for improving health and well-being of children and other family members. Currently, there are 13 agencies statewide providing this service.

- **Individual Service Options (ISO-IH)** is defined as a variety of intensive therapeutic, social, and community-based services provided or coordinated to meet the individual needs of children and youth in the home and their family in their residence to prevent placement or to provide post-placement family support. Currently, there are 13 agencies across the state providing ISO-IH services.
Figure 3 below shows the number of open cases by district office and the number of entities providing these services in each area. Generally, there are more providers available in areas with higher case concentration but all of the district offices have these services available across their catchment areas.
The providers report waitlists for the services above due to workforce shortages, the demands of cases and, in some cases, the distances they have to travel. It is hard to draw conclusions about whether the current DCYF service array is best suited to the needs of children, youth, and families across the state because the assessment data did not yield useful information about the needs of children, youth, and families.

Additional community based services and supports are available outside of services offered by DCYF. Some of the most significant resources are listed below, but this does not represent all services and supports:

- **Family Resource Centers** are non-profit, community-based programs that are available to all families. Family Resource Centers provide Comprehensive Family Support Services (CFSS) which are provided along a continuum of three preventive stages; Prevention, Early Intervention and Crisis services. The array of services includes; home visiting, medical and health education, early childhood education, literacy education, family mentoring and advocacy, life and independent living skills training and trauma-informed services. Participation in these programs is voluntary for families with children ages zero to eighteen years, living in/out-of-home situations. There are 15 centers around the state. Approximately 75% of the referrals come directly from the community through self-referrals of families needing assistance.

- **FAST Forward** is a wraparound based model, was originally funded through a SAMHSA grant, but now is funded through a combination of Medicaid and State general fund dollars The Department’s Bureau of Children’s Behavioral Health oversees the program. DCYF purchases services through a care management entity using a blended daily rate which covers a full array of services including care coordination, in-home services, and supportive services. FAST Forward currently serves about 50 children, youth, and their families across the state. There is a pending application to CMS to create a Home and Community-Based Services (HCBS) 1915i waiver that would increase program capacity to 100 to 130 youth/families. The Department of Education (DOE), in collaboration with DHHS, received a new grant in 2016 called FAST Forward 2020 which expands the original program but with more of a school focus. FAST Forward 2020 is currently confined to three regions of N.H.: White Mountain, Winnisiquam, and Claremont. The Monadnock region (Cheshire County) has a grant doing the same expansion work that DOE is doing. There is a possibility of expanding this program to other areas and it is included in the 1915i waiver.

- **Community Mental Health Centers** (CMHCs) are located in 10 regions of New Hampshire. They are private not-for-profit agencies that have contracted with the New Hampshire Department of Health and Human Services, Bureau of Mental Health Services, to provide publicly funded mental health services to individuals and families who meet certain criteria for services. Services provided by CMHCs include: 24-hour Emergency Services, Assessment and Evaluation, Individual and Group Therapy, Case Management, Community Based Rehabilitation Services, Psychiatric Services, and Community Disaster Mental Health Support. All CMHCs have specialized programs for older adults, children, and families and also provide services and referrals for short-term counseling and support. In 2016, CMHCs accounted for nearly $25 million in expenditures, providing the majority of outpatient behavioral health support in the New Hampshire.

Children in placement, in both the child welfare and juvenile justice systems, are enrolled into Medicaid (with rare exception) and subsequently a managed care organization (MCO) which provides care coordination and further community-based, therapeutic services. Some of the therapeutic services offered through the MCO, paid for by Medicaid are: Family Counseling, Psychological Consultation, Evaluation and Treatment, Alcohol/Substance Abuse Skills, Alcohol/Drug Abuse Services, Crisis Intervention, Mental Health Services, Mental Health Treatment, Group Psychotherapy, Family Psychotherapy, Psychotherapy for Crisis, Psychoeducational Service, Adolescent Behavioral Community Therapeutic Services, Therapeutic Behavioral Services, Rehabilitation Services, Community Support, and Self-help/Peer Services. In addition, there are children served by DCYF that are not in out of home placement receiving in-home services who may or may not be enrolled into Medicaid. Table 10 below represents the number community-based providers that provided services to DCYF-involved individuals or families paid by

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9 Text below from [https://www.dhhs.nh.gov/dcbcs/bbh/centers.htm](https://www.dhhs.nh.gov/dcbcs/bbh/centers.htm)
Medicaid in state fiscal year (SFY) 2017 taken from the New Hampshire Medicaid Management Information System (MMIS).

Table 10: Services Provided by Medicaid for DCYF-involved Families or Individuals in SFY 2017

<table>
<thead>
<tr>
<th>Provider Types</th>
<th>Number of Provider Groups</th>
<th>Total Number of Paid Claims</th>
</tr>
</thead>
<tbody>
<tr>
<td>Early Intervention Services</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Federally Qualified Health Center</td>
<td>5</td>
<td>31</td>
</tr>
<tr>
<td>Mental Health Clinic</td>
<td>13</td>
<td>41,026</td>
</tr>
<tr>
<td>Psychologists Group</td>
<td>27</td>
<td>450</td>
</tr>
<tr>
<td>Psychotherapy Mental Health Professional</td>
<td>251</td>
<td>7,657</td>
</tr>
<tr>
<td>Substance Use Disorder (SUD) Outpatient Program</td>
<td>1</td>
<td>18</td>
</tr>
</tbody>
</table>

The largest number of providers paid by Medicaid are Psychotherapy Mental Health Professionals (N=251). There is only one (1) Early Intervention Services provider group and Substance Use Disorder Outpatient Program. For this analysis, claims paid represent the total number of units of service provided. Therefore, one (1) paid claim could be the results of one (1) hour therapy session, or one (1) week of intensive outpatient therapy. Of the 13 Mental Health Clinic provider groups, which include the CMHCs, the total number of paid claims in SYF2017 was 41,026. To fully understand the paid claims and the number of individual children and families served, a more robust data request and analysis would need to be undertaken between DCYF and Office of Medicaid Business and Policy.

Of the 18,264 cases over the past 4 years which we reviewed, 1,201 (6.6%) individuals have received some type of DCYF therapeutic and/or community based services for a total of 5,628 total services provided. Additional services may have been provided by private insurance or other payers.

One of the most emergent needs is availability and access to substance abuse treatment programming. New Hampshire is experiencing an opioid misuse and overdose crisis, similarly to many other states across the country. According to the Centers for Disease Control (CDC), from 2014 – 2016 there were 1,237 drug overdose deaths. In 2016, New Hampshire ranked third (3rd) in the United States for the number of drug overdose deaths behind West Virginia and Ohio at 39 deaths per 100,000 population. The state has recently adopted Medicaid expansion which allows Medicaid coverage for substance abuse treatment; however, the provider network for treatment is inadequate to meet the needs of children, youth, and their families. The state has also recognized the need for substance abuse treatment programming and has begun construction at SYSC to convert one (1) unit to an inpatient substance abuse treatment unit with a 36-bed capacity, which will be operated by a private vendor independent of DCYF. The unit will be open to all youth needing the treatment services.

Another need is availability and access to mental health services and programming for children and youth. According to SAMHSA’s Behavioral Health Barometer for New Hampshire, 10,658 children and adolescents (aged 17 or younger) were served in New Hampshire’s public mental health system in 2015. Additionally, an annual average of approximately 13,000 adolescents aged 12–17 (13.4% of all adolescents) in 2014–2015 had experienced a major depressive episode (MDE) in the past year, which was higher than the annual average percentage in 2011–2012.

New Hampshire Hospital is the only public hospital with 24 child/adolescent beds. Frequently all 24 beds are filled. Children and youth may wait in the emergency room for an available bed. Furthermore, New Hampshire Hospital is not an appropriate setting for youth with aggressive behavior or other conduct-related behavioral issues. Across the system, there are long waits for mental health screenings and services. Mental health providers and therapists may not provide services to families with Medicaid insurance because of low reimbursement rates. There is a severe shortage of psychiatry services. Primary care doctors are prescribing and managing most psychiatric medications.
Crisis response is only available in Concord and Manchester. There is a lack of crisis response for children, youth, and families with mental health needs in rural areas of the state.

It was not possible to fully assess the service capacity of the state because it was not possible to obtain a full list of services available to children, youth, and families by geographic area in New Hampshire and we were unable obtain service history data provided by agencies or organizations other than DCYF within the timeframe of this project. But it is clear that there is a lack of sufficient services to meet the mental health and substance abuse needs of children, youth, and families in New Hampshire. Additionally, there are waitlists for DCYF services, and limited preventive services available to children, youth, and families, which could reduce the need for higher end services. Some investment in substance abuse prevention services, for example, could have the potential for significant return on investment. Stakeholder feedback, and the timeline presented in the introduction section of this report, suggest a pattern of reductions in preventive services in New Hampshire, largely as a result of budget constraints, that have likely contributed to the number of children, youth, and families in need of acute and crisis services.

C. Bed Capacity

Overall, there is a shortage of residential beds to meet the current demand, particularly for the female population, homeless youth and young adult population, or youth with significant behavioral challenges. Supply is constrained by a long period of insufficient residential rates and a lack of preventive and community based services and supports to meet the needs of children, youth, and families at home or in lower levels of care. Approximately 22% of DCYF’s open cases involve a child or youth in placement, and approximately 43% of children in foster care reside in a residential facility (not in a family-based setting). The current system is skewed to serve children, youth, and families with the most expensive, most restrictive services, rather than with more upstream, preventive services and supports.

Table 11 below represents the census of certified residential treatment programs/group homes in New Hampshire as of April 23, 2018, including a description of each program, licensed capacity, operational capacity and DCYF certified beds. There is one (1) additional, licensed residential treatment program in New Hampshire but it is not certified by DCYF and does not accept DCYF involved youth. There is also one additional certified program which is certified as a pediatric nursing and rehabilitation program for a special population licensed under health care facilities.

There are factors that contribute to the number of youth that can be placed at a residential treatment program/group home. Licensed capacity refers to the number of beds approved by the DHHS Child Care Licensing Unit. DCYF certified beds are the number of beds DCYF certified for access via RSA 170-G:4 XVIII He-C 6350 and He-C 6420. There are no longer any licensed residential substance abuse treatment programs in New Hampshire. These programs closed due to rates and underutilization of services over the past several years. Historically, residential rates have been based on an assumption of 95% utilization, which means that they need to remain nearly full all the time for the rate to cover their costs. This utilization expectation may not be realistic for certain programs, particularly specialty programs, emergency shelter programs, or other types of programs where DCYF may need to maintain bed capacity through utilization fluctuations.
### Table 11: Residential Treatment Programs as of May 2018

<table>
<thead>
<tr>
<th>Residential Treatment Program</th>
<th>Description</th>
<th>Licensed Capacity</th>
<th>Operational Capacity</th>
<th>DCYF Certified Beds</th>
<th>DCYF Certified Beds Filled</th>
<th>Number of Open Beds</th>
<th>Number of Youth in Process</th>
</tr>
</thead>
<tbody>
<tr>
<td>Assessment Treatment Programs</td>
<td>Short-term, therapeutic treatment for 60 days or less</td>
<td>39</td>
<td>29</td>
<td>21</td>
<td>18</td>
<td>1</td>
<td>17</td>
</tr>
<tr>
<td>Intermediate Treatment Programs</td>
<td>Structured, therapeutic treatment including specialized services, crisis intervention, behavioral management, clinical and family services</td>
<td>82</td>
<td>63</td>
<td>66</td>
<td>56</td>
<td>8</td>
<td>8</td>
</tr>
<tr>
<td>Intensive Treatment Programs</td>
<td>Multi-disciplinary, self-contained service delivery approach with on-site education and intensive services</td>
<td>633</td>
<td>466</td>
<td>291</td>
<td>210</td>
<td>71</td>
<td>71</td>
</tr>
<tr>
<td>Shelter Care Programs</td>
<td>Short-term, stabilization services for youth ages 11-18 in crisis for 60 days or less</td>
<td>22</td>
<td>12</td>
<td>16</td>
<td>11</td>
<td>1</td>
<td>4</td>
</tr>
</tbody>
</table>

In January 2018, DCYF procured 16 additional beds for males and six (6) additional beds for females. Two (2) of the additional female beds were previously certified under the Intensive Treatment Program. DCYF also increased the number of certified beds by 15. 16 additional Shelter Care certified beds were also added. These beds are reflected in the chart above. To address the lack of certified substance abuse treatment programs available to youth across in New Hampshire, the state has begun construction at SYSC to convert one (1) unit to a 36-bed inpatient substance abuse treatment unit operated by a private vendor independent of DCYF through a competitive bid process.

Factoring in true operational capacity, and the number of youth in process, there is a shortage of residential beds as of May 2018. A facility may be licensed or certified for a certain number of beds, their actual “operational capacity” may be significantly lower. A facility’s “operational capacity” may depend on a number of factors including the facility’s ability to acquire and keep necessary staffing, its ability to recruit and retain qualified individuals to provide clinical and special education services, program costs and the adequacy of its reimbursement rate to cover those costs.

