



Justice Center

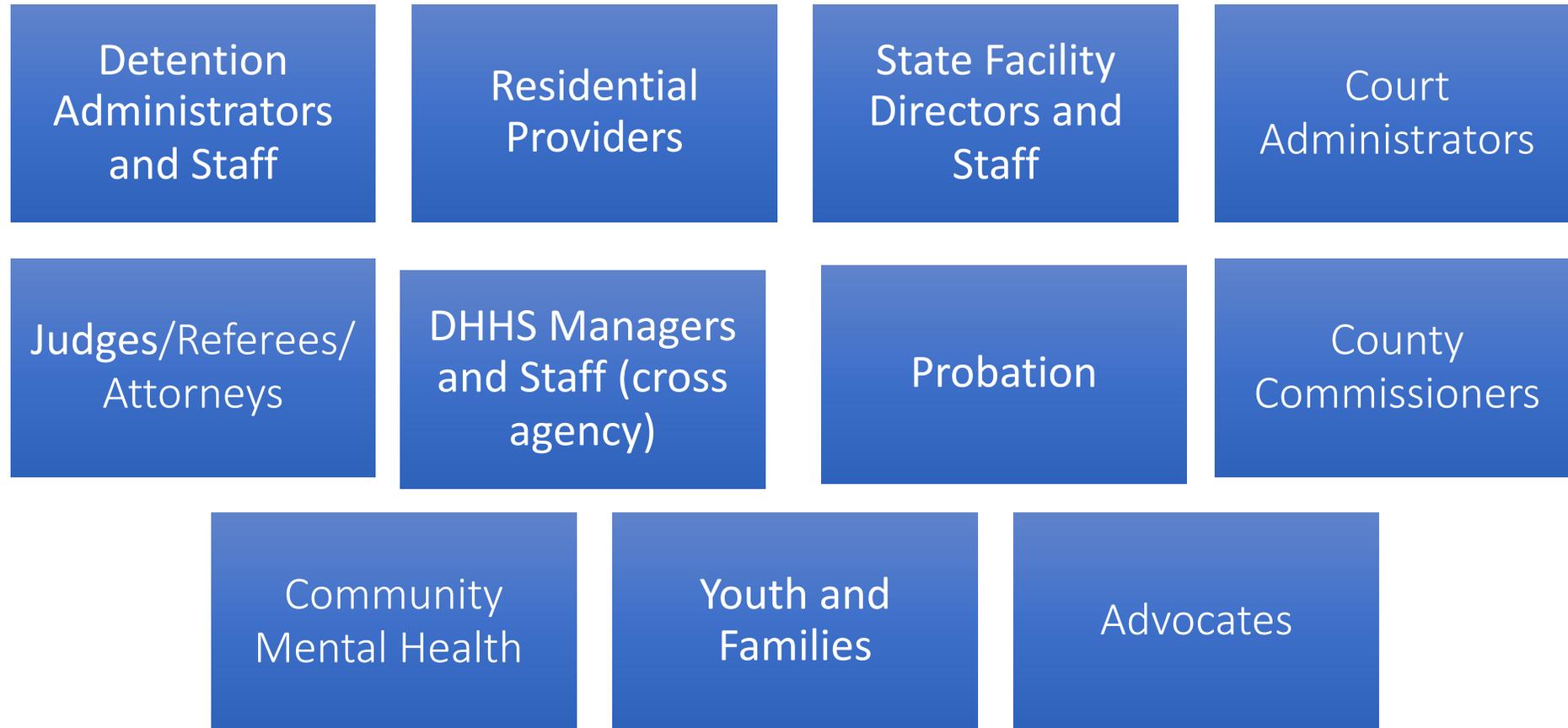
THE COUNCIL OF STATE GOVERNMENTS

MICHIGAN TASK FORCE ON JUVENILE JUSTICE REFORM

PRESENTATION OF FINDINGS: DETENTION AND RESIDENTIAL PLACEMENT

FEBRUARY 28, 2022

Key findings presented today are based on focus groups with hundreds of stakeholders across Michigan.



Key findings are also informed by analysis of case level data from multiple sources.

Data Sources	Description
Michigan Department of Health and Human Services (MDHHS)	2015-2020 case level data on youth placed in juvenile residential facilities under the supervision of MDHHS (dual status and juvenile)
County Court Data	2016-2020 case level data from 10 counties representing approximately 20% of state juvenile population. Data include information related to placements in detention, and placements in residential facilities under the supervision of the court and MDHHS.



There are important caveats about our data analysis.

MDHHS	<ul style="list-style-type: none">• Unreliable offense data not included in analysis• Missing risk information because disposition risk assessment is not always conducted (e.g., direct court placements)• Unreliable incident data not included in analysis
County Courts Data	<ul style="list-style-type: none">• Data collected from a sample of 10 counties, which may not be fully representative of the state• Non-standardized placement type definitions across counties• Difficult to look at unique episodes vs. individual placements so overall analysis is less comprehensive than state wards• Inability to clearly distinguish state from county wards• Non-standard/incomplete race, offense, and risk data• Limited data on violations

➤ Data limitations should reinforce commitment to data improvements while not being used to undermine qualitative feedback, structural challenges, or momentum for system transformation.



Assessment Findings in Context

Focus is on Opportunities for Improvement

- Michigan is implementing many research-based programs and practices across the state. We uplift these best practices while focusing primarily on opportunities for improvement.

Charge is a Statewide Assessment

- Individual counties, detention facilities, residential providers, and staff are implementing best practices. Our charge is to provide a broader assessment of Michigan's juvenile justice system for youth/families irrespective of where they live, under who's oversight, or who serves them.

All Residential Systems Face Substantial Challenges

- The population placed in facilities has a complex array of risks and needs, and every jurisdiction we have worked with is challenged to provide these youth with a supportive and effective treatment milieu and reintegration process.
- Workforce instability, COVID-19, and facility tragedies have exacerbated these challenges in Michigan to an unprecedented degree.





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DETENTION

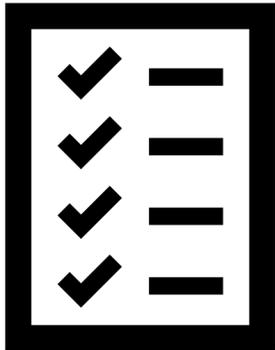
There are several local jurisdictions that have key strengths in their approach to detention:

- ✓ Many counties strive to ensure that secure detention is an option of last resort.
- ✓ Some counties are using a detention screening tool, mental health screening tool, and even a human trafficking screening tool to inform detention decisions and to address youths' needs.
- ✓ Some counties have established criteria to use detention for only more serious offenses.
- ✓ Some counties have developed partnerships and established policies to try and provide seamless continuity of care for youth with behavioral health needs while inside and upon release from detention.
- ✓ The state established Regional Detention Support Services to aid more rural jurisdictions with detention alternatives.

Key Finding #1:

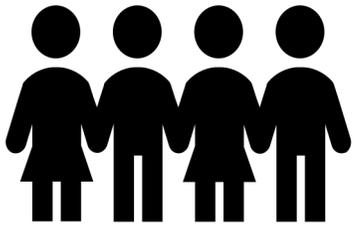
Michigan lacks statewide policies and guidelines to ensure detention is used only for youth that are a public safety or flight risk, including an adequate array of detention alternatives.

Limited statewide policies exist to inform eligibility for detention, and local practices vary considerably.



- No statewide requirement to use a detention screening tool to inform detention decisions.
- No statewide minimum age for placement in secure detention.
- Criteria for who is eligible for secure detention and how decisions are made to place youth in detention are highly variable across jurisdictions.
 - In one jurisdiction a facility can deny a law enforcement official's detention referral based on results from a detention tool, while in another county the facility must accept every youth referred.
 - In one jurisdiction law enforcement confers with the prosecutor for detention eligibility, in another, they may need to confer with a judge/referee, and in another, detention staff make these decisions.
- Stakeholders, particularly law enforcement, expressed frustration with a lack of clearly documented criteria. And where they may exist, law enforcement officers are not always aware.
- Youth 15 or older can be placed in an adult jail, if they are kept separate, for up to 30 days in response to behavioral issues in a juvenile facility. To the extent this happens in practice varies by jurisdiction.

As a result of varying eligibility policies and criteria, detention is used for a myriad of reasons other than public safety.



- Detention is used for youth pre-adjudication, as a sanction for violations of supervision, and post-disposition.
- Jurisdictions vary in their use of detention for youth committing status offenses. While some facilities indicate that they only accept felony offenses, others hold youth with status offenses.
- Youth with intensive behavioral health needs, runaways, and youth in crisis are being placed in secure detention to address their immediate needs, and not because they are a risk to public safety.
- Younger youth that are placed in secure detention are often cases that should be addressed by the abuse and neglect or behavioral health systems.
- Increasingly, due to bed shortages, detention is used to hold youth awaiting residential placement, and these youth can sit in secure detention for extended periods of time.
- Likewise, youth are being placed in detention facilities post-disposition, but many of these facilities are not oriented for long-term treatment nor required to follow QRTP standards.

Options for secure detention and community-based alternatives are limited across the state.

No statewide system of support and alternatives

- Regional Detention Support Services (RDSS) is limited and lacks sufficient funding.
- RDSS targets rural and Tribal jurisdictions that lack their own facility.
- RDSS is more surveillance oriented (electronic monitoring, home detention, etc.) rather than focused on supports/interventions.
- RDSS relies on volunteers.
- No statewide or centralized detention bed management process

Counties/Tribes lack support to find alternatives

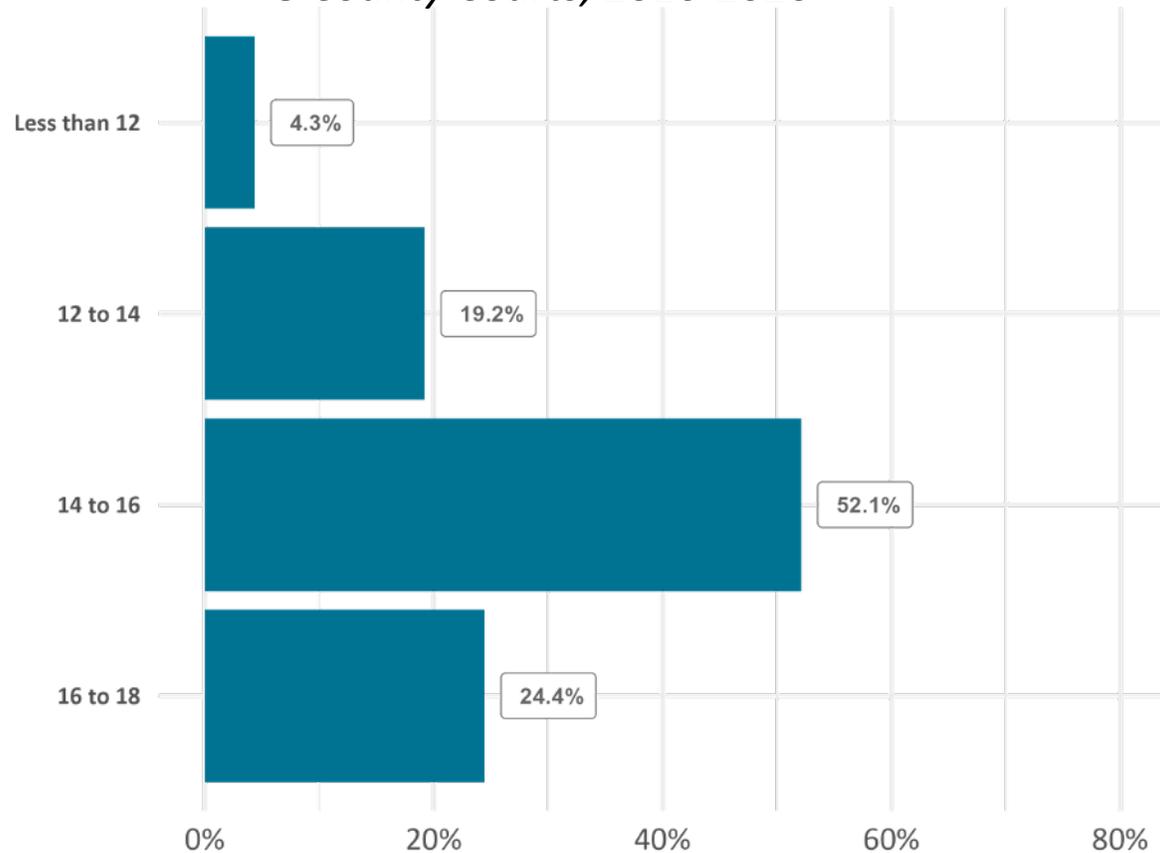
- Counties/Tribes must search for beds or alternatives on their own.
- Lack of formal collaboration across counties and systems to find alternatives or beds.
- Lack of community-based alternatives for kids in crisis or with behavioral health needs. Hospitals and institutions often reject youth with a delinquency history.
- Racial bias also identified as a factor as to why youth were not admitted into an alternative setting.

