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RESEARCH

Mental Health Services for Justice-Involved Youth

A Process and Outcome Evaluation of QUEST Futures

By Kelli Henry

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Mental Health Services for Justice-Involved Youth:
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Executive Summary

QUEST Futures began operations in October 2008 as a demonstration project designed to meet the mental health needs of justice-involved youth in Queens, New York. The program was established by the Center for Court Innovation in collaboration with the New York City Office of the Criminal Justice Coordinator, the Queens Family Court, the New York City Departments of Probation and Health and Mental Hygiene, and other juvenile justice and mental health stakeholders.

Researchers from the Center for Court Innovation conducted an evaluation covering the program's planning process, which began in 2003, and its first 24 months of operations, from October 2008 through September 2010. The evaluation was designed to assess the planning process; describe key features of the program's model; and present six in-depth case studies as well as quantitative data on participant characteristics and outcomes.

I. Planning

The planners of QUEST Futures were successful in reaching out to the juvenile justice, mental health, and substance abuse treatment communities. These communities agreed on the need for a new mental health program for justice-involved youth. During the lengthy planning process (2003-2008), stakeholders wrestled with several challenging issues:

- Program Goals: Planners decided that the overarching goal of the program was to reduce recidivism by young people with mental illness in the juvenile justice system. This goal would be achieved by (a) focusing primarily on youths in the early stages of delinquency proceedings (prior to adjudication); (b) increasing the capacity and willingness of the juvenile justice system to link these youths to services in lieu of confinement; and (c) engaging youths and their families in effective community-based mental health services.

- Target Population: The program model focused on moderate-risk youths whose court cases were in the *pre-adjudication* stage. Planners hoped that successful service engagement in the pre-adjudication stage might increase the likelihood of a final case disposition that did not involve residential placement.

- Scope and Location of Services: Planners decided that the program would provide only assessment and case management services on-site, in addition to select psychoeducational groups for youth and support groups for parents. For more intensive treatment, QUEST Futures would link youths and their families to preexisting community-based providers in Queens.

- Program Staffing: Planners decided that QUEST Futures would share office space and staff with QUEST ATD (a preexisting alternative-to-detention program operated by the Center for Court Innovation in Queens) and that both programs would operate under a single administrative structure.

- Universal Assessment: Having linked QUEST Futures and QUEST ATD under one structure, planners implemented a protocol for universal screening of all QUEST ATD youths for mental health issues, utilizing a formal tool known as the Diagnostic Predictive Scales (DPS) and, where indicated, a follow-up clinical assessment by QUEST staff.

- Information-Sharing: QUEST Futures provides mental health information about youths to family court judges and attorneys. Due to the sensitive nature of this information and the vulnerability of the population, program planners implemented strict information-sharing protocols, balancing concerns about privacy against public safety concerns.

II. Implementation

QUEST Futures opened in October 2008. Over the ensuing months, QUEST Futures implemented procedures to receive referrals from QUEST ATD, Queens Family Court judges, the Department of Probation, attorneys, and parents.

- Screening: QUEST Futures screened a total of 399 cases during its first two years (October 2008-September 2010), of which 86% came via the universal QUEST ATD screening protocol, and 14% came from other referral sources.

- Participant Volume: QUEST Futures enrolled 138 program participants in its first two years. Volume was slightly lower than the projections of 80-90 participants per year. Of the 138 participants, 95% enrolled in the pre-adjudication stage, and the remaining 5% enrolled after a final case disposition that involved a sentence to probation.

- Mandated/Voluntary Status: The majority of the 138 participants (70%) were enrolled voluntarily, not by judicial mandate. In the planning stages, however, it had been expected that most participants would be mandated to QUEST Futures.

III. Participant Profile

- Demographics: The 138 participants enrolled in the first two years ranged in age at intake from nine to 17 years, with 86% aged 14, 15, or 16. Most youths identified themselves as “black” (54%) or “Hispanic” (34%).

- Cross-System Involvement: Almost one-third (31%) of participants were at some point involved in a case involving the Administration for Children’s Services (suggesting a case related to child abuse or neglect).

- Mental Health History: The majority of participants (58%) self-reported a history of mental illness, 19% reported a previous psychiatric hospitalization, and one-quarter reported receiving treatment for a mental health issue at the time of intake. Nearly four in 10 (39%) reported they were in a special education program. Males reported special education involvement more than three times as often as females (48% vs. 14%).

- Current Diagnosis: The primary clinical issue as determined at assessment was attention deficit/hyperactivity disorder (21%); followed by depression (19%), with significantly more females receiving a depression diagnosis than males (33% vs. 14%). Other common diagnoses included bipolar disorder (16%); adjustment disorder (14%), with many more males receiving an adjustment disorder diagnosis than females (18% vs. 3%); and borderline intellectual functioning (9%).

- Juvenile Delinquency Charges: The underlying arrest charge was most often assault (24%), followed by robbery (20%), and larceny (15%). Forty-five percent of participants were arrested on a felony (45%) and 29% were arrested on a violent felony charge.

IV. Service Linkages

At the outset, staff most often referred participants to outpatient mental health services (72%), although residential treatment was recommended for some (14%). Nearly one-fifth received a Committee on Special Education (CSE) evaluation (19%). The number of initial service referrals ranged from one to five for each participant. It was common for participants to receive subsequent referrals throughout their participation, in response to emerging needs. These needs were explored in a series of six case studies, which revealed the following themes:

- Multiple Needs: Participating youths and their families face many challenges, including: (1) family dysfunction and conflict; (2) family involvement in crime, drug abuse, mental illness, and domestic violence; (3) family resistance to some or all services; (4) youth noncompliance with appointments; (5) problems in school; and (6) child welfare system involvement.

- Complex Treatment Plans: Staff deemed one-size-fits-all treatment plans to be inappropriate. Most youths received individualized plans involving multiple referrals, spanning individual and family therapy, crisis intervention, hospital-based services, substance abuse treatment, special educational placements, and wrap-around referrals for family members.

- Modifications to Initial Treatment Plans: QUEST Futures staff often made numerous attempts at finding appropriate services and providers for the participants; initial treatment plans were often significantly revised.

- Educational Needs: QUEST Futures staff frequently addressed educational issues, including undiagnosed learning disabilities and chronic truancy. Collaboration with Department of Education (DOE) officials, and knowledge of DOE policies, was essential in many cases.

- Family Engagement: QUEST Futures routinely encountered severe family dysfunction, necessitating intensive work to gain family member “buy-in.”

V. Program Outcomes

- Reasons for Case Closure: Of the youths who enrolled at the pre-adjudication stage (95%), 50% had their QUEST Futures case closed due to a parent request, 42% had their case closed because their court case closed or probation ended, and the remaining 3% had their case closed for miscellaneous other reasons. Of the youths who enrolled at the post-adjudication stage (5%), 1% had their case closed due to a parent request, 3% had their case closed because their court case closed or probation ended, and 1% had their case closed for miscellaneous other reasons.

- Juvenile Delinquency Case Outcomes: Of those participants with closed family court cases for which such data were available (N = 91), the final dispositions were as follows: probation (58%), institutional placement (22%), case dismissal (14%), and adjournment in contemplation of dismissal (6%).

- Re-arrests: Of the 138 participants, 28 (20%) were re-arrested. The median time to re-arrest was exactly two months, indicating that half of those re-arrested were re-arrested relatively soon after their participation began. (A separate impact evaluation to be released in early 2013 will compare these re-arrest outcomes to a matched quasi-experimental comparison group.)

- Youth and Family Functioning: For each participant, staff completed a standardized instrument that measures multiple areas of psychological functioning—the Child and Adolescent Needs and Strengths (CANS) assessment—at baseline, three-months, one-year, and case closing. From baseline to case closing, the scores on 25 of the 38 items (with each item measuring a different area of functioning) demonstrated an improvement over time. Among the areas that concern only the youth, and not family members, 20 of 27 demonstrated improvement. The areas showing improvement include: school behavior, school achievement, school attendance, family strengths, interpersonal strengths, optimism, educational strengths, delinquency, and judgment.

CHAPTER I: INTRODUCTION

Across the United States, young people who are involved in the juvenile justice system display far higher rates of mental health problems than the general population. Whereas approximately 21% of all children and adolescents have a diagnosable mental health disorder (Shaffer et al. 2010), among those who are involved in the juvenile justice system, approximately 65-70% have at least one disorder (Shufelt and Cocozza 2006; Teplin et al. 2002; Wasserman et al. 2002). Justice-involved youths are also more likely than the general youth population to be diagnosed with anxiety (34%) or a mood disorder such as depression (18%). Furthermore, according to a multi-state prevalence study, among justice-involved youths with at least one mental health disorder, 79% were diagnosed with two or more and 60% with three or more disorders (Shufelt and Cocozza 2006). In New York City, these prevalence rates are reflected in a recent report issued by the Administration for Children's Services, which concluded that 44% of nearly 5,400 youths who were housed in detention received in-care mental health services in 2010 (City of New York 2011).

Despite compelling evidence that a sizable proportion of youths involved in delinquency proceedings might benefit from specialized mental health treatment, these types of programs are relatively new (National Center for Mental Health and Juvenile Justice, 2005). Indeed, before, judges in New York City had few options in delinquency cases where there was concern relating to mental health; there were insufficient resources for assessment, treatment planning, or assisting with referrals to community-based services. Youths sent to a juvenile detention facility or, as the final case disposition, to placement in a confinement or treatment facility, would be screened for mental health issues and receive a full assessment if necessary. However, upon discharge, there was no system in place to convey relevant mental health information about the youth to the family, the court, or other justice agencies. This lack of information sharing undermined the family's and the system's capacity to sustain the youth's treatment services in the community. In turn, this lack of sustained treatment set up many juveniles to re-offend soon after leaving detention or placement (Wasserman et al. 2010).

An effort to provide judges with additional options for deciding cases involving youths with mental illnesses, Queens Engagement Strategies for Teens (QUEST) Futures works with young people who have a diagnosed mental health disorder beginning as early as possible in the delinquency process and continuing as long as they have an open delinquency case or are on probation. The program was established by the Center for Court Innovation in 2008, in collaboration with the New York City Office of the Criminal Justice Coordinator, the Queens Family Court, the New York City Department of Health and Mental Hygiene, the New York City Department of Probation, and other juvenile justice and mental health stakeholders. QUEST Futures is the first of its kind in New York State. The QUEST Futures clinical team serves as a resource to families and as a bridge between the juvenile justice and mental health systems, providing screening, assessments, treatment planning, service coordination, case management and supervision.

The overarching goal of QUEST Futures is to reduce repeat offending by participants. The program seeks to achieve this goal by:

1. Focusing on youths in the early stages of their delinquency proceedings, primarily those who are at a "moderate" risk of detention;
2. Increasing the capacity and willingness of the juvenile justice system to link these youths to community-based treatment; and
3. Engaging both the youths and their families in an effective array of community-based services that will improve their functioning.

QUEST Futures is a component of a larger program known as Queens Engagement Strategies for Teens (QUEST). QUEST started in June 2007 as an alternative-to-detention (ATD) program for youths with pending juvenile delinquency cases in the Queens Family Court who were determined to be at moderate risk of re-offending or failing to appear in court. QUEST Futures began more than a year later in October 2008. The two programs, QUEST ATD and QUEST Futures, operate under a single organizational and staffing structure. (The same staff members may perform roles for both programs as deemed appropriate.) QUEST Futures solely targets justice-involved youths who have a diagnosable mental health disorder. Initially, QUEST ATD was the sole referral source for QUEST Futures. Subsequently, judges, probation officers, attorneys and parents/guardians began referring youth to QUEST Futures. In June 2010, QUEST Futures also began accepting alternative-to-placement cases: i.e., cases that are *not* in an early stage of court proceedings but have reached a final disposition of probation in lieu of upstate residential placement.

This report presents a process and outcome evaluation of QUEST Futures' first 24 months of operations, from October 2008 through September 2010. The report documents the planning and implementation process and provides a blueprint for other jurisdictions considering a mental health program for justice-involved youths. The evaluation highlights the program referral and eligibility determination process; participant characteristics, program retention, recidivism, and court outcomes; and changes in psycho-social functioning over time. The evaluation is based on interviews with stakeholders, attendance at team meetings, and analysis of quantitative data. In 2013, an impact evaluation will be completed that will compare re-arrests, days in detention, and other outcomes between QUEST Futures participants and comparable youths whose delinquency cases were handled either in Queens before QUEST Futures opened or in the nearby New York City boroughs of Brooklyn or Staten Island during a period that coincides with QUEST Futures operations.

The report is organized as follows:

Chapter I: Provides a brief introduction to QUEST Futures.

Chapter II: Describes the research methodologies used in the process and outcome evaluations.

Chapter III: Presents the final QUEST Futures program model.

Chapter IV: Describes the planning process, including a timeline of key events that gave shape to QUEST Futures and its target population.

Chapter V: Describes the process of implementation, including the phasing in of referral sources.

Chapter VI: Describes the background characteristics of QUEST Futures participants, such as their age, gender, race/ethnicity, underlying arrest charge and primary clinical diagnosis.

Chapter VII: Presents and analyzes six in-depth case studies, selected purposefully to illustrate the complex and multiple needs of QUEST Futures participants; common youth and family services; and challenges to service utilization.

Chapter VIII: Analyzes program outcomes as regards both the legal outcomes of participant court cases and outcomes related to youth and family functioning.

CHAPTER II: METHODOLOGY

This report includes both a process and outcome evaluation. The process evaluation documents the program planning process and the extent to which the implementation of QUEST Futures remained faithful to its original goals and objectives. The outcome evaluation presents a baseline profile of QUEST Futures participants, including information on demographics, mental health history, underlying arrest charges, and primary clinical issues. The outcome evaluation also presents information on the duration of program participation, reasons for case closing, and changes in psychosocial functioning from baseline to case closing. This chapter presents information on the sampling frame and data sources.

Sampling Frame

For this evaluation, participants were selected based on their enrollment in QUEST Futures during its first 24 months of operations, from October 1, 2008 through September 30, 2010. All participants had a mental health disorder, had a juvenile delinquency case in the Queens Family Court, and resided in Queens, New York (see Chapter III for details on program eligibility). Participants were ages 9 to 15 years old at the time of the instant case arrest and included males and females as well as voluntary and mandated enrollees. Participants were referred to QUEST Futures from a range of sources, including probation officers, attorneys, and judges. Most came from the alternative-to-detention program, QUEST ATD. The total number of youths enrolled during the evaluation period (October 1, 2008 through September 30, 2010) was 138.

Data Sources

Quantitative data
QUEST Futures staff collected much of the quantitative data used in this evaluation.

A. QUEST Futures Spreadsheets. QUEST Futures staff created various customized spreadsheets in Microsoft Excel to track information on referrals, participant background characteristics, and program participation. Specific data elements are listed below.

- Case-level: program start date; referral source; voluntary/mandated at program entry; age at intake; sex; race/ethnicity; primary clinical diagnosis; known history of mental illness at intake; whether in mental health treatment at intake; whether in special education at intake; use of drugs/alcohol; underlying arrest charge; program close date; program close reason; and length of time in program.

- Aggregated by month: referral source, as well as the number of: referrals, screenings (using the Diagnostic Predictive Scales (DPS), see Chapter III for details), DPS flags, in-depth biopsychosocial assessments, pre-adjudication cases and post-disposition cases, new cases, closed cases, active cases, and inactive cases.

B. Justice Center Application (JCA). The Justice Center Application is a database that facilitates tracking of referrals, program enrollment, and case management notes. The JCA is used by all of the ATD programs in New York City as a data capture tool. The JCA was customized for

QUEST Futures to record additional information such as: referral source; participation start date; status of the family court case at time of referral; whether the youth is participating on a mandated or voluntary basis; the youth's demographics (age, sex, race); the youth's national origin; the primary language spoken at home; the youth's education level; Administration for Children's Services (ACS) involvement; physical and mental health history; drug use; primary and secondary presenting issues; mental health service needs; other services the youth and other family members are receiving; medical insurance; and family living arrangement. As this list makes clear, there is overlap between the data collected in the QUEST Futures case-level spreadsheet and the JCA. This report uses data from both sources; where there is overlap, the evaluator exercised judgment concerning which was the more complete or reliable source of information.

C. Child & Adolescent Needs & Strengths (CANS). The CANS is a comprehensive assessment of psychological and social factors for use in treatment planning. Research has demonstrated that the CANS has acceptable levels of reliability and validity (Anderson, et al., 2003). The target population for the CANS is children and adolescents with mental, emotional, or behavioral problems. The instrument is not administered directly to the youths. Rather, its questions are intended to be completed by mental health professionals based upon their assessments across a range of domains. The QUEST Futures case managers assessed participants using the CANS at baseline, 3 months, 12 months, and case closing (which may either have preceded or followed the 3-month or 12-month assessment) on 39 measures including life domain functioning, child strengths, acculturation, caregiver needs and strengths, and child risk behaviors (see instrument in Appendix A). QUEST Futures case managers entered their assessments into an Excel spreadsheet. The CANS data was analyzed using analysis of variance (ANOVA) methods to document trends in youth and family functioning.

Qualitative data

The following sources of qualitative data were used for this process evaluation.

A. Stakeholder Interviews. There were two rounds of stakeholder interviews. In the first round, five key stakeholders were interviewed. These interviews took place in the summer of 2009 (about nine months after QUEST Futures opened) and included individuals who had been involved in the planning process. About one year later, in the summer and fall of 2010, a second round of interviews was conducted with six stakeholders. These interviews included individuals who had been involved in the planning of QUEST Futures. A different set of stakeholders was interviewed in the second round because the political and administrative environment in New York City had changed dramatically in the interim, making it useful to understand the perspectives of those in key policymaking roles (see Chapter IV below). Stakeholder interviews were used to document the planning process as well as to measure the fidelity of program implementation. Across the 11 total interviews, the following agencies were represented:

- Office of the New York City Mayor's Criminal Justice Coordinator (1)
- New York City Department of Probation (2)
- New York City Department of Health and Mental Hygiene (1)
- Queens Family Court (2)
- New York City Law Department (prosecutorial agency in juvenile delinquency cases) (2)

- New York City Health and Hospitals Corporation (1)
- Legal Aid Society (2)

In addition to these formal interviews, ongoing exchanges were held with key planning and operations staff at the Center for Court Innovation to gain their perceptions of key operational decisions and challenges.

B. QUEST Meetings. In mid-2007, Center for Court Innovation (CCI) staff began to hold regular QUEST Futures planning meetings approximately every three to four weeks. Once QUEST Futures launched in October 2008, these meetings continued, transformed from planning to operational meetings. The principal investigator attended, took notes, and collected the agenda of a significant subset of the planning meetings held from March 2008 until October 2008, and the subsequent operational meetings held throughout the evaluation period (October 2008 through September 2010). These notes, observations, and agendas provided documentation of some of the planning and operational issues discussed by senior QUEST staff.

C. Program Observation. The principal investigator observed court proceedings for youths mandated to QUEST ATD as well as the subsequent intake process twice during the evaluation period. The principal investigator also observed the initial meeting of a youth and family with QUEST Futures staff after the youth was mandated to a QUEST Futures assessment.

D. Program Documents. Document review included memoranda of understanding, information-sharing protocols, the QUEST Policy and Procedures Manual, meeting agendas, and clinical case files. The documents reviewed also included quarterly reports on screenings, referrals, assessments, enrollments, participant profiles, treatments plans, service linkages, community-based services, compliance, case outcomes, and other topics. Program staff produced these reports from January 2009 through June 2010.

CHAPTER III: PROGRAM MODEL

This chapter describes the final QUEST Futures operational model. (Please see Appendix B for the program's official logic model.) Subsequent chapters explore how this model emerged and evolved during the planning process (Chapter IV) and early implementation (Chapter V). This chapter covers the following topics:

- Policy context: alternative-to-detention and alternative-to-placement programs in New York City
- QUEST management structure, staffing and stakeholders
- Eligibility criteria
- Referral sources and procedures
- Intake procedures
- Assessment, development of treatment plans and formal program entry
- Program elements
- Requirements and expectations for program participants
- Monitoring of program participation and compliance
- Responses to non-compliance
- Program exit and follow-up

Policy Context: Alternatives to Detention and Placement in New York City

The Alternative-To-Detention Continuum in New York City

Early in 2006, the New York City Department of Probation shut down the only program that provided an alternative to detention while a juvenile delinquency case was pending. The closure of this program created a clamor among various stakeholder groups and raised concerns about reduced decision-making options for judges and the potential for increased use of detention. In response, the Mayor's Office of the Criminal Justice Coordinator (CJC) initiated two types of reforms. First, with assistance from the Vera Institute of Justice, the CJC developed and implemented a Risk Assessment Instrument (RAI) that measures a youth's risk of re-arrest and failure to appear in court while a case is pending (see Appendix C for the RAI instrument). The instrument, administered by the Department of Probation at intake (immediately after arrest), classifies youth as high-risk (appropriate for detention), moderate-risk (appropriate for release *with supervision*), or low-risk (appropriate for unsupervised release). Second, the CJC conceptualized and funded a new continuum of community-based alternative-to-detention (ATD) programs, intended primarily for those youths classified by the RAI as posing a moderate risk.

Exhibit 3.1, adapted from the CJC's graphic depiction of the ATD continuum, displays and briefly describes the continuum of possible responses while a delinquency case is pending. They are, in ascending order of restrictiveness:

- Unsupervised release with court appearance notification and family outreach
- ATD Tier 1: Community Monitoring
- ATD Tier 2: After-School Supervision
- ATD Tier 3: Intensive Community Monitoring (ICM)
- Non-Secure Detention
- Secure Detention.

Based on the RAI score, combined with the exercise of judicial discretion, a family court judge can mandate a youth to one of the above responses. Each of the five boroughs of New York City—the Bronx, Brooklyn, Manhattan, Queens, and Staten Island—have separate ATD programs serving Tier 1 and Tier 2 youth. The Center for Court Innovation runs the ATD programs in both Queens and Staten Island. QUEST ATD serves Tier 1 and Tier 2 youth in the borough of Queens. QUEST ATD was launched in June 2007, the first of the five nonprofit-run programs to open.