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10 These numbers are assessed over the course of each month as they fluctuate. They are not point in time numbers.  
11 Number of youth in the process of being matched to an appropriate placement setting.
costs. As a result of these and other factors the actual “operational capacity” of a number of DCYF certified facilities may be substantially lower than their licensed or certified capacity. Stakeholders indicated shortages of beds especially for youth with significant behavior issues, homeless youth, and girls. Shortages have been created in part by rate freezes in New Hampshire; residential providers receive higher rates for children placed from neighboring states. The number of out-of-state placements has increased consistently over the past five (5) years.

Of the 18,264 cases over the past four (4) years, 1,691 individuals have been in DCYF placement for a total of 3,697 placements. Of the state paid placements from 2014 - 2017, 95% (N=3,515) of youth were placed in the state of New Hampshire and 5% of youth were placed out of state; out of state placement were highest in Vermont (2.5%, N=92), Massachusetts (1.1%, N=40), and Maine (.5%, N=15). There are some instances where families close to border states may be placed closer to home by going out of state, but out of state placements have consistently increased over the past few years, 2014 (N=27), 2015 (N=35), 2016 (N=42), 2017 (N=54). The vast majority of out of state placements are for residential treatment. According to the June 2018 residential census, 71 children and youth were in out of state placements.

As noted earlier, young adults can stay in the care of DCYF until they are 18 years old and/or graduate high school. Many states have extended the age of foster care through 21 to assist young adults to transition to independence more successfully. Right now, DCYF has limited ability to assist older teenagers which may be exacerbating the number of youth and young adults who are homeless in New Hampshire.

D. Workforce and Workload

Workforce challenges were continually noted throughout this engagement. The challenges impact staffing, and as a result, service levels at both the state and at provider agencies. Challenges include:

- Difficulty retaining a sufficient workforce population in New Hampshire due to the high cost of living in the state and lower wages relative to adjacent states;
- A prolonged period of rate suppression for provider services which has suppressed wages;
- High rates of turnover at the state and provider agencies due to rising caseloads, lack of support staff, and frustration with being able to sufficient address the needs of children and families with limited resources; and
- Backlogs in professional credentialing and licensing.

The workforce issues above are directly impacting the availability of services and supports to children, youth, and families. As previously stated, New Hampshire is experiencing an opioid misuse and overdose crisis, similarly to many other states across the country and research shows there is a relationship between substance abuse indicators and child welfare caseloads. According to a recent research brief from the U.S. Department of Health and Human Services, substance use indicators correlate with rates of more complex and severe child welfare cases. If caseloads in New Hampshire are rising due to opioid abuse, the complexity of caseloads overall are also increasing, which can lead to higher turnover rates and other workforce issues.

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Youth and families reported a range of experiences with their workers and the degree to which their workers were able to make regular visits and spend time with them due to workload issues. The charts below show the caseload trends for ongoing CPSW cases, JPPO cases, and CPSW assessments. Caseloads for ongoing CPSW cases and JPPO caseloads have been rising and are higher than national standards and best practice. The CPSW assessment caseloads have been declining, but are still well above national standards.

Figure 4: Average Number of Cases and Children assigned per CPSW 2016-2018
Figure 5: Average Number of Cases Assigned Per JPPO, 2017-2018

Figure 6: Average Number of Assessments Assigned per CPSW 2016-2018
VI. SUMMARY OF KEY FINDINGS

The findings below are intended to assist New Hampshire to continue to move toward a system of "every door is the right door" where every child and youth receives the right services, at the right time. System transformation is already underway and changes are in motion. These findings, and later the recommendations are intended to sustain and scale the transformation efforts that area already underway by aligning all of the levers needed to support and maintain change efforts including practices, policies, regulations, and fiscal activities. The findings apply to all children, youth, and families involved in the child welfare and juvenile justice systems, including youth who need to be released or diverted from SYSC.

As noted previously, DHHS/DCYF desires a more preventive, integrated, and organized continuum of services and supports that are aligned to the needs of the children, youth, and families they serve. This vision is new and the concept is not yet fully shared across all stakeholders:

- There is strong support and desire for more integrated, comprehensive, and accessible services and supports but there is inconsistency in people’s understanding of what this means and looks like in application, including both an array of services and natural supports.
- There is some lack of confidence that the system can employ this model (lack of resources, skill, and capacity).
- Currently, the experience of children, youth, and families varies from school to school, location to location, court to court, district office to district office, worker to worker; experiences are inconsistent across the state.

To help define the vision, the project team looked to System of Care (SOC) definitions and guiding principles against which to assess the current system strengths and weaknesses of the current system. SOC is a concept that is familiar to New Hampshire. Below is the definition of SOC and associated Guiding Principles utilized by the project team.13

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**System of Care Definition:**

An agile network of child and family centered services and supports for children and their families experiencing complex challenges organized into a coordinated network, across child serving systems that builds deep partnerships with children, youth, and families to help them achieve better outcomes at home, school, and in the community. Supports include formal and natural supports. Formal support is provided by professionals and others who are paid to provide those services such as therapists, child welfare workers, paid mentors, or parent aides. Natural support is provided by individuals and resources who are accessible to a child, youth, and family through normal means like social or spiritual networks; such as friends, neighbors, ministers, relatives, community groups, and others.

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13 The System of Care (SOC) definitions and principles were developed by SAMHSA’s National Technical Assistance Network for children’s mental health, but edited by the project team to be more suitable for the child welfare/ juvenile justice population and this engagement.
The SOC definitions and principles herein are consistent with those found in RSA-135 F, a statute requiring a system of care for children’s behavioral health services in New Hampshire. However, we have broadened the definitions and principles here beyond behavioral health services, to incorporate a more comprehensive array of services and supports. Our findings are organized below under each SOC Principle.

**System of Care Guiding Principles:**

1. Ensure availability and access to a comprehensive array of community-based services and supports for children, youth, and their families that address their unique physical, emotional, social, cultural, linguistic, and educational needs including existing supports, and those that need to be developed.
2. Provide services and connections to supports tailored to the unique needs of each child, youth, and family, that are strengths-based, utilize a wraparound planning process, and are linked to an individualized service plan developed in full partnership with the family and child.
3. Deliver services within the least restrictive environment consistent with the needs of the child, youth, and family.
4. Incorporate prevention, early identification, and early intervention, including mechanisms to identify problems at an earlier stage, to improve long term outcomes, lower the cost curve, and create population level change,
5. Ensure cross-system, child, youth, family, and community collaboration and create linkages across administrative and funding boundaries with mechanisms for system level management, coordination, and integrated care management. Funding and resources should be flexible and follow the needs of the child, youth, and family.
6. Provide integrated care coordination aligned with system of care principles to ensure multiple services and supports are delivered in a concurrent and coordinated manner and that children, youth, and families can move through the system of services and supports based on their changing needs.
7. Provide youth-centered, strengths-based, developmentally appropriate supports and services to facilitate the successful transition of youth to adulthood.
8. Incorporate continuous accountability, quality improvement, and data mechanisms to track, monitor and manage the achievement of system of care goals, fidelity to the system of care philosophy, and quality and effectiveness at the geographic, agency, system, and individual level.

**SOC Principle 1:** Ensure availability and access to a comprehensive array of community-based services and supports for children, youth, and their families that address their unique physical, emotional, social, cultural, linguistic, and educational needs including existing supports, and those that need to be developed.

**Findings:**

- **There is a lack of accessible and comprehensive mental health services for children, youth, and their families.** There are shortages of hospital beds for children and adolescents, screening services, psychiatry services, and crisis response services. Mobile crisis response services can reduce the need for hospitalization and higher end services.

- **There is lack of accessible and comprehensive substance abuse services for children, youth, and families.** Data on drug overdose deaths and out-of-home removals suggests the opioid and substance abuse epidemic is at crisis levels in New Hampshire.
• The current level of DCYF community based and residential services are not sufficient to meet the needs of DCYF involved children, youth, and families. The current need exceeds capacity for residential, Individual Service Option (ISO), Home Based Therapeutic Services (HBTS), and Child Health Support (CHS) services.

• There is a need for a workload study, workforce development, and investments in staff retention at the state and provider level. Turnover and high caseloads have a direct, negative effect on outcomes for children, youth, and families. Experiences and perceptions of DCYF by families varies from office to office and worker to worker, creating trust issues for some youth and families. Some root causes for the workforce issues include:
  o Lack of affiliation with universities to address workforce issues.
  o Lower salaries and higher cost of living in NH, specifically housing, as compared to adjoining states.
  o A prolonged period of provider rate suppression, which has suppressed wages at provider agencies.
  o Increased caseload sizes and workload due to the opioid epidemic, lack of parent aides to assist with transportation needs, and the need to travel to visit children and youth.
  o Frustration with lack of services and supports to offer to families, in part due to CHINS laws which restrict service options and intervention.

• The population of youth placed out of state has steadily increased over the past several years, which is disruptive to youth and their families. There is not enough bed capacity to meet current needs, particularly for females and/or children/youth with significant behavioral challenges, including aggressive behaviors. Some causes for the shortages are insufficient residential rates, workforce shortages, and lack of preventive and community based services to prevent the need for residential placement.

• The current FAST Forward program offers a wraparound care coordination approach to children, youth, and families with behavioral health needs; but the number of slots and capacity for multi-system involved children, youth, and their families is limited.

• The Division recently implemented after-hours hotline service and emergency on-call staff as part of their system improvements. However, after hours calls to the child abuse and neglect hotline are handled by contractors who may not understand child welfare issues and laws as well as experienced child protection social workers.

• Multiple CHINS law changes over the past decade have limited the types of children and youth who can be served under the law and the types of services that can be provided, making it harder to match youth and families with services.

• The New Hampshire Integrated Assessment Tool (NHIA) does not yield useful information about the strengths and needs of children, youth, and families across the state, as most families are scored as adequately functioning in the tool domains. The tool may not be used to fidelity. Similarly, the Structured
Assessment of Violence Risk in Youth (SAVRY) assessment tool is only completed post adjudication by the probation officer and focuses only on risk, unlike other more comprehensive risk assessment tools.\textsuperscript{14}

- There is lack of individualized, appropriate, integrated, and comprehensive initial response services and supports for children and youth with complex needs, including those with significant intellectual disability, mental health, or special healthcare conditions and their families. These children, youth, and families require specialized and highly tailored services and supports, including assistance to parents to support their children's needs. Children and youth with intellectual disabilities, mental health issues, or special health care conditions and their families should have access to necessary services without the need for a finding of abuse or neglect, CHINS petition, or juvenile delinquency charges. There is a significant gap in the system for youth between the ages of 18 and 21 who have a Developmental or intellectual Disability diagnosis and are not being served by the school.

- Parents and other system stakeholders report a range of challenges working with DCYF. Examples below are what we summarize as “trust issues.”
  - Parent aids are often overloaded and not well-trained.
  - Effective programs like Fast Forward exist, but can be too limited.
  - Residential facilities lack an ombudsperson role to transparently resolve parental or family concerns.
  - Case planning and family engagement strategies are not always customized based on individual and community risk and promotive factors.
  - Inconsistent information is provided by different touch points in the system. For example, there are varying levels of understanding about special education rules and utilization of Best Interest Determination forms.

SOC Principle 3 and 4: Deliver services within the least restrictive environment consistent with the needs of the child, youth, and family. Incorporate prevention, early identification, and early intervention, including mechanisms to identify problems at an earlier stage, to improve long term outcomes, lower the cost curve, and create population level change.

Findings:

- There is a lack of more “upstream” prevention and early intervention services; the current system is skewed toward the higher end of the system with reliance on placement. Over the years, state budgetary constraints have resulted in the termination of some preventive services that may have yielded longer term savings and benefits. Laws and statutes have prohibited DCYF from providing voluntary services absent a finding of abuse or neglect although many families face challenges that don’t warrant an abuse or neglect filing with the courts. Recent legislation, such as SB 592 and HB 1103 would help to correct these issues. Currently, there is no authority or flexibility for DCYF/DHHS to develop preventative services and supports and then re-invest associated savings from reduced reliance on higher end services into more preventive services and support.

- Juvenile probation is treating youth who would be more appropriately served in other systems, including children and youth with significant intellectual disability, mental health, or special healthcare

\textsuperscript{14} More comprehensive risk assessment tools include but are not limited to the Child and Adolescent Needs Survey (CANS), the Multi-Dimensional Youth Assessment (MDYA) 360, the Treatment Outcome Package (TOP), or possibly tools listed in the research and best practices section of the document.
conditions and their families who would be more appropriately served by other programs and services, such as D2 CHINS. If youth with the most complex needs can be diverted and served within the system of care, JPPOs will be able to focus on supervision, community safety, and restorative justice efforts for the appropriate, delinquency population and CHINS youth who may not be part of the CHINS D2 population.