Current context exacerbates these challenges

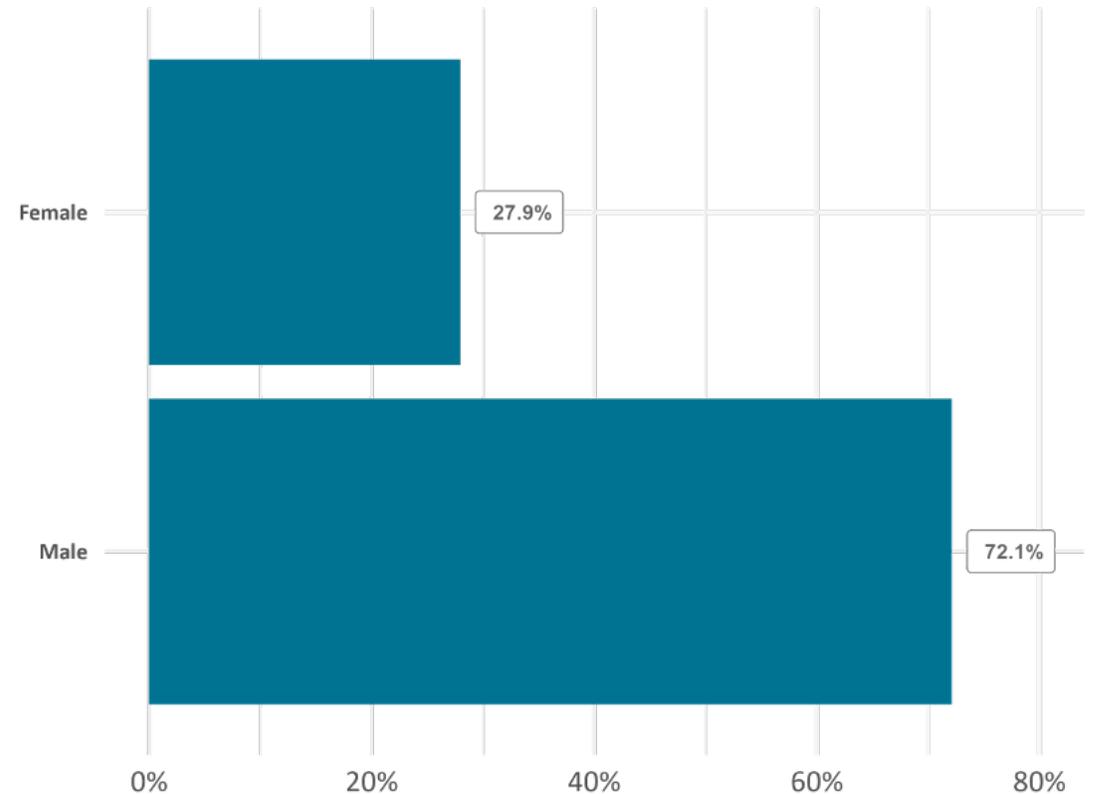
- A systemic staffing crisis exists across the state.
- COVID-19 limits the availability of beds in each facility.
- Transportation issues exist for counties without their own facility.

The average age for secure detention is 14.4 years old, and nearly $\frac{3}{4}$ of youth detained are male.

*Distribution of Detentions by Age at Filing,
8 County Courts, 2016-2020*

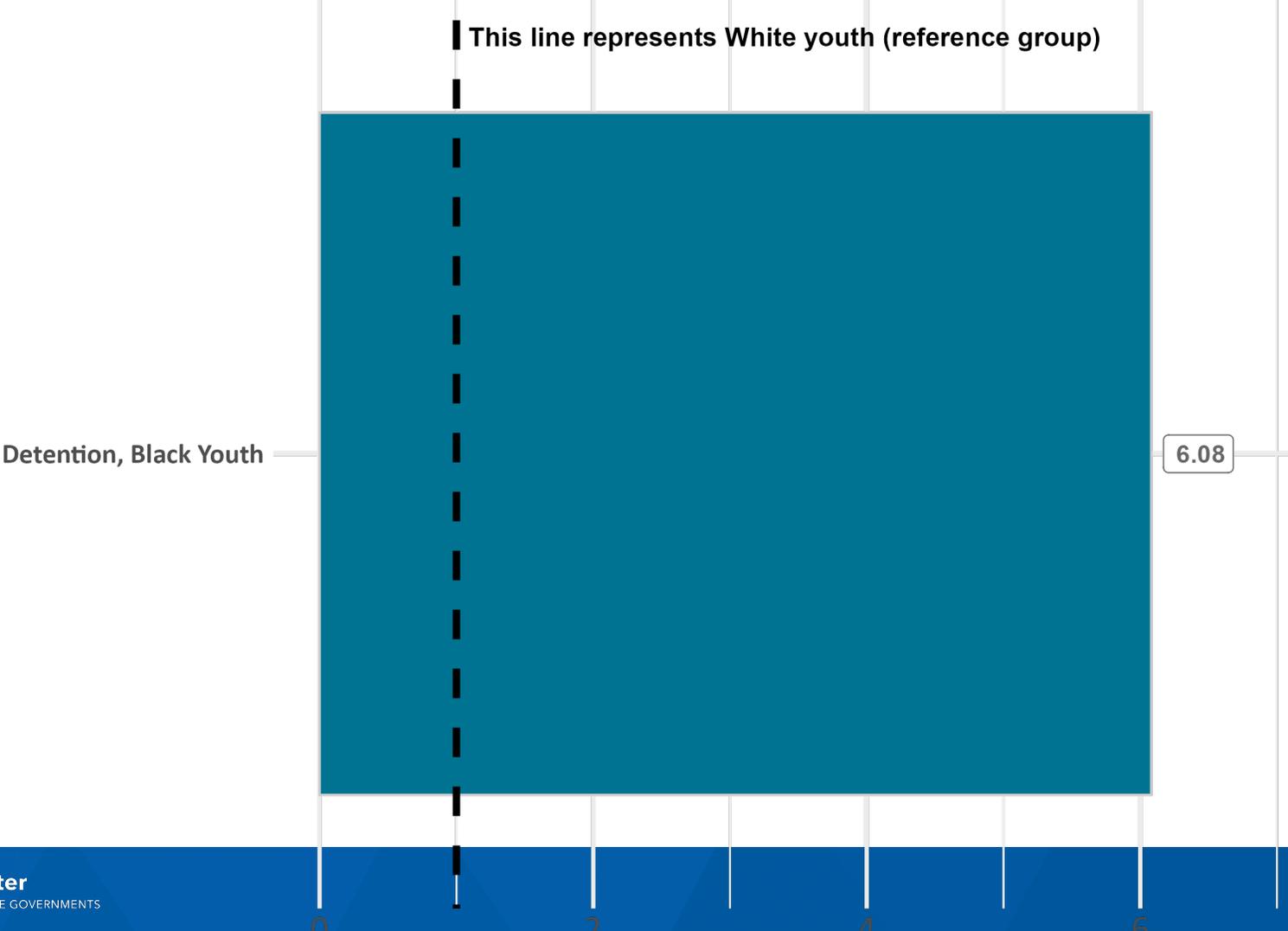


*Distribution of Detentions by Gender,
8 County Courts, 2016-2020*



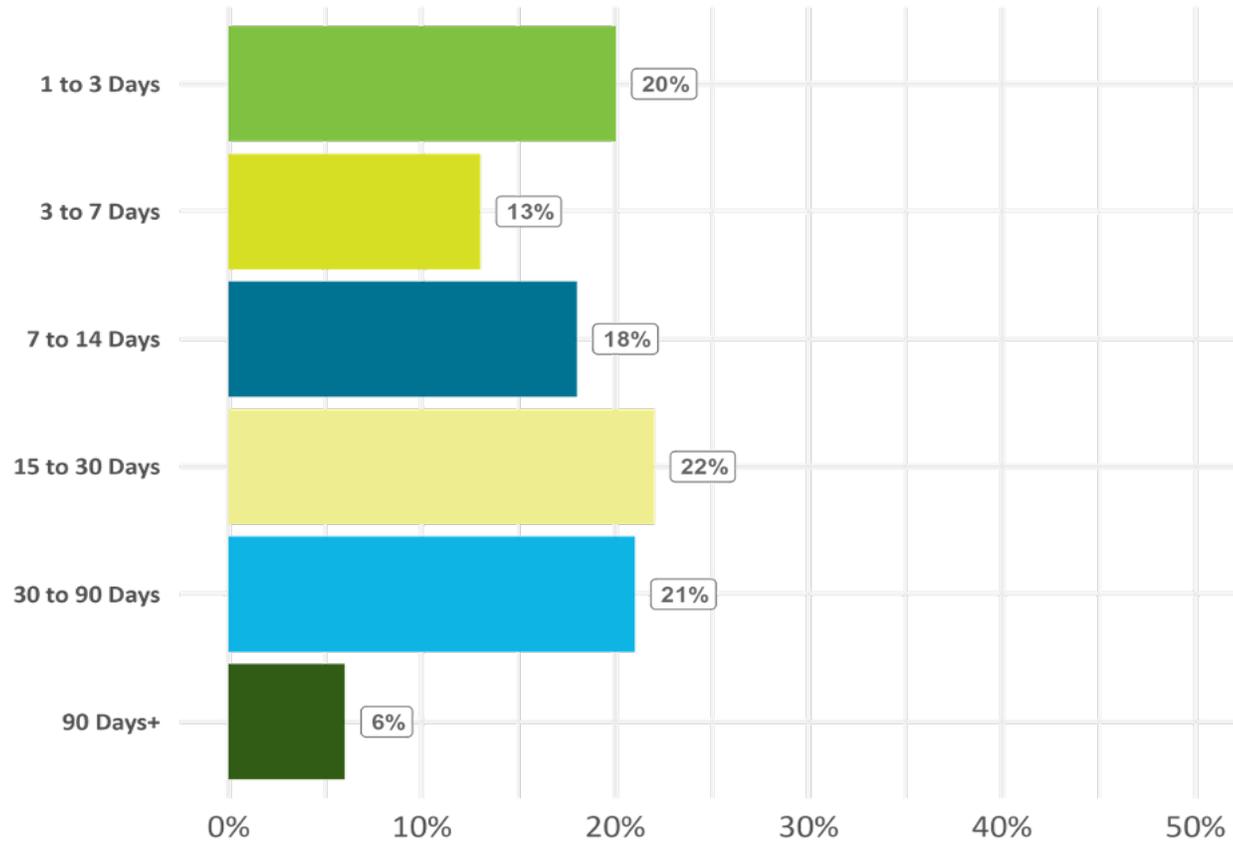
Black youth are detained at 6 times the rate of White youth.

Relative Rate Index Black vs White for Detention, 8 County Courts, 2016-2020



One in four detention placements have a length of stay of one month or longer.