Exhibit 3.1
Continuum of Alternative-to-Detention Options in New York City

←Youth may move up or down the continuum based on their performance →					
Low Risk	Moderate-Risk			High Risk	
Unsupervised Release	Tier 1: Community Monitoring	Tier 2: After-School Supervision	Tier 3: Intensive Community Monitoring (ICM)	Non-Secure Detention	Secure Detention
Unsupervised release to the community, with court appearance notification and a family outreach meeting to explain the court process and the importance of appearing in court.	School attendance monitoring, curfew checks, and home check-ins.	Community-based after-school programs, onsite services, and service referrals.	Court-ordered programs, frequent curfew checks, home visits, phone check-ins, and a contract agreement with parent/guardian.	Structured residential care for youth with cases in Family Court.	Facilities serve both alleged JDs, and JOs and provide a level of security that ensures the juvenile's appearance in court and protects the community from re-offending.

Alternative-To-Placement Options in New York City
Utilization of an alternative-to-detention option (summarized above) occurs while a delinquency case is pending, whereas utilization of an alternative-to-placement (ATP) option arises *after* a finding of responsibility for a delinquent act. Although a youth found responsible for a delinquent act may face placement in a residential facility as the final case disposition, the court may decide on an alternative disposition, such as sentencing the youth to probation, conditional on compliance with ATP services.

For several years, the Department of Probation has operated two ATP programs that provide intensive community-based services and/or supervision for youth who are sentenced to probation. The *Esperanza* program, begun in 2003, is a four- to six-month program that offers in-home counseling from a field counselor, who works in a complementary fashion with the youth's probation officer. Esperanza's services are designed to help the youth and their family to communicate and solve problems using a variety of therapeutic approaches. *Enhanced Supervision Probation (ESP)*, begun in 2005, is a nine-month program targeting the most serious juvenile offenders. This program provides in-home supervision and services, including frequent contact with probation officers, unannounced home visits, and family engagement to identify problem areas affecting the youth. It is not therapeutic in nature but rather delivers additional monitoring.

More recently, in February 2007, the Administration for Children's Services launched the Juvenile Justice Initiative (JJI), a third program designed to serve as an alternative to placement. The JJI utilizes intensive services such as Family Functional Therapy (FFT) and Multisystemic Therapy (MST) and typically lasts for six months.

The QUEST Futures Team

QUEST Futures operates alongside and in tandem with QUEST ATD. The two programs share office space and staff. There is also considerable overlap in the participants they serve.

Over most of the two years covered by this process evaluation, QUEST Futures has utilized the following staff roles:

Director, Mental Health Court Programs, CCI. The CCI Director of Mental Health Court Programs oversees the development, implementation, and management of QUEST Futures, including the development of program protocols, training programs, and a short- and long-term strategic plan for the program. The Director, an attorney, is also responsible for managing senior-level relationships with project stakeholders from other agencies and for spearheading fundraising efforts for QUEST Futures.

Director, Implementation, CCI. The CCI Director of Implementation oversees QUEST ATD and a similar program in Staten Island. The Director is responsible for the development and implementation of QUEST ATD programmatic protocols, policies and procedures and oversees all grant management and administrative support for QUEST. The Director, a licensed clinical social worker, also provides clinical supervision to the QUEST Clinical Director and helps guide clinical program development. The Director also represents CCI in a host of city-wide ATD and juvenile justice reform working groups, advisory panels and committees.

Project Director, QUEST. QUEST's onsite Project Director has overall management and administrative responsibility for both QUEST ATD and QUEST Futures. The Project Director, an attorney, reports to both the Director of Mental Health Court Programs and the Director of Implementation.

Clinical Director, QUEST. The Clinical Director is responsible for all clinical aspects of QUEST, including conducting psychosocial evaluations, developing individualized treatment plans, monitoring outcomes for individual participants, and developing relationships with community-based service providers. The Clinical Director, a licensed clinical social worker, reports to the Project Director and receives clinical supervision from the Director of Implementation.

Case Managers. There are two Case Managers for QUEST Futures. They provide intake, assessment, case management, family outreach, psycho-educational groups and clinical coordination services to QUEST Futures participants and their families. They also prepare regular reports on participant progress for the Queens Family Court, Probation, and attorneys. Four individuals, all with masters' degrees in social work or psychology, have served as QUEST Futures Case Managers.

QUEST Social Worker. The QUEST Social Worker has primary responsibility for administering the Diagnostic Predictive Scales (DPS) to all QUEST ATD youth at intake, referring those who flag as having a possible mental health disorder to QUEST Futures for further assessment. This Social Worker also handles case management responsibilities for some of the participants in both the QUEST ATD and QUEST Futures programs. This position was eliminated in June 2010; subsequently, the related duties were largely subsumed under the Case Manager positions.

Youth Developers. There are two QUEST Youth Developers. They monitor curfew and school attendance for the QUEST ATD youth. The QUEST Futures program does not impose curfews, but if a QUEST Futures participant is also mandated to QUEST ATD, then a Youth Developer monitors their QUEST ATD mandated curfew and school attendance. In cases where the youth is not in the QUEST ATD program, QUEST Futures staff monitor school attendance, and, in post-adjudicated cases, curfew as well. Youth Developers facilitate onsite psychoeducational groups which are primarily for youth mandated to QUEST ATD Tier 2 but may be attended by QUEST Futures participants.

Court Liaison. The Court Liaison works with the family court judges to enroll eligible young people in the program, travels between the delinquency courtrooms to retrieve newly referred families, and provides the judges with timely reports on QUEST Futures participant compliance and progress. The liaison is also responsible for entering all data related to court appearances into the JCA database.

Psychiatric Consultant. QUEST Futures utilizes the services of a psychiatrist to conduct psychiatric evaluations of potential program participants who present with acute symptoms or present significant clinical challenges. The psychiatric consultant assists program staff in determining program eligibility, developing a thorough understanding of participants' mental health disorders, and creating appropriate individual treatment plans.

Other roles critical for the functioning of QUEST Futures:

Judges. There are three Queens Family Court judges who hear potential QUEST Futures cases and mandate youth either to the QUEST ATD program or, in some cases, directly to QUEST Futures for an assessment (see details below on referral sources and mechanisms).

Attorneys for the Children (also referred to as Law Guardians). Private attorneys and court-appointed attorneys for indigent respondents (from both The Legal Aid Society and an assigned counsel panel) may make referrals to QUEST Futures and may work with QUEST Futures staff to develop a fuller understanding of their client, the youth.

New York City Law Department. Attorneys from the NYC Law Department (the prosecutorial agency in juvenile delinquency cases) work with QUEST Futures staff, attorneys for the child, and judges to become better informed about the youth's mental health issues in their effort to ensure public safety.

New York City Department of Probation. Probation officers may work with youth at the pre-adjudication, disposition, and post-disposition stages of their cases. At the pre-adjudication stage, when a family court judge has mandated a youth to ICM, probation officers conduct mental health screens of these youth and refer them to QUEST Futures for an assessment by QUEST Futures staff if they are identified as having mental health issues.

At the disposition stage, a family court judge may order the probation department to conduct an investigation and report (I & R). Also at the disposition stage, probation officers may be ordered to conduct explorations of placement (EOP) of a youth. In these cases, QUEST Futures staff may provide information and recommendations, respectively.

At the post-disposition stage, the probation department may be responsible for general supervision or for monitoring those who were mandated by a judge to Enhanced Supervision Probation (ESP) or Esperanza.

If a youth was participating in QUEST Futures on a voluntary basis at the pre-adjudication stage of his/her case, then he or she may continue to participate in QUEST Futures on a voluntary basis after receiving a disposition of probation in the case. She or he may also be mandated to participate in QUEST Futures as a condition of probation.

Youths who are mandated by a family court judge to the Juvenile Justice Initiative (JJI) or Esperanza may be referred by the probation department or mandated by a family court judge to participate in QUEST Futures following their participation in these programs.

If a probation officer suspects that a youth who is on probation has a mental health issue, the probation officer may refer the youth to QUEST Futures to avoid filing specifications in family court.

Eligibility Criteria

Legal Eligibility

Participants are respondents in delinquency cases (maximum age at arrest, 15 years old) initiated in the Queens Family Court through a petition filed by the New York City Law Department. Most become participants early in delinquency proceedings, before their cases are adjudicated, although a small number are referred after adjudication. Youths with risk assessment

classifications of high, moderate or low—as reported on the Risk Assessment Instrument (RAI) administered by the Department of Probation—may participate in QUEST Futures. Most participants are in the moderate risk category.

There are no criminal charges that automatically disqualify a youth from participating in QUEST Futures. QUEST Futures staff will work with any respondent in a delinquency case who has been allowed by the family court judge to remain in the community while his or her case is pending or who has received a disposition of probation. Youth charged with the following offenses are unlikely to be referred or mandated to the program (with exceptions considered on a case-by-case basis):

- Homicides
- Armed robbery
- Guns
- Assault or other action resulting in serious physical injury or death
- Sex offenses
- Arson

Clinical Eligibility

Youth are clinically eligible for QUEST Futures if they:

- Have a designated mental health disorder (as described below);
- Have experienced impairment in functioning in self-care, family life, social relationships, self-direction, self-control, or learning ability;
- Would not present a foreseeable risk to public safety if linked to appropriate services in the community; and
- Have a parent/guardian or other responsible adult (not necessarily a biological family member or legal guardian) who will provide support to the youth in addressing his or her mental health issues.

Mental health disorders that qualify for participation in QUEST Futures include diagnoses in the DSM-IV (or ICD-9-CM equivalent) other than (i) alcohol or drug disorders, (ii) developmental disabilities, or (iii) organic brain syndromes. Examples include:

- Psychotic disorders (such as schizophrenia or schizoaffective disorder);
- Mood disorders (such as major depression or bipolar disorder);
- Anxiety disorders; and
- Behavior and impulse control disorders (such as conduct disorder, oppositional-defiant disorder, or attention deficit/hyperactivity disorder).

Youths with one or more of these qualifying mental health disorders who *also* have substance abuse disorders, learning disorders, or borderline intellectual functioning are still eligible to participate. Youth who have substance abuse disorders, learning disorders, or borderline intellectual functioning but do not also have a qualifying mental health disorder are generally *not* eligible for QUEST Futures.

Referral Sources and Judicial Mandates

A youth becomes a participant in QUEST Futures via a voluntary referral or a judicial mandate. After youth are either referred or mandated, QUEST Futures staff makes a final eligibility determination (see eligibility criteria above).

Voluntary Referrals

Youths may be referred for an assessment for voluntary participation in QUEST Futures by a variety of sources:

- The QUEST Alternative-To-Detention (ATD) program (ATD Tiers 1 or 2)
- Probation's Intensive Community Monitoring (ICM) program (ATD Tier 3)
- Probation, as part of the expansion of QUEST Futures to serve as an Alternative-To-Placement (ATP) program, as described below
- Any other source, such as the child's attorney, a parent, or another agency.

Judicial Mandates

A judge may mandate a youth to a QUEST Futures clinical assessment. If the youth is found ineligible, QUEST Futures immediately sends a report to the court. If the youth is found eligible, QUEST Futures provides a detailed report to the court on the next court date. If a youth and/or family refuse to sign consents regarding program participation and information-sharing (described below) or refuse to follow the recommendations of QUEST Futures staff for community-based services, then this is stated in the court report and the judge may make a finding that the youth has violated the court order. (While QUEST Futures has indicated in several court reports that a youth and/or family have refused their recommendations, during the program evaluation period covered in this report, no judge had made a finding of a violation of the court order.) At that point, a judge can decide whether to detain the youth or give him or her another chance.

An eligible youth may be mandated to participate in QUEST Futures exclusively or in conjunction with mandated participation in the QUEST ATD program, the Probation ICM program, or a Probation alternative-to-placement (ATP) program. It is also possible for a judge to mandate a youth to participate in QUEST Futures whose participation in QUEST Futures was hitherto voluntary. A judge may also mandate a youth to QUEST Futures not as an *initial* condition of a probation sentence but as an added condition while the adjudication of a violation of probation (VOP) is pending. Or, a judge might reinstate probation as part of the *outcome* of a VOP hearing with a new condition added that the youth participate in QUEST Futures.

When a family court judge has ordered the Department of Probation to conduct an exploration of placement (EOP) for a youth, the Department of Probation may refer the youth to QUEST Futures and/or the judge may mandate the youth to participate in QUEST Futures. In these cases, QUEST Futures provides ongoing case management prior to placement, maintains contact with the relevant facility personnel and family members during placement, and provides transitional support to the youth and family upon the youth's release from placement.

Referral Sources
QUEST Futures participants may be referred from the following programs:

QUEST Alternative-To-Detention (QUEST ATD). QUEST ATD is a *pre-adjudication* referral source. As noted above, QUEST ATD is an alternative-to-detention program that serves the borough of Queens. The youths who participate in QUEST ATD are mandated to do so by a Queens Family Court judge. Youth in Tier 1 (community monitoring) have their school attendance and curfew compliance monitored. Youth in Tier 2 (after-school supervision) receive both community monitoring and community-based after-school programming each weekday. All QUEST ATD participants are screened for mental health disorders at intake, using the Diagnostic Predictive Scales (DPS). If a youth flags for a mental health issue—and this is confirmed in a follow-up face-to-face meeting with the clinical team—the youth is referred to QUEST Futures for further evaluation. QUEST ATD participants who do not flag on the DPS may still be referred to QUEST Futures if there is a later indication of a mental health problem. Importantly, it is often the case that participation in QUEST Futures ATD youth is voluntary. The number of youths accepted into QUEST Futures from QUEST ATD during the evaluation period was 101; of these, 83 were participating voluntarily in QUEST Futures and 18 were mandated by judges to participate.

Probation: Intensive Community Monitoring (ICM). ICM is another pre-adjudication referral source. Youths who score on the high end of the moderate-risk range on the Department of Probation's RAI may be mandated by a Queens Family Court judge to the ICM program (ATD Tier 3), the most rigorous of the three ATD tiers. Noncompliant QUEST ATD participants may also be mandated to ICM as a "step-up" of their supervision. Youths in ICM attend school and court-ordered programs; receive frequent curfew checks; receive home visits; participate in phone check-ins; and have a "contract" agreement with the parent/legal guardian. QUEST Futures began screening youths referred by ICM and offering participation on a voluntary basis in February 2009 (four months after opening with an exclusive focus on QUEST ATD referrals).

The original expectation by QUEST Futures staff was that the Probation Department would refer all youths mandated to ICM in Queens to QUEST Futures for mental health screening and possible voluntary participation. However, only 15 youths mandated to ICM were referred to QUEST Futures during the evaluation period, and the number of youths actually accepted into QUEST Futures was seven. Of these, five were referred by Probation and were participating voluntarily and two were mandated by judges to participate.

Probation: Alternative-To-Placement (ATP). The New York City Department of Probation may make post-adjudication referrals to QUEST Futures when a youth is at risk of a probation violation and the senior probation officer believes the behavior is exacerbated by a mental health issue. The Department of Probation may also refer youths to QUEST Futures while they conduct an exploration of placement (EOP). QUEST Futures began accepting post-adjudication referrals from the Probation Department in June 2010. Judges can order QUEST Futures participation as a condition of probation at disposition. Probation can also refer probationers who show signs of mental health problems, are having difficulties complying with the terms of probation, and are at risk of being found in violation of probation.

QUEST Futures can also accept stepped-down cases—both voluntary and mandated—from all three pre-existing ATP programs: the therapeutic Juvenile Justice Initiative (JJI) and Esperanza, and the non-therapeutic Enhanced Supervision Probation (ESP). QUEST Futures is able to pick up these cases when these programs end in order to ensure continuation of care. QUEST Futures receives the treatment plans and a detailed discharge summary from JJI and Esperanza, which allows staff to make appropriate referrals.

During the evaluation period, QUEST Futures enrolled four youth as post-adjudication referrals from Probation; two were voluntary and two were mandated. Also within the evaluation period, one youth was enrolled who was a step-down from JJI and participated on a voluntary basis. Therefore, a total of five youth enrolled in QUEST Futures as an alternative-to-placement.

Other Referral Sources. In March 2009, QUEST Futures accepts began accepting referrals from attorneys for the children and parents/guardians. During the evaluation period, five such youths were accepted into QUEST Futures and participated on a voluntary basis. QUEST Futures does *not* accept referrals from the Law Department (the prosecution agency). The Law Department has expressed interest in making referrals directly to the program, especially in cases where a youth's charge involves violence against a family member, but, as of the writing of this report, the attorneys for the children were not comfortable with a mental health screen being triggered by a referral from the presentment agency without the agreement of the child's attorney.

Judicially-Mandated Participation. A Queens Family Court judge may order a youth to QUEST Futures in conjunction with any of the above programs or on a standalone basis, if the youth is found clinically eligible. A family court judge may also order a QUEST Futures assessment as part of a final case disposition. The judge may do this in connection with any of the following dispositions: adjournment in contemplation of dismissal, conditional discharge, or probation. QUEST Futures began accepting participants who had been mandated by a judge in March 2009 (until that time, all participants were voluntary). During the evaluation period, the number of participants who were mandated exclusively to a QUEST Futures assessment was 20.

Intake and Assessment

Summary of the QUEST FUTURES Intake Process

The QUEST Futures Clinical Director or a case manager meets with each youth and the parent/guardian to obtain consent and to explain why the referral was made, how the program works, and what a mental health disorder is. As part of the intake process, QUEST Futures staff may conduct up to three screens and assessments of the youth: the DPS, an in-depth biopsychosocial assessment, and the Child and Adolescent Needs and Strengths (CANS. Some young people may receive a fourth screen—the V DISC-IV.[1] The intake process is designed to

[1] The *Voice Diagnostic Interview Schedule for Children (V DISC-IV)* is a fourth screen that some participant youth receive. The results from the V DISC-IV are not a part of the clinical assessment process; the V DISC-IV results are for research purposes only. The results will contribute to a prevalence study to be completed, along with an impact evaluation of QUEST Futures, in 2013. Once youth have become QUEST Futures participants, they are invited to take the V DISC-IV and are offered two movie tickets to compensate for their time. The V DISC-IV is a comprehensive, structured interview that covers 36 mental health disorders for children and adolescents, using DSM-IV criteria. The V DISC-IV is a self-administered, fully structured audio computerized diagnostic tool that provides DSM-IV psychiatric diagnoses. In addition to data files for research, it produces a series of reports including a diagnostic report that indicates endorsed symptoms, criteria and

determine whether a youth meets the program's eligibility standards; and, if the youth is eligible, to establish a preliminary treatment plan and appropriate service referrals.

Table 3.2
Total Number of Participants and Number of Voluntary and Mandated Participants by Referral Source
(October 2008 – September 2010)

Referral Source	Number of Participants	Voluntary Participants	Mandated Participants
QUEST ATD	101	83	18
Probation: ICM	7	5	2
Probation: ATP[1]	5	3	2
Other	5	5	0
Judicial Mandate	20	0	20
Total	138	96	42

1) Includes five post-adjudicated youth: four from Probation (two voluntary; two mandated) and one from ACS (one voluntary).

A young person becomes an official QUEST Futures participants once staff obtains a written assent/consent to engage in community-based treatment and related services and to authorize the exchange of specified information with several different parties. (See Appendix D for a description of the consents to share confidential information that are associated with mandatory and voluntary participation.) If a mandated youth and/or the parent/guardian refuse to give consent to engage in QUEST Futures, staff will immediately report this to the judge, law guardian, and presentment attorney. The youth may face legal consequences for failure to comply with the treatment plan and participate in program services. Voluntary participants may withdraw at any time without any legal consequences.

The sections below describe each of the three assessment tools and processes used by QUEST Futures.

Diagnostic Predictive Scales (DPS)
All QUEST ATD participants are automatically administered the DPS as part of their intake process. The DPS is a screening tool for children and adolescents. The DPS contains 18 diagnosis-specific scales: Social Phobia; Specific Phobia; Separation Anxiety; Generalized

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diagnoses. It is designed for use by children ages 9 to 17 and has both English and Spanish language versions. Its results are associated with those of the DPS. The product description indicates that it has a mean duration of 90 minutes and has reasonable psychometric indicators of reliability and validity (Schaffer et al., 2000). Although the original plan was for all the QUEST Futures youth to take the V DISC-IV, only 29 participants completed the V DISC-IV during the evaluation period. There appear to be three primary reasons for this low completion rate: 1) youth report that it takes "too long" and so do not sit at the computer through to completion, 2) once the youth are connected to a treatment provider they are rarely onsite at the QUEST Futures office where the computer with the V DISC-IV program is located, 3) youth take the V DISC-IV on a voluntary basis so staff have no leverage to make youth complete the screen; the offer of two movie tickets was not enough to compensate for the time it would take to complete for the vast majority of the QUEST Futures participants.

Anxiety; Panic Disorder; Agoraphobia; Obsessive-Compulsive Disorder; Anorexia/Bulimia; Elimination Disorders; Depression; Suicidal Ideation/Attempts; Mania; Schizophrenia; Attention Deficit/Hyperactivity; Oppositional Defiant Disorder; Conduct Disorder; Alcohol, Marijuana and Drug Abuse/Dependence; and Post-Traumatic Stress. The DPS also contains a global impairment scale. The product description indicates that the DPS has a mean duration of less than 15 minutes, but QUEST staff reported that completion time ranges from 15-30 minutes. The DPS instrument has reasonable psychometric indicators of reliability and validity (Leung, et al 2005; Schaffer et al 2000).

Potential QUEST Futures participants self-administer the DPS on a computer in a quiet, confidential room with a clinical staff member available for questions and concerns. After administration, the DPS provides a report listing clinically important information, including a listing of all questions asked together with subject responses. Clinical staff members at QUEST were trained on how to proctor and read DPS results. If the results are clinically significant, a member of the clinical team conducts a brief follow-up face-to-face interview to rule out any false-positives and to assess the urgency of any concerns. For youths who complete the DPS as part of the QUEST ATD intake process, if a flag on the DPS is confirmed, the youth will be referred to QUEST Futures for further assessment. For youths who were referred specifically to QUEST Futures by other referral sources, additional assessment activities will occur regardless of the DPS results. Urgent concerns—such as suicidality—are handled by the Clinical Director or a licensed mental health professional who conducts a face-to-face assessment and immediately determines what steps are necessary to ensure the youth's safety, including, where warranted, hospitalization.