**SOC Principle 5 and 6: Ensure cross-system, child, youth, family, and community collaboration and create linkages across administrative and funding boundaries with mechanisms for system level management, coordination, and integrated care management. Funding and resources should be flexible and follow the needs of the child, youth, and family. Provide integrated care coordination aligned with system of care principles to ensure multiple services and supports are delivered in a concurrent and coordinated manner and that children, youth, and families can move through the system of services and supports based on their changing needs.**

**Findings:**

- **The current child and family service array is not structured to operate as a system of care but rather as siloed systems.** There is not a single point of access for children, youth, and families to enter the system and have their needs assessed ("No Wrong Door"). Each division has separate budgets that are not very flexible to responding to the needs of children, youth, and families and meeting needs across the system with new programs or services. There is lack of consistent and scaled care coordination across agency services as well as formal agreements between the agencies to allow for cross agency coordination or for blending or pooling funds. Programs like FAST Forward are exceptions due to flexible and diverse funding, however, the capacity for the program to serve children, youth, and families involved with the child welfare or juvenile justice systems is limited.

- **Provider funding models have limited the degree to which providers have evolved and adapted their services.** Rate methodologies have historically not taken into account seasonal utilization fluctuations or start-up periods for any services, making it risky for providers to develop new or pilot programs. Additionally, rate methodologies have not incorporated flexibility to allow providers to re-invest savings into additional service capacity.

**SOC Principle 7: Provide youth-centered, strength-based developmentally appropriate supports and services to facilitate the successful transition of youth to adulthood.**

**Findings:**

- **DCYF only provides services/supports and placement for youth through high school graduation.** Research shows poor outcomes for youth who age out of foster care. As a result, many other states have better aligned their approach with system of care principles by extending services for transitional aged youth beyond age 18 and beyond high school through the Fostering Connections to Success and Increasing Adoptions Act of 2008. DCYF did not significantly expand services, in part due to budget constraints at the time. There is a lack of transitional living and supportive housing programs for transitional aged youth. In a recent NYTD survey, 38% (11) of youth reported experiencing homelessness within the past two years.
There are a limited number of evidence based practices (EBPs) being implemented and a lack of ability to generate evidence across services for children, youth, and families. Where EBPs are utilized there is often a lack of fidelity. A prolonged period of constrained service rates and lack of rate flexibility have suppressed the implementation of EBPs.

The system lacks a single data system, data inter-operability with common client identifier, and integrated data warehouse between agencies to create a holistic view of the children, youth and families served. DCYF’s systems, Bridges and CourtStream, interface with each other but do not interface with other DHHS Division systems or other agencies. There is limited or lack of data sharing agreements and/or memoranda of understanding between agencies and informed client consent devices.

There is a feedback loop lacking between families and state agencies to make continuous quality improvement and performance management a natural part of the learning and change cycle within DHHS.

There is an over-representation of minority youth in confinement as compared to white youth. Disproportionate Minority Contact (DMC) data is tracked at all points of access in the juvenile justice system; from arrest to commitment. DMC is present in four counties of the state, three of which are the most populous according to the most recent data by the U.S. Census Bureau.

There is not an integrated service network with specified and documented outcomes. Some services are “vendored” rather than procured, which means that vendors submit applications and while they must comply with administrative rules, they are not held to any formal contract requirements or outcomes.

Community Mental Health Centers (CMHC), which provide mental health services to many DCYF involved children, youth, and families are not consistently held accountable for the quality, consistency, or availability of services to DCYF involved children, youth, and families. DHHS’ quality assurance activities are only focused on adults and not children served by the CMHCs.

VII. RECOMMENDATIONS

DHHS and DCYF leadership were praised throughout this engagement by multiple stakeholders for their commitment to children and families, and the transformations they have already set in motion. There are numerous examples of effective services and success across the state that can be built upon moving ahead.

Consistent with DHHS’ reorganization into a more integrated service system focused on prevention and early intervention, the recommendations below intend to make the system more accountable and adaptable to meet the needs of the New Hampshire’s children, youth, and families and to skew the system more toward the front-end of the system. Some key gaps are noted in the current service array in this report. However, filling the immediate
service gaps, without additional accountability and without the ability to build and adapt capacity, will not fix the system for the long term.

The first five recommendations are ordered and presented as priority recommendations as they are the most fundamental to creating a more upstream, effective SOC, and more effectively meeting the needs of children, youth, and families in the system. Following the priority recommendations are supporting recommendations and further considerations. The recommendations apply to all children, youth, and families involved in the child welfare and juvenile justice systems, including youth who need to be released or diverted from SYSC.

### Priority Recommendations:

- **Priority Recommendation:** DHHS/DCYF should define and describe the desired future state using the language and principles of system of care (SOC). We recommend continued adoption and expansion of the SOC principles and model that New Hampshire has put into law under RSA 135-F and that this include stronger coordination and integration of the model between DCYF and the Bureau of Children’s Behavioral Health within DHHS, with links and coordination between all of the interdependent system stakeholders including courts, law enforcement, and schools. DCYF is only one part of this larger ecosystem and is dependent on and aided by these multiple partners and stakeholders in the system.
  - Amend RSA 135-F to incorporate greater system-wide integration beyond behavioral health services than is currently identified in RSA 135-F and to reflect the recommendations herein, so that the intent and vision of this engagement is codified.
  - Review all existing CHINS and delinquency laws to determine the extent to which they are aligned with the principles and outcomes of system of care, and make recommendations for changes where needed.
    - Work is already underway to better align some existing child welfare laws (SB 592 and HB 1103). This work should be continued and completed
    - Consider review of other laws such as laws that dictate which services can be provided to children under CHINS. Service decisions would be more appropriately guided by a comprehensive assessment.
  - Take steps to facilitate the cultural and paradigm shift necessary to move from a system that is finding-oriented to one that is oriented to risk identification and mitigation:
    - Review agency policies and practices to ensure they align to SOC principles. Revise as needed.
    - Provide training to embed system of care principles throughout the ecosystem
    - Develop clear job descriptions across the system of care, including JPPO’s and CPSW’s. Ensure that job descriptions, training curricula, and performance management expectations align to SOC principles.
    - Train all JPPO, child protection, SYSC, and other relevant staff to understand and embrace system of care principles, outcomes, and wraparound approaches to be more child and family centered with an emphasis on how to maintain children, youth, and families safely in their homes and community. Training will be required to move from a system that is finding-oriented, due to the restrictive nature of current laws, to one that is more oriented toward risk mitigation.
    - Create an Office of Training, Education and Best Practice Dissemination within DYCF and DHHS that will conduct cross systems trainings that promote the SOC model in New Hampshire.
Hampshire at least twice a year to include judges, law enforcement, providers, schools, JPPO's, child protection, mental health, family resource centers etc.

- Engage providers and staff already inclined toward or skilled in demonstrating system of care principles to be champions of the effort and provide peer support.
  - Review current regulations, rules, and memoranda of understanding through the system of care lens and revise any that do not align.

**Priority Recommendation:** Consistent with creation of system of care and plans currently under discussion by the state Medicaid agency, leverage existing MCO contracts or create a new care management entity consistent with models in Milwaukee, New Jersey, Maryland and elsewhere that will oversee, manage, and accept financial risk for payment for residential treatment, psychiatric hospitalization, and the development/funding of a continuum of community based services and supports for children and youth with more complex needs. The care management entity could focus on the return of youth already in out of state or in state residential treatment placements and the CHINS D2 population could be served here.
  - Review other state systems (see implementation plan section)
  - Develop a model that will work for NH. Include stakeholders, including families with youth in the system and agencies across the child serving system in the development of the expectations and model for the new care management entity/system.
    - This model could be leveraged via pooled funding and reinvestment of savings from reduced need for institutional care and operate under a high fidelity wraparound approach with care coordination and flexible funding that follows children, youth, and families. The risk sharing arrangements can incentivize a shift to more front-end services and supports and allow savings to be invested in additional system capacity.
  - Consider a phased-in approach if that is more sustainable and scalable for New Hampshire.

**Priority Recommendation:** Ensure there are adequate staffing resources to handle the current workload and implement the recommendations herein. Invest in recruitment and retention of staff.
  - Conduct a workload study for child protection workers and JPPOs. The study should consider changes in workload that may be necessary to implement the new system of care. Make recommendations for staff adjustments based on the study.
  - Review the results of the current administrative staff survey around resources needed to better procure and manage contracts. Assess the fiscal, contracting, procurement, and other administrative resources needed to implement the new system of care and align resources accordingly.
  - Expand current partnerships with local universities, such as Dartmouth or Granite State College to create a Center of Excellence or Center for Innovation for workforce development, effective supervision, training, evaluation, dissemination of evidence based practices, policy and practice development, and other professional development opportunities. DCYF currently partners with Granite State College to train DCYF staff, relatives, foster care and residential providers. The University of New Hampshire provides a Title IV-E stipend training program for college students which provides tuition assistance in exchange for a work commitment in public child welfare.
  - Develop a task force to conduct a study and think creatively about the credentials, experience, life skills, and characteristics that could make effective workers in the modern workforce. Test new models and approaches, such as peer support programs.
  - Conduct a salary and retention study for child protection workers and juvenile justice (including private sector workers) personnel to determine the appropriate salary levels and how to better retain staff.
• **Priority Recommendation:** Leverage the Family First Prevention Services Act of 2018, specifically the family preservation funding and provisions around Qualified Residential Treatment Programs (QRTP) to provide funding and momentum for rebalancing the system\(^15\).
  o Assess current service landscape for prevention programs that meet the definition of promising, supported, or well supported.
  o Assess the extent to which current residential/congregate care providers meet the QRTP requirements.
  o Educate providers, staff, courts, and other stakeholders across the state. Ask about their concerns and what they see as opportunities.
  o Develop an implementation plan.

• **Priority Recommendation:** Make a plan to address immediate service capacity needs and organize the existing service array into a more integrated continuum of services and supports, while the larger system transformations are occurring. Some immediate options may include:
  o Leverage the new voluntary services dollars in SB 592 to provide needed services including possibly:
    ▪ Expanding the FAST Forward program to serve additional youth and specifically youth with complex needs such as emotional disturbance, mental health issues, developmental or intellectual disabilities, and/or special medical conditions.
    ▪ Specifically consider and focus on how the options above could be targeted toward more appropriately serving the CHINS D2 population.
  o Work with behavioral health partners to implement the provisions of SB 590 to develop more mental health services and/or a new mobile crisis unit, so that the needs of families involved with DCYF are represented.
  o Identify youth who could be transitioned out of residential placements (either in state or out of state residential placements) and into the Fast Forward program.
  o Examine near-term opportunities that may be available through the Family First Prevention Services Act of 2018 such as the expansion of Chafee and Education and Training Voucher funds, foster family recruitment and retention grants (for states with higher numbers of youth in congregate care settings), and funding for kinship navigator programs.
  o Work with stakeholders and providers to consider ways to adapt current services to be more flexible and preventive using more flexible funding mechanisms.
  o Develop a map that documents the programs, service capacity, and target service populations available across the state and across DHHS Divisions. This will be useful for organizing the current service array into a more integrated continuum of services and supports and will be informative for the system of care design.
  o Find a way to get better child, youth, and family needs assessment data at DCYF, either through better use of the NHIA or by immediately implementing or phasing in a different assessment tool that could be scaled across DHHS later.

**Supporting Recommendations:**

• **Supporting Recommendation:** Implement a universal strengths-based assessment tool, like the Child and Adolescent Needs Survey (CANS) used in New Jersey, Massachusetts, California, and Connecticut for assessment, case planning, treatment planning, and disposition/adjudication so that the individualized needs of each child and his/her family can be adequately assessed and appropriate services and supports can be provided as soon as possible.

\(^{15}\) Federal guidance is pending to better define key provisions of this law.
Select and develop a tool that works for New Hampshire.
- Establish a centralized assessment unit and process.
- Train across DHHS agencies and providers; workers need to be appropriately certified to utilize the assessment tools.
- Monitor fidelity.
- Utilize the tool on its own or combine it with a risk assessment tool for juvenile justice cases (to be utilized prior to adjudication).

**Supporting Recommendation:** Invest in data interoperability between agencies, not just within DHHS, including development of common client ID and an integrated data warehouse to allow for a full view of children and families and for cross agency case planning and coordination. This will allow for data analytics to help drive root cause-based decision making, predictive modeling, priorities, and continuous quality improvement.
- Create memoranda of understanding, data sharing agreements, and regular information sharing practices.

**Supporting Recommendation:** Redesign and modernize procurements and contracting for all services that are outcomes focused and risk based with maximum flexibility so that the right services at the right time can be provided for all children, youth, and families. Discontinue the practice of “vending” services.
- Embed evidence based and promising practices into procurements and monitor for fidelity. Consider the cost of scaling up EBPs and make a plan to sustain and scale their use.
- Allow for innovation.
- Develop formal agreements or MOU’s between child welfare juvenile justice and mental health agencies related to definition of roles, shared expectations, exchange of information and how funding can be pooled across agencies.
- Consider no eject / no reject policies for some services.