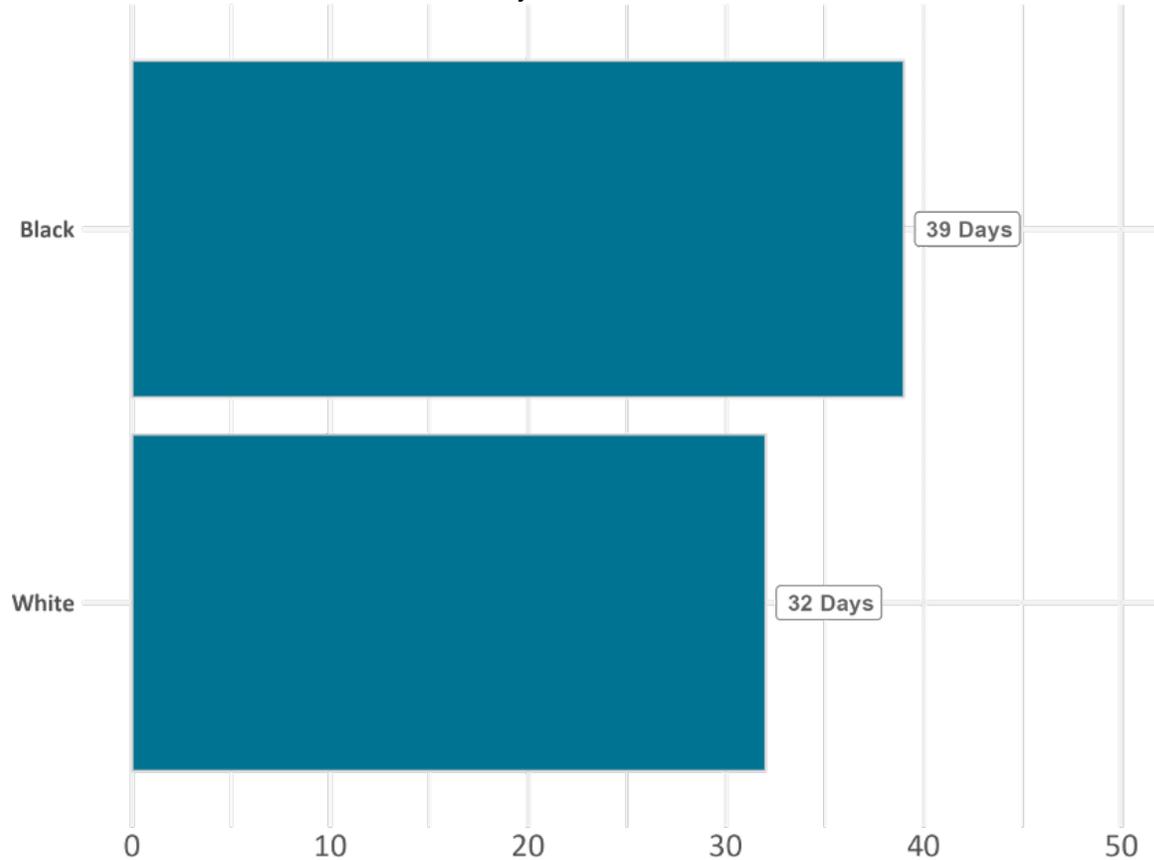
Length of Stay in Detention Distribution, 9 County Courts, 2016-2018



- The median length of stay is 14 days.
- 20% of detention placements were for 1-3 days.
- No statutory time limits exist for the length of time youth can spend in detention.

The average length of stay in detention is seven days longer for Black youth than White youth.

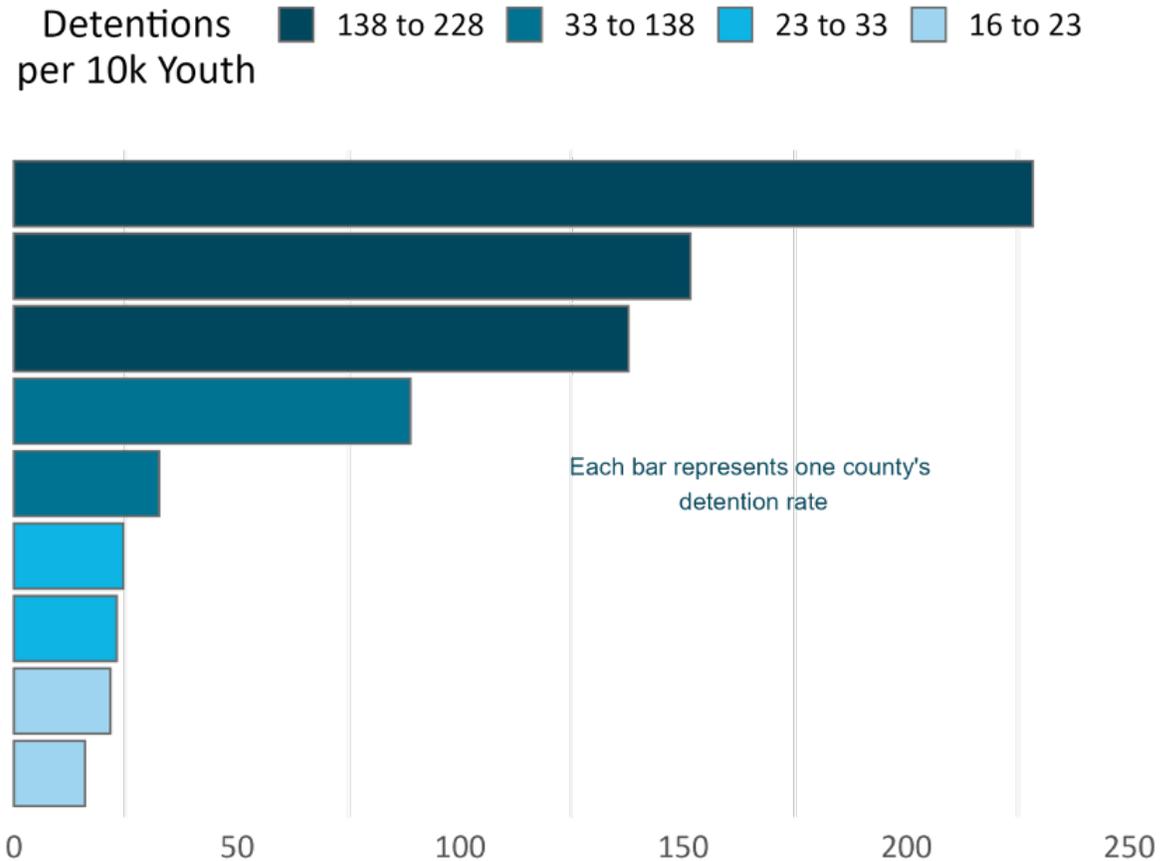
Average Length of Stay in Detention for Black vs White Youth, 8 County Courts, 2016-2018



The difference between the mean length of stay for detention for Black youth (mean = 38.7 days) and White youth (mean = 32.1 days) is statistically significant ($P < 0.05$, which indicates less than a 5% probability of concluding that a difference exists when there is no actual difference).

Detention rates vary considerably across counties.

Detentions per 10,000 Youth by Counties, 9 County Courts, 2016 - 2020



- Counties represent a mix of rural, middle-sized counties, and one large county from different regions in Michigan.
- Only a few counties in this data set have their own detention facility.

Key Finding #2:

The services and supports youth receive in detention do not fully address their needs, and statewide transparency and accountability for these services and youth outcomes is limited.

Variability exists in the services and treatment available to youth in detention, and facilities struggle to support an increasing population of youth with behavioral health needs.



- The use of screenings and assessments to identify and address youths' needs varies across jurisdictions but is limited for the most part.
- Facilities struggle to provide intensive behavioral health or crisis stabilization services and providing youth with a continuity of care is a challenge – limited providers are available to work with youth in a detention facility, and facilities struggle to staff behavioral health positions internally.
- In some counties, Community Mental Health Services provide services to kids while in a facility, and in others they only provide services in the community.
- Medicaid eligibility for youth is discontinued when they are placed in detention (or any residential placement), which can result in ineligibility for certain services or medications. It can then also take time to reactivate their eligibility status upon release leading to disjointed service provision in the community.

Oversight and accountability of detention facilities is inconsistent and differs depending on governance structure.

Operations

- County facilities may have limited engagement with the courts/juvenile justice systems. While detention staff are supposed to work closely with the court, disagreements may exist with who is admitted, how long youth are kept, and other decisions.
- Court facilities may have a better understanding of the juvenile justice population as programming and training is provided by the court. Court operated facilities also have control over hiring and staffing.
- County facility staff report a desire to transition to a court-run facility to improve operations, streamline funding, and provide a seamless continuum of options for youth.

Licensing/ Standards

- A court operated facility is inspected by the state annually in accordance with state licensing rules for court operated facilities but is not licensed by the state. The state cannot pull the license of a court facility or have other control over operational decisions.
- A county facility is licensed by the state as a Child Caring Institution - the same rules that apply to QRTPs/residential placements.
- Differences exist between court vs. County standards, and while both lack sufficient specificity, the licensing standards for court facilities are also less rigorous.
- Some detention staff report that recent policy changes limiting restraint and seclusion has had an impact on staff and facility safety.

Statewide data is unavailable to answer critical questions about juvenile detention and guide system decisions and improvement.

- No statewide data on the number of youth in juvenile detention, who these youth are, and why they are placed in detention (offense, demographics, etc.)
- Challenges with existing datasets in disentangling who is in juvenile detention pre vs. post adjudication, for a sanction, or as part of a dispositional order - as a result, it is very difficult to understand the average length of stay for various populations
- No centralized approach to using data to match the availability of detention beds with county needs
- Lack of data on the use of restraints/seclusion and how these may differ based on demographics or facilities

Potential Opportunities for System Reform and System Transformation

Potential Opportunities for System Reform and Transformation

- ❖ Ensure secure detention is used statewide only for youth that are a risk to public safety and/or flight risk that can't be addressed through a robust system of community alternatives.
- ❖ Establish a more centralized, coordinated approach/policies to detention bed planning and community-based alternatives to detention.
- ❖ Strengthen collaboration/establish partnerships across systems to address behavioral health and crisis needs of youth and families outside of secure detention.
- ❖ Establish more robust, statewide research-based standards and accountability and quality assurance mechanisms that are consistent across all types of detention facilities and that ensure that staff are trained, facilities have capacity, and services are effective.
- ❖ Establish the statewide data infrastructure necessary to describe, track, evaluate, and improve the detention system.



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RESIDENTIAL PLACEMENT

Michigan's approach to residential placement has key strengths, including at the local level:

- ✓ The use of state supervision placements declined approximately 20-30% from 2015-2019.
- ✓ Many counties strive to ensure that residential placement is an option of last resort.
- ✓ Some counties use validated risk assessments to guide disposition/placement decisions.
- ✓ Some counties use multi-disciplinary meetings to identify alternatives to placement.
- ✓ Some counties engage in active case management while youth are in placement and for reentry planning/reintegration.

Michigan's approach to residential placement has key strengths, including at the state level:

- ✓ All state wards are supposed to receive a risk assessment and go through a data-driven placement process to determine the most appropriate placement.
- ✓ All state wards receive ongoing risk/needs assessments throughout placement.
- ✓ Provider service agreements emphasize research-based practices such as evidence-based programs, trauma informed care, and family engagement.
- ✓ Juvenile Justice Division staff are committed to improving outcomes for youth and leveraging limited resources/service options as effectively as possible.
- ✓ Growing effort to conduct more pro-active quality assurance with providers.

Michigan's approach to residential placement has key strengths, including at the facility level:

- ✓ Many facility staff are passionate about serving youth effectively and committed to doing so amidst intense staffing, public health, resource, and oversight challenges.
- ✓ All private facilities are accredited and certified as Qualified Residential Treatment Programs.
- ✓ Youth receive a wide range of services including counseling, behavioral health treatment, family therapy, education, vocational training, and life skills/independent living supports.
- ✓ Staff are adept at navigating a complex array of stakeholders, policies, and protocols.
- ✓ Youth in state facilities report positive experience with the program and staff, including an effort to plan for reentry and reintegration from placement inception.