Biopsychosocial Assessment

QUEST Futures staff conduct a biopsychosocial assessment (Appendix E) based on an interview with the youth and parent/guardian or other adult(s) serving a parental role. The assessment includes questions about the youth (*e.g.*, age, sex, race/ethnicity, primary language); family (*e.g.*, parents' marital status, siblings, other household members, major family stresses, and how family is coping with the youth); school (*e.g.*, current and historical academic performance); employment/socialization (*e.g.*, relationship with peers, friends, community); and health (*e.g.*, insurance, development, allergies, substance abuse). In addition, staff may gather information about the youth from other sources, such as:

- Home visits
- Interviews with key school and community supports, including teachers, guidance counselors, staff of faith-based institutions and youth programs, important adult figures in the youth's life (such as grandparents or family friends, etc.)
- A psychiatric evaluation
- Records from and/or conversations with current or past treatment providers

A biopsychosocial assessment is typically completed within three days of intake. The results of the assessment provide the basis for a provisional diagnosis that is then noted in the youth's clinical file.

Child and Adolescent Needs and Strengths (CANS)

The CANS is an instrument that measures youth and family functioning. (See description in Chapter II and assessment items in Appendix A.) QUEST Futures staff completed a baseline CANS—and follow-up CANS as appropriate—for each participant.

Youth and Family Engagement

QUEST Futures works to engage families throughout the life of the QUEST Futures case. Participant and parent/guardian "buy-in" is critical to achieving successful outcomes. The work of family engagement may take many forms and may be more or less intense at different junctures of the case, depending on how the youth is doing and what is happening in their lives. Initially, many families are reluctant to participate in QUEST Futures. This may be because they believe they have been failed by agencies before. Some may feel they are being blamed for the youth's negative behavior. Others may attach a negative stigma to mental health services. QUEST Futures works to identify the reasons for the reluctance to participate and show respect for the youth and/or parent's concerns.

Once trust is established, staff works to keep the lines of communication open, for example, by having an open-door policy for youth and family. In this way, QUEST Futures seeks to understand what is happening in each youth's life—which, in turn is critical for making appropriate assessments and referrals.

Case Management

At intake, each youth is assigned a case manager. Within three days, the case manager conducts a biopsychosocial assessment. Within five days of this assessment, the case manager develops an individualized treatment plan that includes links to mental health providers and services for other needs identified in the assessment, such as education, substance abuse, health, employment and family stability. The goal is to secure an intake appointment with a service provider within two weeks of enrollment in QUEST Futures.

For those youths who become program participants, the case manager has two basic functions: service coordination and monitoring.

Service Coordination

The case manager refers each youth to specific community-based providers, assists the youth and family with making and getting to appointments, and engages in ongoing communication with the providers about progress.

Referrals to community-based providers begin as soon as the assessment is complete, except where there is difficulty forming a preliminary diagnosis or evaluating the potential risks of leaving a youth in the community. Delays can also occur when there is a potential need for a high-end service that requires a referral to C-SPOA (Children's Single Point of Access—a centralized referral system for children ages 5 to 18 with serious emotional disturbance who need intensive mental health services to remain at home or in their community).

Once a youth is engaged in services, the case managers reduce their direct contact with the youth/family. The case manager will provide different or additional referrals, if this is needed. QUEST Futures case managers also communicate with the youth's school and with the Administration for Children's Services (ACS) about educational progress or the status of any pending child welfare involvement, if appropriate. Case managers use this information to identify service needs.

Monitoring and Accountability

Case management staff monitors:

- Attendance at scheduled treatment sessions;
- School attendance and engagement;
- Quality of engagement with community-based treatment services;
- Interactions with peers, QUEST program staff and providers' staff;
- Positive toxicology results (if a provider tests for alcohol or drug use); and
- Significant accomplishments, setbacks, and warning signs, in participants' lives.

The level of monitoring and accountability fluctuates over time as the youth experiences new stressors like a change in school, moving, an argument with a teacher or parent, or breaking up with a partner. Unlike most therapists, he QUEST Futures staff is available for the youth to talk to every day of the week. At any given time, QUEST Futures staff has both active and inactive cases. The inactive cases are those where the youth is in placement, receiving JJI or Esperanza, or doing very well. The active cases are those where the youth is in the process of being linked to community-based services or the youth is not doing well and there are significant behavioral and/or attitudinal issues that must be dealt with.

In general, case managers maintain weekly contact with all community-based service providers to facilitate a quick response if the youth is doing poorly in treatment or is not complying with court mandates. When a case manager learns that a youth is not following his or her treatment plan, the case manager contacts the youth directly and has him or her come in to QUEST Futures to learn why. If the case manager decides that the youth and the provider are not a good fit, the case manager makes an intake appointment with another provider. Alternatively, if the reason for non-attendance is not acute and does not involve treatment, the case manager may invite the youth to onsite groups and provide counseling as needed.

Besides receiving and acting upon updates from the service providers, the QUEST Futures case managers are also responsible for reporting to the court or, where applicable, other justice entities such as the Department of Probation, the Administration for Children's Services, or the Department of Education. The level of information reported to these entities is subject to distinct consents and information-sharing protocols for voluntary and mandated participants (see Appendix D).

For *mandated* participants, at the first court appearance following QUEST Futures intake, the case manager prepares a four-page report comprising the following: the biopsychosocial narrative, the treatment plan, the individual/family care coordination/outreach plan, and the case update report. Also at the first appearance, the case manager provides the court with records of the participant's school attendance and grades. At subsequent court dates or as ordered by the

family court judge, the case managers only provide the case update report and, where applicable, an update of the treatment plan.

For *voluntary* participants, case managers do not provide formal reports. Instead, they provide oral updates upon request to the participants' attorneys and, for Intensive Community Monitoring (ICM) participants, to the Probation Department and Law Department. These updates focus on the youth's overall functioning in the areas of school (attendance, grades, participation in clubs, sports, etc.), compliance with mental health treatment, and family relationships.

For those participants who receive a probation disposition, the QUEST Futures case managers share information on the participant with the Probation Department, with the goal of ensuring continuity of services during the probation period.

Onsite Psychoeducational Services and Support

In addition to case management services, QUEST Futures works to ensure family engagement and to provide onsite groups for participating youths and parents.

Psychoeducational groups for youth

QUEST Futures youths may attend onsite psychoeducational groups alongside QUEST ATD participants. These groups meet every afternoon during the school week and cover topics such as the following:

- Depression and suicide;
- Emotional intelligence;
- Coping skills;
- Substance abuse prevention;
- Self-esteem;
- Consequential thinking; and
- Medication management.

After QUEST Futures participants are connected to outside service providers, however, onsite services typically are limited to case management.

Support groups for parents

QUEST Futures offers support groups for parents and other family members. QUEST Futures staff held 26 parent support groups during the evaluation period, averaging a little more than one per month. Attendance fluctuated based on the needs of the cohort families and ranged from a low of one family to a high of eight families. Sometimes parents brought other family members. Usually, the participating youth would join the parents at the dinner that was provided afterwards. The following topics were presented:

- Gang awareness;
- Cognitive and moral development of adolescents;
- Substance abuse and signs of use for various types of drugs;
- School refusal and anxiety;
- Summer Youth Employment Information Workshop;

- Alternative school programs;
- Depression;
- Overview of the juvenile justice system;
- Self-esteem;
- Conduct and oppositional defiant disorders; and
- Overview of special education services.

Fewer parent support groups were held than the originally planned three per month due to scheduling and attendance challenges. QUEST Futures staff originally scheduled the parent support groups for 9:00 a.m. to 10:00 a.m., thinking this would be a good time for families, particularly for single mothers, as their children would already be at school. QUEST Futures offered breakfast and covered transportation costs in the form of a one-fare metro card. QUEST Futures staff sent out flyers the first week of each month outlining the topics to be covered in the following three sessions. Two days before each session, QUEST Futures staff would call each family to remind them of the upcoming session. It became apparent over time, however, that different cohorts of parents wanted to attend at different times. Therefore, parent support groups also were sometimes held later in the day, at 5:00pm.

QUEST Futures partnered with United We Stand, a parent advocacy group that facilitates onsite groups using curricula created by the National Family Advocacy Support and Training Project. United We Stand began conducting workshops at QUEST in July 2010 and conducted three workshops before the end of the evaluation period in September 2010: "The Journey to Adulthood: What Parents Need to Know about Sexuality," "Getting and Keeping the First Job," and "Skills for Effective Parent Advocacy."

QUEST Futures staff conducts individualized psychoeducational sessions with participants and their families on an as-needed basis. QUEST Futures maintains an open door policy for families; neither parents nor youth need to schedule their visit in advance. QUEST Futures staff is available onsite from 11:00 a.m. to 7:00 p.m. during the school year and 10:00 a.m. to 6:00 p.m. during the summer and school breaks.

Community-Based Service Linkages

The range of services to which QUEST Futures refers youth and/or family members are presented below (see Appendix F for the list of 37 agencies to which staff referred participants):

Treatment and Other Behavioral Health Services

QUEST Futures can refer participants and their family members to community-based agencies that provide: (a) individual or family therapy—which are usually psychotherapy or "insight-oriented" therapy in nature but are sometimes cognitive behavioral therapies (CBT) such as Family Functional Therapy (FFT) and Multisystemic Therapy (MST); (b) evaluation services to determine if there is a psychiatric concern, a neurological issue, or special education needs; or (c) substance abuse services, which may be preventive, outpatient, or residential. QUEST Futures may also refer participants to inpatient psychiatric treatment to provide short-term, acute care.

Entitlements for Parents

QUEST Futures rarely makes direct referrals to public agencies that provide benefits. However, QUEST Futures staff will identify unclaimed benefits and refer parents or guardians to an agency that can assist them further—in most cases, this is Single Stop, a non-profit organization. These include public assistance, medical insurance, food stamps, social security benefits, and preventive services to keep youth out of foster care.

Services for Parents/Guardians and Siblings
QUEST Futures refers parents to a host of other services to support family stability, including Early Head Start and Head Start, housing advocacy, the home energy assistance program (HEAP), employment assistance, child care, summer camp, transportation assistance for the disabled, GED programs, English as a Second Language (ESL) programs, financial consultation, legal assistance, assistance with filing taxes, and domestic violence counseling.

Education/Employment for Youth
QUEST Futures staff can make education-related referrals that include transfer schools, residential schools, and pre-GED and GED programs. Staff also refers participants to internships and employment.

Placements by Judge

QUEST Futures recommends placement options to probation once a judge has ordered probation to conduct an exploration of placement (EOP). QUEST Futures recommendations are based on knowledge of the placement facility and of the youth. Probation, however, is the entity that drives the search process and makes the referral. Once a youth is placed, QUEST Futures maintains contact with the relevant facility personnel and the youth's family throughout the duration of the placement in order to facilitate family engagement and shape a treatment plan upon the youth's release. While the youth is in placement, QUEST Futures continues to provide referrals to community-based services for the family members. Upon release, QUEST Futures staff provides community-based referrals to the youth.

Program Length

In pre-adjudication cases, QUEST Futures provides case management services to participants and their families for up to 60 days after the family court case is disposed to help them solidify ongoing connections to community-based services. For example, if a participant is remanded for noncompliance with court orders, QUEST Futures will continue to treat the case as open and will remain involved with the youth and the youth's family to facilitate re-engagement in community-based services upon the youth's release. Although QUEST Futures withdraws its case management services after 60 days, participating families may continue working with their community-based service providers for as long as they wish.

In post-disposition cases, QUEST Futures participation generally lasts until up to 60 days after the end of the probation period (if the youth was sentenced to probation) or up to 60 days after the period of mandated services (if the judge mandated QUEST Futures programming for a specified period of time).

It is important to note, however, that while, as a matter of general policy, staff keeps the QUEST Futures case open for only 60 days after a final disposition or the end of the probation period, QUEST Futures staff will work with the youth and their family whenever the youth and/or family member asks them to do so—even after the 60-day post-disposition period.

Those participants who are not mandated to QUEST Futures by a family court judge may end their participation at any time.

CHAPTER IV: PLANNING

This chapter covers the following planning elements:

- Background context
- Needs assessment findings
- Conceptual development of a pilot program
- Final stages of program planning
- Final program design
- External changes during program implementation
- Planning for the future

Background Context

In the early 2000s, the then Chief Judge of New York State, Judith S. Kaye, indicated an interest in improving the ability of family court judges to understand the needs of youths with mental disorders and reducing the use of detention and placement for these youths. Simultaneously, the Mayor's Office of the Criminal Justice Coordinator (CJC) in New York City contacted the Center for Court Innovation (CCI) to discuss justice-involved juveniles with mental health issues.

A formal planning process began in late 2003, with funding from the New York City Council and the American Psychiatric Foundation. This funding enabled the Center for Court Innovation to conduct a needs assessment to determine the potential target population and scope of a future program. The needs assessment involved interviewing many stakeholders in the local juvenile mental health and juvenile justice systems.

In 2004, while the needs assessment process continued, CJC formed a committee to discuss juvenile justice and mental health issues throughout New York City. In 2005, the committee invited the Center for Court Innovation's Director of Mental Health Court Programs to speak about the intersection between juvenile justice and mental health and to join the committee as a member.

In broad terms, the planning process for QUEST Futures developed in three stages:

- Stage 1 (from late 2003 to mid-2005): Planners conducted a needs assessment to better understand the problems posed by juveniles with mental disorders;
- Stage 2 (from mid-2005 to late 2006): Planners developed the basic concept for a juvenile justice/mental health program; and
- Stage 3 (from 2007 through project launch in 2008): Planners refined the QUEST Futures program model.

Stage 1: Needs Assessment Findings

In June 2005, the Center for Court Innovation produced a needs assessment report. Some of the most significant issues are listed below (see CCI (2005) for the original report).

- Prevalence Data: Comprehensive, reliable and detailed statistics on the incidence of justice-involved youth with mental disorders in New York City were scant.

- Clinical Concerns and Stigmatization: Recognizing that mental disorders can be difficult to diagnose, many stakeholders were concerned about labeling and stigmatizing a young person before it is firmly established that she or he really has a disorder.

- Insufficient and Untimely Clinical Information: Stakeholders reported that the information available to judges, attorneys and probation officers about respondents' mental health issues tended to focus on their problems and not on the opportunities for achieving behavioral improvements through appropriate treatment in the community. Moreover, mental health evaluations would typically be done at the end of the adjudication process and raised in an adversarial context. Stakeholders complained that efforts to obtain mental health assessments, develop treatment plans and link respondents to community-based services at the dispositional stage would often slow case proceedings down for months.

- Cross-system Coordination: Stakeholders noted that before or during a family court proceeding, information about a youth's mental health needs may be identified by a number of different agencies—Family Court Mental Health Services (MHS) clinics, the (former) Department of Juvenile Justice (DJJ), the Department of Probation, the Administration for Children's Services (ACS), the Office of Children and Family Services (OCFS) or the Department of Education (DOE)—which may or may not share what they know. Failure to share information was viewed as an obstacle to achieving continuity of care.

- Local Treatment Capacity: Stakeholders believed the treatment capacity in New York City was limited. Stakeholders were concerned about the lack of coordination across multiple sectors—mental health, medical, development disabilities, education, and child welfare.

- Knowledge and Acceptance of Community-based Treatment: Some parties to family court proceedings did not agree that community-based treatment approaches were preferable to residential or in-patient services. Very few judges and attorneys were aware of the range of community-based treatment services available for youth with mental health disorders.

- Parent Engagement: Many stakeholders believed the following: that some parents deny the existence or extent of their child's mental illness and/or fail to support a treatment plan; that some parents may resent the stigma surrounding mental illness and fear being blamed for their children's problems; that some parents may have had bad or frustrating experiences with the mental health system and become averse to using it; that some

parents may need mental health or substance abuse treatment services themselves; and, that even the most committed and responsible parents may find it daunting to navigate the mental health system. Stakeholders also recognized that although family dynamics may contribute to a youth's mental health problems in delinquency proceedings, family court has no jurisdiction over the parents.

- Judicial Training: Stakeholders observed that judges need but rarely receive training in how to set appropriate standards and mandates for youths with mental health disorders.

- Specialized "Mental Health Court": Noting the high incidence of mental health issues among respondents in delinquency cases, judges, probation officers and attorneys interviewed during the planning process all wanted access to clinical information and resources, rather than funneling cases—and resources—to a dedicated judge and court team. In interviews conducted after the launch of QUEST Futures, stakeholders were asked to note the most significant reasons for having a program like QUEST Futures rather than a mental health court.

  > *[Unlike a mental health court] QUEST Futures provides multiple services—including those for mental health issues, substance abuse, education, and parenting. These are community-based services to help children grow.*
  >
  > *[With a mental health court] I don't like that we [would be] asking for a commitment to the [mental health] court's program when defendants are at their most vulnerable. They may have even just spent the night in jail and are still detoxing.*
  >
  > *Adolescents are people in a particular point of complex development. A mental health court would label them. I don't think it's necessary. It could make youth and family more hostile to the court process. QUEST Futures is enough.*

Stage 2: Conceptual Development of a Pilot Program

During stage two of program planning, the CJC's juvenile justice mental health committee continued meeting on a regular basis; the Center for Court Innovation also continued to hold meetings with stakeholders.

In fall 2005, the Center for Court Innovation developed a concept paper that described the following major components of a proposed pilot program:

- Early intervention: The program would create a clinical team to screen, assess, and link youths to community-based services as early in the family court delinquency case as possible. This would be post-petition (after the filing by the Law Department of a delinquency petition in Family Court) but before adjudication/fact-finding. The target population would be youth in detention or at risk of detention pending adjudication. DJJ, through its existing mental health screening and assessment procedures, would identify detainees with mental disorders and refer them to the clinical team for further assessment and treatment planning.

- Program structure: The program would not take the form of a specialized juvenile mental health court; rather, the program would be available to all juvenile delinquency court parts. The clinical team would serve as a resource to clients and their families as well as to all juvenile justice players. The program would not serve as a direct service provider; rather, it would provide case management and family support, including links to community-based providers. Program participation would not be time-bounded; rather, participants would be able to access the case management and family support services at any time until the closing of the family court case or the end of a term of probation. It was expected that most program participants would be mandated to the program as a condition of release from detention. The clinical team would monitor compliance with court conditions, including attendance at treatment sessions; make reports to the family court judge; and offer guidance on clinically and developmentally appropriate rewards and sanctions to motivate engagement in treatment and compliance with court requirements.

The concept paper left open several issues. While the pilot program would be implemented in the Bronx or Queens—because there was a consensus that these boroughs had the greatest need—the final location was not determined. Another issue was how to identify, refer and assess detained youths. This issue was particularly sensitive because information about respondents' mental health needs would be developed and shared *before* their cases were adjudicated. Attorneys for the children argued that they should be the ones to determine which other juvenile justice players would receive clinical information and when. While the Department of Juvenile Justice (DJJ) would be a critical player in identifying and referring prospective program participants, DJJ appeared reluctant to: 1) assume responsibility for obtaining consents from parents to share mental health information with the clinical team and other parties; 2) share information with the Legal Aid Society that was not also shared with the Law Department and the judge; and 3) allow the clinical team to conduct assessments within DJJ facilities.

Notwithstanding these unresolved issues, in June 2006, the Center for Court Innovation submitted funding proposals to the Bureau of Justice Assistance (BJA) in the United State Department of Justice and the Jacob and Valeria Langeloth Foundation to create the Family Court Assessment, Referral, and Treatment (ART) Team. The ART Team would target youth who were in detention with pending delinquency cases and who had been identified by DJJ as having mental health problems. All major stakeholders in the planning process provided letters of support for these proposals, while recognizing that significant issues had to be addressed before the project could be implemented.

Shortly thereafter, there were two important shifts in the juvenile justice landscape in New York City that affected the proposed project design.

New Alternative-to-Detention Initiative

In January 2006, the Department of Probation disbanded New York City's only established alternative-to-detention (ATD) program for pre-adjudicated youth. To fill this void, the CJC developed a new continuum of supervision options for youths who were at moderate risk of not showing up for court and for re-offending. A risk assessment instrument (RAI) was developed by the Vera Institute of Justice. To replace Probation's dismantled ATD program, each borough

would have its own ATD program, providing a combination of supervision (monitoring of school attendance and curfews) and after-school programming.

In late 2006, the CJC awarded the Center for Court Innovation the contract to run the ATD program for the borough of Queens. Queens Engagement Strategies for Teens (QUEST) was launched in June 2007 in a church basement located near Queens Family Court. The QUEST ATD program monitored school attendance and curfews and provided after-school services for pre-adjudicated youths with moderate risk scores on the RAI in the borough of Queens.

New Juvenile Mental Health Initiatives

In February 2007, ACS created and launched the Juvenile Justice Initiative (JJI), which provides intensive, evidence-based services—primarily Multisystemic Therapy (MST)—designed to reduce further delinquent behavior among youths who would otherwise be placed in correctional facilities. A relatively small number of JJI slots were reserved for youths with severe mental health issues, who received additional therapeutic services. (See previous chapter for description of JJI.)

Also in February 2007, the City of New York created the Collaborative Family Initiative (CFI), a discharge planning initiative which would connect youths with mental health needs with immediate treatment in the community to reduce the likelihood of being re-detained while their cases were being adjudicated.[2]

As a result of these developments, the focus of the Center for Court Innovation's program planners shifted from, "How do we promote community-based treatment as an alternative to detention and placement?" to, "How can we avoid competing with other new programs for clients and ensure that we are not duplicating services?"

In late 2006, the Administrative Judge for New York City Family Court, the Honorable Joseph Lauria, selected Queens as the borough for the pilot program because it had a particularly high rate of youths held in detention pending adjudication of their cases.