**Supporting Recommendation:** Conduct an independent rate study to identify the true costs of services, and develop rates that are appropriate to cover the cost of services, including adjustments for any anticipated changes to services or populations.
- Rate study should consider the cost of implementing the recommendations herein such as scaling up the use of EBPs and promising practices, conducting a private agency salary study, and creating financial incentives to improve outcomes for children and families.
- Develop a schedule for periodic rate reviews, with an agreed upon method for adjusting rates in between full rate reviews based on inflation or changes in cost of living.

**Supporting Recommendation:** Develop a statewide 24/7 mobile crisis response system for assessing child, youth, and family mental health and behavioral needs.
- Extend to foster homes and across systems including schools, law enforcement, residential programs, and juvenile justice programs.

**Supporting Recommendation:** Develop, enhance, and expand transitional services for young adults. This would require an intensive partnership between child welfare, juvenile justice, educational, and many other critical stakeholders. Youth need to be uniquely engaged and be connected to relationships, post-secondary education, housing, employment, and additional necessary services such as mental health and substance abuse services.
- Extend effective services, supports, and placement to young adults beyond high school graduation. This may require a change to the Title IV-E State Plan, but has been done by many states. Some states have phased in the expansion.
- This model should consider the development of peer supports or young adults serving as navigators and mentors for other youth and young adults transitioning to adulthood.
Explore the capacity for evidence-based models such as YVLifeSet, which is intended to help youth formerly in foster care or juvenile justice custody, or otherwise unprepared for adult life, make the transition to independent living\(^{16}\).

Develop more transitional living and supportive housing programs.

- **Supporting Recommendation:** Create a new office of Continuous Quality Improvement (CQI), or expand the functions of the Bureau of Organizational Learning and Quality Improvement (BOLQI), to undertake evaluation of cross-system data to better target investments in prevention and early intervention services by geography and need.
  - Create a feedback loop with families to inform CQI.
  - Share data regularly with policy and law makers to demonstrate how investments in preventive services create longer term savings and program success.
  - Share information with the Office of the Ombudsmen and the Child Advocate.

- **Supporting Recommendation:** Create an annual training program for all agencies and system stakeholders on cultural competency and adoption of National Culturally and Linguistically Appropriate Services (CLAS) standards and the state’s plan to address DMC required by OJJDP to reduce placement and detention of minority youth.
  - Conduct a root cause analysis to better understand the root causes for over-representation of minority youth in confinement in certain counties.
  - Identify counties or regions with diverse populations that are performing well in this area and scale their success more broadly if possible.

- **Supporting Recommendation:** Conduct a root cause analysis of the current opioid crisis to better understand the system-level drivers of out of home placements and workforce issues associated with the crisis and to make recommendations for how to better address the crisis and prevent a future crisis of this nature.

**Further Considerations:**

- Continue the positive work that has been done to develop a 24/7 hotline by shifting the staffing to trained, experienced child protective social workers, rather than contractors, so that calls are appropriately screened and responded to with required actions taken, or closely monitor the existing contracts.

- To reduce the reliance on high cost and out of state residential treatment care, conduct a multi-year assessment and prospective placement plan of anticipated bed capacity needs by type and geography, to allow providers to build a business plan with the needed levels of residential and community-based service within close proximity to families.

- Leverage Family Resource Centers (FRC) more effectively
  - Review FRCs across the state and how they can be further engaged and enhanced to be integral partners, especially in rural areas.

A. Next Steps

Key aims of the recommendations are to make NH’s child, youth, and family services more preventive, more comprehensive, more accessible, more coordinated, and more integrated. The recommendations align to and are consistent with numerous initiatives already underway in NH. But even still, implementation of the recommendations will take significant time and effort.

The project team has identified four priority action steps below, that will address immediate service needs, while also rebalancing the system toward more preventive, integrated, and comprehensive services:

1. Chose a model for, assign responsibility for, and develop a care management/care coordination entity that can cross mental health, child welfare, and juvenile justice systems to create a single point of access and accountability to effectively meet the needs of children, youth, and families with complex needs.

2. Implement new services with the voluntary services with the funds included in SB592, parental assistance funds included in SB592, and dollars that were allocated for 6 residential beds that were not implemented. Invest in programs that align to the principles of system of care and the Family First Prevention Services Act of 2018. Concurrently, work with behavioral health partners to implement the provisions of SB 590 to develop more mental health services and/or a new mobile crisis unit, so that the needs of families involved with DCYF are represented. Aim to reduce the number of children in foster care by 10% by the end of the first year of implementation.

3. Begin utilizing FAST Forward in a more targeted, expansive way for children, youth, and families involved in the child welfare and/or juvenile justice system. Enroll three to five DCYF involved children into FAST Forward each month with an emphasis on children and youth placed in out of state residential facilities, children and youth who could be diverted from residential services if they were provided more support at home or in a family-based setting, and/or youth who could be diverted from SYSC. Aim to reduce the number of children placed out of state by 30% by the end of the first year of implementation.

4. Begin implementation of the Family First Prevention Services Act of 2018, including assessing the current capacity of evidence-based preventive programs and the extent to which the current residential providers meet QRTP requirements. Identify near-term options for program enhancements such as expansion of ETV eligibility and kinship navigator programs.
Immediate progress on these items will help close existing gaps, while at the same time moving the system forward toward the desired future state. This will instill more confidence in the change effort and the system overall, and this phased approach is consistent with the Human Services Value Curve\textsuperscript{17} model. The Value Curve model describes how services are provided to individuals at four progressive levels of value, each building upon the previous levels.

At the regulative level individuals receive a product or service that is timely, accurate, cost-effective and easy to understand. At the collaborative level, the individuals can “walk through a single door” and have access to a more complete array of products and services. At the integrative level, products and services are designed and customized with individual input and an understanding of root causes so that their true needs are addressed. Meaningful connections occur “upstream” to prevent problems from occurring “downstream.” And at the generative level, root cause analysis is done at a population-wide level, resulting in prevention strategies and other forms of support that are broader than what an individual or family would receive directly and advance the well-being of the entire community. Confidence in the system comes from the ability for children, youth, and families to receive timely, appropriate, and understandable services. DCYF and DHHS leadership will need to move the larger change effort forward incrementally, with the dual aims of better meeting the immediate needs of children, youth, and families and developing a system that is more integrated and comprehensive to become more upstream and to impact population-level change.

**Task Force**

As these early initiatives are underway, the state should begin to make longer term plans to implement the remaining priority and supporting recommendations through an implementation task force. We recommend;

- A cross-sector advisory committee to oversee the entire endeavor;
- Cross sector working groups to make plans for specific change efforts and/or aspects of the system that need to change with clear expected outcomes and timeframes in which they must accomplish their work; and
- Regular work group meetings with periodic convenings by the advisory committee across groups to report progress, challenges, and lessons learned.

There are some existing committees in NH, involved with the implementation of the Quality Assurance Review completed by the Center for Support of Families and implementation of HB 517. These initiatives should be cross checked and coordinated or streamlined with the advisory committee and workgroups created for this initiative.

Involving stakeholders from across the child serving system will be key for driving the change effort. DCYF is dependent on multiple partners from across the system to truly transform the experience and outcomes for children, youth, and families. These partners must be deeply involved and engaged in the implementation process. The figure below shows how the New Hampshire System of Care Task Force could be structured. The workgroups are example only, and there will likely be more needed for actual implementation.

\textsuperscript{17} The Human Services Value Curve was introduced in 2010 by Antonio Oftelie and Harvard’s Leadership for a Networked World
B. Visioning the System for NH

One of the key elements of the new system of care will be the provision of a care management entity to be accountable for effectively meeting the needs of children and youth with complex needs and their families and rebalancing the system toward more preventive services. Many states have implemented approaches to managing complex cases similar to the recommendations in this report. Activities and functions that are critical to success include:\textsuperscript{18}:

- Wraparound implementation
- Development and management of provider networks, including natural supports
- Screening, assessment, and clinical oversight
- Utilization management and quality improvement
- Intensive care coordination
- Outcomes management
- Information management, including real-time data
- Training for staff, providers, families, and referring entities
- Access to family and youth supports and advocacy
- Care monitoring and review
- Access to crisis supports

\textsuperscript{18} Center for Health Care Strategies: A Primer on Care Management Entities, March 2011, retrieved from https://www.chcs.org/media/CHIPRACMEPrimer.pdf
Financing structures can vary significantly but blended or case rates are often utilized, drawn from multiple funding streams, with the goal to redirect dollars from “high cost/poor outcome” services to more appropriate home and community-based care.\(^{19}\)

While the fundamentals described above are key elements for success, there are many different ways that jurisdictions can implement care management/wraparound approaches. Below are three examples of jurisdictions that have implemented these systems differently but successfully: Milwaukee, New Jersey, and Indiana.

Examples\(^{20}\)

**New Jersey**

**Who is served:** Children and youth with complex behavioral health challenges, developmental and/or intellectual disability, and/or primary substance abuse challenges and their families. Approximately, 12,000 children and youth are receiving care management/care coordination through a wraparound approach.

**How does it work?** The New Jersey Children’s System of Care (state office within the Department of Children and Families) is the purchaser. The state retains responsibility for developing the provider network, contracting, rate setting, and payment. Families access services through a contracted systems administrator (CSA). The CSA assess the child/family needs and eligibility for services, authorizes services, and provides care coordination. Complex cases are referred to care management organizations (CMOs) which provide care management to youth with both moderate and high needs through a comprehensive Medicaid waiver. Less complex cases may be referred to community agencies for services.

**How is it funded:** The system of care is funded through a combination of state and Medicaid dollars. NJ’s model does not pass any financial risk on to the CSA or the CMO’s. Instead the state agency retains the responsibility and risk of projecting service needs and developing the necessary community based service capacity to serve children in the least restrictive environment.

**Cost:** The cost is approximately $775 per member per month for care coordination. Services and supports are paid outside of that bundled rate through a fee-for-service basis and total about $1,000 per member per month.

**Results:** NJ has reduced the utilization of residential treatment/group home beds by 100%, from 2,000 to 1,000.

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\(^{19}\) Center for Health Care Strategies: A Primer on Care Management Entities, March 2011, retrieved from https://www.chcs.org/media/CHIPRACMEPrimer.pdf

\(^{20}\) Data from this section was collected from interviews with personnel involved with the programs as well as information from The Center for Health Care Strategies, Intensive Care Coordination Using High-Quality Wraparound for Children with Serious Behavioral Health Needs: State and Community Profiles. July 2014 retrieved from: http://www.chcs.org/media/ICC-Wraparound-State-and-Community-Profiles1.pdf
Wraparound Milwaukee

Who is served: Children and youth with serious emotional, mental health and behavioral needs that cross child serving systems who are at imminent risk of institutional type placements and their families. In Milwaukee County, 1,700 youth with serious emotional mental health needs in the juvenile justice and child welfare systems are served by Wraparound Milwaukee.

How does it work? Wraparound Milwaukee (WM) is the CME and is part of the county’s behavioral health division. Wraparound Milwaukee contracts with six community agencies for over 100 care coordinators. The coordinators facilitate planning teams, implement wraparound approaches, see children weekly, provide crisis intervention services, and coordinate with child welfare and juvenile justice based on identified roles. Mobile crisis services are available 24/7 and there are dedicated crisis teams that travel to homes, schools, foster homes, emergency rooms and wherever they are needed. Wraparound Milwaukee has also organized an extensive “fee-for-service” provider network of over 160 agency and individual providers that offer an array of over 70 services to families based on standardized rates and performance standards. All providers and care coordinators

21 Center for Health Care Strategies: A Primer on Care Management Entities, March 2011, retrieved from https://www.chcs.org/media/CHIPRACMEEprimer.pdf
are linked through one internet based information technology system for service authorizations, plan submission, invoice, payment and progress notes.

**How is it funded?** Wraparound Milwaukee pools $52 million across child serving systems to increase flexibility and availability of funding. A combination of state and county agencies, including the Bureau of Milwaukee Child Welfare, the County’s Delinquency and Court Services, and the State Division of Health Care Financing who operates Medicaid, provide funding for the system. Funding is pooled through agreements and contacts among these agencies. WM, as the CME, oversees the management and disbursements of those funds.

**Cost:** Cost is approximately $2,825 per member per month inclusive of care coordination, services and supports, and out of home care. WM utilized a system of care grant from SAMHSA to help support the initial cost of setting up the care management entity, and then phased in enrollment over 18 months with a focus on youth in out of home residential treatment and those at risk of such placement to generate funds to re-invest into building more service capacity and community-based services.

**Results:** The average monthly cost of a youth enrolled in WM is significantly less than the monthly cost of a youth in an institutional setting. WM reduced the total child population use of psychiatric hospitalization from an average of 5,000 to less than 500 days annually and reduced its average daily residential treatment facility population from 375 to 100 youth and lengths of stay from over one year to under 120 days.

*Figure 10: Wraparound Milwaukee*
Indiana Choices:

**Who is served?** Youth with significant behavioral health diagnosis at risk of being placed in restrictive facilities away from their parents or caregivers, or at risk of juvenile detention. Choices serves about 600-700 youth per year in Indiana.