Key Finding #1:

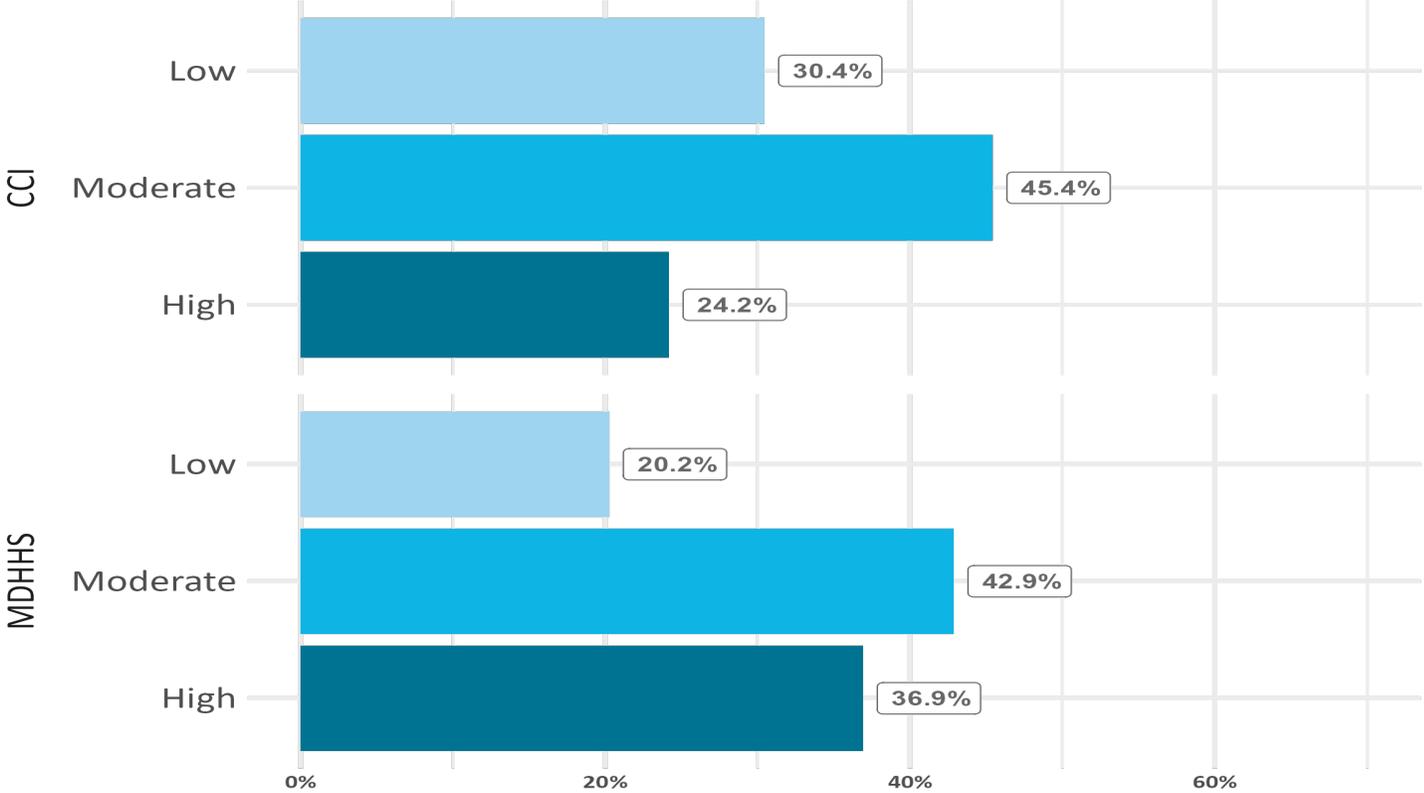
Youth are incarcerated in Michigan based on varying adherence to research-based criteria and processes.

Michigan has minimal state laws or court rules that guide or govern the use of juvenile incarceration and residential placement.

Key State Laws/Rule Areas (common to other states)	Michigan Laws/Rules
Criteria for Placement	➤ None other than least restrictive alternative
Pre-Disposition Risk Assessment	➤ None required
Pre-Disposition Behavioral Health Screening/Assessments	➤ None required
Pre-Disposition Report	➤ None required
Minimum Age	➤ None
Sentencing/Lengths of Stay	➤ None other than youth who commit a firearm offense are required to spend a year in a local detention facility.
Reentry/Custodial Time/Revocation	➤ None

Most state supervised youth (who have a completed dispositional risk assessment) are assessed as low or moderate risk to reoffend.

Disposition Risk Level for State Supervised Youth Placements, 2016-2020



- 23% of CCI placements have no recorded disposition risk assessment.
- 42% of MDHHS placements have no recorded disposition risk assessment.

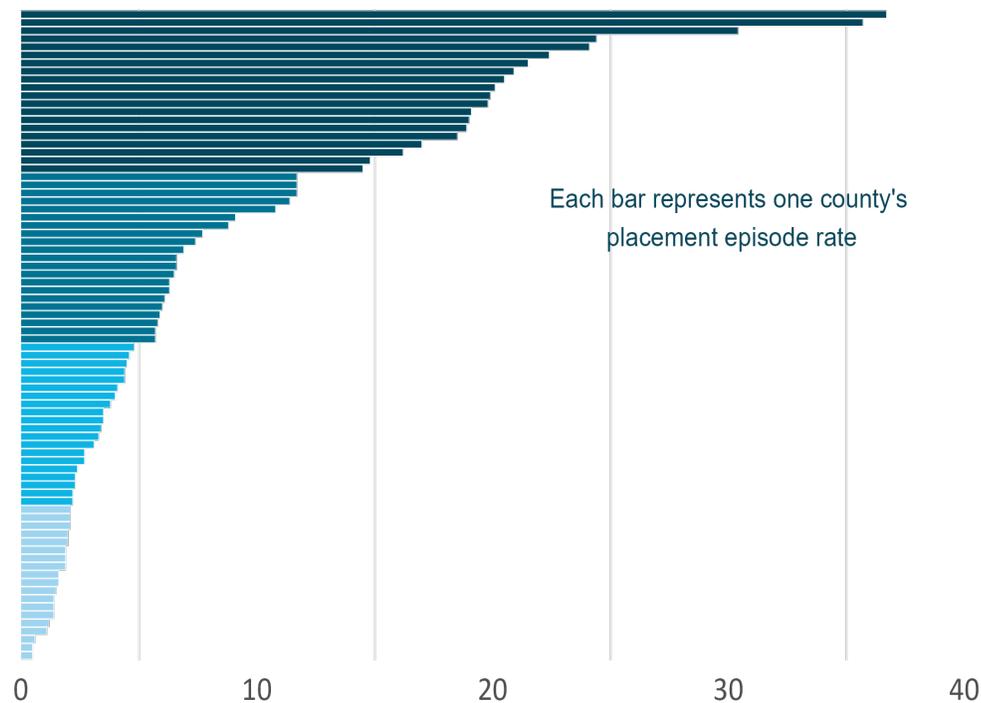
➤ Many facility staff believe that at least some youth who are placed as county/state wards could have been more effectively served in the community and/or in a primary behavioral health treatment setting.

Counties vary in the rate at which they use of out of home placement.

State Supervised Youth Placement Episodes per 10,000 Youth by County, 2015-2020

Placement Episodes per 10k Youth

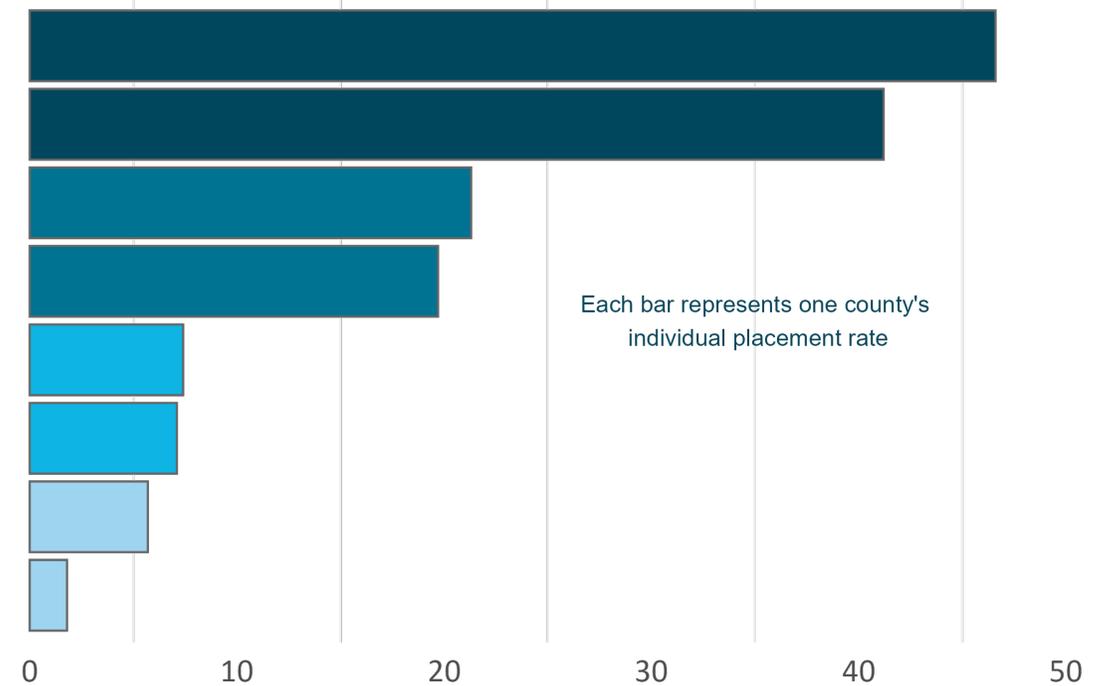
- 12 to 37
- 6 to 12
- 2 to 6
- Less than 2



Placements per 10,000 youth by County, 8 County Courts (county and state wards), 2016-2020

Placements per 10k Youth

- 26 to 47
- 14 to 26
- 7 to 14
- 2 to 7



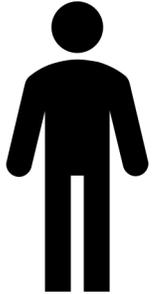
Key Finding #2:

Michigan's approach to wardship and the placement process leads to youth being treated unequally, as well as operational challenges and inefficiencies for facilities.

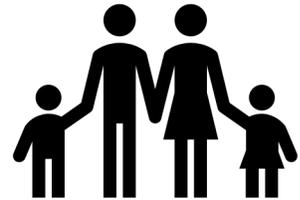
Youth's placement experiences can differ substantially depending on wardship and their county of origin.

Policy/Process	State Ward	County Ward
Post-Disposition Assessment	<ul style="list-style-type: none"> ➤ MJAS risk assessment ➤ Maximus CANS assessment 	<ul style="list-style-type: none"> ➤ None
Placement Process	<ul style="list-style-type: none"> ➤ Juvenile Justice Assignment Unit based on risk/need 	<ul style="list-style-type: none"> ➤ County discretion
Service Agreement	<ul style="list-style-type: none"> ➤ Standardized service agreements 	<ul style="list-style-type: none"> ➤ County/provider discretion and negotiated agreement
Funding	<ul style="list-style-type: none"> ➤ State approved/standardized rates 	<ul style="list-style-type: none"> ➤ County/provider discretion
Ongoing Risk Assessments	<ul style="list-style-type: none"> ➤ Required 	<ul style="list-style-type: none"> ➤ Not required/infrequent
Case Management	<ul style="list-style-type: none"> ➤ Monthly contact youth/family 	<ul style="list-style-type: none"> ➤ Discretionary/often monthly
Reentry	<ul style="list-style-type: none"> ➤ Contracted/state agency supports 	<ul style="list-style-type: none"> ➤ Discretionary/variable

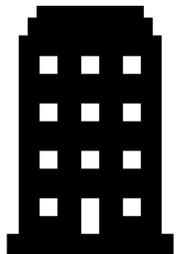
Youth, families, and facilities can face undue challenges as a result of inconsistent placement processes and adherence to research-based practices.



- Youth who are not high risk are incarcerated when research generally shows improved community safety and youth outcomes when youth are served in the community.
- Youth's key criminogenic/behavioral health needs may not be consistently identified and addressed.
- Youth's treatment may depend heavily on county of origin, individual judge, and individual case worker.



- Collaboration and communication is highly variable, leading families to report feeling confused, left out of decision making, and with limited access for visitation, treatment, or reentry planning.