Stage 3: Final Stages of Program Planning

In late 2006, the Langeloth Foundation expressed interest in the new juvenile justice/mental health program and awarded the Center for Court Innovation a planning grant. Grant funds were used, in part, to convene an advisory committee consisting of the same stakeholder agencies that had participated in CJC's juvenile justice mental health committee. There were, however, two important changes:

- For some agencies, representatives from Queens became involved, either in addition to, or instead of, representatives in citywide positions. (For example, the New York City Family Court was represented by a Queens judge and Queens court attorney and The Legal Aid Society and the Law Department turned over planning responsibility to Queens supervising attorneys.)

[2] Hernandez, N. "For Juveniles, Alternatives to Incarceration", *Gotham Gazette,* June 2, 2008.

- At Langeloth's request, two new members were brought into the advisory committee: a representative of Family Justice, an organization that had developed a model for enlisting support from families and social networks to help individuals under justice supervision avoid re-incarceration, and a consultant on project and research design.

The Advisory Committee included representatives from the following organizations:

Center for Court Innovation
Director of Mental Health Court Programs (convener)
Deputy Director
Director of Implementation
Director of Youth Programming
Project Director, QUEST
Clinical Director, QUEST

New York City Department of Juvenile Justice
Assistant Commissioner for Program Services
Director of Health and Mental Health Services

New York State Office of Mental Health
NYC Field Office Director
NYC Field Coordinator, Division of Children and Families

New York City Department of Probation
Deputy Commissioner
Assistant Commissioners (2)

New York City Family Court
Coordinator of Special Projects, NYC Family Court
Court Attorney, Queens Family Court
Supervising Judge, Queens Family Court

New York City Law Department
Queens Borough Chief, Family Court Division

New York City Health and Hospitals Corporation
Senior Director, Family Court Mental Health Services

New York City Department of Health and Mental Hygiene
Assistant Commissioner for Child and Adolescent Services

New York City Department of Education
Director of School Mental Health Services

New York City Legal Aid Society
Assistant Attorney-in-Charge, Juvenile Rights Division
Supervising Social Worker, Queens Juvenile Rights Division

Office of the Criminal Justice Coordinator
Deputy Criminal Justice Coordinator for Research and Policy

Assigned Counsel Panel
Director, Attorneys for Children, Appellate Division, Second Department
Director of Social Work Services
Attorney (Law Guardian, Jamaica, NY)

Other
Family Justice
Nonprofit consultant

The Advisory Committee laid the groundwork for the implementation of the program. In the words of one Advisory Committee member:

> *I attended the Advisory Committee meetings. At these meetings, which were well-attended by representatives of each of the relevant agencies, concerns were brought up, ideas were vetted, limits were established. Because so many agencies were involved, protocols on information-sharing had to be worked out. At the meetings, I would represent [my agency's] position and would bring back to my office the content of the discussions and consult/discuss with colleagues, staff, and my supervisor. These meetings took place over a fairly long period of time and were very useful. Because all of the stakeholders were brought in at an early stage, there were no serious implementation problems. By the time the program was rolled out, everyone who would be affected already knew about the program and had a sense of what to expect.*

The critical issues addressed during the final stage of the planning process are discussed below.

- Program goals
- Target population
- Scope and location of services
- Program staffing and coordination with QUEST ATD
- Voluntary vs. mandated participation
- Sharing mental health information with juvenile justice players

Program Goals
When applying for funding for QUEST Futures, the Center for Court Innovation developed a grant proposal that stated the program's goal (then still called the ART Team) quite clearly: "to reduce repeat offending by young people with mental illness in the juvenile justice system." Program goals were further elaborated in an official policy and procedures document.

In research interviews, stakeholders confirmed that the primary goal of QUEST Futures was to reduce re-offending. One stakeholder framed this goal succinctly:

> *Provide services to juveniles who need services to prevent further involvement with the juvenile justice system.*

Expanding on how to achieve this primary goal, another stakeholder emphasized the importance of effective mental health assessment and identification:

> *Research shows that kids who are identified as having mental health issues and who are linked to appropriate mental health services will experience symptom reduction and are, therefore, less likely to end up in court.*

Yet another stakeholder emphasized the importance of quick linkages to services:

> *Speed up time to link families to appropriate services so kids do not decompensate. There were instances when youth with mental health issues left detention facilities with medicine but did not receive follow-up services for six months, which lead to decompensating behaviors.*

QUEST Futures program planners communicated the goal of the program clearly to stakeholders, orally and in official program documents; and stakeholders themselves articulated a consistent understanding of program goals.

When asked what factors would help QUEST Futures in achieving its goals, stakeholders cited different factors, such as effectively accessing the target population, promoting family engagement, finding appropriate community-based providers, and cultivating relationships with key personnel in both the local justice and treatment systems:

> *Strong leadership at the QUEST Futures program. Quality of the staff. Relationship with judges, local attorneys (defense bar) and the Law Dept. Putting in place things that get the youths through the front door. The ability to locate sufficient and appropriate services for the youths.*
>
> *Focus on getting the kids—locating them asap. They may be missing kids because judges and others are not picking up on the program.*
>
> *The program will have to work with a family as a whole—that includes parents and siblings. It must address family dynamics.*
>
> *Having enough community services, engagement with the kids and families, and having those services that truly meet their needs. More effective treatment models like MST and FFT that are not expensive.*

Target Population
Ultimately, the coincidence of the implementation of the new RAI, the Center for Court Innovation receiving the contract to run the new Queens ATD program, and Judge Lauria selecting Queens as the borough for the pilot juvenile mental health program, combined to give program planners an opportunity to change the target population from detained youth to youth at risk of detention as determined by a validated instrument, the RAI. One stakeholder described this turning point in the program planning:

> *The goals changed. The [original] goal was to assess the needs of kids [in detention]. But, another organization that had funding developed that sort of program first. Fortunately, there was flexibility in planning and it was decided to change the goal to focus on youth in ATD programs. So, the goal became to prevent the detention of youth. Also, QUEST Futures adopted the goal of staying committed to the families throughout the disposition of the case, which is very valuable, because no one else does it. Other programs have time limits. For example, ATDs have 120-day time limit. This commitment really empowers the family.*

Keeping the focus on pre-adjudicated youths also avoided possible conflicts with the Juvenile Justice Initiative (JJI) launched by ACS for adjudicated youths.

Program Staffing and Coordination with QUEST ATD
In July 2008, after a search process, a Clinical Director was hired. QUEST Futures officially launched three months later in October 2008.

One stakeholder observed the importance of this position:

> *QUEST Futures staff is excellent, especially [the Clinical Director]. [The Clinical Director] really knows the Queens mental health community. I mean, really, personally know them.*

The decision to connect the program with the recently established QUEST ATD program seemed logical, as they were both operated by the Center for Court Innovation and could share office space, resources, and some personnel. Once the decision was made to link the two programs, CCI chose a new name for the ART Team to reflect its connection to the QUEST ATD program: QUEST Futures.

The integration of QUEST ATD and QUEST Futures posed many implementation challenges. Among these were the use of space and staff. There were also challenges because the QUEST ATD program is much stricter and more narrowly defined than the QUEST Futures program, and the two programs have different court reporting requirements. Finally, if a youth is in both programs, it is a challenge to make sure that staff provides consistent messages to the court as well as to the youth and their family.

Scope and Location of Services
Planners had to decide what kinds of services QUEST Futures would provide onsite and what services the program would make available offsite, through referrals to other community-based providers. Concerns about the difficulties of accessing and coordinating care drove the decision to have the program provide assessment and case management services onsite, while linking youths and their families to community-based providers who would then provide the actual

treatment. This program model reflected the belief that appropriate community-based services already existed in New York City, but that previous justice programs were ineffective in linking juveniles to the services they needed.

Voluntary vs. Mandated Participation

Some youths participate in QUEST Futures on a voluntary basis and some are mandated to participate by a judge. This brings into question the role of implicit and explicit coercion. Stakeholders were asked to comment on the role of coercion—or, in the case of those who enroll voluntarily, the *lack* of legal coercion. In considering this topic, several stakeholders took the opportunity to highlight the role of the parents in successful engagement:

> *The kids are mandated—not the parent . . . the key is parent buy-in.*
>
> *To the extent that participants and parents are engaged, it's good.*
>
> *For it to work, it has to be voluntary. But sometimes in order to get kids/someone to do something, you have to use leverage. The problem is the parents—they have to get on board. Bring an abuse/neglect petition against the parent.*

Sharing Mental Health Information with Juvenile Justice Players

The development of information-sharing protocols was the greatest challenge program planners faced. In order to function effectively, the program had to provide mental health information about minors to family court players. As noted above, the attorneys for the children were extremely concerned about clinical information being made available to judges and the presentment attorneys before fact-finding. They were concerned that their clients might make incriminating statements that would be shared with the judge and the presentment attorneys. They were also concerned, based on years of past experience, that some judges and presentment attorneys would view their clients in a negative light once they learned of mental health problems. In the past, some young people had been detained or placed once their mental health problems came to light, either because judges assumed that their mental illness increased public safety risks or that they would get mental health services in a confinement facility.

Due to the sensitive nature of this information and the vulnerability of the population—minors, the mentally ill, and respondents whose cases had not yet been adjudicated—strict information-sharing protocols had to be worked out among all the relevant parties—which included the youth and parent/guardian, the Department of Probation (DOP), family court judges, the attorney for the child, Legal Aid Society, the youth's school, the Law Department, the Department of Juvenile Justice (DJJ), and service providers. During this process, privacy issues had to be balanced against concerns about public safety. Ultimately, the New York City Law Department agreed that it did not need to receive any clinical information about voluntary participants. Once the Law Department took this position, family court judges were willing to allow the attorneys for the children to be the information gatekeepers for voluntary participants. All stakeholders recognized that honoring the confidentiality of mental health information would encourage QUEST Futures participation.

Although the formulation of the information-sharing protocols constituted a significant implementation challenge, the program's success in doing so could serve as a blueprint for other jurisdictions hoping to establish a similar program.

External Changes during Program Implementation

Two changes that were external to QUEST Futures occurred during program implementation that changed the landscape of juvenile justice in New York State. These were (1) a federal Department of Justice (DOJ) investigation of juvenile placement facilities in New York State and the state's response to the DOJ report, and (2) the merger of the Department of Juvenile Justice (DJJ) and the Administration for Children's Services (ACS).

Department of Justice Report on NYS Placement Facilities

In August 2009, the federal Department of Justice issued a report on juvenile placement facilities in New York State that detailed how staff at four facilities "routinely" used "uncontrolled, unsafe applications of force," departing from "generally accepted standards" regarding the treatment for juveniles (U.S. Department of Justice, 2009). The report cited inappropriate restraints and excessive use of force, which it blamed for serious injuries, including concussions, broken or knocked-out teeth, and spinal fractures. The report also asserted that the state failed to provide adequate mental health treatment to youths in the four detention centers.

In response, Governor of New York David Paterson created a Task Force charged with improving the juvenile justice system. Their report, released in December 2009, called for a reduction in the number of youths placed in institutional facilities and a shift to community-based services where appropriate. The report also called for adequate mental health treatment in placement facilities (Governor David Paterson's Task Force on Transforming Juvenile Justice, 2009).

QUEST Futures is in line with the Task Force's recommendations toward keeping justice-involved youth in their communities.

Merger of the Department of Juvenile Justice and the Administration for Children's Services

In January 2010, the Mayor of New York City announced the merger of the Department of Juvenile Justice and the Administration for Children's Services. The merger was intended to provide better services to youths who come into contact with both agencies. Given that research (Teplin et al. 1994; Walsh, MacMillan, and Jamieson 2003) suggests an overlap of the delinquent, abused, and mentally-ill juvenile population, it is likely that this merger will help streamline the processing of the delinquency cases of these youth. It is unclear whether or not this merger will have an impact on the QUEST Futures program.

Planning for the Future

Stakeholders were asked how they saw QUEST Futures in relation to ATD programs throughout the city. Stakeholders consistently voiced an interest in replicating the program.

Very interested in possibility of replication, but there is no money. The fiscal crisis is real and long. Other opportunities to support it will be followed. The program is seen as an ATD enhancement. The state seeks a new focus on ATDs in hard-hit communities.

Start a QUEST Futures where the need is the greatest—the Bronx.

If the data show that it is working, then it should be replicated.

It should look exactly like QUEST Futures does in Queens. Each borough is different so it would have to take the uniqueness of their community into consideration but they should use QUEST Futures in Queens as a model.

CHAPTER V: IMPLEMENTATION

This chapter covers the implementation of QUEST Futures from October 2008 through September 2010. In particular, it documents the extent to which program implementation reflected the original design and highlights areas in need of improvement.

Stages of Program Implementation

QUEST Futures was launched in October 2008. Until its initial *pilot stage* concluded after January 2009, QUEST Futures only accepted referrals from the QUEST ATD program. These QUEST ATD participants were offered the opportunity to participate in QUEST Futures on a purely voluntary basis.

The *second stage* of the QUEST Futures rollout began in February 2009, when QUEST Futures began screening Intensive Community Monitoring (ICM) participants (ATD Tier 3) and offering participation on a voluntary basis. During the first quarter of 2009, four ICM participants were referred to QUEST Futures for screening (and 15 ICM referrals were made throughout the two-year sampling frame for this evaluation).

The *third stage* began in March 2009. In this stage, QUEST Futures: (1) began accepting voluntary referrals from law guardians and other sources; and (2) began accepting cases that were mandated by a family court judge to receive an assessment and, if eligible, to participate in QUEST Futures.

The *fourth stage* of the QUEST Futures rollout began in June 2010, when QUEST Futures began accepting cases at the post-disposition stage, both as referrals from probation officers for voluntary participation and mandates from judges as a condition of probation following a hearing on a violation of probation.

As QUEST Futures expanded, the staffing of the program had to be reconsidered. In September 2009, program planners held an all-staff meeting to facilitate a staffing structure change from staff assigned to the QUEST ATD program and/or the QUEST Futures program to one where all staff are part of QUEST and perform duties for each program as appropriate.

Screening, Referral and Participation

Initially, staff screened for mental health issues using the Massachusetts Youth Screening Instrument—Second Version (MAYSI-2).[3] Over time, the program switched to using the Diagnostic Predictive Scales (DPS) to screen youth. This change was made because the DPS

[3] The MAYSI-2 is a computer-based self-report inventory of 52 questions designed to assist juvenile justice facilities in identifying youth 12 to 17 years old who may have mental health needs. Youth wear headphones to hear the questions being read to them as they read along (5th grade reading level). Youth select YES or NO concerning whether each item has been true for them "within the past few months." The MAYSI-2 assesses responses on scales for the following topics: alcohol/drug use, angry/irritable, depressed/anxious, somatic complaints, suicide ideation, thought disturbance (boys only), and traumatic experiences. Administration takes about 10 to 15 minutes and scoring requires approximately 3 minutes. The MAYSI-2 is available in both English and Spanish and a paper-and-pencil version is also available.

provides more specific information about mental health disorders, identifies more internalizing disorders such as depression and anxiety, and has a much higher degree of correspondence with symptom and impairment scores on the Voice Diagnostic Interview Schedule for Children (V DISC-IV), which program planners were planning to use in the impact evaluation.

Prior to program implementation, QUEST screened 22 youths with the MAYSI, from January 2008 to May 2008, and nine youths with the DPS, from May 2008 to October 2008. Of this total of 31, 13 flagged for a mental health issue and will be included in the comparison group in the impact evaluation.

Table 5.1 shows the percentages of new screens, referrals, and mandates (first column) and of actual program participants (second column) that came from each key source. During the evaluation period of October 1, 2008 to September 30, 2010, 342 QUEST ATD participants received a mental health screen, and 57 young people were referred to QUEST Futures from other sources, for a total of 399 young people screened, referred or mandated.

Table 5.1
Number of Screens, Referrals and Mandates and Number of Participants by Source
(October 2008 – September 2010)

Source	Mental Health Screens, Referrals and Mandates N=399	Participants N=138
Quest ATD[1]	86%	73%
Probation: Intensive Community Monitoring[2]	4%	5%
Judicial Mandate[3]	6%	14%
Probation: Post-Adjudication Referral	2%	4%
Other	3%	4%
Total	101%*	100%

(1) Includes all QUEST ATD youth—both those who received a mental health screen as part of the standard intake procedure into QUEST ATD and those mandated by a judge to QUEST Futures in addition to QUEST ATD.
(2) Includes ICM youth mandated by a judge to a QUEST Futures assessment.
(3) Excludes QUEST ATD and ICM youth mandated by a judge to a QUEST Futures assessment.
* Does not total to 100% due to rounding.

While QUEST ATD was the largest source of screens, referrals, and mandates (as well as participants), it also was the source least likely to lead to participation. The source most likely to lead to participation was a judicial mandate (87% of youth mandated to a QUEST Futures assessment became participants); followed by probation (post-adjudication) (63%), probation ICM (47%), other (45%) and QUEST ATD (30%). All QUEST ATD youth are screened for mental health issues, regardless of whether their past behavior indicated a mental illness, which results in the low yield of actual participants. Conversely, among the reasons for the relatively high rate of participation among youths who were mandated by judges or referred by probation, the most plausible are that (1) the judges and probation officers have specific information about the youth's behavior which suggests the presence of a mental illness and (2) the alternative to participation is remand, which motivates young people to enter the program.

Most youths who are found eligible for QUEST Futures agree to participate. Indeed, during the evaluation period, there were only seven youths (6%) who received a full biopsychosocial assessment and were found eligible for QUEST Futures who did not become participants. The reasons that these youths did not become participants were: youth was already linked to services (3 youths), youth was re-arrested and remanded before consents were signed (1), youth was placed in ICM before consents were signed (1), parent/guardian of youth refused (2). Each of these youth had been referred to QUEST Futures by QUEST ATD.

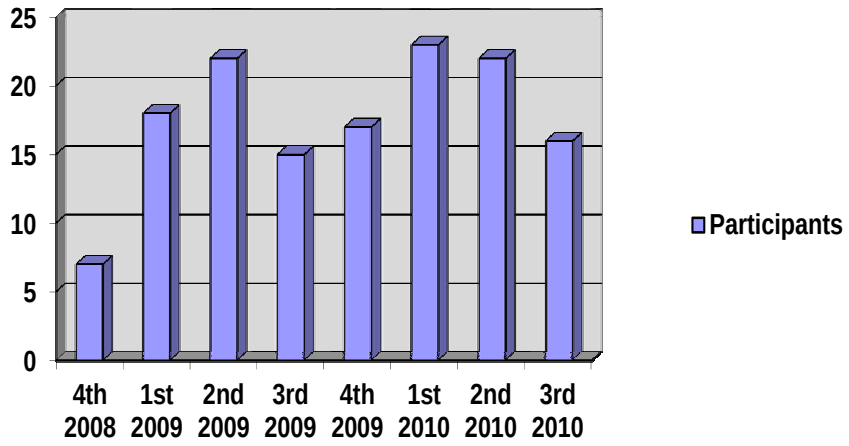
Program Volume

Volume was a challenge for QUEST Futures throughout the evaluation period. In the original evaluation design, the target number of participants per year was estimated at 80-90. This estimate was based on a statistic published by The New York City Department of Juvenile Justice (DJJ) which reported that approximately 68% of nearly 6,000 detained youths received mental health services in 2006. Therefore, QUEST Futures expected that about two-thirds, or 200, of the approximately 300 youths in QUEST ATD to be screened per year would be flagged with a mental health issue. QUEST Futures staff also expected to receive an additional 20 referrals per year from other sources (described in Chapter III and noted in Table 5.1 above).

During the evaluation period, the target of 80-90 new participants each year was not attained. As shown in Figure 5.1, the number of new participants fluctuated by quarter, with an average quarterly enrollment of 17.5 (*i.e.*, 70 per year).

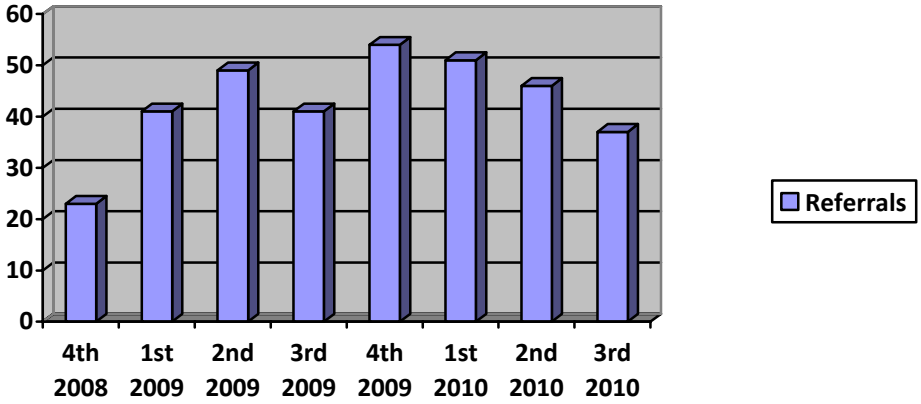
The number of enrolled program participants is in part a function of the number of youths who are referred to QUEST Futures for an assessment. As Figure 5.2 shows, after the first quarter, the number of youths receiving a mental health screen and/or referred to QUEST Futures has remained between 37 and 54, with an average of 43 referrals per quarter.

Figure 5.1
Number of Participants by Quarter
(October 2008-September 2010)



Quarters (N=138)

Figure 5.2
Number of Referrals, Screens and Mandates by Quarter
(October 2008-September 2010)



Quarters (N=399)

The Department of Juvenile Justice adjusted its original statistic of detainees receiving mental health services downward in FY2009, reporting that only 44% of detained youth—not 68%, as previously reported—are referred for mental health services. QUEST Futures volume during the evaluation period was just slightly below this adjusted figure.