**How does it work?** Choices currently has a contract with Indiana Department of Child Services (DCS) for Cross System Care Coordination (CSCC). Choices assumes risk for the level of care for a youth and if the youth needs more intensive intervention (i.e. residential placement) Choices will ensure the youth gets the required level of service and pays for those services. Choices pays for all community based services, placement services (residential, group home, and therapeutic foster care) and discretionary funds.

**How is it funded?** Choices is paid a capitated per member per month rate for managing the cases.

**Cost:** Choices is paid a capitated monthly rate per child. There are different rates based on the child’s level of need: Intensive ($239 per day), Intervention ($160 per day), Early Intervention ($98 per day), and Non-eligible sibling ($50 per day).

**Results:**
- 81% of youth served by Choices in Indiana are in a non-congregate care setting
- Youth spend 40-45 fewer days in residential settings than other DCS youth, for a savings of $11,000-12,500 per youth.

**CONSIDERATIONS**

With the FAST Forward program, NH already has a care management infrastructure from which to build. Cases can flow through the system similar to how they do now, with some cases receiving only a child welfare or juvenile justice response, and some receiving a more comprehensive, wraparound response.

To enroll an additional three to five DCYF-involved children, youth, and families into Fast Forward each month would require approximately five more service coordinators to be phased in over the course of the year (that is in addition to the new coordinators Fast Forward is already planning to hire). The estimated cost to accomplish this staffing increase, staggered over the course of a year, inclusive of salaries, fringe, training, supervision, and flex funds is approximately $500K over the course of the first year.

Additionally, the cost per child enrolled in the Fast Forward program is $1,000 to $2,000 per month, which would be an additional cost. However, if Fast Forward can be utilized to shift children and youth from costly placement settings into family-based settings or keep children at home, then the overall cost for services may not be higher than it is now. Further, NH has applied for a 1915i waiver to expand the Fast Forward program already, which will also help cover the costs if approved.

If the CME role is expanded to be more like Wraparound Milwaukee additional investments may be necessary. There may also be technological enhancements recommended going forward to improve data inter-operability. The future and ongoing costs will need to be assessed as the recommendations are implemented, however, many jurisdictions have realized savings with these models over time.
APPENDIX A: OVERVIEW OF FAMILY FIRST PREVENTION SERVICES ACT OF 2018
AND KEY PROVISIONS AND TIMELINES

Background

The Family First Prevention Services Act of 2018 (Family First) significantly reforms federal funding for child welfare services. The U.S. Congress passed the Act in February; the federal ACF is working on specific guidance on how to implement the Act. Each state will also have some say in how they implement the requirements in the Act; how much say may vary by requirement.

Overview

*Family First provides federal funding for prevention services when certain conditions are met.* Eligible children include children or youth identified as a candidate for foster care at imminent risk for removal from family or at risk of adoption/guardianship disruption or a youth in foster care who is pregnant or parenting. Children and/or youth must have a prevention plan that authorizes prevention services. Eligible prevention services include: mental health prevention and treatment, substance use disorder prevention and treatment; and/or in-home family support services up to a maximum of 12 months, and the prevention services must have an evidence base and meet the definition of promising, supported, or well-supported. Additionally, prevention services must be provided under a trauma-informed framework. States will be required to meet a maintenance of effort requirement and document coordination with other relevant agencies, such as state Medicaid agencies, as appropriate. Eligibility for these service is de-linked from AFDC standards.

*Family First restricts funding for congregate care under many circumstances and introduces Qualified Residential Treatment Programs (QRTP).* To obtain federal reimbursement for congregate care placements beyond the first three (3) weeks of placement, one of the following placement conditions must exist: a Qualified Residential Treatment Program (QRTP); specialize in providing prenatal, post-partum, or parenting supports for the youth; the child is 18 years old and placed in a supervised independent living program; or the placement provides high quality residential care and support services to children and youth who have found to be or are at risk of becoming sex trafficking victims.

QRTP requirements include:

- An independent assessment must be conducted and documented in the treatment plan within 30 days of the placement is made stating the need for this type of placement.
- Documentation of continued need for placement must be submitted in every status hearing or permanency hearing.
- The program must:
  - Operate under a trauma informed treatment model
  - Have registered or licensed nursing and clinical staff available
  - Be licensed according to state standards and accredited by CARF, JCAHO, COA, etc.
  - Include discharge planning as well as family-based aftercare support for at least 6 months
- Family members must be engaged in a child’s treatment, if in their best interests and outreach and engagement of family, including siblings, must be documented.
- If the child is in a QRTP for a length of stay more than 12 consecutive months or 18 nonconsecutive months, or when a child under age 13 has a length of stay of more than 6 consecutive or non-consecutive months, the State agency must submit to HHS:
The most recent versions of case plan documentation, and
The signed approval by the head of the State agency for continued placement.

Additional provisions in the Act

- Supports the cost of children residing in substance use disorder treatment centers with a parent receiving treatment.
- Expand eligibility for support, education and training opportunities to independent living youth.
- Extends time limits on eligible reunification programs under Title IV-B
- Requires training on QRTP in order for states to receive Court Improvement Grant funding.
- Reauthorization of a variety of Child and Family Services programs such as: Title IV-B, Subpart 1, Title IV-B Subpart 2, and Regional Partnership Grants.
APPENDIX B: FULL SUMMARY OF FAMILY FIRST PREVENTION SERVICES ACT OF 2018

Subtitle A – Investing in Prevention and Supporting families

Sec. 50702. Purpose (423, 17)
PART I – PREVENTION ACTIVITIES UNDER TITLE IV-E

Sec. 50711. Foster Care Prevention Services and Programs (424, 3)

States (optional)

Who is eligible?

A child who has been identified as a candidate for foster care (425, 20-21) for whom there is a written prevention plan (426, 23) that identifies the child as at imminent risk of removal (426, 8-9) that includes a foster care prevention strategy for maintaining the child safely at home or temporarily with a kinship caregiver, and lists the services or programs to be provided to the child or on behalf of the child (427, 5-15). This includes children whose adoption or guardianship arrangement is at risk of disruption or dissolution that would result in a foster care placement (426, 8-9).

A foster child who is a pregnant or parenting foster youth (426, 1-2) for whom there is a prevention plan that lists the services or programs to be provided to or on behalf of the youth to ensure that the youth is prepared or able to parent, and that describes the foster care prevention strategy for the child born to the youth (428, 1-9).

Covered services can be provided to the child or youth as described above, or to the parents or kinship caregivers of the child when the need of the child, parent, or caregiver for the service or programs are directly related to the safety, permanence or wellbeing of the child or to prevent the child’s entry into foster care (424, 20 - 425, 2).

What services are covered?

- Mental Health treatment services for a maximum of 12 months (425, 3-9)
- Substance abuse prevention and treatment services provided by a qualified clinician for a maximum of 12 months (425, 3-9)
- In-home parent skill-based programs for a maximum of 12 months that include parenting skills training, parenting education, and individual and family counseling (425, 10-16)

Covered services must be:

- Provided under a trauma-informed organizational structure and treatment framework (428, 13-22)
- Promising, supported or well supported practices, meaning that:
  - The practice must have a book manual or other writing that specifies the protocol and how to administer the practice
  - There is not an empirical basis suggesting that the practice has a risk of harm
  - If multiple studies have been performed, the overall weight of evidence supports the
practice
- Outcome measures are reliable, valid, and administered consistently (429, 10 – 430, 10)

And meets definitions outlined of promising, supported, or well supported practice, each of which require study designs of increasing scientific rigor (430, 15 – 433, 25).

HHS will release a list of pre-approved practices and guidance regarding these requirements no later than October 1, 2018 (434, 3 - 10).

What outcome measures are required? (434, 15 – 435, 12)

The state must report to HHS regarding any child who, or on behalf of whom, a prevention service was provided the following:
- The services and total expenditure for each service
- Duration of services
- For a candidate, the child’s placement status at the beginning and end of the one-year period and whether the child entered foster care within 2 years after being determined a candidate for foster care.

What changes to the State Plan are required?

There are several requirements for updates to the Title IV-E state plan describing the services, outcomes, monitoring, risk assessments, and practices, how the services/practices were selected, etc. (435, 14 – 437, 25). Additional state plan requirements include:
- Description of the consultation that the state agency engaged in with other state agencies responsible for administering health programs, including mental health and substance abuse treatment and prevention and community-based organizations (438, 1-14).
- How the state assesses children and their parents or caregivers to determine eligibility for the prevention services described (438, 15-19).
- How the prevention services will be coordinated with other services provided to the family under the state plan part B (438, 20 – 439, 3).

State plan requirements related to workforce include:
- A description of the steps the state is taking to support and enhance a competent, skilled, and professional child welfare workforce to deliver trauma-informed and evidence-based services (439, 4-16).
- A description of how the state will provide training and support for caseworkers performing needs assessments, connecting to services, and knowing how to access trauma-informed and evidence-based practices, and overseeing/monitoring the effectiveness of the service (439, 17-25).
- Description of how caseload size and type for prevention caseworkers will be managed, determined and overseen (440, 1-3).

HHS can require additional reporting regarding performance measures (440, 4-12).
What limitations are placed on reimbursement for these services? (440, 15)

Federal funds are not permitted for practices that are not promising, supported or well-supported unless the plan includes a well-designed and rigorous evaluation strategy for that practice (440, 16-22). The secretary may waive this limitation under some conditions (440, 23 – 441, 6).

How will prevention services be measured? (441, 7)

Beginning in federal fiscal year 2021, and annually thereafter, HHS will establish these prevention services measures:

- Percent of candidates for foster care who do not enter foster care (441, 17-25)
- Per child Spending (442, 1-7)

HHS shall establish and annually update the prevention services measures based on the median state values of the information provided under each measure for the three most recent years (442, 8-14), and considering differences in price levels of goods and services using regional price parities established by the Bureau of Economic Analysis of the Department of Commerce or other data as deemed appropriate by HHS (442, 15-21).

HHS shall publish the prevention services measures for each state annually (442, 22-25).

What is the Maintenance of Effort requirement for state foster care prevention measures?

If a state elects to provide prevention services measures as defined under this law, the state foster care prevention expenditures for the federal fiscal year cannot be less than the amount of expenditures for federal fiscal year 2014 (443, 3-10). States that had less than 200,000 children as of the 2014 US Census can elect to use federal fiscal year 2015 or 2016 (443, 8-10, 445, 3-7).

State foster care prevention expenditures means:

- Expenditures for mental health and substance abuse prevention services
- State expenditures for foster care prevention services and activities funded under TANF, including federal TANF funds, under the state plan developed under Title IV-E Part B, or under SSBG, (443, 14-23).
- State expenditures for foster care prevention services and activities under any other state program, other than any state expenditures for foster care prevention services and activities under Title IV-E, including a waiver (443, 24 – 444, 6).
- The term “state expenditures” means all state or local funds that are expended by the state or local agency, including state and local funds that are matched or reimbursed by the federal government and state and local funds that are not matched or reimbursed by the federal government (444, 7-14).

Prevention services and activities means:

- States electing to provide prevention services under this law must report the expenditures defined above for federal fiscal year 2014 and for federal fiscal years after to determine that the state is
in compliance with the MOE requirement (444, 16-23).

The Secretary of HHS will specify the specific services and activities that are “prevention services and activities” for the purpose of the report (444, 23 – 445, 2). [Editorial note: it does not appear that the legislation specifies that the MOE requirement only relates to expenditures on prevention services as covered under this law (mental health, substance abuse, in home services that meet the promising, supported and well-supported requirements) but rather allows HHS to define the services that are to be reported as part of MOE. May require further inquiry].

Funding used to meet the MOE requirement can’t be used to match new Title IV-E prevention funds under this law (445, 8-15).

Some caveats to Title IV-E prevention funding include:

- Administrative costs covered under Title IV-E prevention are not eligible for payment under other Title IV-E programs (445, 18-20).
- Administrative costs are eligible for payment without regard to whether a child is eligible for foster care maintenance payments. [Editorial note: no foster care eligibility rate needs to be applied to administrative costs associated with prevention services] (445, 21-25).
- Services provided under this law are not considered aid or assistance under Title IV-E or any other program under this act (TANF, SSI, Medicaid, etc.) (446, 2-8).

*If a child is in kinship care for more than 6 months and is provided with prevention services, but enters foster care, how will that impact their Title IV-E eligibility for foster care?*

A child who receives prevention services under this law for more than 6 months while in the home of a kin caregiver, and who would otherwise meet the AFDC-related eligibility requirements to be eligible for Title IV-E reimbursement in foster care except in that the child has lived in a kinship care placement for more than 6 months prior to removal, will meet the AFDC requirement for foster care maintenance payments (446, 9-20).

*How will Title IV-E fund the described prevention services for eligible children, youth and their caregivers?*

**Reimbursement Rates:**

- In federal fiscal years **2020 – 2026**, the reimbursement rate for covered prevention services that are promising, supported or well supported, will be 50 percent (447, 22 – 448, 8).
- In federal fiscal year **2027** and beyond, the reimbursement rate for covered prevention services will be the state FMAP rate (448, 9-16).