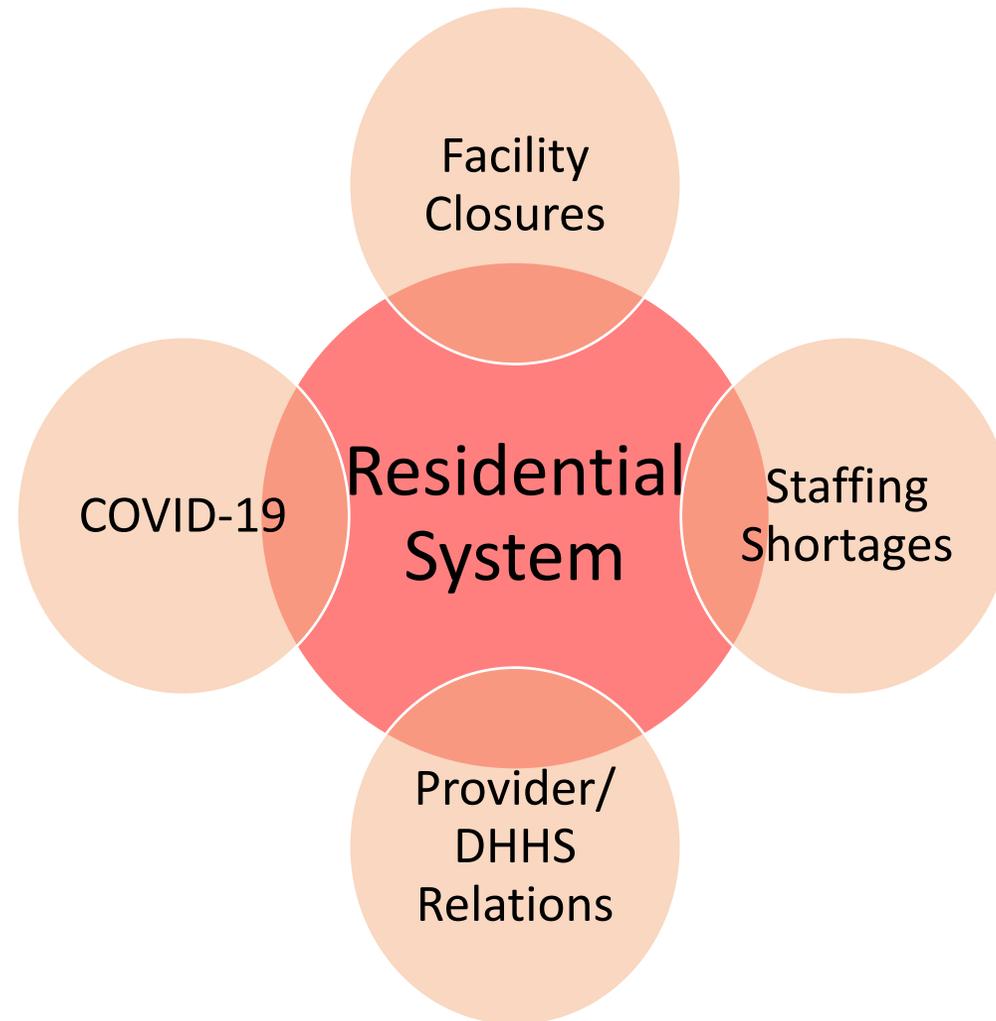


- Operational complexities/inefficiencies due to varying assessment/service requirements and funding.
- Challenge of collaborating with stakeholders with varying policies, protocols, engagement, and expertise.
- No centralized system/measures for data collection or court progress reporting.

Key Finding #3:

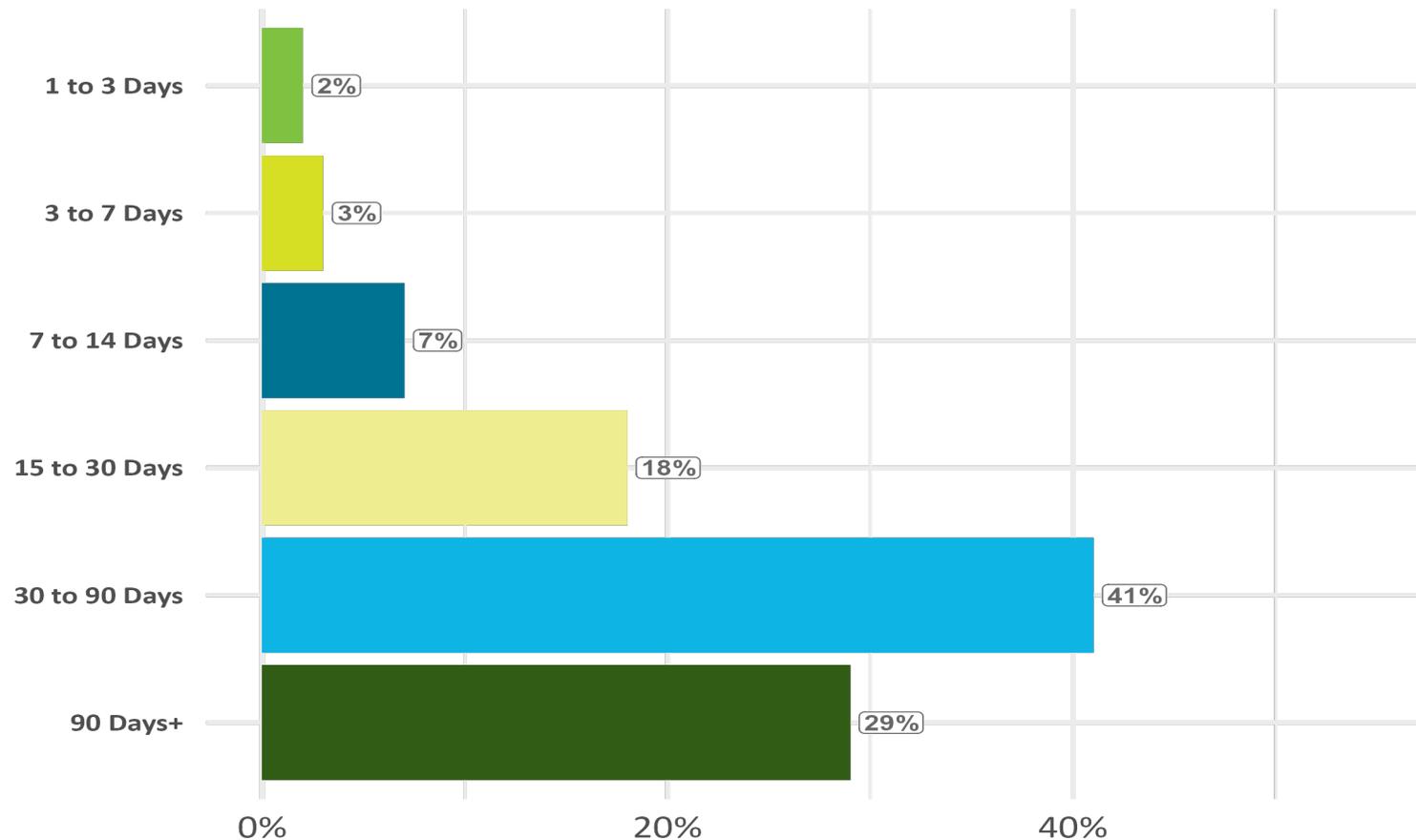
Residential system challenges are exacerbated by both recent events and a historical lack of capacity and attention to the specific needs of the juvenile justice system.

The residential system for youth in the juvenile justice system is in a state of upheaval.



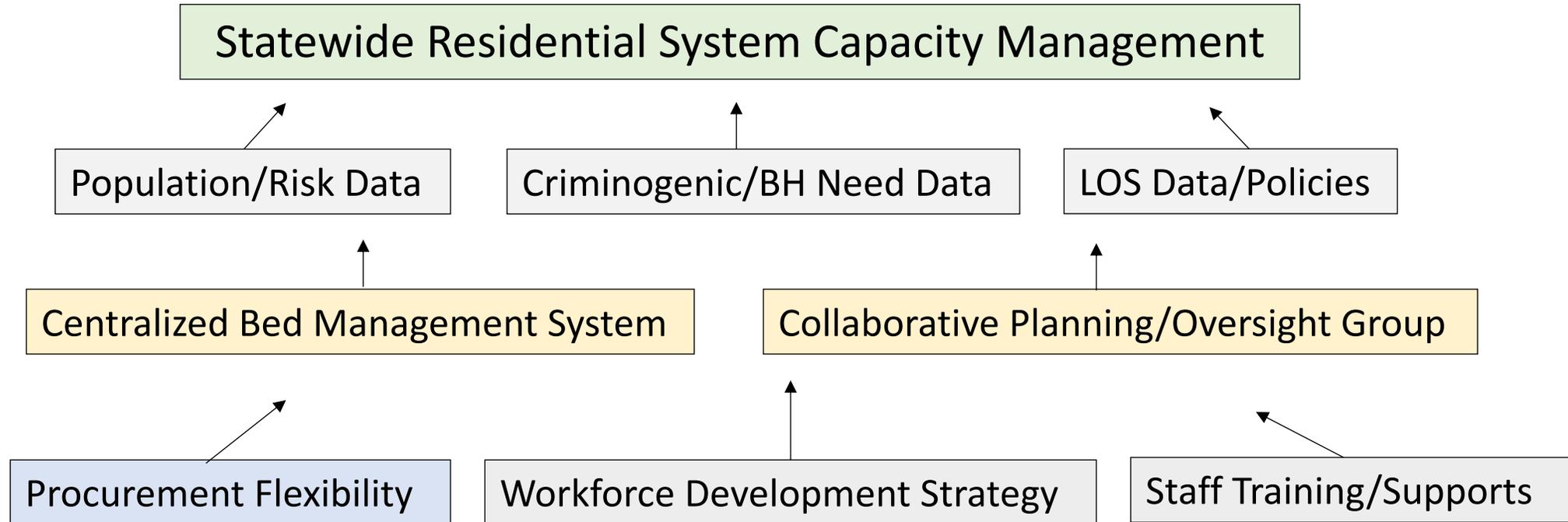
Even before recent events, 70 percent of state supervised youth placement episodes involved more than 30 days spent in detention.

Total Detention Length of Stay Distribution within State Ward Placement Episodes, 2015-2018



➤ No statutory time limits exist for the length of time youth can spend in detention.

The disjointed nature of the residential system makes state planning, flexibility, and crisis management challenging.



- By statute, DHHS can't make changes to provider service agreements or funding rates without provider consultation.

The juvenile justice residential system has historically received limited attention and capacity building support.

Juvenile Justice Division

- Isolated, under-resourced, and lacks the staff, mandate, and both internal/external support needed to play statewide leadership/coordination role.

Juvenile Justice Specialists

- Not supervised by the Division or formally integrated with Division in any systemic way (supervised by local child welfare field offices).
- Largely not specialized in or experienced with juvenile justice, and minimal training/support.
- Juvenile justice cases are not counted in caseloads calculations and no cap on # of cases.

DHHS

- Licensing standards, quality assurance/oversight, training, QRTP regulations, provider relations, and data collection are designed for the child welfare system and not tailored for the unique challenges/needs of the juvenile justice system/population.

Facilities

- State and many private facility staff feel isolated, unsupported, and that both DHHS and judges lack appreciation for the challenging nature of the JJ population and their needs.

Key Finding #4:

Michigan's approach to funding residential placements may hinder improved youth outcomes and the efficient use of resources.

The current residential funding structure does not appear to satisfy the needs of any key stakeholders.

State Concerns

- x No incentive to keep youth in community (state reimbursement rate is the same).
- x No competitive procurement process (unlike for community-based services).
- x No individualized contracts enabling more specific service expectations/outcomes.

Shared Concerns

- x Not performance based or outcome-driven.
- x No incentive for innovation.

Provider Concerns

- x Funding rates are insufficient for population's needs and administrative burden.
- x No cost-of-living increase in years and on an ongoing basis.
- x No unfilled bed rate (typically a reduced funding level that covers unfilled beds).

Key Finding #5:

The quality and consistency of services that youth receive in facilities vary in terms of whether they are research-based and tailored to youth's specific needs.

Adoption of research-based practices and programs varies across facilities and youth populations: Risk Assessment.



➤ County wards typically don't receive ongoing risk assessments in private placements.



➤ For state wards, facility staff report mixed buy-in for the use of the MJAS risk assessment.



➤ Limited ongoing training, quality assurance, or review of data to ensure fidelity/use.

Adoption of research-based practices and programs varies across facilities and youth populations: Services.



- Limited parameters for what an “evidence-based” program entails or statewide capacity building around specific proven programs or a related training/quality assurance system.



- Facilities cite a dearth of substance use and mental health interventions and expertise.



- Many youth and families feel medication is overly used in lieu of therapeutic treatments.

Adoption of research-based practices and programs varies across facilities and youth populations: Education/Vocational.



- Facility teachers are generally not employees of the local school district, raising concerns for stakeholders on teachers' credentials, curricula rigor/alignment, and accountability.



- Broad concerns about how much teacher instruction time youth receive in some facilities vs. sitting in front of a computer, particularly for youth with special education needs.



- Access to post-secondary education, vocational training, workforce certifications, and post-placement apprenticeship/employment varies by wardship, facility, and county of origin.



- Limited scrutiny or accountability on educational/vocational progress or outcomes in placement and school reintegration back in the community.