During planning, the Department of Probation had agreed that all youths mandated to Intensive Case Monitoring (ICM) program (ATD Tier 3) in Queens would be screened for mental health issues, and all youths who were found to have a potential mental health issue would be referred to QUEST Futures. In February 2009, QUEST Futures worked out procedures with Probation staff in Queens for QUEST Futures to screen all ICM participants, expecting this referral source to boost participation levels substantially. In all, QUEST Futures received only 15 ICM referrals during the entire two-year evaluation period, of which only seven subsequently became QUEST Futures participants.

The number of youths mandated to ICM in Queens during the evaluation period was approximately 200.[4] Of these, 42 had been bumped up from QUEST ATD and, therefore, had received a mental health screen at QUEST ATD intake. Thus, there were approximately 158 youths enrolled in ICM during the study period who should have received a mental health screen, yet only 15 were referred to QUEST Futures for screening. QUEST Futures program personnel noted that during the evaluation period, the two Queens-based ICM probation officers were very skilled at making referrals to community-based services; they may have made referrals directly to community-based mental health agencies.

Speed of Linkages to Community-Based Services

The QUEST Policy and Procedures Manual asserts that provider intake appointments are scheduled for a date within two weeks of intake into the QUEST Futures program. A random selection of 50 cases that were opened within the evaluation period—October 1, 2008 through September 30, 2010—revealed 35 cases that had provider intake appointments scheduled. The other 15 cases did not have intake appointments scheduled because the youth and/or parent chose to engage only in onsite QUEST services (6), the youth was detained or placed (3), or the youth was already linked to appropriate community-based services (6). Of the 35 cases that did have provider intake appointments scheduled, the length of time from intake into QUEST Futures to provider intake appointment ranged from 3 days to 140 days. Three-fifths (21) of the cases had provider intake appointments scheduled within 14 days of QUEST Futures program intake. One-quarter of the cases (9) had provider intake appointments scheduled between 15 and 21 days of the program intake date. There were three cases with provider intake appointments within 22 to 35 days of program intake and one case where the provider intake appointment was 140 days after QUEST program intake. (The participant in that instance spent 88 days in detention during that period.) The average length of time from program intake to provider intake appointment was 17 days, including the participant with a 140-day gap; the average length of time was 14 days with that participant excluded from the sample. The median length of time was 14 days, and the modal length of time was 16 days.

[4] This estimation is based on 26 months of data: 200 youths enrolled in ICM from September 5, 2008 to November 4, 2010.

Program Tenure

Participation in QUEST Futures is not time-bounded, and this is reflected in the varying lengths of time that youth participated in the program. There were 61 QUEST Futures cases that closed during the evaluation period—October 1, 2008 through September 20, 2010. Of these, program tenure ranged from 21 days to 629 days, with an average tenure of 227 days and a median tenure of 172 days. Extending the analysis, 116 cases were closed through July 31, 2011. Of these, program tenure ranged from 20 days to 788 days, with an average tenure of 332 days and a median tenure of 319 days. Only 13 QUEST Futures cases were open for fewer than 90 days.

CHAPTER VI: PARTICIPANT PROFILE

This chapter presents a profile of QUEST Futures participants. The following information is presented for QUEST Futures program participants:

- Primary Clinical Diagnosis
- Background Information

Primary Diagnoses

Table 6.1 shows the primary clinical issues among QUEST Futures participants. Diagnoses were based on the Clinical Director's clinical judgment after drawing on the sources of information described in Chapter III. The primary clinical issue facing the greatest number of participants was attention deficit/hyperactivity disorder (21%), followed by depression (19%), bipolar disorder (16%), and adjustment disorder (14%). While these diagnoses were the most common among both male and females, the precise percentages receiving each individual diagnosis differed considerably between the two sexes, and these differences were statistically significant (or approached significance) for all but bipolar disorder. Specifically, 25% of males were diagnosed with attention deficit/hyperactivity disorder, but only 11% of females were. While 33% of females were diagnosed with depression, only 14% of males were. While 18% of males were diagnosed with adjustment disorder, only 3% of females were. Differences approaching significance were also found between males and females regarding diagnoses of post-traumatic stress disorder and obsessive-compulsive disorder, but these two diagnoses applied to only a small percentage of QUEST Futures participants overall.

Table 6.1
Primary Clinical Issue
(QUEST Futures Participants Enrolled October 2008-September 2010)

Primary Clinical Issue	Male N=102	Female (N=36)	Total (N=138)
Attention Deficit/Hyperactivity Disorder	25%$^{+}$	11%	21%
Depression	14%**	33%	19%
Bipolar Disorder	14%	22%	16%
Adjustment Disorder	18%*	3%	14%
Borderline Intellectual Functioning	10%	6%	9%
Conduct Disorder	9%	3%	7%
Oppositional Defiant Disorder	5%	8%	6%
Substance Abuse	5%	3%	4%
Post-Traumatic Stress Disorder	2%$^{+}$	8%	4%
Obsessive Compulsive Disorder	0%$^{+}$	3%	1%
Total	100%	100%	100%

+ p < .10, * p<.05, ** p < .01, ***p < .001

Background Characteristics

Table 6.2 shows the background characteristics of QUEST Futures participants as well as differences between males and females. Participants ranged in age at intake from nine to 17 years old, with most entering at the age of 15 (43%); 86% were aged 14, 15, or 16. Most participants were identified as "black" (54%), followed by "Hispanic" (34%).

About 82% of QUEST Futures participants self-reported that they were born in the United States. Many of their parents were not born in the United States: only 46% of mothers (N=102), and 38% of fathers (N=100), reported being born in the United States. Forty-seven percent of fathers (N=49) and 51% of mothers (N=57) were born in a Central/South American country, with the Dominican Republic and Mexico being the two single countries most often represented. Of the 121 families that provided information on the primary language spoken at home, 80% reported that English was the primary language spoken at home; the most common non-English language to be the primary language spoken in the home was Spanish.

Almost one-third (31%) of QUEST Futures participants were at some point involved in a case involving the Administration for Children's Services.

The majority of participants (58%) had a known history of mental illness at the time of program intake, and one-quarter reported that they were receiving treatment for a mental health issue at the time of intake. Thirty-nine percent of QUEST Futures participants indicated that they were in some sort of special education program. Males reported special education involvement more than three times as often as females (48% vs. 14%).

The underlying arrest was most often assault (24%), with a significantly higher percentage of females than males reporting this charge. This was followed by robbery (20%) and larceny (15%). QUEST Futures participants were more than twice as likely to have been arrested on a nonviolent charge (71%) as compared to a violent charge (29%). Forty-five percent were arrested on a felony; 55% for a misdemeanor.

The vast majority of youths who became participants did so before their cases were adjudicated (95%); the remainder (5%) became participants post-disposition while under probation supervision. (It is worth noting that this data reflect only 2-3 months of QUEST Futures receiving post-disposition referrals so it is likely that this percentage will increase over time.) The majority of youths became participants on a voluntary basis (70%). Thirty percent became participants pursuant to a mandate from a judge to participate in the program as a condition of avoiding detention or placement.

Table 6.2
Participant Background Information
(October 2008-September 2010)

	Male N=102	Female N=36	Total N=138
Age at Program Enrollment			
12 years old and under	5%	0.0%	4%
13 years old	9%	11%	9%
14 years old	26%	28%	27%
15 years old	46%	33%	43%
16 years old	12%*	28%	16%
17 years old	2%	0%	1%
Average Age	15.1	15.2	15.1
Race/Ethnicity			
White	6%	0%	4%
Black	58%	44%	54%
Hispanic	28%*	50%	34%
Other[1]	8%	6%	7%
Who is Raising Youth			
Both Parents	16%	17%	17%
Mother	63%	59%	60%
Father	3%	13%	10%
Other	19%	12%	17%
Born in United States[2]			
Youth	88%	79%	82%
Youth's Mother	52%	44%	46%
Youth's Father	44%	35%	38%
Ever Involved with ACS	28%	42%	31%
Ever Homeless	0%	3%	1%
Ever Tried Drugs[3]	58%	65%	60%

Table 6.2 *(Continued)*

	Male N=102	Female N=36	Total N=138
Self-Reported Mental Health History			
History of Mental Illness	58%	56%	58%
In Mental Health Treatment at Program Enrollment	27%	19%	25%
Previous Hospitalization for Psychiatric Reasons	20%	16%	19%
Education			
At Grade Level at Program Enrollment	49%	35%	45%
In Special Education at Program Enrollment	48%***	14%	39%
Charge Type			
Property crimes	26%+	36%	29%
Larceny	*13%*	*19%*	*15%*
Burglary	*4%*	*3%*	*4%*
Trespassing	*4%*	*6%*	*4%*
Other[4]	*5%*	*8%*	*6%*
Robbery	23%*	8%	20%
Assault	20%*	36%	24%
Sex crime	5%	3%	4%
Arson	2%	0%	1%
Weapon charge	5%	3%	4%
Drug	8%	8%	8%
Graffiti	3%	3%	3%
Pre-petition	1%	0%	1%
Other[5]	7%	7%	6%
Violent Charge[6]			
Yes	30%	27%	29%
No	70%	73%	71%
Case Status at Time of Referral			
Pre-adjudication	96%	92%	95%
Post-disposition	4%	8%	5%

Table 6.2 ***(Continued)***

	Male N=102	Female N=36	Total N=138
Voluntary/Mandated Status at Time of Program Entry[7]			
Voluntary	72%	64%	70%
Mandated	27%	36%	30%

+p<.10, *p<.05, **p<.01, ***p<.001.

1) Includes Asian-Indian Subcontinent (9), and Asian-Pacific Islander/Other (1).

2) N varies due to missing data: youth (N=112); youth's mother (N=102); and youth's father (N=100).

3) Includes alcohol, marijuana, cocaine (all forms), and other drugs.

4) Other property crimes include: criminal mischief, criminal possession of stolen property, criminal possession of a forged instrument, possession of stolen vehicle, and shoplifting as a violation of probation.

5) Includes obstructing government administration, false impersonation, inciting to riot, unlawful assembly, criminal contempt, and riot first degree.

6) Includes the following charges: assault, assault 2nd degree, burglary 2nd degree, robbery 2nd degree, attempted robbery 2nd degree, sexual abuse 1st degree, and rape 1st degree. Due to missing data, N ranges from 91 to 119; percent is given based on valid percent.

7) The voluntary category includes all voluntary participants in QUEST Futures regardless of the referral source; the mandated category includes all mandated participants in QUEST Futures regardless of the referral source.

CHAPTER VII: SIX CASE STUDIES OF ASSESSMENT, CASE MANAGEMENT, AND TREATMENT

This chapter presents six case studies of QUEST Futures participants. The following areas are addressed:

- Assessment, case management, and treatment
- Case study review and analysis

Assessment, Case Management, and Treatment

Participants in QUEST Futures typically bring with them a complex set of issues involving not only their own mental illness and criminal behavior but often the mental illness and criminal behavior of a close family member, their own and/or a family member's substance abuse problem, poverty, a lack of medical insurance, the absence of a parent or parents, educational deficits, and the experience of abuse and neglect, often with Administration for Children's Services (ACS) involvement. The role of QUEST Futures in this complex web of circumstances is to remove any and all barriers to effective mental health treatment. The QUEST Futures case managers work to link the youth and family members to service providers and to encourage follow-through with the treatment plan. For the case manager, this entails multiple contacts—in person and via the telephone—with the youth and family as well as with potential treatment providers, as the case manager seeks to find the right providers for each youth and family member.

In order to illustrate the complex assessment, case management, and treatment process that is typical of QUEST Futures, a series of vignettes follow. The vignettes do not comprise a representative sample of cases but were purposefully selected to illustrate the story of QUEST Futures participants with both "successful" and "not so successful" case outcomes. The vignettes highlight the seemingly intractable nature of some of the problems the youth and families face. The cases presented were selected by the principal investigator in collaboration with the QUEST Clinical Director. The Clinical Director provided an initial write-up in each case, edited by the principal investigator to highlight key events related to case management, services, and compliance. To preserve anonymity, the vignettes were also edited to remove references to specific dates or community-based treatment programs.

Vignette 1: John

Working Together Toward a Successful Outcome

John was a 14-year-old youth arrested for assault. He was mandated by a Queens Family Court judge to Tier 2 of QUEST ATD (the after-school alternative-to-detention program), which he had to attend five days per week for three-and-a-half hours each day. Upon admission, he was living with his biological mother, who had a mental illness but was not receiving treatment. John had a lengthy history of mental illness and was struggling with issues of gender orientation. Previously, he had been diagnosed with bipolar disorder. John had an inconsistent treatment history. He also had had special education status since elementary school due to emotional disturbance/disability. After unsuccessful efforts to provide services and support in his zoned school, he had been moved to a special education school district. John came to the attention of QUEST Futures staff when he flagged for mental health issues on the Diagnostic

Predictive Scales (DPS) that he took as part of his intake at QUEST ATD. John then became a voluntary participant in QUEST Futures simultaneously with his mandated participation in QUEST ATD.

During the intake process for QUEST Futures, it became clear that there was a lengthy history of domestic violence between his biological parents, who had separated some years previously. There was also violence between John and his mother. In fact, his arrest was for assaulting his mother at home. There had also been longstanding Administration for Children's Services (ACS) involvement with the family. This included investigations by Child Protection Services of allegations which were found to be true and for which ACS preventive services had been put in place.

Given the volatile situation at home and the presence of significant mental health issues for both mother and son, QUEST Futures staff immediately conducted a mental health assessment for John and made a speedy referral for home-based crisis intervention (HBCI) services provided by a local hospital. The hospital completed an in-home psychiatric assessment and subsequently referred John to an outpatient child and adolescent clinic for ongoing individual therapy and medication management. The hospital also offered referrals and support to John's mother. Since John's mother spoke only Spanish, John was assigned to a Spanish-speaking case manager at QUEST. In close consultation with his mental health provider, QUEST staff referred John to a program that works with gay, lesbian, bi-sexual, transgendered, and questioning (GLBTQ) youth and their families. At this program, John participated in peer support groups as well as leadership and job-readiness skills groups.

QUEST also provided John with academic support and tutoring. Staff contacted John's school guidance counselor, who subsequently faxed assignments and materials to QUEST in efforts to assist John in completing homework and catching up with school projects. John also attended regularly-scheduled workshops held for QUEST ATD youth that focused on such topics as anger management, coping skills, and substance abuse prevention.

Despite ongoing conflicts at home, John adhered to his QUEST ATD curfew. Once established in his QUEST Futures treatment plan, John was less volatile and became compliant with all program rules and regulations. Based on his excellent progress at QUEST ATD, John ultimately received a disposition of 12 months of probation. He continued to participate in services at both the outpatient child and adolescent clinic and the program for GLBTQ youth throughout his probation period. During this time, John's QUEST Futures case manager checked in with him periodically to provide emotional support, he continued to attend school regularly, and his school work improved.

Vignette 2: Shaquan

Lack of Trust and Mixed Results

A Queens Family Court judge mandated Shaquan to participate in Tier 1 of QUEST ATD after being arrested for possession of a controlled substance. The judge also mandated that QUEST ATD make a referral to a substance abuse treatment program within 24 hours. Shaquan was accompanied to QUEST ATD by his biological father. Shaquan flagged for a mental health

disorder on the DPS and was referred to QUEST Futures. Both Shaquan and his father agreed to enroll in QUEST Futures on a voluntary basis.

Shaquan was a 16-year old African-American male born with positive toxicology for crack cocaine. His biological mother had a long history of substance abuse. Shaquan had had only minimal contact with her and did not even know where she was. He was residing with his disabled father in a one-bedroom apartment. His relationship with his father was full of conflict. Shaquan's father was the subject of multiple Administration for Children's Services (ACS) cases related to educational neglect. Shaquan had a history of school non-attendance since first grade, at one point missing an entire year of school. Shaquan was born with cognitive deficits and was in the borderline range of intellectual functioning. He was diagnosed with a major depressive disorder and had made one suicide attempt prior to participating in QUEST.

Shaquan's strengths included being likeable and healthy. He also had a fairly positive relationship with an older sister who did not live in the home. He was compliant with house rules and curfew, but had a history of fighting in school. The family had a history of noncompliance with recommended services. QUEST Futures had referred the family to a home-based crisis intervention (HBCI) program, but this program engagement ended after three visits, because Shaquan's father stopped allowing anyone in the home. A school-based support team—a psychologist, social worker, and education evaluator who identify and evaluate students who need special services—agreed to provide Shaquan with "home-schooling," but this was not successful either. A great deal of engagement was needed to gain the family's trust, but due to the father's disability, Shaquan was often unable to keep appointments with the case manager, hindering this relationship.

Through the initial QUEST Futures assessment, it was discovered that Shaquan did not have health insurance and, therefore, QUEST was unable to make referrals to treatment programs. Appointments with Single Stop—a non-profit organization that assists families in obtaining entitlements—were scheduled, but his father missed at least two of these appointments before insurance could be put in place. Shaquan was referred to a local treatment center but his case was closed soon thereafter due to poor attendance. A referral was also made to the local educational opportunity center for General Education Diploma (GED) Prep, but Shaquan never followed through. The QUEST case manager offered to accompany Shaquan to appointments, but this did not happen because Shaquan's father did not want anyone accompanying Shaquan anywhere. When the case manager made reminder phone calls to the family on the day of the scheduled appointments, the phone calls were not returned.

Due to Shaquan's history of depression and suicidality, QUEST Futures, once again, referred the family to home-based crisis intervention services, but after one visit, his father discontinued this service.

QUEST ultimately assisted the family with obtaining health insurance for Shaquan. Multiple attempts were made to engage the family, but his father's belief that "all systems" are intrusive and "will fail" contributed to his lack of trust and follow-up. Although home-based services were assessed to be the best option for service delivery, the family would not agree to this since this would involve at least three different workers—a Department of Education teacher, a home-based crisis intervention worker, and an ACS preventive worker—coming into the home.

Shaquan also had been ordered by the Family Court judge to participate in substance abuse treatment, which would have involved a fourth service provider.

Regarding court compliance, Shaquan was remanded on an outstanding warrant on one of his court dates. The QUEST case manager accompanied Shaquan's father on a visit to the non-secure detention facility where he was held. Shaquan was released to his father at his next court date but was a no-show at his adjournment date and another warrant was issued. At this point, his father informed QUEST that he was no longer interested in participating in the QUEST Futures program.

Vignette 3: Patricia

On-going Support Despite Setbacks

Patricia was a 15-year-old, New York City-born female of Puerto-Rican descent. She resided with her biological mother and her 13-year-old half-sister. Two additional half-siblings were not residing with them; however, Patricia maintained contact with them. Patricia's parents were never married, and they separated when she was approximately one year old. Over the six years prior to her arrest, Patricia experienced several significant traumas, including an alleged rape when she was 11 years old, her father's imprisonment, the violent murders of close relatives, and a custody battle over her half-brother resulting in their loss of contact for several years.

Patricia admitted to intermittent alcohol and marijuana use and ran away from home several times. Patricia admitted to a history of self-mutilating behavior and suicidal actions. Patricia was sent to a local hospital for a psychiatric evaluation on one occasion after making suicidal statements in school. Although this resulted in a recommendation for outpatient therapy, it never took place because Patricia refused. When she was 14 years old, Patricia was mandated to participate in QUEST's ATD Tier 2 program after an arrest for assaulting a peer at school. Patricia came to the attention of QUEST Futures staff after she flagged for mental health issues on the DPS. She and her mother agreed that Patricia would become a voluntary participant.

Patricia presented with a number of strengths, including a mother who was involved and generally supportive. Despite being a teenager when Patricia was born, Patricia's mother managed to finish school, obtain a job, and maintain a household for the family. However, she and Patricia had a contentious relationship that at times became physical. Nevertheless, Patricia relied on her mother for support and guidance. Patricia also had good relationships with her siblings. She was open to therapy and craved support from adults around her. She was quite forthcoming and wanted to share her story. Patricia was bright and demonstrated a capacity for insight. Despite these strengths, she often struggled to make good judgments, resulting in poor life decisions.

From the start, Patricia and her mother established a supportive relationship with her QUEST case manager, meeting regularly and sometimes making unannounced visits. Despite recommendations to consider medication, Patricia and her mother preferred to proceed with therapy before considering this option. QUEST referred Patricia and her mother to an intensive Family Functional Therapeutic (FFT) intervention, as many of Patricia's involved relationships with family members. The family enrolled in the FFT intervention, which was covered by the mother's private insurance.

Patricia struggled in school. It was agreed that she would benefit from a smaller, more supportive educational environment. An interview was scheduled at a high school that often serves adolescents who have a history of court involvement. Unfortunately, the appointment was missed due to illness and never rescheduled by Patricia's mother. After continued discussions with her mother, she opted to have Patricia return to her regular high school.

Several months into her QUEST Futures participation, Patricia's mother contacted her QUEST case manager expressing concerns with Patricia's behavior at home. She mentioned considering having Patricia move in with her father or entering residential placement. Her mother agreed to a referral to a local mental health center which could provide home-based crisis intervention (HBCI) services. The next day, Patricia was involved in a small physical altercation with a male peer at the QUEST ATD program, which resulted in a two-day suspension from the program. Despite several efforts made by the local mental health center, Patricia's mother did not return calls and was not home when they arrived to meet with her.

As planned, Patricia returned to her regular high school. QUEST staff made numerous attempts to contact her guidance counselor to and address issues pertaining to school, but the school was unresponsive. About this time, Patricia's mother reported that she lost her job due to excessive absences. This resulted in the family losing their private insurance coverage. Eventually, Patricia's QUEST case manager got in touch with her guidance counselor and it was agreed that the guidance counselor would refer Patricia for in-school counseling, as there was no active insurance, which prohibited Patricia from receiving services in the community.

Patricia ultimately received a final disposition of two years' probation with enhanced supervision and 60 hours of community service.

Patricia's mother subsequently contacted the QUEST case manager with suspicions that Patricia could be pregnant. This was later confirmed by a medical doctor. The probation officer was made aware of this during a home visit; however, she did not inform Patricia's school. In response to Patricia's determination to keep her child, Patricia met with her case manager and was provided literature, services, and programs available to her as a teen mother-to-be, including daycare. A copy of the same material was provided to Patricia's mother. Patricia was referred to a Nurse-Family Partnership program which would work with her, during and after the pregnancy, to enhance her parenting skills. Unfortunately, Patricia opted out of the services during her pregnancy.