**Conditions:**

- Not less than 50 percent of the total amount payable to the state starting in federal fiscal year 2020 must be for **well-supported practices** (449, 18-24).
- Well-supported practices are defined as a practice that is (432, 19 – 433, 25):
  - Superior to an appropriate comparative practice, in conventional standards of statistical significance in 2 studies that were rated by an independent review board as well-
• designed and well-executed, use rigorous random control trials or use quasi-experimental research design, and were carried out in a usual care or practice setting, and
  o At least one of the studies established that the practice had a sustained effect for at least one year after the end of treatment.

_How will Title IV-E fund administrative and training costs associated with covered prevention services? (450, 5 – 451, 11)_

The reimbursement rate is 50 percent for administrative and training expenditures (450, 5-10 and 450, 19-22).

Title IV-E prevention covers administrative expenditures that are necessary for the proper and efficient administration of the state plan for the provision of covered services, including expenditures to establish processes and procedures to implement the provision of services and expenditures for data collection and reporting (450, 5-18).

Training topics covered by Title IV-E prevention include:

- training with respect to the provision of covered services (450, 20-22)
- how to determine who is eligible for covered services or programs (451, 5-7)
- how to identify and provide appropriate services and programs (451, 7-9)
- how to oversee and evaluate the ongoing appropriateness of the programs (451, 9-11)

Training can be provided to:

- Personnel who are employed or preparing for employment by the state or local agency administering the state plan (450, 22 – 451, 1).
- Staff of state-licensed or state-approved child welfare agencies providing services to children and their parents or caregivers (451, 1-5).

_What technical assistance and best practices will be available?_

HHS is required to provide technical assistance and disseminate best practices (451, 20 – 452, 3).

Through grants, contracts, or interagency agreements, HHS is required to evaluate research on promising, supported and well-supported practices and establish a clearinghouse that includes:

- culturally specific, location- or population-based adaptations of practices (452, 11-12)
- specific outcomes associated with each practice, including whether the practice reduces abuse or neglect and reduce the likelihood of placement by supporting birth and kinship families, and improving targeted supports for pregnant and parenting youth and their children (452, 15-22)

HHS may also conduct their own evaluations and/or collect additional data to assess how the provision of covered services and programs reduce foster care placement, increase kinship care or improve child wellbeing (452, 23 – 453, 9).

HHS is also required to prepare periodic reports to Congress and is appropriated $1M annually (453, 11- 25)
Indian Tribal Organizations (454, 2-456, 14)

Who is eligible?

The same children, youth, and their parents or caregivers are covered as described above (454, 17-20).

What services are covered?

The HHS secretary can specify the requirements applicable for the provision of services and programs. The requirements should be consistent with the requirements for states, described above, and should allow for programs and services that are adapted to the culture and context of the tribal communities served (455, 6-16).

What are the outcome/performance measures?

The HHS secretary shall establish specific performance measures for each tribe, organization or consortium that elects to participate (455, 17 – 456, 3).

Sec. 50712. Foster Care Maintenance Payments for Children with Parents in a Licensed Residential Family-Based Treatment Facility for Substance Abuse (456, 15)

Who is eligible?

A child who would be eligible for foster care maintenance payments, except that the child does not have to meet the AFDC related income requirement (457, 5-10) if the child is:

- placed with a parent in a licensed residential family-based treatment facility for substance abuse for not more than 12 months (457, 11-14), and
- the recommendation for the placement is documented in the case plan prior to placement (457, 15-17), and
- the treatment facility provides parenting skills training, parent education and individual and family counseling (457, 22-25), and
- the treatment program and parenting program are provided under an organizational structure and treatment framework that is trauma-informed (457, 25-458, 6).

Only children who meet the AFDC requirement will be considered recipients of assistance or aid for purposes of Medicaid and/or SSBG (458, 9-14).

Sec. 50713. Title IV-E Payments for Evidence-Based Kinship Navigator Programs (458, 19)

Title IV-E will reimburse costs for kinship navigator programs that are promising, supported or well-supported practices at 50 percent, without regard to eligibility for foster care maintenance payments (459, 1-12).

PART II – ENHANCED SUPPORT UNDER TITLE IV-B

Sec. 50721. Elimination of Time Limit for Family Reunification Services While in Foster Care and Permitting Time-Limited Family Reunification Services When a Child Returns Home from Foster Care (459, 15)
How are the time limits for reunification services changed?

Family reunification services can be provided while the child is in foster care without limitations on the amount of time the child is in foster care (460, 6-10) and for 15 months after a child has returned home from foster care (460, 11-15).

Sec. 50722. Reducing bureaucracy and unnecessary delays when placing children in homes across state lines. (461, 1)

How will the Interstate Compact on the Placement of Children (ICPC) electronic case processing system be funded?

By October 1, 2027, for states (and excluding Puerto Rico, Guam, American Samoa the US Virgin Islands and Indian tribes, tribal organizations, or tribal consortium) the state plan regarding Interstate Compact Agreements will include the use of an electronic interstate case-processing system (461, 9-25-462, 2).

HHS can provide funding for the development of an electronic interstate case-processing system to expedite the interstate placement of children in foster care or guardianship, or for adoption.

- Purpose of funding: to develop a system that will expedite the placement of children in foster care, guardianship or adoption across state lines (462, 13-18).

- Request for funding: A state seeking funding shall submit to HHS the following information:
  - A description of the goals and outcomes to be achieved during the time of the grant including (462, 22 – 463, 12):
    - Reducing the length of time to place across state lines
    - Improved administrative processes and reducing costs in foster care
    - Secure exchange of information
  - A description of the activities to be funded in whole or in part by the grant (463, 13-15)
  - A description of strategies for integrating programs across state lines (463, 16-18)
  - Other information as required by HHS (463, 19-20)

- Use of Funds: To connect to the interstate case-processing system (464, 3-8)

- Evaluation: ACF must submit to Congress one year after final grant is awarded an evaluation of the following:
  - The use of grant funds has changed the length of time it takes to place a child across state lines (464, 15-18)
  - The number of cases subject to ICPC were placed using the interstate case-processing system and the number of ICPCs that were processed outside of the system by each state in each year (464, 19-25)
  - The progress made by states implementing the interstate case-processing system (465, 1-3)
  - How the interstate case processing system has affected child safety and well-being (465, 4-8)
  - How the interstate case processing system has affected administrative costs and case worker time processing interstate placements (465, 9-12)

- Data Integration: Secretary must work in conjunction with states to assess how the interstate case processing system could be used to better serve children by: (465, 13-18)
  - Connecting system to other systems (FBI, Judicial Systems etc.)
  - Simplify reporting on children that have been victims of sex trafficking (466, 1-5).
  - Improve the ability of states to quickly complete background check (466, 6-10).

- Funding: Secretary should reserve $5,000,000 of funds made available for federal fiscal year 2018 for
Sec. 50723. Enhancements to Grants to Improve Wellbeing of Families Affected by Substance Abuse (466, 21)

How are the existing regional partnership grants to improve child well-being changed?

- Existing regional partnership grants to improve child well-being have been changed to specifically target the well-being of and permanency of children and families affected by the heroin and opioid epidemic (467, 2-8).

- Regional partnerships have been redefined to mean a collaborative agreement within a state or between states that must include the following partners (467, 11-14):
  - The state child welfare agency (467, 18-20)
  - The state agency responsible for administering the substance abuse prevention and treatment block grant (467, 21-25)

- If the regional partnership grant intends to serve children in out-of-home placement, the Juvenile Court of Administrative office of the court that is most appropriate to address families who are involved in the court due to child abuse or neglect must also be included (468, 1-10).

- Optional partners for regional partnership grants may include Indian tribes, non-profit/for profit child welfare providers, substance abuse treatment providers, community mental health providers, schools, law enforcement, tribes, any other community agencies (468, 11-468, 7).

- There is an exception to the mandatory partners. Tribes do not have to partner with State child welfare agency. Tribes may not partner solely with other tribal child welfare agencies. Tribes may partner with tribal court organizations in lieu of state judicial partners (468, 8-24).

How long are the grants authorized and how are they funded?

- Regional partnership grants are funded from federal fiscal year 2017 – 2021 (470, 2-3).
- Grants will be not less than $250,000 and not more than $750,000 per grant per federal fiscal year (470, 4-6).
- Grants will be disbursed in two phases, a planning phase and an implementation phase. The planning phase is not to exceed 2 years and not to exceed a cost of $250,000 total (470, 15-23).
- Funds can be disbursed when HHS determines that the partnership has made progress towards the goals of the grant. The following goals for the regional partnership grant have been added:
  - increase reunification rates for children who have been placed in out-of-home care
  - improve substance abuse treatment outcomes for parents, including retention in treatment and successful completion of treatment (471, 19-21, 472 1-4)
  - facilitate the implementation, delivery and effectiveness of prevention services and programs under section 471(e) (472, 5-7)
- Grant applications must also include a plan to sustain the program created through the regional partnership grant once the grant ends by using funds under 471(e) (472, 13-20)
- Additional language clarifies how the grant can be used for substance abuse treatment programs, must demonstrate collaboration between child welfare, substance abuse and mental health agencies, and include a set of core indicators (473, 11-474, 10)
- A semi-annual report to HHS is required (474, 17-475, 9)
PART III– MISCELLANEOUS

Sec. 50731. Reviewing and Improving Licensing Standards for Placement in a Relative Foster Family Home (475, 13)

How will licensing standards for foster family homes be impacted?

Not later than October 1, 2018, the Secretary of Health and Human Services shall identify reputable model licensing standards with respect to the licensing of foster family homes (475, 17-20).

State Plan Requirements: Not later than April 1, 2019 States must provide to the Secretary:(475, 22- 476, 6)

a) Whether state licensing standards are in accordance with model standards identified by the Secretary, and if not, specific reason for deviation; and (476, 7-13)

b) Whether the State has elected to waive standards established in 471(a) (10) (A) for relative foster family homes (pursuant to waiver authority provided by 471(a) (10) (D)), a description of which standards the State most commonly waives, and if the State has not elected to waive the standards, the reason for not waiving these standards; and (476, 14-21)

c) If the State has elected to waive standards specified in subparagraph (B), how caseworkers are trained to use the waiver authority and whether the State has developed a process or provided tools to assist caseworkers in waiving non-safety standards per the authority provided in 471(a) (10) (D) to quickly place children with relatives; and (476 22-477, 4)

d) A description of the steps the State is taking to improve caseworker training or the process, if any (477, 5-7).

Sec. 50732. Development of a statewide plan to prevent child abuse and neglect fatalities (477, 8)

How will states be required to address the prevention of child fatalities from abuse and neglect?

In the state plan, states must document the steps taken to track and prevent child maltreatment deaths by including:

- a description of the steps the State is taking to compile complete and accurate information on child deaths, including gathering relevant information on the deaths from the relevant organizations in the State, including entities such as State vital statistics department, child death review teams, law enforcement agencies, offices of medical examiners or coroners (477, 15-24), and
- a description of the steps the State is taking to develop and implement a comprehensive, statewide plan to prevent the fatalities that involves and engages relevant public and private agency partners, including those in public health, law enforcement and the courts (478,1-6).

Sec. 50733. Modernizing the Title and Purpose of Title IV-E (478, 7)

The heading for part E of title IV of the Social Security Act is amended to include the Title IV-E prevention program: “Subtitle E – Federal Payments for Foster Care, Prevention, and Permanency” (478, 9-13).
The purpose of the act is updated to include kinship guardianship assistance programs and prevention programs (478, 18-20).

**Part E – Federal Payments for Foster Care, Prevention, and Permanency (478, 12)**

**Sec. 50734. Effective dates (478, 23)**

For Parts I-III of this act are effective on October 1, 2018 (federal fiscal year 2019), with exceptions noted below (479, 1-7). The act includes provisions that will not take effect until subsequent years, including:

- Reimbursement for services under the prevention plan is effective October 1, 2019 (447, 22 – 448, 8).
- Reimbursement for kinship navigator program is effective October 1, 2018 (479, 1-4).
- HHS will establish prevention services measures in federal fiscal year 2021 (441, 9-14).
- By October 1, 2027, the state plan regarding Interstate Compact on the Placement of Children (ICPC) Agreements will include the use of an electronic interstate case-processing system (461, 12).
- Grants for developing interstate case processing systems will be made available beginning in federal fiscal year 2018-2022 (466, 15-20).
- Regional partnership grants are funded from federal fiscal year 2017 – 2021 (470, 2-3).
- State plans must be updated with additional information regarding foster family licensing no later than April 1, 2019 (476, 4-6).
- State plan requirements regarding child abuse and neglect fatalities as of the effective date of this act, October 1, 2018 (479, 1-4).
- The change in the name of Title IV-E to include prevention is effective on the date of enactment of this Act February 9, 2018 (478, 7, 479, 6-7).

If the state must make changes to state law, some flexibility regarding timelines for updating state plans is allowed (479,12-480, 2).