Adoption of research-based practices and programs varies across facilities and youth populations: Family Engagement.



- Family engagement and team meetings occur with varying frequency, and families often don't feel empowered to truly guide treatment/reentry decisions.



- Families report that some providers employ a “cookie cutter” approach instead of tailoring treatment to youth/ families’ individualized risks, needs, goals, and culture.



- Few if any structures exist at the state or local level to obtain feedback from families, address their concerns, or engage families in shaping residential/reentry practices.

Adoption of research-based practices and programs varies across facilities and youth populations: Behavior Management.



- Provider agreements require trauma informed care but it's not well defined in practice, and there is limited formal, ongoing training or quality assurance.



- No statewide ban on the use of restraints or isolation, and recent restrictions around their use by DHHS has been experienced by providers as unrealistic, punitive, and insufficient regarding viable alternatives, leading to feelings of less safety/security for staff and youth.



- There is no independent ombudsman or process for youth to anonymously report concerns with facility staff/treatment—they must make such reports through their facility provider.



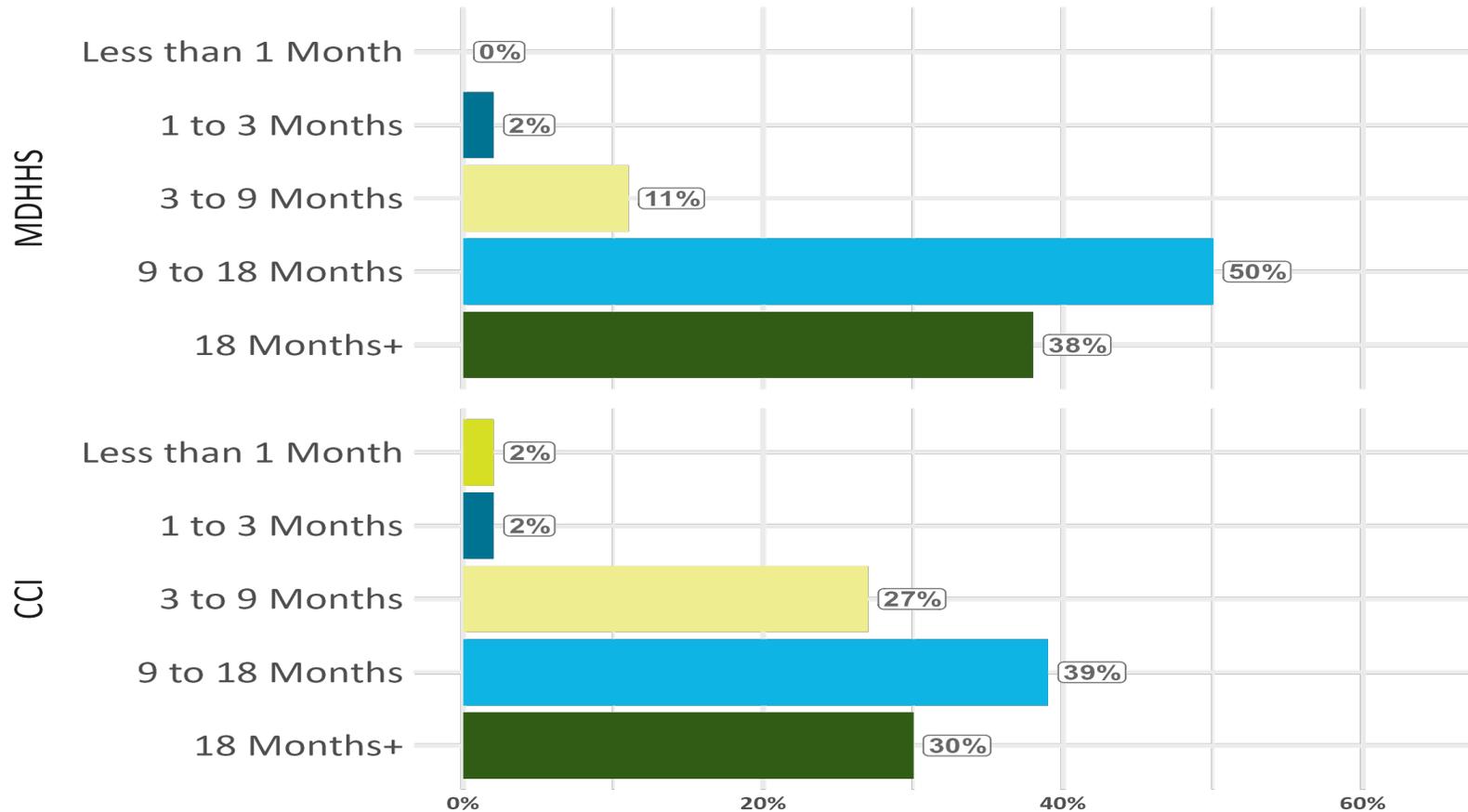
- Data on the use of restraints, isolation, and other incidents may not be reliable.

Key Finding #6:

Youth placed as state wards spend substantial time out of home, in multiple placements, and often end up with a subsequent episode of state wardship.

Almost 90 percent of state supervised youth who start in a state facility and 70 percent who start in a CCI spend nine months or more total time out of home.

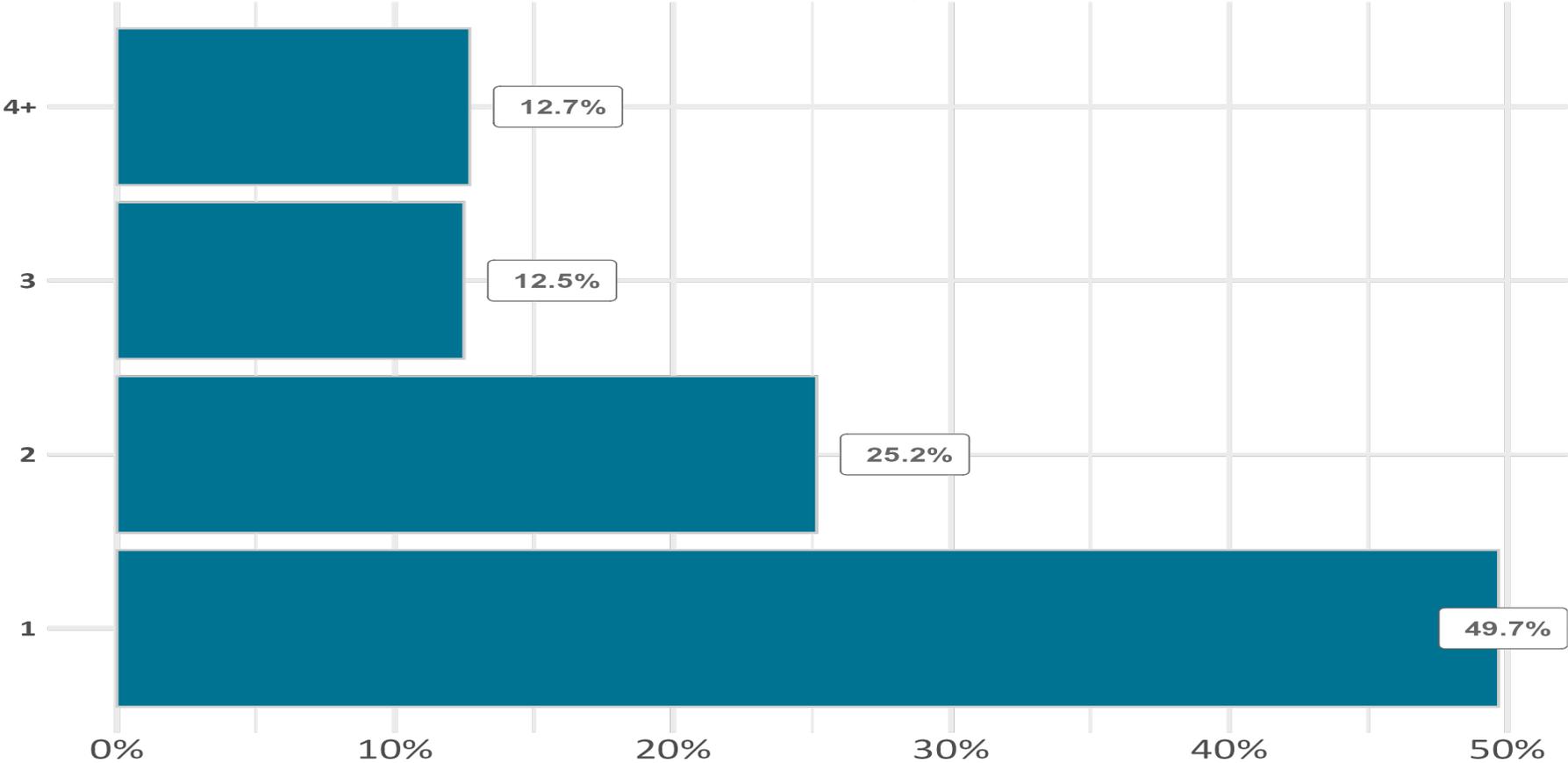
Total Length of Stay Distribution within Placement Episodes by Starting Placement for State Supervised Youth, 2015-2018



- Median LOS in a single MDHHS placement 2019 = 461 days
- Median LOS in a single CCI placement 2019 = 164 days
- LOS for county placements in a single placement appear to be similar

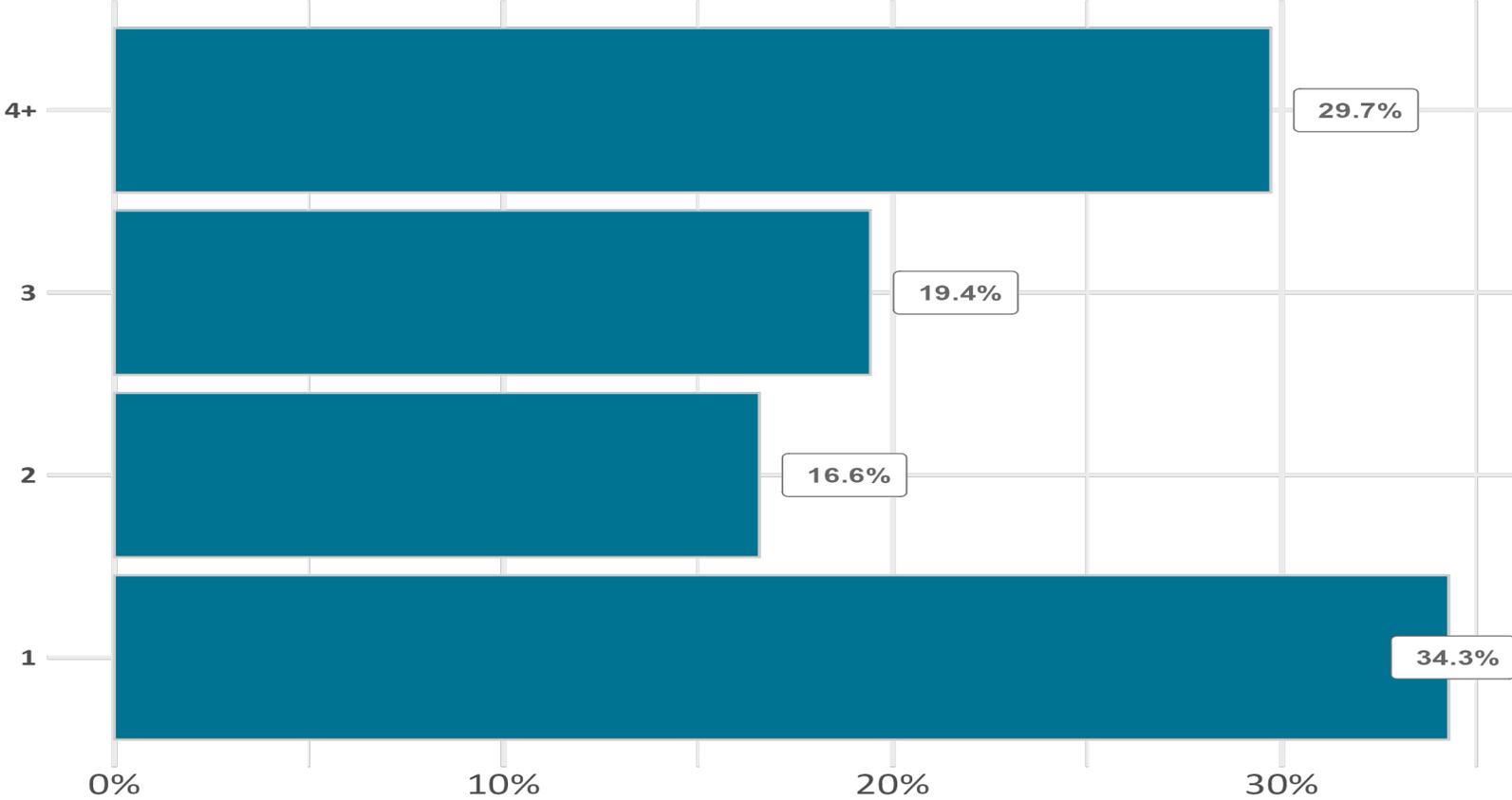
Total time under state supervision can be extensive in part because over half of these youth experience multiple residential placements.