Patricia disclosed to her case manager that she became pregnant after her mother allowed her then 18-year-old boyfriend to spend nights in the home. Following this disclosure, QUEST's Clinical Director called the child abuse hotline and asked that an investigation be conducted due to suspicions of inappropriate supervision. A child protective services case was initiated but not found to be indicated.

Patricia's mother complained that probation was not providing the enhanced supervision that was expected. She complained about Patricia's increasingly poor school attendance, excessive sleeping, and poor attitude. Patricia was also smoking marijuana almost daily.

Two months later, Patricia appeared in court to address a violation submitted by her probation officer for failure to attend school regularly and to attend community service. Despite these violations, her disposition was adjusted such that she was "bumped down" to regular probation and her sentence reduced to one year of probation.

Patricia gave birth to a healthy baby boy. Initially, she seemed a motivated parent. She wanted to transfer to a school offering daycare services to teen mothers, but later agreed that the commute might be too long. She resumed school while her mother watched the baby at home. Patricia continued to meet with her QUEST case manager and her therapist.

Gradually, relations at home became strained with the pressures of a newborn. The family was encouraged to resume family therapy, and the case manager worked diligently to alleviate issues regarding school and child care. An appointment was set for Patricia to interview at a new school. Unfortunately, the interviewer was unsure of Patricia's dedication to school and so she was not accepted. During this time period, relationships at home continued to spiral downward. Patricia became increasingly depressed and distressed.

Patricia's therapist reinstated family therapy and held sessions in the home to ensure attendance.

Although Patricia did not re-offend, she continued to struggle with school, parenting, health, and family—her mother in particular. QUEST continued to coordinate services among probation, community-based providers and Patricia's school. Eventually, Patricia was hospitalized for three weeks in Queens for a medication evaluation and stabilization. Upon her discharge, her probation period ended and the QUEST Futures case was closed at the request of the family. QUEST Futures staff indicated that they would be willing to reopen the case at the families' request should they need further assistance.

Vignette 4: Oscar

The Inability to Locate a Clinically-Appropriate Level of Intervention

Oscar was a 13-year-old Hispanic male mandated to QUEST ATD Tier 1 by Queens Family Court after being charged with an attempted assault against his mother. A mental health screen and face-to-face assessment indicated a probable mental health disorder. QUEST ATD staff referred him to QUEST Futures and he began participating in both programs—on a mandated basis with QUEST ATD and on a voluntary basis with QUEST Futures.

At the time of QUEST Futures enrollment, Oscar was residing in Queens with his paternal aunt after an order of protection was issued forbidding him to live in the same home with his biological parents. Although Oscar had a positive relationship with his father, his interactions with his mother, who was also diagnosed with a mental illness, were conflicted. Oscar had a long history of emotional and behavioral problems dating back to first grade. He had been hospitalized numerous times and disappeared for days at a time, at which point he became non-compliant with medication and therapy appointments. He was in the 9th grade. Prior to his current school placement, Oscar had attended a residential school in Long Island. Despite the appropriateness of this placement, his parents requested that he be placed in a community-based academic setting and he was transferred to his current school.

QUEST Futures made referrals to two outpatient mental health clinics. Oscar had not been on medication for several months; his chronic disappearances and missed treatment appointments led to his case being closed at one of the mental health clinics. Before he could attend intake at the second clinic, however, he was hospitalized after an angry outburst at home. The QUEST case manager met with Oscar, his father, and the hospital social worker to create an appropriate treatment and discharge plan. Oscar was stepped down into a hospital-based outpatient program. While in this program, the QUEST case manager assisted his father in requesting a Committee on Special Education evaluation (CSE) for placement back into a residential school setting. But Oscar again disappeared from the hospital program and did not show up for his court date and a warrant was issued.

Oscar arrived home several days later and was brought to court by his father. He was remanded until his next court date and then released once again into the custody of his father. The QUEST Futures case manager attended the CSE meeting with Oscar's father, and his individualized educational plan (IEP) was updated to reflect that placement in a residential setting was necessary. QUEST Futures made a referral to a residential school setting, but Oscar left this setting without permission several times and was subsequently placed in Administration for Children's Services (ACS) custody at his next court date. Instead of leaving with ACS, he left the courtroom on his own and was found several days later by his father, living on the street. He was re-arrested on a Persons in Need of Supervision (PINS) petition and again placed in ACS custody. At this time, the QUEST Futures case was closed at the request of the father, and ACS attempted to have Oscar placed with his uncle in New Jersey.

Vignette 5: Lashaun

Persistence in Finding the Right Fit

Lashaun was a 16-year-old Latino male residing in Queens with his biological mother and a younger sister. Lashaun had four older siblings: a brother in the military and residing out of state, another sister residing out of state and a sister and a brother residing in New York City. All siblings have been diagnosed with a mental illness, either anxiety or depression, and all family members have struggled with substance abuse, including Lashaun's biological father who is minimally involved with Lashaun. Lashaun's mother is a recovering alcoholic, but has been sober for 12 years. She is also a victim of domestic violence. Lashaun was not witness to the abuse, but his dad spent several years in prison for shooting his mother. Lashaun was mandated to participate in QUEST's ATD program after an arrest for possession of marijuana. The DPS screen and a face-to-face assessment indicated the presence of mental health issues, so he was referred to QUEST Futures on a voluntary basis.

Lashaun presented with a number of strengths. His mother is supportive, employed, and provides stable housing. His siblings are supportive of one another, and his elder siblings are employed. Lashaun and his family are willing to accept help. Despite these strengths, Lashaun and his mother were experiencing conflict in their relationship, and he had a long history of physically aggressive behavior, both at home and in school. He also had a history of truancy and academic failure, and had few social supports outside of his family. His mother reported that Lashaun could be very engaging, but that he struggled with coping skills, often "getting high" to "calm down."

Soon after QUEST Futures participation began, Lashaun became aggressive towards his mother and was brought to a psychiatric emergency room, where he was evaluated and released. Lashaun was also referred to a substance abuse residential treatment program, since he had admitted to almost daily marijuana abuse. His QUEST Futures case manager began exploring alternative school placements as a means of addressing chronic truancy and multiple suspensions. While in the residential treatment program, Lashaun became depressed, irritable, and disruptive. As a result, he was discharged and, after becoming physically aggressive at home, was admitted to a hospital-based inpatient unit for evaluation and observation. At the hospital, he was diagnosed with a mood disorder, placed on psychotropic medication, and discharged with a referral to a family-based treatment program for intensive outpatient substance abuse services. However, before an intake could be scheduled, the court ordered Lashaun to be interviewed for admission into a new residential program. Lashaun was admitted and transported to the program but discharged soon after for attempting to leave without permission. QUEST Futures immediately referred Lashaun for intensive outpatient substance abuse services, since he had at this point failed in two residential programs. He completed his intake and began treatment nine days later.

At this point, Lashaun expressed an interest in job training, and QUEST referred him to a job readiness program for court-involved youth. Several months later, he tested positive for marijuana at a court date and, as a result, was remanded, closing out his outpatient program involvement. While in remand, QUEST referred him to a new residential program, but the family court judge, after finding him responsible for the crime he committed, gave him a disposition of 18 months of probation with participation mandated in the Juvenile Justice Initiative (JJI) run by ACS. Initially, Lashaun was cooperative with JJI and attended school regularly. He and his mother also continued meeting weekly with the QUEST Futures case manager for support. However, conflicts with his mother began to escalate when Lashaun resumed a relationship with his biological father, whom his mother believed was a negative influence. Due to increasing conflicts, Lashaun left the home and moved in with his biological father, transferring back to his previous school in the process. Soon after, ACS did not approve his father's home as the custodial residence, and Lashaun moved in with his paternal grandmother. Eventually, the family court judge ordered Lashaun placed in a private residential treatment center.

Throughout the course of Lashaun's participation in QUEST Futures, his case manager continued to offer support to the family and coordinate all his support systems. The focus of the relationship was always strengths-based and geared towards problem-solving, decision-making, and coping. Over time, family members improved their capacity for collaboration and negotiation. Throughout the multiple failed treatment efforts, Lashaun continued to meet with the QUEST Futures case manager, keeping many court dates in the process. His mother also contacted QUEST Futures, on behalf of her oldest daughter, for a referral to a domestic violence program. QUEST Futures continued to work with Lashaun's family on a regular basis and to collaborate with Lashaun's probation officer after the case was disposed.

From a juvenile justice perspective, being found "responsible" and being placed may be considered a negative outcome—although it is notable that the judge chose a placement option where Lashaun would receive the treatment services he required. From a mental health perspective, Lashaun's placement in a private residential treatment center is considered a positive outcome because Lashaun was receiving the appropriate level of care relative to his

mental health status at the time—he was in a structured setting, being consistently held accountable for his behavior, and receiving treatment consistently.

Vignette 6: Carlos

Collaboration, a Family Reunion and Academic Success

Carlos was a 16-year-old Latino male who was living with his grandparents. His biological mother was his legal custodian, but she sent Carlos to live with his maternal grandmother because she was having difficulty coping with his behavioral issues at home and his refusal to attend school. Carlos' parents had separated several years prior to his coming to QUEST Futures, and both of his parents had remarried and were living in Queens.

Carlos was arrested for unlawful possession of a weapon. After reviewing his file and hearing from family members, the family court judge mandated Carlos to a QUEST Futures assessment and to participation should he meet eligibility criteria. QUEST Futures staff administered the Diagnostic Predictive Scales (DPS), and the results indicated the presence of an anxiety disorder, which was confirmed by a follow-up face-to-face interview. QUEST Futures staff also learned that Carlos was abusing alcohol and marijuana in an effort to self-medicate.

At QUEST Futures, both parents said that Carlos was angry and depressed about his life and had received some counseling at an outpatient clinic. According to QUEST Futures staff, both parents tended to minimize his mental health struggles. Carlos' father attributed his depression and anger to his "fear of being sent away." His father also told QUEST Futures staff that Carlos had some gang involvement, and Carlos later admitted to his case worker that he had been gang affiliated though stated that he had renounced his gang association. Unfortunately, gang members continued to threaten and assault Carlos despite three school safety transfers. Carlos also explained to his QUEST Futures case manager that he had to take alternate routes to get to his grandmother's house after school in order to avoid gang "bangers." At this time, neither of Carlos' biological parents were willing to have him live with them. His mother worked for ACS and felt that his truancy and court involvement would jeopardize her job. His father said that he did not want to bring Carlos into his home because he was concerned that his son's peers would be disruptive to his new family.

QUEST Futures made a referral to a new school, which offered on-site counseling. Despite the change in setting, however, Carlos continued to abuse drugs and miss school. During this time, Carlos was assaulted again. His probation officer recommended placement out of the community for 12 months for his safety. QUEST Futures staff were in agreement with this recommendation. QUEST Futures staff had made several referrals prior to the placement—for truancy prevention and for individual psychotherapy for anxiety and substance abuse—but there was no follow-up by the biological parents, so Carlos was never admitted into these programs. Nevertheless, Carlos continued to meet weekly with his QUEST Futures case manager, who also met regularly with his parents.

Fortunately, Carlos did well in the out-of-community placement. The treatment program's therapist and case manager kept in touch with the QUEST Futures case manager in order to develop a discharge plan to help Carlos transition back into the community. While Carlos was out of the community, QUEST Futures staff continued to meet with the biological parents to

keep them informed of Carlos's status. The reports were consistently positive. Carlos passed all of his classes and received his high school diploma. Because Carlos performed so well, he was discharged after six months and ordered to participate simultaneously in the Juvenile Justice Initiative and QUEST Futures. QUEST Futures referred him to an internship program, which he completed. Carlos was subsequently accepted into an Ivy League college, but since this was too costly, the mother decided that he would attend a State University of New York school instead. Carlos is currently a freshman. Carlos now has a positive relationship with both parents. Carlos has been a guest speaker at the QUEST after-school program, where he inspires other youth with his story.

Case Study Review and Analysis

As these vignettes illustrate, QUEST Futures participants face many challenges, including: (1) family dysfunction and conflict; (2) family involvement in crime, drug abuse, mental illness, and domestic violence; (3) missed treatment appointments, often caused or compounded by a parent or guardian's inability or unwillingness; (4) poor school performance, often exacerbated by an inappropriate school placement; (5) ACS involvement; and (6) involvement with multiple juvenile justice agencies. In each case, QUEST Futures staff work to identify resources to overcome these challenges. Then, QUEST Futures staff works to address the common occurrence that an initial referral does not work out. In particular, in linking QUEST Futures participants and their families with appropriate services, QUEST Futures staff focuses on:

- Information Coordination: QUEST Futures case management involves a great deal of interagency communication and coordination. QUEST Futures staff must not only keep the participant youth and family members engaged, but must also keep the youth's school, service providers, and other agencies such as ACS engaged and informed.

- Individualized Referrals: As the vignettes illustrate, most youth require multiple types of referrals, and treatment plans are highly individualized, spanning multiple modalities of individual and family therapy; crisis intervention; hospital-based services; substance abuse treatment; school placements; special needs programming (e.g., GLBTQ); and wrap-around referrals for family members.

- Rapid Linkages: QUEST Futures staff link participants and their family members to service providers relatively quickly, because they know the service providers in the community and the enrollment criteria for the individual programs.

- Modifications to Initial Treatment Plan: In a great many cases, QUEST Futures must make multiple attempts at finding the right array of services. QUEST Futures staff must also often make multiple readjustments in the youth's treatment plan as new information surfaces and as the mental health status of the youth and/or family members change over time.

- Family Engagement: Many of the vignettes reveal the prevalence of severe family dysfunction and conflict. Accordingly, when managing a case, QUEST Futures works to engage not just the youth but also relevant family members; a lack of family member "buy-in" is a frequent problem. The "buy-in" from the parent/guardian can be critical in

assisting the youth in practical matters like making and keeping appointments. If a service provider is not a good fit, the QUEST Futures staff works to find a good fit. If a refusal is based on the stigma surrounding mental health issues, QUEST Futures staff work to de-stigmatize mental health issues and to convince parents/guardians to engage in QUEST Futures despite the frustration they may feel due to past involvement with "the system."

- Educational: QUEST Futures staff works to identify education issues, which may include a need for special education, inappropriate school settings, undiagnosed learning disabilities or chronic truancy. To address these issues, QUEST Futures assists the family in navigating Department of Education bureaucracy.

- On-site Engagement: The QUEST Futures clinical staff works to encourage participants to accept appropriate services and avoid further illegal activity.

- Open-Ended Duration: These vignettes underline the extent to which the QUEST Futures program is open-ended, and case management services continue to be offered well after a case disposition or even after other agencies (e.g., JJI or residential placement facilities) become involved.

CHAPTER VIII: PROGRAM OUTCOMES

This chapter presents program outcomes for QUEST Futures participants and their families.

Service Linkages

Service linkages occur after a youth has become a QUEST Futures participant. The service plan may identify multiple types of services and providers. The plan may be modified based on changes in the youth's or family's situation. This section presents information on initial service linkages for QUEST Futures participants and/or their family members. In many cases, QUEST Futures made additional referrals at later dates but program staff only recorded the initial service linkages in a database; staff also recorded the initial identified service needs for family members in the Justice Center Application (JCA).

Tables 8.1 and 8.2 show the service linkages for participant youths and identified service needs of participants' family members, respectively.[5]

Table 8.1 shows the range of service linkages for QUEST Futures participants. While 72% of QUEST Futures youths were linked to services at an outpatient mental health clinic, 14% received services in a residential setting. Of the 19% of QUEST Futures participants who were referred to the Committee on Special Education (CSE) for an evaluation, it is notable that most of the referrals were for males. In fact, 23% of males were referred for a CSE evaluation in contrast to only 8% of females. Of the 11% of QUEST Futures participants who received substance abuse treatment, 4% received treatment in a residential setting.

Table 8.2 shows the service needs that were identified for the families of QUEST Futures participants. Of the 138 families, 55 were identified as having service needs when the youth's program participation began. The most common service needs identified were for mental health treatment (15%), followed by education services (11%), preventive services (9%), entitlements (7%), anger management services (4%), parenting services (4%), and job/vocation employment services (4%). It is notable that male participants were more likely to have a parent/guardian identified as needing mental health treatment than females (18% versus 8%). It is also notable that female participants were more likely to have a parent/guardian identified as needing preventive services than males (17% versus 4%).

[5] Using a database specially designed for this purpose, QUEST Futures case managers tracked the following participant service utilization elements: name of providing agency, type of service(s) provided, and the date the referral to the providing agency was made. The database did not contain information about specific numbers of treatment sessions or additional details about the treatment modality or approach. For example, the database tracked whether or not a participant was placed in a residential facility but not whether or not they received individual or group therapy in the facility. Data for the service needs of family members identified by QUEST Futures staff was obtained from the JCA.

Table 8.1
Participant Service Linkages at In-Program Baseline
(October 1, 2008-September 30, 2010)

Type of Service	Male N=102	Female N=36	Total N=138
Mental Health Services			
Outpatient mental health clinic	77%	58%	72%
Residential treatment[1]	15%	11%	14%
Substance Abuse Prevention			
Substance abuse	4%	3%	4%
Substance Abuse Treatment			
Outpatient	8%	6%	7%
Residential	4%	6%	4%
Evaluation			
Psychiatric evaluation	7%	8%	7%
Neurological evaluation	1%	0%	1%
Committee on Special Education	23%	8%	19%
Education/Employment for Youth			
Internship	4%	6%	4%
Employment	1%	0%	1%
Transfer school	4%	6%	4%

1) Includes both residential placements and inpatient psychiatric treatment.

Table 8.2
Family Service Needs Identified at In-Program Baseline
(October 1, 2008-September 30, 2010)

Type of Service	Male N=102	Female N=36	Total N=138
Service Recommendations			
Parent/guardian mental health treatment	18%	8%	15%
Education services	10%	14%	11%
Preventive services (to keep youth out of foster care)	4%	17%	9%
Entitlements[1]	5%	8%	7%
Anger management services	4%	6%	4%
Parenting	4%	6%	4%
Job/vocation employment services	4%	3%	4%
Housing	1%	8%	3%
Medical insurance	2%	3%	3%
Parent/guardian drug and/or alcohol treatment	2%	3%	3%
Family therapy	1%	6%	2%
Parent support and/or psychoeducational support	2%	0%	2%
Sibling mental health and/or drug treatment	2%	0%	1%
Home-based crisis intervention (HBCI)	2%	0%	1%
Grief/bereavement support	1%	0%	1%
Immigration services	1%	0%	1%
Legal services	1%	0%	1%

1) QUEST Futures staff rarely makes direct referrals to public agencies that provide benefits but do identify unclaimed benefits and refer parents or guardians to an agency that can assist them further. In most cases, this is Single Stop, a non-profit organization that assists families in claiming benefits to which they are entitled and a wide range of additional services, including Early Head Start and Head Start, housing referral and advocacy, home energy assistance program (HEAP), unemployment and employment assistance, child care referrals, summer camp referrals, transportation assistance for the disabled, GED referrals, ESL referrals , financial consultation, legal assistance, assistance with filing taxes, and domestic violence counseling.

Program Outcomes

Table 8.3 shows the status as of September 30, 2010, of all 138 QUEST Futures participants included in this evaluation. The vast majority (95%) had family court cases that were in the pre-adjudication stage at referral (of which 30% were open as of September 30, 2010, and 70% closed), while a small minority (5%) had cases in the post-disposition stage at referral (of which 57% were open and 43% were closed). The low number of post-adjudication cases is not surprising given the fact that QUEST Futures only began accepting post-disposition cases three months before the end of the evaluation period, in June 2010.

Table 8.3
Program Status as of July 22, 2011
N=138

Status	Percent (%)
Pre-Adjudication	95%
Open	*30%*
Closed	*70%*
Post-Disposition	5%
Open	*57%*
Closed	*43%*
Total	100%

Table 8.4 shows the final disposition of the family court case for those youths whose QUEST Futures case had closed as of the writing of this report and for which the final disposition could be determined from data that is maintained by the program staff (N = 91).[6] The most common dispositions were probation (58%), institutional placement (22%), and case dismissal (14%).

[6] Although the current process and outcome evaluation relies on records maintained by the QUEST Futures program, which are missing case dispositions for 16 closed cases, the impact evaluation of QUEST Futures that will be completed in 2012 will utilize official data from the New York City Family Court to provide a complete distribution of disposition outcomes.

Table 8.4
Disposition of QUEST Futures Participants' Cases
For Participants Enrolled October 1, 2008 – September 30, 2010
(as of July 22, 2011)
N=91

Disposition	Percent
Probation	58%
Institutional Placement	22%
Case Dismissal	14%
Adjournment in Contemplation of Dismissal (ACD)	6%
Total	100%

Table 8.5 shows the reasons for QUEST Futures case closings as of the writing of this report. Of those cases for which a reason could be determined from data maintained by the program staff (N=115), 95% were cases that had come to QUEST Futures at the pre-adjudication stage (109 cases) and 5% post-adjudication (6). Of the pre-adjudication cases, half (50%) of the cases that closed during the evaluation period were closed due to a parent request. This was followed by cases where the court case closed or probation ended (42%). Of the post-adjudication cases, only 1% of cases were closed due to a parent request while 3% of cases were closed because the court case closed or probation ended.

Table 8.5
Reason QUEST Futures Participation Ended
For Participants Enrolled October 1, 2008 – September 30, 2010
(as of July 31, 2011)
N=115[1]

Reason for Case Closing	Percent
Pre-Adjudication Cases	95%
Parent Request[2]	*50%*
Court case closed or probation ended[3]	*42%*
Other	*3%*
Post-Adjudication Cases	5%
Parent Request	*1%*
Court case closed or probation ended	*3%*
Other	*1%*
Total	100%

1) As of July 31, 2011, 116 of the 138 QUEST Futures cases considered in the evaluation period had closed; however, the reason for the closing of one of these cases was not available.
2) One of the parent requests for a withdrawal was for a mandated case.
3) Includes both positive case closings (such as case dismissal, ACD concluding, and probation concluding) and negative terminations (such as placement in either correctional or child welfare facilities).