Tribes will be granted the appropriate extensions based on the estimated time needed for compliance with the act (480,3-19).

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22 Part IV, Section 50746 allows a state to request a delay of the change in reimbursement with regard to child caring institutions. If HHS allows the delay, reimbursement for kinship navigator programs and prevention services will also be delayed.
Sec. 50741. Limitation on Federal Financial Participation for Placements That Are Not in Foster Family Homes (481, 4)

How are Title IV-E foster care maintenance payments restricted for children placed in child caring institutions (i.e. group homes, congregate care facilities, etc.)?

Federal Title IV-E foster care maintenance payments will not be paid on behalf of a child placed in a child care institution after the third (3rd) week for which maintenance payments have been paid, (481, 18-24) unless:

- The placement is a qualified residential treatment program (QRTP) (482, 12);
- The placement specializes in providing prenatal, post-partum, or parenting supports for the youth (482, 14);
- The child is 18 years old and placed in a supervised independent living setting (482, 17); or
- The placement provides high quality residential care and support services to children and youth who have found to be, or are at the risk of becoming, sex trafficking victims, in accordance with each State’s policies and procedures (482, 20-24).

What is a qualified residential treatment program (QRTP)?

The QRTP is a newly defined placement setting that has several requirements that must be met to receive federal funding.

- An assessment must be conducted and documented in the treatment plan within 30 days after the placement is made stating the need for this type of placement. If the assessment is not made within this timeframe no federal foster care maintenance payments can be claimed (483, 4-12).
- The program has a trauma-informed treatment model to address clinical needs documented in the treatment plan (484, 18-25).
- The program must have registered or licensed nursing staff and other licensed clinical staff who provide care within the scope of their practice, as defined by State law, are on-site in accordance with the selected treatment model, and available 24-hours a day and 7 days a week (485, 1-10).
- Facility must be licensed in accordance with existing Title IV-E requirements and accredited by any of the following organizations: CARF, JCAHO, COA, any other non-for-profit agencies approved by HHS (486, 4-16).
- If it’s in the best interest of the child/youth, family members must be involved in the child’s treatment (485, 11-14). There must also be documentation on outreach to family members and fictive kin, including siblings, how those family members are integrated into the treatment process and involved post-discharge, and how sibling connections are maintained throughout (485, 15-20).
- The program must provide discharge planning and family-based aftercare support for at least 6 months post discharge (486, 1-3).

Does this section also limit reimbursement for administrative costs for children placed in child caring institutions?

No. The prohibition on federal payments related to foster care maintenance payments for children who are not placed in a foster family home does not extend to federal payments for administrative expenditures (485, 17-23).
How is a foster family home defined?

Foster family home is defined as the home of an individual or family that is licensed or approved by the State, and the individual has been licensed as a foster parent (487, 18-21).

Foster parent is defined as adhering to a/the reasonable and prudent parent standard, providing 24-hour care, and who provides care for not more than 6 foster children (488, 3-12) with some flexibility allowed.

Foster parent are not prohibited from renting a home in which they care for the child(ren) (489, 7-11). A foster family home can provide care for more than 6 children only in these cases:

- To allow a parenting foster youth to remain with their child (488, 19-21).
- To allow siblings to live together (488, 22-23)
- To allow a child with an established relationship with the family to remain with the family (489, 1-3).
- allowing a family with special training to care for a child(ren) with severe disabilities (489, 4-6).

Definitions of child care institution and supervised settings remain the same (489, 12-25, 490, 1-7). How will the Act address the concern that placements in the juvenile justice system will increase?

Because of changes to the allowability of maintenance payments for placements that are not a foster family home, the State plan must include a certification that the State will not enact or advance policies or practices that would result in a significant increase in the population of youth in the State’s juvenile justice system (490, 20-25, 491, 1-66).

The GAO will conduct a study to ensure that States are not enacting or advancing policies or practices that would result in a significant increase in the State’s juvenile justice system. The Comptroller General shall evaluate the following:

- Whether the change in maintenance payments for placements that are not a foster family home has impacted juvenile justice systems, and
- The extent to which children or youth who are placed in foster care and who are also subject to the juvenile justice system are placed in a facility under the jurisdiction of the juvenile justice system, and
- Whether a lack of available congregate care placements under the jurisdiction of the child welfare system is a contributing factor to these placements.

This study will be completed and presented to Congress by December 31, 2025 (491, 7-25).

Will judges and courts be trained on the new restrictions on funding for placements that are not foster family placements?

To be eligible to receive Court Improvement Program grant funding, courts must provide for the training of judges, attorneys, and other legal personnel in child welfare cases on Federal child welfare policies and payment limitations with respect to children in foster care who are not in a foster family home (490, 8-17)

Sec. 50742. Assessment and Documentation of the Need for Placement in a Qualified Residential Treatment Program (492, 1)

What are the requirements for an assessment?

Within 30 days of the start of placement, a qualified individual defined as a trained professional or licensed clinician who is not an employee of the state or affiliated with any placement setting in which the child is
placed by the state (492, 14-16), must document in the assessment the following:

- Strengths and needs of the child using age-appropriate evidence-based, validated, assessment tool approved by HHS (492, 17-20).
- A determination of whether the needs of the child can be met with a family member or through placement in a foster family home (492, 21-26, 493, 1-4).
- If a child is deemed in need of a placement that is not with a family member or foster family home, it must be specified which approved setting would provide the most effective and appropriate level of care for the child in the least restrictive environment and be consistent with the short- and long-term goals for the child, as specified in the child’s permanency plan.
- A list of child-specific short- and long-term mental and behavioral health goals (493, 5-7).

HHS can waive the requirement that the trained professional or licensed clinician is not an employee of the state agency and is not connected to or affiliated with any placement setting in which the child is placed. HHS can waive this requirement if the State certifies to HHS that the trained professionals or licensed clinicians with responsibility for performing the assessment maintains objectivity with respect to determining the most effective and appropriate placement (496, 10-18).

The assessment process requires that the State establish a family and permanency team to work in conjunction with the individual doing the assessment (493, 8-14).

- Team shall consist of all appropriate biological family members, relatives, fictive kin as well as professionals who are a resource for the child, such as teachers, medical or mental health providers who have treated the child, or clergy (493, 15, 21).
- If the child is 14 years of age or older the child should be a part of the team member identification process (493, 21, 25).

What are the case plan requirements?

- Reasonable and good faith efforts documented to identify and include all individuals for the family and permanency team (known throughout the rest of this summary as “team”) (494, 3-6).
- Contact information for these team members as well as other family members of fictive kin not part of the team (494, 7-11).
- Evidence that the meetings of the team are convenient to the family and that the assessment was determined in conjunction with the team (494, 12-16).
- If reunification is the goal, evidence showing the parent has input on the members of the team (494, 17-20).
- Placement preferences of the team. If the qualified individual recommends a placement that differs from the team’s recommendation, documentation of the reasons why the placement recommendations are different.
- Recognition that children should be placed with their siblings, unless there is a finding by the court that such placement is contrary to their best interest.
- If the recommended placement is no a family foster home, the case plan must indicate why the child’s needs cannot be met by the family or in a foster family home. A lack of foster family homes shall not be an acceptable reason (495, 18-21).
- If placement in a QRTP is recommended, the case plan shall specify why the QRTP is the most effective, least restrictive setting, providing the appropriate level of care, and how the recommended placement is consistent with goals in the child’s permanency plan (495, 21-25, 496, 1-3).
- Within 60 days of the start of each placement in a QRTP, the court must determine and approve (496, 19-24) the placement and that the placement provides the most effective level of care and meets the goals of the permanency plan (497, 5-14). This documentation will become part of the case plan (497, 16-22).
- Even with the recommendation of the qualified individual, placement preference of the family and permanency team, and recommendation in the case plan, the court may disapprove the placement.

What are the requirements for status reviews and permanency hearings for children placed in qualified residential treatment programs?
If the child remains in a QRTP the agency shall submit, at each status review and permanency hearing, the following evidence:

- Documentation of an ongoing assessment of strengths and needs to support that the needs cannot be met in a foster family home (498, 3-7) and that the QRTP continues to provide the most effective level of care and remains consistent with permanency plan goals (498, 7-13).
- Documentation of the specific treatment services still needed and the length of time the child is expected to need these services (498, 14-17).
- Documentation of efforts made by the State agency to prepare the child to return home, to be placed with a relative or legal guardian, or to be placed in a foster family home (498, 18-22).
- If the child is in a QRTP for a length of stay more than 12 consecutive months or 18 non-consecutive months, or when a child under age 13 has a length of stay of more than 6 consecutive or non-consecutive months, the State agency must submit to HHS: (498, 23-25, 499, 1-10)
  - The most recent versions of case plan documentation, and
  - The signed approval by the head of the State agency for continued placement.

Sec. 50743. Protocols to Prevent Inappropriate Diagnoses (499, 11)

The Title IV-E state plan must include, in collaboration with the Medicaid agency, an outline of the procedures and protocols that ensure that children in foster care placements are not inappropriately diagnosed with mental illness, other emotional or behavioral disorders, medically fragile conditions, or developmental disabilities and, therefore, inappropriately placed in settings that are not foster family homes (499, 21-25, 500, 1-4).

HHS is required to conduct, and present to Congress, an evaluation of the above-mentioned protocols and analyze if the State complies and identify best practices no later than January 1, 2020 (500, 8-18).

Sec. 50744. Additional Data and Reports Regarding Children Placed in a Setting That is Not a Foster Family Home (500, 19)

Replaces requirements for how HHS must report child placement information to Congress annually. A comparison of the changes is below:

- **OLD REQUIREMENT** (i) the number of children in the placements and their ages, including separately, the number and ages of children who have a permanency plan of another planned permanent living arrangement;
- **NEW REQUIREMENT** (i) in respect to a placement that is not a foster family home:
  - (I) the type of the placement setting, including whether the placement is shelter care, a group home and if so, the range of the child population in the home, a residential treatment facility, a hospital or institution providing medical, rehabilitative, or psychiatric care, a setting specializing in providing prenatal, post-partum or parenting supports, or some other kind of child-care institution and if so, what kind (501, 3-14)
  - (II) the number of children in the placement setting and the age, race, ethnicity, and gender of each of the children (500, 15-18)
  - (III) for each child in the placement setting, the length of the placement of the child in the setting, whether the placement of the child in the setting is the first placement of the child and if not, the number and type of previous placements of the child, and whether the child has special needs, or another diagnosed mental or physical illness or condition; (500, 19-25, 501, 1-3)
  - (IV) the extent of any specialized education, treatment, counseling or other services provider in the setting (502, 4-7)
OLD REQUIREMENT (ii) the duration of the placement in the settings (including for children who have a permanency plan of another planned permanent living arrangement);

NEW REQUIREMENT (ii) separately, the number and ages of children in the placements who have a permanency plan of another planned permanent living arrangement (502, 8-11)

Sec. 50745 Criminal Records Checks and Checks of Child Abuse and Neglect Registries for Adults Working in Child Care Institutions and Other Group Care Settings (502, 12).

Requires states to have provisions to conduct criminal history and child abuse and neglect registry checks, including fingerprint-based checks, on any adult working in a child care institution, including group homes, residential treatment centers, shelters, or other congregate care settings. Effective Oct. 1, 2018. For flexibility, allows for the State to provide the Secretary with alternative criminal records checks the State conducts. (502, 12 – 503, 21).

Sec. 50746. Effective Dates; Application to Waivers (504, 1)

- The effective date is January 1, 2018, subject to the dates below (504, 3-6).
- If the state must make changes to state law, some flexibility regarding timelines for updating state plans is allowed (504, 7-24).
- The effective date for when federal Title IV-E funding will be limited for child caring institutions, as described above, including the requirements for a QRTP going into effect is October 1, 2019 (505, 4-6), excepting that:
  - If a state requests a delay in the effective date for child caring institutions, HHS can delay the effective date for up to 2 years. If the effective date is delayed, reimbursement for prevention services and kinship navigation services as defined in Part I of this act are also delayed (505, 7-25).
- Criminal records checks and checks of child abuse and neglect registries for adults working in child caring institutions and other group care settings shall take effect on October 1, 2018 (506, 1-6).
- If a state is under a Title IV-E waiver the amendments in this legislation take effect after the expiration (without regard to an extension) of the waiver (506, 7-14).

PART V – CONTINUING SUPPORT FOR CHILD AND FAMILY SERVICES

Sec. 50751. Supporting and Retaining Foster Families for Children (506, 17)

The purpose of family support services as defined in the Social Security Act is expanded to include supporting and retaining foster families so they can provide quality family-based settings for children in foster care (507, 1-3).