Distribution of Individual Placements within a Placement Episode, State Juvenile Justice Wards Only, 2015-2018



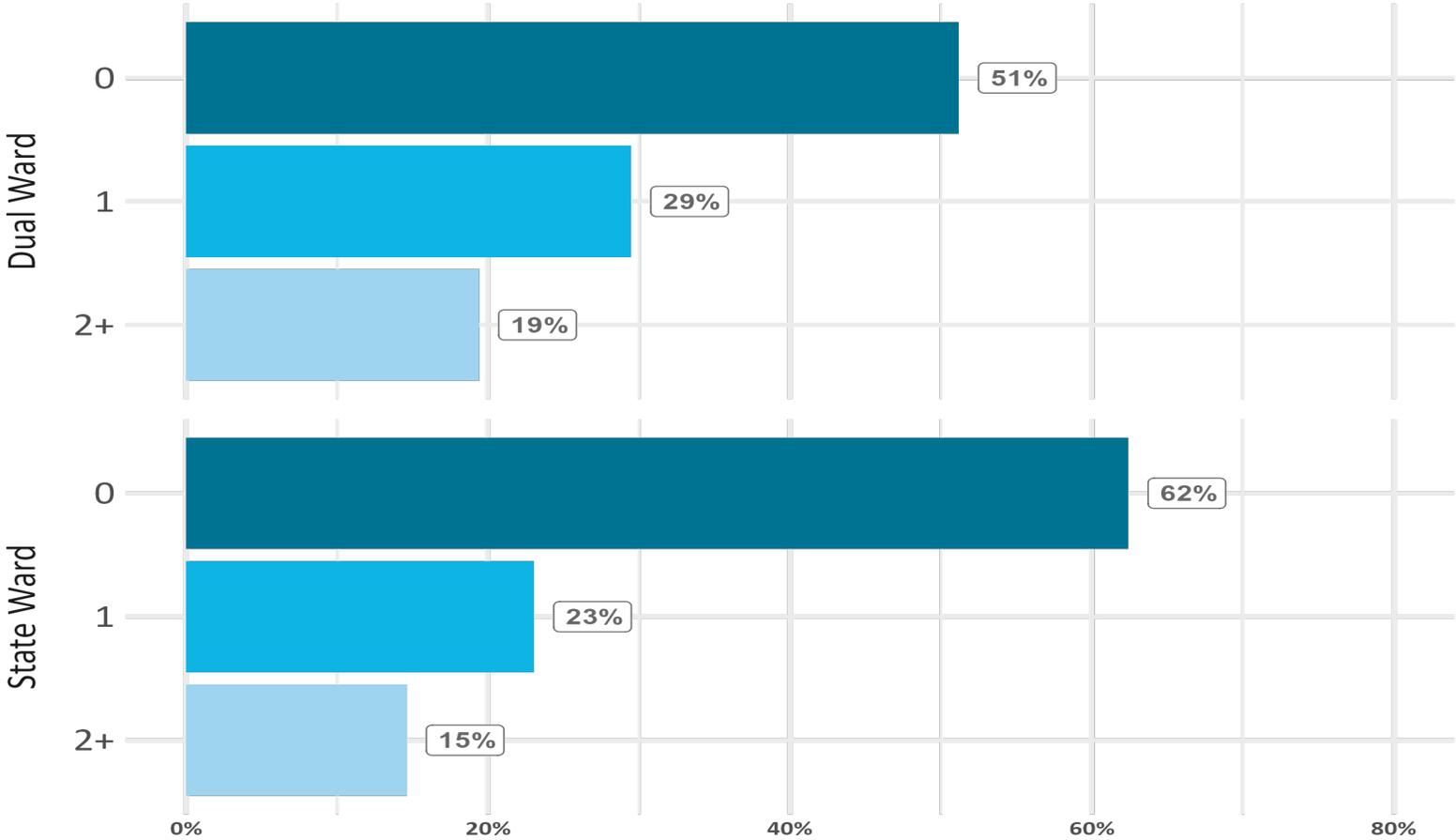
Over 16 percent of all state supervised youth are dual wards, and almost half experience three or more residential placements.

Distribution of Individual Placements within a Placement Episode, Dual Wards Only, 2015-2018



Almost 40 percent of state supervised juvenile justice youth and 50 percent of dual wards had a prior state supervision experience.

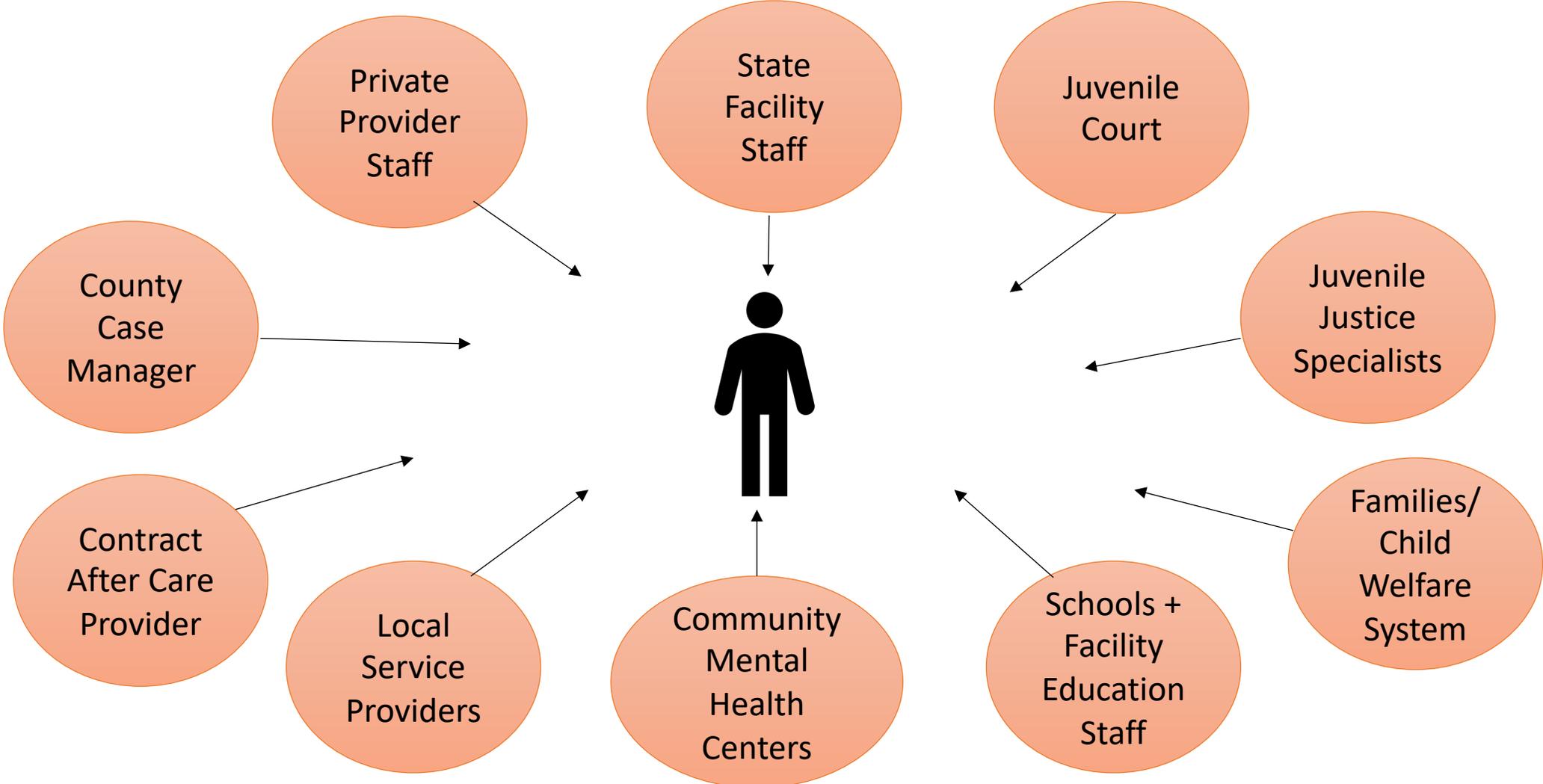
Prior State Supervision Episodes, State Juvenile Justice Only and Dual Wards, 2015-2020



Key Finding #7:

Reentry planning and successful reintegration is complicated by limited formal policies or structures for collaboration.

Reentry planning and services can involve multiple entities with varying coordination and no formal, system-level structures for collaboration.



State staff in particular struggle to identify appropriate reentry services and with their supervision role.

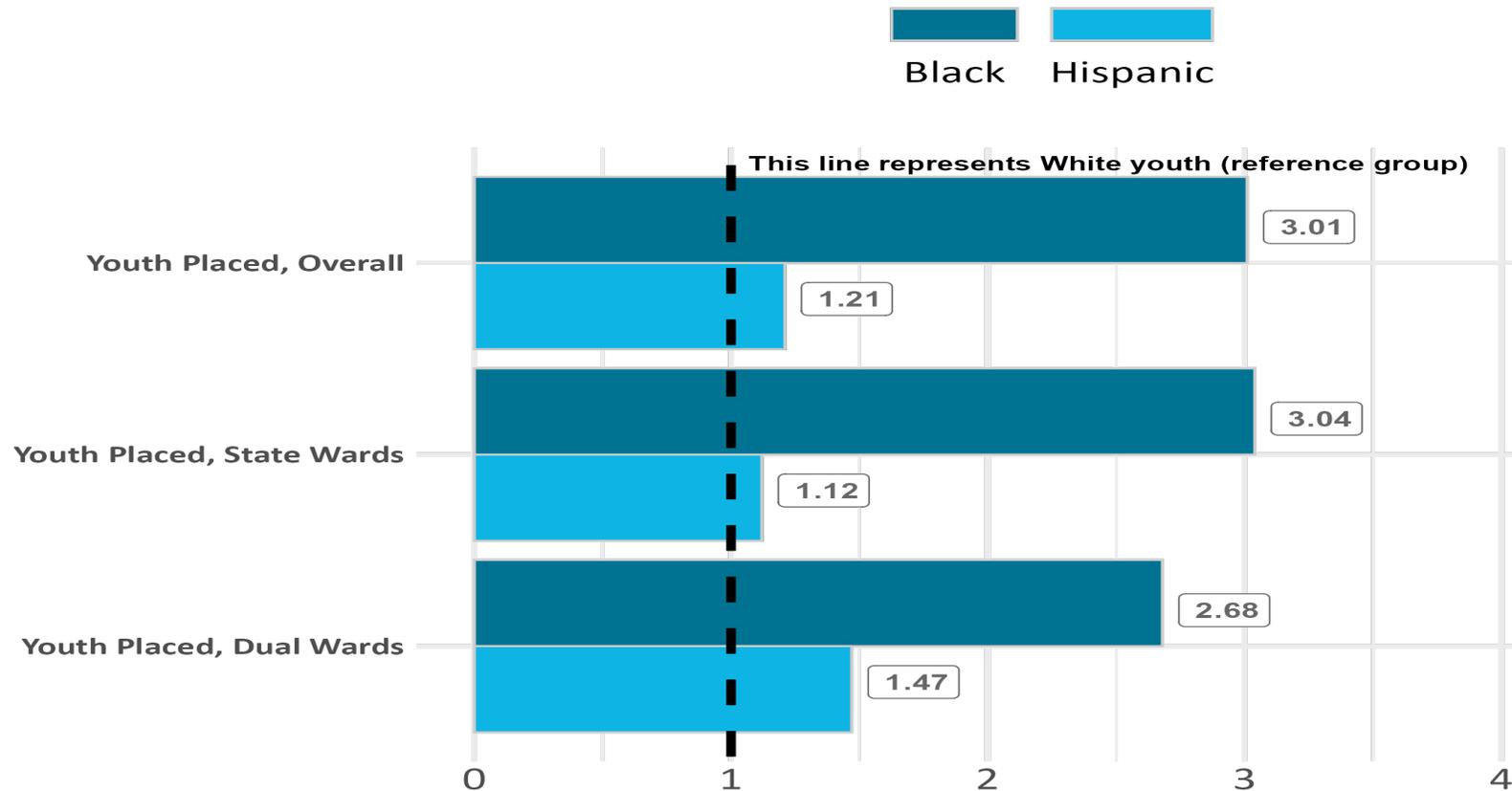
- State and county staff cite a dearth of reentry services, especially for older youth, including behavioral health services, independent living programs, and programs for youth who commit sex offenses.
- Juvenile Justice Specialists are left largely on their own to identify these services, with most programs/training/initiatives focused on the child welfare population.
- Delays/confusion over how to reinstate Medicaid can hinder a continuity of care.
- There are limited if any state policies governing post-placement supervision, including length of time, use of graduated responses/incentives, and revocation criteria/protocols.
- Juvenile Justice Specialists receive minimal training or support for their supervision/public safety role, which is far outside the norm from their responsibilities on child welfare cases.