Re-Arrest Outcomes

Of the 138 youths who became QUEST Futures participants during the evaluation period, 28 (20%) were re-arrested as of September 30, 2010. Of those, the timing of the first re-arrest ranged from three days post-entry to 16.5 months post-entry, with a median time to arrest of exactly two months, indicating that half of those re-arrested at *any* time post-program entry were re-arrested relatively soon after their participation began.

Of the 28 participants who were re-arrested at least once, 11 were arrested once, while others were arrested twice (9), three times (5), or four times (3). Table 8.6 shows the specific kinds of offenses that were involved in each re-arrest. As the table makes clear, robbery was the most common charge (28% of first re-arrests), followed by assault (21%), and larceny (10%).

Re-arrest data for a comparison group composed of similarly situated but non-participating youths is not included in this report. A formal impact evaluation, including a rigorously matched comparison group, will be forthcoming in 2013.

Table 8.6
QUEST Futures Participants' Charges Post-Program Entry for Youth Aged 15 and Under
(October 1, 2008 through September 30, 2010)

Charge	Post-Program Entry Arrest			
	First N=28	Second (N=9)	Third (N=5)	Fourth (N=3)
Robbery	28%	11%	--	--
Assault	21%	22%	40%	--
Larceny	10%	--	--	--
Criminal Mischief	7%	--	--	--
Auto Theft	3%	--	20%	--
Possession of a Controlled Substance	3%	--	--	--
Criminal Possession of Stolen Property	3%	11%	--	33%
Criminal Possession of a Weapon	3%	11%	20%	33%
Marijuana	3%	--	--	33%
Prostitution	3%	--	--	--
Resisting Arrest	3%	--	--	--
Sexual Assault	3%	--	--	--
Criminal Contempt	--	11%	--	--
Unlawful Assembly	--	11%	--	--
Manslaughter	--	--	20%	--
Unknown	10%	22%	--	--
Total	100%	99%*	100%	99%*

* Does not round to 100% due to rounding.

Participant Youth and Family Functioning

To assess changes in youth and family functioning over time, data from the Child and Adolescent Needs and Strengths (CANS) assessment tool was analyzed. QUEST Futures case managers assessed youths and their families on 39 items across a range of domains (see Appendix A for the complete instrument). The ratings on the CANS were as follows: '0' indicates *no need for action*; '1' indicates *a need for watchful waiting* '2' indicates *a need for action*; and '3' indicates *a need for either immediate or intensive action*. Therefore, a downward trend in the scores over time generally signals a change in a positive direction.

The CANS was first administered at baseline and then re-administered at 3 months, 12 months, and case closing (which could either precede or follow the 12-month administration, depending upon the case). The 12-month administration was only for those who were still active in the program after 12 months and, for that reason, includes a non-representative sample composed only of those participants who experienced a relatively long period of program involvement. The completion of the CANS requires that the case manager know a considerable amount about the youth and family, so the baseline assessment was typically completed within 30 days of program entry, which means that it actually reflects an early "in-program" profile of the youth and their family. Regarding the case closing assessment, it was decided that the CANS would be completed at the closing of *the QUEST Futures case* rather than at the *case disposition*, because the QUEST Futures program often continues to work with youth even after the official disposition (per above, usually for 60 additional days). Within the evaluation period, staff completed the following number of CANS at the baseline and follow-up periods: 138 at baseline, 116 at three months, 52 at 12 months, and 64 at case closing. The timing of the case closing assessments ranged from 4 days to 21.8 months after the baseline assessment, with the closing assessment taking place an average of 8.2 months after baseline.

The CANS data was analyzed using analysis of variance (ANOVA) methods to show trends in youth and family functioning over the period that each youth was tracked. The data from the 12-month assessment was not included, because many cases closed before 12 months, resulting in a low sample size—as well as a non-representative sample, as noted above.

Table 8.7 presents mean scores for 39 different aspects of youth and family functioning at baseline, three months, and case closing, along with ANOVA results regarding whether a particular aspect of youth and family functioning significantly changed over the three periods. It is noteworthy that there was a significant change in scores across 27 of the 39 items ($p < .05$ or $p < .01$), while the change approached significance ($p < .10$) for 11 of the 12 remaining items. The final item, fire setting, had an extremely low prevalence from the outset, with little change over time (and, in fact, the extreme low variance meant that an ANOVA could not be properly conducted on this item). When comparing the mean scores at baseline to those at case closing, the scores on 25 of the 38 items that demonstrate a change were *lower* at the later measurement period. This suggests that on most items, youth and family functioning improved over time. Among the items that concern only the youth, and not family members, 20 of 27 items demonstrated improvement.

The measures with the greatest raw changes from beginning to exit were vocational skills (decreased from 2.14 at baseline to 1.71 at case closing), followed closely behind by school achievement (decreased from 2.00 at baseline to 1.58 at case closing) and spiritual/religious interest (decreased from 2.36 at baseline to 1.94 at case closing). There were other measures that significantly changed over time, but in inconsistent directions across the three assessment periods (see detailed results in Table 8.6). These latter findings suggest that improvements in youth and family functioning are not necessarily linear.

Table 8.7
Change in Participant Profile for Selected CANS Measures:
Baseline, Three Months and Case Closing
N=64

	Baseline	3 months	Case closing	Amount of change	Significance of change
Life Domain Functioning					
School behavior	1.56	1.33	1.16	-0.40	+
School achievement	2.00	1.78	1.58	-0.42	+
School attendance	1.30	1.25	1.08	-0.22	*
Child Strengths					
Family	1.55	1.42	1.36	-0.19	*
Interpersonal	1.77	1.70	1.64	-0.13	**
Optimism	1.61	1.45	1.41	-0.20	**
Educational	1.58	1.38	1.35	-0.23	**
Vocational	2.14	2.08	1.71	-0.43	+
Talents	1.77	1.70	1.55	-0.22	**
Spiritual/Religious	2.36	2.00	1.94	-0.42	+
Community life	1.58	1.45	1.29	-0.29	+
Relationship permanence	1.14	1.03	1.16	0.02	**
Resiliency	1.86	1.72	1.65	-0.21	*
Resourcefulness	1.95	1.62	1.66	-0.29	+
Acculturation					
Language	0.36	0.36	0.34	-0.02	***
Identity	0.23	0.19	0.29	0.06	*
Ritual	0.09	0.08	0.24	0.15	+
Cultural stress	0.67	0.2	0.52	-0.15	+

Table 8.7 ***(Continued)***

	Baseline	3 months	Case closing	Amount of change	Significance of change
Caregiver needs and strengths					
Supervision	1.27	1.38	1.42	0.15	**
Involvement	0.97	0.89	0.97	0.00	**
Knowledge	1.39	1.16	1.2	-0.19	*
Organization	0.77	0.77	0.85	0.08	**
Social resources	1.39	1.17	1.27	-0.12	*
Residential stability	0.20	0.25	0.34	0.14	*
Physical	0.06	0.22	0.26	0.20	+
Mental health	0.11	0.22	0.21	0.10	*
Substance use	0.09	0.09	0.06	-0.03	**
Developmental	0.03	0.05	0.02	-0.01	**
Safety	0.23	0.23	0.19	-0.04	**
Child Risk Behaviors					
Suicide risk	0.30	0.23	0.19	-0.11	**
Self-mutilation	0.09	0.02	0.06	-0.03	*
Other self-harm	0.41	0.48	0.47	0.06	**
Danger to others	0.22	0.28	0.29	0.07	**
Sexual aggression	0.06	0.13	0.08	0.02	**
Runaway	0.14	0.25	0.24	0.10	*
Delinquency	1.47	1.27	1.13	-0.34	+
Judgment	1.64	1.47	1.45	-0.19	+
Fire setting[1]	0.03	0.05	0.05	0.02	Na
Social behavior	1.39	1.24	1.24	-0.15	**

+p<.10, *p<.05, **p<.01, ***p.001

Note: Significance tests were based on repeated measures ANOVAs using SPSS 19. Where the assumption of sphericity has been violated, a Greenhouse-Geisser correction was made. Cases were only included in this analysis if data was available at all three periods. The N for specific items varies from 61 to 64.

1) Due to low variance significance could not be established.

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APPENDICES

A: Child and Adolescent Needs and Strengths (CANS)
B: QUEST Futures Logic Model
C: NYC Juvenile Detention Risk Assessment Instrument (RAI)
D: Consents to Share Confidential Information
E: Biopsychosocial Assessment
F: List of Referral Agencies

Appendix A
Child and Adolescent Needs and Strengths (CANS)

LIFE DOMAIN FUNCTIONING

For **Need items**, the following categories and symbols are used:
0 indicates a dimension where there is no evidence of any needs. This may be a strength.
1 indicates a dimension that requires monitoring, watchful waiting, or preventive activities.
2 indicates a dimension that requires action to ensure that this identified need or risk behavior is addressed.
3 indicates a dimension that requires immediate or intensive action.

SCHOOL BEHAVIOR *Please rate the highest level from the **past 30 days***
0 Child is behaving well in school.
1 Child is behaving adequately in school although some behavior problems exist.
2 Child is having moderate behavioral problems at school. He/she is disruptive and may have received sanctions including suspensions.
3 Child is having severe problems with behavior in school. He/she is frequently or severely disruptive. School placement may be in jeopardy due to behavior.

SCHOOL ACHIEVEMENT *Please rate the highest level from the **past 30 days***
0 Child is doing well in school.
1 Child is doing adequately in school although some problems with achievement exist.
2 Child is having moderate problems with school achievement. He/she may be failing some subjects.
3 Child is having severe achievement problems. He/she may be failing most subjects or more than one year behind same age peers in school achievement.

SCHOOL ATTENDANCE *Please rate the highest level from the **past 30 days***
0 Child attends school regularly.
1 Child has some problems attending school but generally goes to school. May miss up to one day per week on average OR may have had moderate to severe problem in the past six months but has been attending school regularly in the past month.
2 Child is having problems with school attendance. He/she is missing at least two days each week on average.
3 Child is generally truant or refusing to go to school.

CHILD STRENGTHS

For **Strengths items** the following action levels are used:
0 indicates a domain where strengths exist that can be used as a centerpiece for a strength-based plan.
1 indicates a domain where strengths exist but require some strength building efforts in order for them to serve as a focus of a strength-based plan.
2 indicates a domain where strengths have been identified but that they require significant strength building efforts before they can be effectively utilized in as a focus of a strength-based plan.
3 indicates a domain in which efforts are needed in order to identify potential strengths for strength building efforts.

FAMILY *Please rate the highest level from the **past 30 days***
0 Family has strong relationships and excellent communication.
1 Family has some good relationships and good communication.
2 Family needs some assistance in developing relationships and/or communications.
3 Family needs significant assistance in developing relationships and communications or child has no identified family.

INTERPERSONAL *Please rate the highest level from the **past 30 days***
0 Child has well-developed interpersonal skills and friends.

1 Child has good interpersonal skills and has shown the ability to develop healthy friendships.
2 Child needs assistance in developing good interpersonal skills and/or healthy friendships.
3 Child needs significant help in developing interpersonal skills and healthy friendships.

OPTIMISM *Please rate the highest level from the **past 30 days***
0 Child has a strong and stable optimistic outlook on his/her life.
1 Child is generally optimistic.
2 Child has difficulties maintaining a positive view of him/herself and his/her life. Child may vary from overly optimistic to overly pessimistic.
3 Child has difficulties seeing *any* positives about him/herself or his/her life.

EDUCATIONAL *Please rate the highest level from the **past 30 days***
0 School works closely with child and family to identify and successfully address child's educational needs OR child excels in school.
1 School works with child and family to identify and address child's educational needs OR child likes school.
2 School currently unable to adequately address child's needs.
3 School unable and/or unwilling to work to identify and address child's needs.

VOCATIONAL *Please rate the highest level from the **past 30 days***
0 Child has vocational skills and work experience.
1 Child has some vocational skills or work experience.
2 Child has some prevocational skills.
3 Child needs significant assistance developing vocational skills.

TALENTS/INTEREST *Please rate the highest level from the **past 30 days***
0 Child has a talent that provides him/her with pleasure and/or self esteem.
1 Child has a talent, interest, or hobby with the potential to provide him/her with pleasure and self esteem.
2 Child has identified interests but needs assistance converting those interests into a talent or hobby.
3 Child has no identified talents, interests or hobbies.

SPIRITUAL/RELIGIOUS *Please rate the highest level from the **past 30 days***
0 Child receives comfort and support from religious and/or spiritual beliefs and practices.
1 Child is involved in a religious community whose members provide support.
2 Child has expressed some interest in religious or spiritual belief and practices.
3 Child has no identified religious or spiritual beliefs nor interest in these pursuits.

COMMUNITY LIFE *Please rate the highest level from the **past 30 days***
0 Child is well-integrated into his/her community. He/she is a member of community organizations and has positive ties to the community.
1 Child is somewhat involved with his/her community.
2 Child has an identified community but has only limited ties to that community.
3 Child has no identified community to which he/she is a member.

RELATIONSHIP PERMANENCE *This rating refers to the stability of significant relationships in the child or youth's life. This likely includes family members but may also include other individuals.*
0 This level indicates a child who has very stable relationships. Family members, friends, and community have been stable for most of his/her life and are likely to remain so in the foreseeable future. Child is involved with both parents.
1 This level indicates a child who has had stable relationships but there is some concern about instability in the near future (one year) due to transitions, illness, or age. A stable relationship with only one parent may be rated here.
2 This level indicates a child who has had at least one stable relationship over his/her lifetime but has experienced other instability through factors such as divorce, moving, removal from home, and death.
3 This level indicates a child who does not have any stability in relationships. Independent living or adoption must be considered.

RESILIENCY *This rating should be based on the individual's ability to identify and use internal strengths in managing their lives*
0 This level indicates a individual who is able to both identify and use internal strengths to better themselves and successfully manage difficult challenges.
1 This level indicates a individual who able to identify most of his/her internal strengths and is able to partially utilize them.
2 This level indicates a individual who is able to identify internal strengths but is not able to utilize them effectively.
3 This level indicates a individual who is not yet able to identify internal personal strengths.

RESOURCESFULNESS *This rating should be based on the individual's ability to identify and use external/environmental strengths in managing their lives*
0 Child is quite skilled at finding the necessary resources required to aid him/her in his/her managing challenges.
1 Child is some skills at finding necessary resources required to aid him/her in a healthy lifestyle but sometimes requires assistance at identifying or accessing these resources.
2 Child has limited skills at finding necessary resources required to aid in achieving a healthy lifestyle and requires temporary assistance both with identifying and accessing these resources.
3 Child has no skills at finding the necessary resources to aid in achieving a healthy lifestyle and requires ongoing assistance with both identifying and accessing these resources.

ACCULTURATION

LANGUAGE *This item includes both spoken and sign language.*
0 Child and family speak English well.
1 Child and family speak some English but potential communication problems exist due to limits on vocabulary or understanding of the nuances of the language.
2 Child and/or significant family members do not speak English. Translator or native language speaker is needed for successful intervention but qualified individual can be identified within natural supports.
3 Child and/or significant family members do not speak English. Translator or native language speaker is needed for successful intervention and no such individual is available from among natural supports.

IDENTITY *Cultural identity refers to the child's view of his/herself as belonging to a specific cultural group. This cultural group may be defined by a number of factors including race, religion, ethnicity, geography or lifestyle.*
0 Child has clear and consistent cultural identity and is connected to others who share his/her cultural identity.
1 Child is experiencing some confusion or concern regarding cultural identity.
2 Child has significant struggles with his/her own cultural identity. Child may have cultural identity but is not connected with others who share this culture.
3 Child has no cultural identity or is experiencing significant problems due to conflict regarding his/her cultural identity.

RITUAL *Cultural rituals are activities and traditions that are culturally including the celebration of culturally specific holidays such as kwanza, cinco de mayo, etc. Rituals also may include daily activities that are culturally specific (e.g. praying toward Mecca at specific times, eating a specific diet, access to media).*
0 Child and family are consistently able to practice rituals consistent with their cultural identity.
1 Child and family are generally able to practice rituals consistent with their cultural identity; however, they sometimes experience some obstacles to the performance of these rituals.
2 Child and family experience significant barriers and are sometimes prevented from practicing rituals consistent with their cultural identity.
3 Child and family are unable to practice rituals consistent with their cultural identity.

CULTURAL STRESS. *Cultural stress refers to experiences and feelings of discomfort and/or distress arising from friction (real or perceived) between an individual's own cultural identity and the predominant culture in which he/she lives. This need reflects things such as racism, discrimination, or harassment because of sexual orientation or appearance or background.*
0 No evidence of stress between individual's cultural identity and current living situation.

1 Some mild or occasional stress resulting from friction between the individual's cultural identity and his/her current living situation.
2 Individual is experiencing cultural stress that is causing problems of functioning in at least one life domain.
3 Individual is experiencing a high level of cultural stress that is making functioning in any life domain difficult under the present circumstances.

CAREGIVER NEEDS & STRENGTHS

SUPERVISION *Please rate the highest level from the **past 30 days***
0 Caregiver has good monitoring and discipline skills.
1 Caregiver provides generally adequate supervision. May need occasional help or technical assistance.
2 Caregiver reports difficulties monitoring and/or disciplining child. Caregiver needs assistance to improve supervision skills.
3 Caregiver is unable to monitor or discipline the child. Caregiver requires immediate and continuing assistance. Child is at risk of harm due to absence of supervision.

INVOLVEMENT *Please rate the highest level from the **past 30 days***
0 Caregiver is able to act as an effective advocate for child.
1 Caregiver has history of seeking help for their children. Caregiver is open to receiving support, education, and information.
2 Caregiver does not wish to participate in services and/or interventions intended to assist their child.
3 Caregiver wishes for child to be removed from their care.

KNOWLEDGE *Please rate the highest level from the **past 30 days***
0 Caregiver is knowledgeable about the child's needs and strengths.
1 Caregiver is generally knowledgeable about the child but may require additional information to improve their capacity of parent.
2 Caregiver has clear need for information to improve how knowledgeable they are about the child. Current lack of information is interfering with their ability to parent.
3 Caregiver has knowledge problems that place the child at risk of significant negative outcomes.

ORGANIZATION *Please rate the highest level from the **past 30 days***
0 Caregiver is well organized and efficient.
1 Caregiver has minimal difficulties with organizing and maintaining household to support needed services. For example, may be forgetful about appointments or occasionally fails to return case manager calls.
2 Caregiver has moderate difficulty organizing and maintaining household to support needed services.
3 Caregiver is unable to organize household to support needed services.

SOCIAL RESOURCES *Please rate the highest level from the **past 30 days***
0 Caregiver has significant family and friend social network that actively helps with raising the child (e.g., child rearing).
1 Caregiver has some family or friend social network that actively help with raising the child (e.g. child rearing).
2 Caregiver has some family or friend social network that may be able to help with raising the child (e.g., child rearing).
3 Caregiver no family or social network that may be able to help with raising the child (e.g. child rearing).

RESIDENTIAL STABILITY *Please rate the highest level from the **past 30 days***
0 Caregiver has stable housing for the foreseeable future.
1 Caregiver has relatively stable housing but either has moved in the past three months or there are indications of housing problems that might force them to move in the next three months.
2 Caregiver has moved multiple times in the past year. Housing is unstable.
3 Caregiver has experienced periods of homelessness in the past six months.

PHYSICAL *Please rate the highest level from the **past 30 days***
0 Caregiver is generally healthy.
1 Caregiver is in recovery from medical/physical problems.
2 Caregiver has medical/physical problems that interfere with their capacity to parent.
3 Caregiver has medical/physical problems that make it impossible for them to parent at this time.

MENTAL HEALTH *Please rate the highest level from the **past 30 days***
0 Caregiver has no mental health needs.
1 Caregiver is in recovery from mental health difficulties.
2 Caregiver has some mental health difficulties that interfere with their capacity to parent.
3 Caregiver has mental health use difficulties that make it impossible for them to parent at this time.

SUBSTANCE USE *Please rate the highest level from the **past 30 days***
0 Caregiver has no substance use needs.
1 Caregiver is in recovery from substance use difficulties.
2 Caregiver has some substance use difficulties that interfere with their capacity to parent.
3 Caregiver has substance use difficulties that make it impossible for them to parent at this time.

DEVELOPMENTAL *Please rate the highest level from the **past 30 days***
0 Caregiver has no developmental needs.
1 Caregiver has developmental challenges but they do not currently interfere with parenting.
2 Caregiver has developmental challenges that interfere with their capacity to parent.
3 Caregiver has severe developmental challenges that make it impossible for them to parent at this time.

SAFETY *Please rate the highest level from the **past 30 days***
0 Household is safe and secure. Child is at no risk from others.
1 Household is safe but concerns exist about the safety of the child due to history or others in the neighborhood who might be abusive.
2 Child is in some danger from one or more individuals with access to the household.
3 Child is in immediate danger from one or more individuals with unsupervised access.
***All referrants are legally required to report suspected child abuse or neglect.**

CHILD RISK BEHAVIORS

Check* SUICIDE RISK** *Please rate the highest level from the **past 30 days
0 No evidence
1 History but no recent ideation or gesture.
2 Recent ideation or gesture but not in past 24 hours.
3 Current ideation and intent OR command hallucinations that involve self-harm.

SELF-MUTILATION *Please rate the highest level from the **past 30 days***
0 No evidence
1 History of self-mutilation.
2 Engaged in self mutilation that does not require medical attention.
3 Engaged in self mutilation that requires medical attention.

OTHER SELF HARM *Please rate the highest level from the **past 30 days***
0 No evidence of behaviors other than suicide or self-mutilation that place the child at risk of physical harm.
1 History of behavior other than suicide or self-mutilation that places child at risk of physical harm. This includes reckless and risk-taking behavior that may endanger the child.
2 Engaged in behavior other than suicide or self-mutilation that places him/her in danger of physical harm. This includes reckless behavior or intentional risk-taking behavior.
3 Engaged in behavior other than suicide or self-mutilation that places him/her at immediate risk of death. This includes reckless behavior or intentional risk-taking behavior.