For federal fiscal year 2018, $8,000,000 is appropriated to provide competitive grants for states, Indian tribes, or tribal consortia to support the recruitment and retention of high quality foster families to increase the capacity to place more children in family settings. Priority is placed on states, Indian tribes or tribal consortia with the highest percentage of children in non-family settings. The funding shall remain available until federal fiscal year 2022 (507, 7-18).
Sec 50752. Extension of Child and Family Services Programs (507, 19)

Authorization for the following programs is extended from 2017 - 2021:

- The Stephanie Tubbs Jones Child Welfare Services Program (507, 21-24)
- Promoting Safe and Stable Families Program (508, 1-6)
- Discretionary Grants (508, 7-10)
- Reservations for Monthly Caseworker Visit and Regional Partnership Grants (508, 11-19)
- State Courts Program (508, 20 – 509, 4). Also repeals the expired provisions (509, 5-6).

Sec. 50753. Improvements to the John H. Chafee Foster Care Independence Program and Related Provisions (509, 7)

- Expands the Chafee program to youth who have aged out of foster care up to age 23, if the State has exercised the option to extend foster care through the age of 21 (509, 13-18).
- Require updates to certifications in the state plan, including:
  - If the state has extended foster care to age 21, or if a state has not elected to extend foster care to age 21, but does provide services similar to those covered under Chafee, Title IV-B or state funds, the State will make the certification that it will provide assistance and services to youth who have aged out of foster care and not reached age 23 (510, 4-19).
  - Additionally, a certification that not more than 30 percent of the amounts paid to the State from its allotment for a federal fiscal year will be expended for room or board for youth who have aged out of foster care and have not turned 21 or age 23 (for those states that have extended foster care up to age 21) (510, 20- 511, 3).
- Allows unspent funds to be redistributed in the next year. If a state does not expend its full allotment of Chafee Foster Care funds for the federal fiscal year, the Secretary may make the funds available for re-distribution in the 2nd succeeding federal fiscal year if the State applies for funds (511, 14-22), and the State will use the funds for the purpose it was originally allotted (511, 24 – 512, 9). The redistributed amount will be the amount made available multiplied by the state foster care ratio (512, 11-18). The amount redistributed should be considered part of allotment made for the federal fiscal year in which the distribution was made (512, 19-24). For purposes of redistribution, State includes Indian Tribes, Tribal Organizations or tribal consortium that receives allotments under this program (513, 1-4).
- Eligibility for Education and Training vouchers is extended until youth attain 26 years of age or for 5 years total, whatever occurs first (513, 5-15). Vouchers under the program may be available to otherwise eligible youth who are at least 14 years of age (513, 16-19).
- Changes the Title of the Act to “John H. Chafee Foster Care Program for Successful Transition to Adulthood” (513, 23 – 514, 2).
- Updates the language for the fund, including:
  - Helping youth attain a high school diploma and post-secondary education (514, 13-14)
  - Training and opportunities to practice daily living skills such as financial literacy and driving instruction (514, 17-20)
  - Achieving meaningful, permanent connections with a caring adult for foster care youth age 14 and older (514, 25 – 515, 2)
  - Engaging in age or developmentally appropriate activities, positive youth development, and experiential learning that reflects what their peers in intact families’ experience, for foster care youth 14 and older (515, 6-11)
- Updates several state plan requirements to update the use of language, for example, “adolescent” is changed to “youth”, and language is updated to address transition to adulthood (515, 16 – 516, 4).
• Updates Reporting Requirements so that HHS must deliver a report to several Congressional committees regarding the National Youth in Transition Database (NYTD) and any other databases regarding children who have aged out of foster care or left foster care for kinship guardianship or adoption no later than October 1, 2019 (516, 15-24). The report should include:
  o A description of the reason for entry into foster care and the foster care experiences, such as length of stay, number of placement settings, case goal, and discharge reason of 17-year-olds who are surveyed by the NYTD and an analysis of the comparison of that description with the reasons for entry and foster care experiences of children of other ages who exit from foster care before attaining age 17 (517, 1-10).
  o A description of the characteristics of the individuals who report poor outcomes at ages 19 and 21 (517, 11-14).
  o Benchmarks for determining what constitutes a poor outcome for youth who remain in or have exited from foster care and plans to incorporate these benchmarks in efforts to evaluate child welfare agency performance in providing services to children transitioning from foster care (517, 15-21).
  o An analysis of the association between types of placement, number of overall placements, time spent in foster care and other factors, and outcomes at ages 19 and 21 (517, 22-25).
  o An analysis of the differences in outcomes for children in and formerly in foster care at age 19 and 21 among states (518, 1-3).

Clarifies that documentation provided to foster youth leaving foster care must include “any official documentation necessary to prove that the child was previously in foster care” (518, 4-9).

PART VI – CONTINUING INCENTIVES TO STATES TO PROMOTE ADOPTION AND LEGAL GUARDIANSHIP

Sec. 50761. Reauthorizing Adoption and Legal Guardianship Incentive Programs (518, 13)

The Adoption and Legal Guardianship programs are reauthorized. States are eligible in federal fiscal years 2016 through 2020 if other existing requirements are met (518, 17-18). Funding is appropriated through 2021 (518, 19-20) and can be expended through 2021 (518, 21-22). [Editor’s note: clarification may be needed to understand why eligibility is extended through 2020 but funding is available through 2021].

PART VII – TECHNICAL CORRECTIONS

Sec. 50771. Technical Corrections to Data Exchange Standards to Improve Program Coordination (519, 2)

• Section 440 of the Social Security Act is amended to change the title to “Data Exchange Standards for Improved Interoperability” (519, 5-8).
• HHS will establish an interagency work group established by the OMB and considering State government perspectives, by rule, designate data exchange standards to govern the following: (519, 9-13)
  o Necessary categories of information that State agencies operating programs under state plans approved under this part are required under applicable Federal law to electronically exchange with another state agency (519, 14-18)
Federal reporting and data exchange required under applicable federal law (519, 19-20)

- The data exchange standards will:
  - Incorporate a widely accepted, non-proprietary, searchable, computer-readable format, such as Extensible Markup Language (519, 23-25)
  - Contain interoperable standards developed and maintained by intergovernmental partnerships such as the National Information Exchange Model (520, 1-3)
  - Incorporate interoperable standards developed and maintained by Federal entities with authority over contracting and financial assistance (520, 4-6)
  - Be consistent with and implement applicable accounting principles (520, 7-8)
  - Be implemented in a manner that is cost effective and improves program efficiency and effectiveness (520, 9-11)
  - Be capable of being continually upgraded as necessary (520, 12-13)

- Not later than 24 months after the date of the enactment of this section, HHS should issue a proposed rule that:
  - Identifies federally required data exchanges, include specification and timing of exchanges to be standardized, and address the factors used in determining whether and when to standardize data exchanges (520, 22 – 521, 2)
  - Specifies state implementation options and describes future milestones (521, 3-4)

Sec 50772. Technical Corrections to State Requirement to Address the Developmental Needs of Young Children (521, 5)

- State plan for child welfare services is amended to require that states include a description of activities that the state has undertaken to reduce the length of time children who are under 5 years old are without a permanent family and the activities the state undertakes to address the developmental needs of all vulnerable children under 5 years of age (521, 8-11).

PART VIII – ENSURING STATES REINVEST SAVINGS FROM INCREASE IN ADOPTION ASSISTANCE

Sec. 50781. Delay of Adoption Assistance Phase-In (521, 15)

Delays assistance without meeting an income test for children with special needs who do not reach their second birthday in the federal fiscal year their adoption assistance agreement is signed. The use of an income test is required for an additional six and a half years. Beginning on January 1, 2018 and through June 30, 2024, the income test would need to be applied for any child who is under the age of two when the adoption assistance agreement is signed, provided the child will not reach his/her second birthday before the last day of the federal fiscal year in which that agreement is signed. As of July 1, 2024, no income test would be used for purposes of determining a child’s eligibility for Title IV-E adoption assistance, regardless of the child’s age.
Sec. 50782. GAO Study and Report on State Reinvestment of Savings Resulting from Increase in Adoption Assistance (522, 1)

The GAO must study how states are compliance with the requirements related to State savings from the increase in adoption assistance, including:

- The requirement that States shall spend any savings resulting from the increase on adoption assistance on services provided to children and families under Title IV-B and IV-E.
- The requirement that states spend 30 percent of the savings on post adoption services, post guardianship services, and services to support permanency for children who do not enter foster care, with at least 2/3 of the required 30 percent to be spent on post adoption and post guardianship services.

The Controller General is required to submit a report to Congress and HHS, but the Act does not give a date for this report.
APPENDIX C: GLOSSARY OF TERMS

Glossary of Terms

- **Administration for Children and Families (ACF):** A division of the U.S. Department of Health & Human Services which promotes the economic and social well-being of children, families, individuals and communities with leadership and resources for compassionate, effective delivery of human services.

- **Care Management Entity (CME):** An organizational entity that serves as a centralized accountable hub to coordinate all care for youth with complex behavioral health challenges who are involved in multiple systems, and their families.

- **Child and Adolescent Needs Survey (CANS):** A multi-purpose tool developed for children’s services to support decision making, including level of care and service planning, to facilitate quality improvement initiatives, and to allow for the monitoring of outcomes of services.

- **Child and Family Service Review (CFSR):** Periodic reviews of state child welfare systems conducted by ACF to achieve three goals: Ensure conformity with federal child welfare requirements, determine what is actually happening to children and families as they are engaged in child welfare services, assist states in helping children and families achieve positive outcomes.

- **Disproportionate Minority Contact (DMC):** Rates of contact with the juvenile justice system among juveniles of a specific minority group that are significantly different from rates of contact for white non-Hispanic juveniles.

- **Family First Prevention Services Act of 2018:** Signed into law as part of the Bipartisan Budget Act on February 9, 2018, the Act reforms the federal child welfare financing streams, Title IV-E and Title IV-B of the Social Security Act, to provide services to families who are at risk of entering the child welfare system.

- **Fostering Connections to Success and Increasing Adoptions Act of 2008 (FCSIAA):** Signed into law on October 7, 2008, as Public Law 110-351 amends parts B and E of Title IV of the Social Security Act to connect and support relative caregivers, improve outcomes for children in foster care, provide for Tribal foster care and adoption access, improve incentives for adoption, and for other purposes.

- **John H. Chafee Educational and Training Voucher (ETV) Program:** The Educational and Training Vouchers Program (ETV) for Youths Aging out of Foster Care was added to the CFCIP in 2002. ETV provides resources specifically to meet the education and training needs of youth aging out of foster care.

- **John H. Chafee Foster Care Independence Program (CFCIP):** Federal grant that offers assistance to help current and former foster care youths achieve self-sufficiency. Grants are offered to states and tribes who submit a plan to assist youth in a wide variety of areas designed to support a successful transition to adulthood.

- **Managed Care Organization (MCO):** Health care provider or a group or organization of medical service providers who offers managed care health plans to deliver services in ways that improve quality and control costs.

- **National Culturally and Linguistically Appropriate Services (CLAS):** A set of 15 action steps intended to improve health care quality and advance health equity by establishing a framework for organizations to serve the nation’s increasingly diverse communities.

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23 Care Management Entities: A Primer Center for Health Care Strategies March 2011 retrieved June 2018 from: https://www.chcs.org/media/CHIPRACMEPrimer.pdf
• **National Youth in Transition Database (NYTD):** NYTD collects information on youth in foster care, including sex, race, ethnicity, date of birth, and foster care status. It also collects information about the outcomes of those youth who have aged out of foster care. States began collecting data in 2010, and the first data set was submitted in May 2011.

• **Office of Juvenile Justice and Delinquency Prevention (OJJDP):** An office of the U.S. Department of Justice and a component of the Office of Justice Programs which assists local community endeavors to effectively avert and react to juvenile delinquency and victimization.

• **Qualified Residential Treatment Programs (QRTP):** One of the settings, other than a foster family home, approved for Title IV-E foster care reimbursement after two weeks of placement that must meet the following criteria: be licensed and be accredited by at least one of three federally approved accreditors: The Commission on Accreditation of Rehabilitation Facilities (CARF), Council on Accreditation (COA) or The Joint Commission (formerly JCAHO); use a trauma-informed treatment model; have registered or licensed nursing staff and other licensed clinical staff, available 24/7, on-site according to the treatment model; demonstrate family engagement and outreach, including siblings, in the child’s treatment; provide discharge planning and family-based aftercare supports for at least six months post-discharge.

• **Statewide Automated Child Welfare Information System (SACWIS):** A federally funded, voluntary, comprehensive, and automated case management tool that supports child welfare practice in states.

Other Acronyms:

**CHINS** – Children in Need of Services  
**CMHC** – Community Mental Health Center  
**CHS** – Child Health Support  
**CPS** – Child Protective Services  
**CPSW** – Child Protective Services Worker  
**CW** – Child Welfare  
**DCYF** – Division for Children, Youth and Families  
**DHHS** – Department of Health and Human Services  
**HBTS** – Home Based Therapeutic Support  
**ISO** - Individual Service Option  
**JPPO** – Juvenile Probation and Parole Officer  
**JJS** – Juvenile Justice Services  
**NHIA** – New Hampshire Integrated Assessment  
**SAVRY** - Structured Assessment of Violence Risk in Youth  
**SED** – Severe Emotional Disturbance  
**SYSC**: Sununu Youth Services Center  
**WM** – Wraparound Milwaukee