Key Finding #8:

Youth of color are disproportionately likely to be placed out of home, and there is limited attention statewide to ensuring the residential system is equipped to serve them effectively.

Black youth are placed at three times the rate as state supervised White youth.

Relative Rate Index Disparities for State Supervised Youth Episodes, 2015-2020

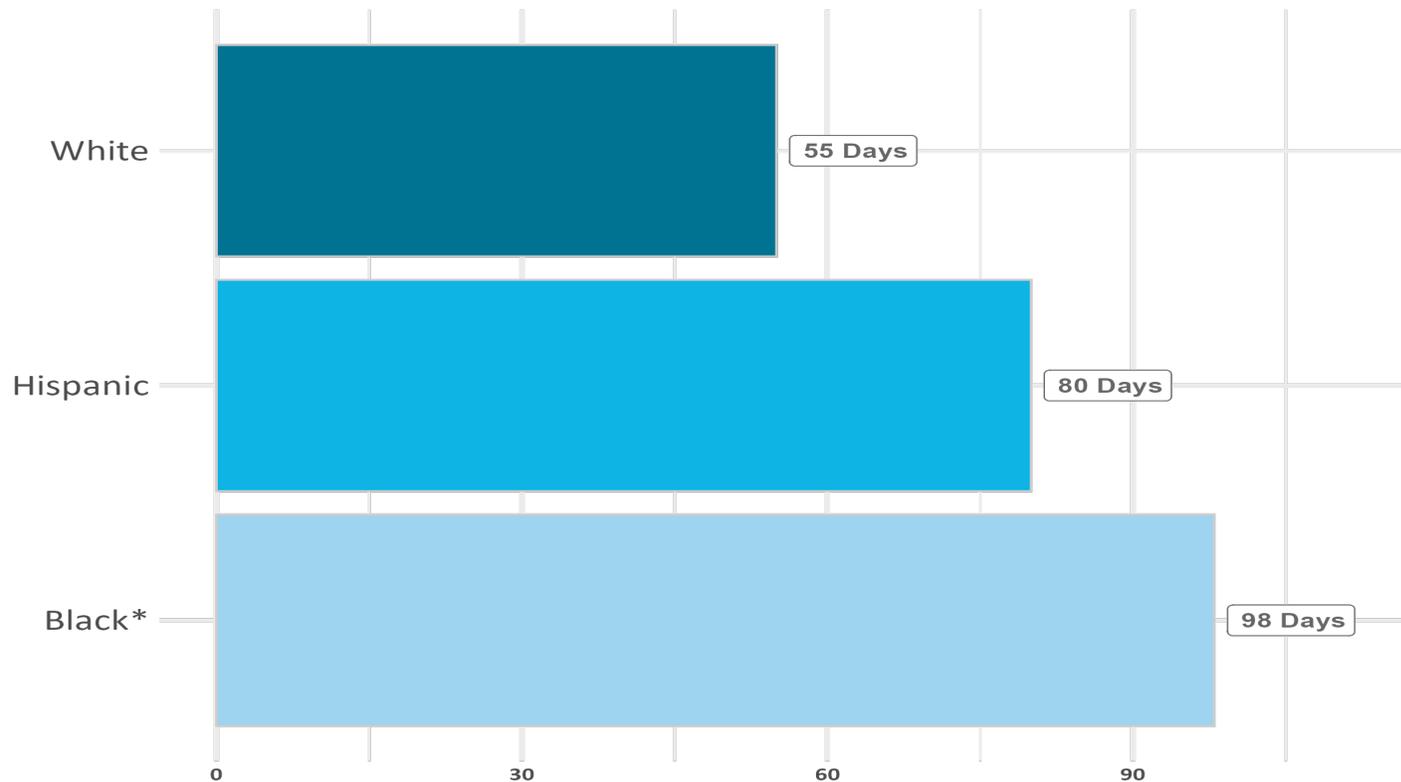


➤ The county placement population sample is small but suggests an even higher RRI for Black youth (4.7).

➤ The Native American population was too small for RRI analysis but focus groups raised significant concerns in this regard.

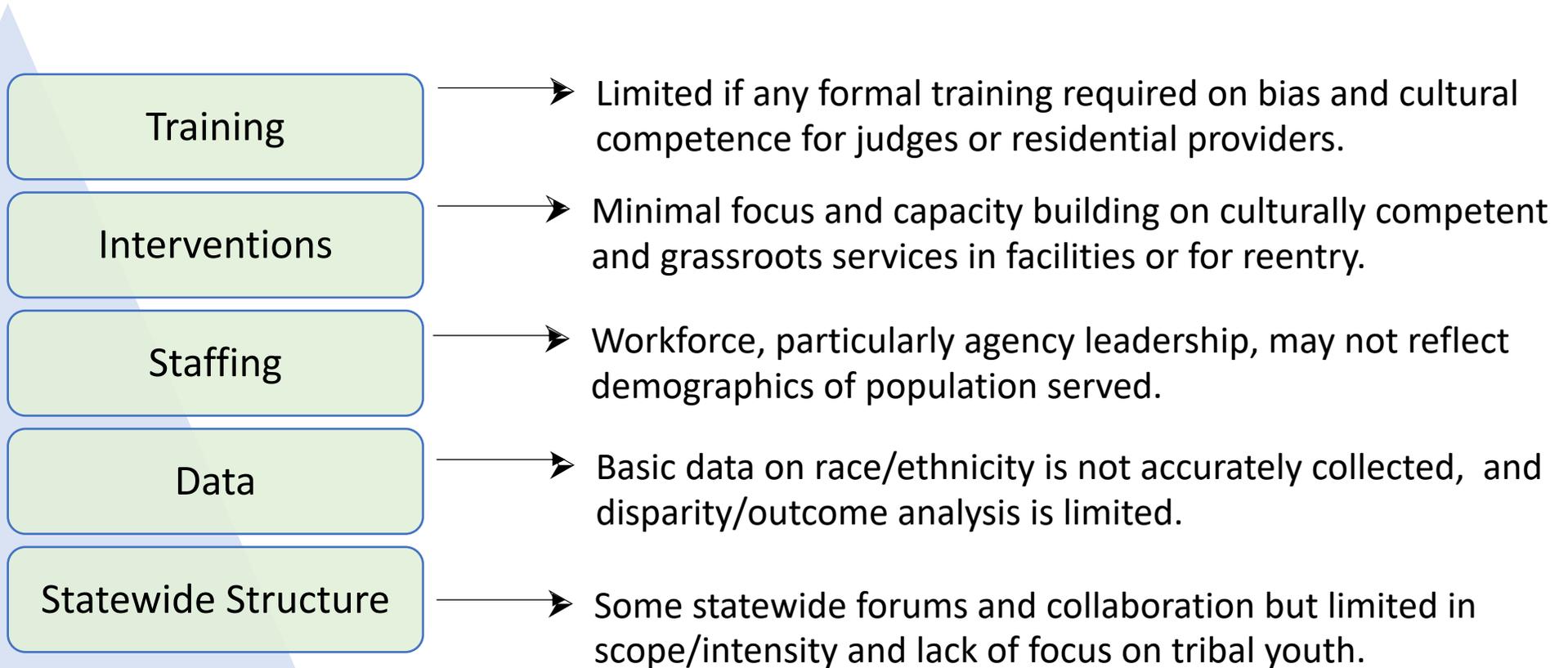
As part of their state supervision experience, Black youth spend significantly more days in detention than White youth.

Length of Stay for State Supervised Youth in a Detention Facility by Race/Ethnicity, 2015-2018



Race/Ethnicity differences in length of stay in CCI and state facilities were not found to be statistically significant.

Michigan has given limited attention to reducing residential disparities and improving residential outcomes for youth of color/tribal youth.



Key Finding #9:

Michigan lacks a dedicated system of quality assurance, data collection, and continuous quality improvement specifically for juvenile justice residential providers.

Quality assurance processes are limited and are not tailored to juvenile justice research/best practices.

Licensing

- x No specific licensing standards for QRTPs serving justice-involved youth.
- x Review staff lack experience/expertise/training in juvenile justice.
- x Licensing reviews examine case files for state wards, but not county wards.
- x Providers experience reviews as cumbersome, arbitrary, and punitive.

Risk Assessments

- x Outside of one-time training, no system for fidelity monitoring or support.
- x No review/analysis of risk/need data and case plan/service alignment.

Service Delivery

- x No evaluation of residential service matching, dosage, or fidelity.
- x No dedicated structure for program development, staff training, and TA.
- x Lack of accountability/measures for family engagement, trauma informed care, and developmentally appropriate approaches.

Data is unavailable or unreliable to answer basic and critical questions about the residential system and guide system decisions and improvement.

- How many youth are placed annually? How many are placed at a point in time?
- How do placement rates vary across counties, and how do these rates align with the goal of reserving placement for only those youth who are a risk to public safety?
- What is the race/ethnicity of youth in placement and what drives placement disparities?
- Do youth receive services in placement matched to their needs? At what dosage? Are these services completed successfully?
- How do lengths of stay differ across counties/facilities, what drives these lengths of stay, and do shorter/longer lengths of stay lead to better/worse outcomes?
- What is the incident rate in facilities and how does this vary by facility/youth demographics?
- What are the recidivism rates for youth in residential placement? Revocation Rates? Education/Vocational Outcomes? How do these outcomes differ by locale, facility, population, and facility/reentry services? Are resources used efficiently to improve public safety and youth outcomes?



Potential Opportunities for System Reform and System Transformation

Potential Opportunities for System Reform and Transformation

- ❖ Ensure out-of-home placement is used statewide only for youth that are a risk to public safety and/or have intensive service needs that can't be addressed through a robust system of community alternatives.
- ❖ Establish a more centralized, coordinated approach/policies to residential bed planning, procurement and contracting, lengths of stay, and bed utilization, including potentially rethinking the current bi-furcation of wardship.
- ❖ Ensure all youth benefit from a similar set of research-based assessment, placement process, service, case management, family engagement, and reentry policies and practices.
- ❖ Develop statewide capacity to support the implementation of evidence-based programs and approaches in facilities, including program development, training, quality assurance, technical assistance, and evaluation.
- ❖ Develop a comprehensive strategy to reduce residential disparities in the use of facilities and improve residential outcomes for youth of color, including potentially training, community investment, funding incentives, and ongoing data analysis.
- ❖ Invest in a dedicated system of training, capacity building, and quality assurance tailored to juvenile justice (as opposed to child welfare), including rethinking facility standards/monitoring, staff training, the role/structure of the Juvenile Justice Division and Juvenile Justice Specialists, service quality assessments, data collection, and provider/DHHS collaboration.
- ❖ Establish the statewide data infrastructure necessary to describe, track, evaluate, and improve the residential system.

Next Steps

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1. Share presentation and key findings with other key stakeholders.
2. Convene initial meetings of all the working groups and begin discussing options for system reform/transformation inside and outside of the working groups.
3. Host Taskforce listening sessions with youth and families in March.
4. Next abbreviated taskforce meeting on March 21 at 1:30pm.
5. “Front End” system findings Taskforce meeting tentatively scheduled for April 5.