DANGER TO OTHERS *Please rate the highest level from the **past 30 days***
0 No evidence
1 History of homicidal ideation, physically harmful aggression or fire setting that has put self or others in danger of harm.
2 Recent homicidal ideation, physically harmful aggression, or dangerous fire setting but not in past 24 hours.
3 Acute homicidal ideation with a plan or physically harmful aggression OR command hallucinations that involve the harm of others. Or, child set a fire that placed others at significant risk of harm.

SEXUAL AGGRESSION *Please rate the highest level from the **past 30 days***
0 No evidence of any history of sexually aggressive behavior. No sexual activity with younger children, nonconsenting others, or children not able to understand consent.
1 History of sexually aggressive behavior (but not in past year) OR sexually inappropriate behavior in the past year that troubles others such as harassing talk or excessive masturbation.
2 Child is engaged in sexually aggressive behavior in the past year but not in the past 30 days.
3 Child has engaged in sexually aggressive behavior in the past 30 days.

RUNAWAY *Please rate the highest level from the **past 30 days***
0 No evidence
1 History of runaway from home or other settings involving at least one overnight absence, at least 30 days ago.
2 Recent runaway behavior or ideation but not in past 7 days.
3 Acute threat to runaway as manifest by either recent attempts OR significant ideation about running away OR child is currently a runaway.

DELINQUENCY *Please rate the highest level from the **past 30 days***
0 No evidence
1 History of delinquency but no acts of delinquency in past 30 days.
2 Recent acts of delinquency.
3 Severe acts of delinquency that places others at risk of significant loss or injury or place child at risk of adult sanctions.

JUDGMENT *Please rate the highest level from the **past 30 days***
0 No evidence of problems with judgment or poor decision making that result harm to development and/or well-being.
1 History of problems with judgment in which the child makes decisions that are in some way harmful to his/her development and/or well-being. For example, a child who has a history of hanging out with other children who shoplift.
2 Problems with judgment in which the child makes decisions that are in some way harmful to his/her development and/or well-being.
3 Problems with judgment that place the child at risk of significant physical harm.

FIRE SETTING *Please rate the highest level from the **past 30 days***
0 No evidence
1 History of fire setting but not in the past six months.
2 Recent fire setting behavior (in past six months) but not of the type that has endangered the lives of others OR repeated fire-setting behavior over a period of at least two years even if not in the past six months.
3 Acute threat of fire setting. Set fire that endangered the lives of others (e.g. attempting to burn down a house).

SOCIAL BEHAVIOR *Please rate the highest level from the **past 30 days***
0 No evidence of problematic social behavior. Child does not engage in behavior that forces adults to sanction him/her.
1 Mild level of problematic social behavior. This might include occasional inappropriate social behavior that forces adults to sanction the child. Infrequent inappropriate comments to strangers or unusual behavior in social settings might be included in this level.

2 Moderate level of problematic social behavior. Social behavior is causing problems in the child's life. Child may be intentionally getting in trouble in school or at home.
3 Severe level of problematic social behavior. This level would be indicated by frequent serious social behavior that forces adults to seriously and/or repeatedly sanction the child. Social behaviors are sufficiently severe that they place the child at risk of significant sanctions (e.g. expulsion, removal from the community)

Appendix B
QUEST Futures (previously known as ART Team) Logic Model

Overarching Goal: Reduce repeat offending by young people with mental health disorders in the juvenile justice system.

Project Objectives & Targets for Intervention	**Project Activities**	**Outputs**	**Project Impacts**	**Project Evaluation Approaches**

Objective 1: Establish a comprehensive, coordinated response to mental illness among youth involved in juvenile delinquency proceedings in the borough of Queens, New York (focusing on youth in the pre-adjudication stage who are at moderate risk of detention or already in detention)
 	
Targets for intervention:
Juvenile justice system players: Family Court delinquency judges, law guardians, NYC Law Department, NYC Department of Probation, NYC Department of Juvenile Justice, alternative-to-detention programs
 	
Child welfare, mental health and education system players: Administration for Children's Services, NYC Dept. of Health & Mental Hygiene, NYS Office of Mental Health, NYC Health & Hospitals Corporation, NYC Department of Education
	Establish centralized clinical resources that will assist all players in the juvenile justice system by facilitating assessments, treatment planning, service coordination, case management and monitoring of young people involved in delinquency proceedings.
	• Hire clinical team and retain consulting psychiatrist
	• Create procedures for:
	  • referrals to clinical team from (a) alternative-to-detention programs, (b) law guardians or DJJ for young people in detention, and (c) judges or law guardians if detention is being considered
	  • systematic screening for mental health disorders early in delinquency proceedings,
	  • assessment and developing individualized treatment planning for those identified in the screening process
	
	Develop protocols for communication and coordinated supervision among juvenile justice stakeholders (including juvenile justice, child welfare, mental health and education agencies) for youth with mental health disorders from first court appearance to closing of case.
	• Create project oversight team
	• Draft policies and procedures manual, including procedures for case review meetings and client report sharing among system players
	
	Develop and implement a sustainability plan
		All young people enrolled in alternative-to-detention programs in Queens (QUEST and ICM) are screened for mental health issues at intake
		
		For those youth flagged at screening, ART Team conducts mental health assessment, determines program eligibility and develops individualized treatment plans
		
		Project oversight team meets regularly (at least quarterly)
		
		Policies and procedures manual accepted by key stakeholders
		
		MOUs between agencies regarding information sharing and coordinated supervision
		
		Proposals for sustained funding of the ART Team Program are submitted to appropriate funding agencies.
			System players will meet for case reviews and share written reports.
			
			Project oversight team monitors the implementation of coordinated policies and procedures to respond to the needs of youth with delinquency cases who have mental health disorders and revises them as necessary to achieve program goals.
			
			Greater coordination among juvenile justice and other city agencies results in improved continuity of care for ART Team participants.
			
			Funding and institutional support is in place for the project's continuation.
				Process evaluation (initial implementation and first 30 months of program operations)
				
				Log of case review meetings
				
				Log of sharing client reports
				
				Pre/post questionnaire for key stakeholders (includes network communication analysis and knowledge measures)
				
				Project oversight meeting log: invitees and attendees (by role), topics discussed, action items, noteworthy program developments

Project Objectives & Targets for Intervention	Project Activities	Outputs	Project Impacts	Project Evaluation Approaches
Objective 2: Increase the capacity and willingness of the juvenile justice system to link youth in delinquency proceedings who have mental health disorders with community-based treatment in lieu of confinement *Targets for intervention*: Juvenile justice system players: Family Court delinquency judges, law guardians, NYC Law Department, NYC Department of Probation, NYC Department of Juvenile Justice, alternative-to-detention programs Child welfare, mental health and education system players: Administration for Children's Services, NYC Dept. of Health & Mental Hygiene, NYS Office of Mental Health, NYC Health & Hospitals Corporation, NYC Department of Education Mental health and other child and family service providers	Implement protocols for providing useful, timely information on each respondent's mental health status, treatment options and progress in treatment to juvenile justice players at appropriate points during delinquency proceedings: • Provide reports on a regular schedule, as well as reports on unusual events • Provide clinical guidance to justice system players on appropriate response to promote compliance with treatment plans Establish a network of community-based providers willing to provide mental health and related services to ART Team participants and their families • Create and maintain a comprehensive list of mental health and other service providers • Build partnerships with providers of mental health, family support, youth development and other relevant services, with a focus on those who are providing evidence-based services • Establish protocols for sharing information between providers and juvenile justice system players • Enter into at least six linkage agreements Create and implement educational program on child and adolescent development, mental illness and mental health treatment and services for Family Court judges, presentment attorneys, law guardians, detention staff and probation officers.	Justice system players refer young people to the ART Team for evaluation, treatment planning, linkage to community-based services, and case management ART Team links young people and their families to community-based providers ART Team staff provides appropriate, timely information on respondents' mental health status and progress in treatment and related services to relevant justice system players. Two to three educational sessions will be held with juvenile justice players in the first year. Follow-up sessions and sessions for new staff will be held in years two and three.	Judges decide to allow 80-90 ART Team participants per year to remain in the community in lieu of detention Compared to the comparison group, ART Team participants will have (a) fewer days detained during pre-adjudication stage and (b) higher rates of community-based (non-custodial) dispositions Linkage agreements are in place with service providers Community-based providers accept referrals, deliver services to ART Team participants and provide reports to ART Team. Family Court judges and other juvenile justice players have better information regarding individual respondents to make informed decisions Family Court judges and other juvenile justice players have increased knowledge of juvenile mental health issues and available treatments.	*Process evaluation (initial implementation and first 30 months of program operations)* Track voluntary participants (eligibility and enrollment) Track court-mandated participants (eligibility and enrollment) Log of referrals to community-based providers Track treatment plans Track utilization of mental health and related services throughout the course of participants' delinquency cases (service modalities, providers and participants' attendance) Track community-based providers' compliance with reporting schedules Baseline/follow-up interviews with stakeholders, including assessment of referrals to ART Team and providers, quality of information regarding individual respondents, and increased knowledge of juvenile mental health and treatment *Impact evaluation (data collected during first 24 months of program operations; see Objective 3 for research design):* Days in detention and dispositions tracked through Universal Case Management System

Project Objectives & Targets for Intervention	Project Activities	Outputs	Project Impacts	Project Evaluation Approaches
Objective 3: Engage juveniles and their families in effective community-based services that will improve functioning of both youth and family and reduce offending *Targets for intervention:* Young people in delinquency proceedings who are at risk of or in detention and have mental disorders Parents/guardians of the young people ART Team Family Court players: delinquency judges, law guardians, NYC Law Department, NYC Department of Probation, alternative-to-detention programs Child welfare, mental health and education system players: Administration for Children's Services, NYC Dept. of Health & Mental Hygiene, NYS Office of Mental Health, NYC Health & Hospitals Corporation, NYC Department of Education Mental health and other child and family service providers	Screen 220-250 youth per year in alternative-to-detention programs using MAYSI-II. Receive referrals from law guardians, judges, and DJJ of youth not in alternative-to-detention programs (approximate N=20) Obtain parental consent to evaluate at least 60-65% of youth flagged during screening or referred from other sources Conduct mental health evaluations of 100% of youth with parental consent Employ strengths-based youth and family engagement strategies to: • link youth to services • link parents to services that will increase their capacity to support their children • provide guidance to children and parents or guardians on navigating the juvenile justice and mental health systems • provide ongoing case management services until delinquency case is closed Develop treatment plans in accordance with Columbia University Guidelines for Child & Adolescent Mental Health Referral Monitor program participants and report, as appropriate, to justice system players including QUEST, Probation, Family Court judges, presentment attorneys and law guardians Respond quickly and appropriately to progress and problems, including use of incentives and, for those under court mandates, sanctions	Enroll 80-90 young people per year in the ART Team program ART Team will provide on-going support to young people and their families through strength-based engagement strategies. Young people and their families will be engaged in appropriate community-based services ART Team will provide regular reports to justice system players and advise where appropriate on incentives and sanctions to help motivate engagement in services	Justice system players will respond to progress and infractions with appropriate incentives and sanctions. Compared to the comparison group, ART Team participants will have lower rates of recidivism for (1) 12 months following enrollment and (2) six months after closing of delinquency case (if longer than period (1)) ART Team participants will show improvements in functioning Families of ART Team participants will show improvement in functioning	*Process evaluation:* Baseline/follow-up interviews with stakeholders, including assessment of willingness to utilize a broader range of incentives and sanctions. Log of incentives and sanctions used in ART Team cases from ART Team case files *Impact evaluation (data collected for participants in the first 24 months of program operations):* Quasi-experimental design to assess impact on psychosocial functioning of youth, functioning of families, and juvenile justice outcomes of case proceedings: • Recruitment of comparison group (youth participating in alternative-to-detention program in another borough of New York City) • Recruitment of youth participating in Queens alternative-to-detention program (QUEST) prior to implementation of ART Team Child and Adolescent Needs and Strengths (CANS) instrument implemented at baseline, 3-month follow-up, disposition and closing of delinquency case

Appendix C
Risk Assessment Instrument

NYC Juvenile Detention Risk Assessment Instrument (RAI)

Demographic Data

RIN#: _____ Last Name: _____ DOP Intake Date: ___/___/___

CASE#: _____ First Name: _____ Intake Staff Name: _____

Arrest #: _____ Date of Birth: ___/___/___ *(Enter as first initial last name, as in JSmith)*

Court Docket #: _____ NYSID #: _____ Borough of Arrest: _____

Top Arrest Charge (Penal Code): _____ Referred to Corp Counsel (Y/N)? _____

Gender: ☐ F ☐ M Race: ☐ White ☐ Black ☐ Hispanic ☐ Asian ☐ Other

Section A. Risk of Failure to Appear (FTA)

One point will be added for each of the following that apply:

A1. The youth has an open JD warrant	☐ Yes	☐ No		
A2. The youth has a prior JD or PINS warrant	☐ Yes	☐ No		
A3. An adult did not appear on behalf of the juvenile at probation intake	☐ Yes	☐ No		
A4. The youth's school attendance was less than 30% in the last full semester	☐ Yes	☐ No	☐ System Down	☐ No Parental Permission

Total Risk of FTA Score ***(Total Yes responses for QA1 through QA4)*:** _____

Section B. Risk of Re-Arrest

One point will be added for each of the following that apply:

B1. The youth has an unsealed prior arrest	☐ Yes	☐ No		
B2. The youth has an unsealed prior felony arrest	☐ Yes	☐ No		
B3. The youth has a prior JD adjudication	☐ Yes	☐ No		
B4. The youth has a prior designated felony adjudication	☐ Yes	☐ No		
B5. The youth is currently on JD probation	☐ Yes	☐ No		

One point will be subtracted if the following applies:

B6. The youth's school attendance was 80% or more in the last full semester	☐ Yes	☐ No	☐ System Down	☐ No Parental Permission

Total Risk of Re-Arrest Score:
(Total Yes responses for OB1 through OB5, minus 1 point if Yes response for OB6): _____

Total

Mark the cell corresponding to the Risk of FTA and Risk of Re-Arrest scores, as recorded above.

Risk of Re-Arrest \ Risk of FTA	0	1	2	3+
-1	Low	Low	Mid	Mid
0	Low	Mid	Mid	High
1	Mid	Mid	Mid	High
2	Mid	Mid	High	High
3	High	High	High	High
4+	High	High	High	High

RAI Score *(check only one)*: ☐ **Low** ☐ **Mid** ☐ **High**

Additional Factors

None of the following will factor into the scoring:

C1. Homicide or Attempted Homicide	☐ Yes	☐ No
C2. Designated Felony	☐ Yes	☐ No
C3. Possession or Use of Firearm	☐ Yes	☐ No

For CLO or Resource Coordinator Use Only

Court Outcome:

☐ Release to Home

☐ Alternative to Detention → ☐ CM ☐ AS ☐ ICM

☐ Detained

Court Docket #: _____

Arraignment Date: ___/___/___

Appendix D
Consents to Share Confidential Information

I. Index of Consents

A. <u>Consents used in specific participant categories</u>

Scenario 1: Participant in QUEST ATD – Referred to QUEST Futures for voluntary participation in mental health services

1. QATDV #1: Youth and Parental Consent for Screening and the Release of Confidential Health and Mental Health Related Client Information
2. QATDV #2: Parent Consent for Full Clinical Assessment
3. QATDV #3: Parent and Youth Consent for Ongoing Exchange of Information During Participation in QUEST Futures

Scenario 2: Participant in Probation ICM – Referred to QUEST Futures for voluntary participation in mental health services

4. ICMV #1: Youth and Parental Consent for Screening, Assessment and the Release of Confidential Health and Mental Health Related Client Information for Participants in Intensive Community Monitoring
5. ICMV #2: Parent and Youth Consent for Ongoing Exchange of Information During Participation in QUEST Futures for Participants in Intensive Community Monitoring

Scenario 3: Youth has been mandated to QUEST ATD or Probation ICM and is voluntarily participating in QUEST Futures, then is mandated by the judge to participate in QUEST Futures

6. QATD-ICM-M #1: Parent and Youth Consent for Ongoing Exchange of Information During Mandated Participation in QUEST Futures [Participants in QUEST ATD and/or Intensive Community Monitoring]

Scenario 4: Participation in QUEST Futures is mandated by Judge for young person who has not been a participant in QUEST ATD or Probation ICM

7. JM #1: Parent and Youth Consent for Assessment and Release of Confidential Information: Mandated Participation in QUEST Futures
8. JM #2: Parent and Youth Consent for Ongoing Exchange of Information During Mandated Participation in QUEST Futures

Scenario 5: Other referrals – Voluntary participation in QUEST Futures

9. OV #1: Parent and Youth Consent for Assessment and Release of Confidential Information: Voluntary Participation in QUEST Futures

10. OV #2: Parent and Youth Consent for Ongoing Exchange of Information During Voluntary Participation in QUEST Futures

B. Consents used in more than one participant category

[To come]

11. VDISC: Parent and Youth Consent for Administration of V-DISC for Research [QUEST ATD participants only]
12. Dispo-OCFS: Parent Consent to Share Confidential Information with OCFS
13. Dispo-Probation: Parent and Youth Consent for Ongoing Exchange of Information with Probation and Service Providers

II. Description of Consents Needed for Each Category of QUEST Futures Participant

Scenario 1: Participant in QUEST ATD – Referred to QUEST Futures for voluntary participation in mental health services

1. QATDV #1: Parent consent for:
    a. mental health screen using DPS (including brief clinical interview),
    b. release of confidential information from current or previous treatment providers,
    c. notifying attorney for the child whether or not the child is eligible on other grounds to participate in QUEST Futures, and
    d. authorizing the attorney for the child to redisclose to the Family Court judge whether or not the child is eligible for QUEST Futures.
2. QATDV #2: Parent consent for full clinical assessment, including obtaining information from other sources, such as schools and other relatives
3. VDISC: Parent consent for administration of VDISC for research project
4. QATDV #3: On young person becoming a participant in QUEST Futures, parent consent to:
    a. share assessment with service providers and child's school and have ongoing exchange of information with them;
    b. inform attorney for the child about parent's decision to participate in QUEST Futures, describe components of treatment plan (type and frequency of services), and provide general periodic report on engagement in services;
    c. authorize the attorney for the child to tell the Family Court judge that the child is participating in QUEST Futures;
    d. share information about assessment, treatment plan and engagement with DJJ if child should be detained while case is pending, and receive similar information from DJJ upon the child's subsequent release to the community;
    e. at the I&R stage, if asked by Probation, inform Probation that the child has been a participant in QUEST Futures (this consent will only be sought if parent has consented to informing the attorney for the child that the child is participating in QUEST Futures); and
    f. at the I&R stage, if the judge orders an MHS report, provide MHS with a current assessment report and a summary of treatment engagement.

5. Dispo-OCFS: Consent to share summary report with assessment, diagnosis and summary of treatment engagement with OCFS
6. Dispo-Probation: Consent to share ongoing information about compliance with treatment plan with Probation, school, attorney for child, Law Department and service providers

Scenario 2: Participant in Probation ICM – Referred to QUEST Futures for mental health screening and voluntary participation in mental health services

1. ICMV #1: Parent consent for:
    a. mental health screen using the DPS (including a brief clinical interview);
    b. full clinical assessment if warranted by symptom or impairment scores on DPS;
    c. release of confidential information from current or previous treatment providers;
    d. informing Probation and the attorney for the child whether or not the child is eligible to participate in QUEST Futures; and
    e. permitting the attorney for the child to redisclose to the Family Court judge whether the young person is (i) ineligible for QUEST Futures, (ii) a participant in QUEST Futures, or (iii) eligible for QUEST Futures but not a participant.
2. ICMV #2: On young person becoming a participant in QUEST Futures, parent consent to:
    a. share assessment with service providers and child's school and have ongoing exchange of information with them;
    b. tell Probation, attorney for child and Law Dept. that child is participating voluntarily in program, describe components of treatment plan (type and frequency of services), and provide general periodic report on engagement in services;
    c. share information about assessment, treatment plan and engagement with DJJ if child should be detained while case is pending, and receive similar information from DJJ upon the child's subsequent release to the community; and
    d. at the I&R stage, if the judge orders an MHS report, provide MHS with a current assessment report and a summary of treatment engagement.
3. Dispo-OCFS
4. Dispo-Probation

Scenario 3: Youth has been mandated to QUEST ATD or ICM and is voluntarily participating in QUEST Futures, then is mandated by the judge to participate in QUEST Futures.

1. QATD-ICM-M #1: Parent consent to share current assessment report, periodic reports regarding compliance with the treatment plan, and critical incident reports with the judge, the attorney for the child, the Law Department and, for ICM participants, Probation.

Scenario 4: Participation in QUEST Futures mandated by Judge for young people who have not been participants in QUEST ATD or ICM

1. JM #1: Parent consent to:
    a. conduct a mental health screen using the DPS, followed by a full clinical assessment if warranted by symptom or impairment scores on the DPS (including obtaining information from treatment providers and other sources); and

b. share the assessment report with judge, the attorney for child and the Law Department.

2. JM #2: On becoming a participant in QUEST Futures, parent consent to:
    a. share assessment with service providers and child's school and have ongoing exchange of information with them;
    b. provide periodic reports regarding compliance with the treatment plan and critical incident reports with the judge, the attorney for the child, and the Law Department;
    c. share information about assessment, treatment plan and engagement with DJJ if child should be detained while case is pending, and receive similar information from DJJ upon the child's subsequent release to the community; and
    d. at the I&R stage, provide Probation with a description of the treatment plan and a summary of treatment engagement; and
    e. at the I&R stage, if the judge orders an MHS report, provide MHS with a current assessment report and a summary of treatment engagement.
3. Dispo-OCFS
4. Dispo-Probation

Scenario 5: Other referrals – Voluntary participation in QUEST Futures

1. OV #1: Parent consent to conduct mental health screen using the DPS, followed by full clinical assessment if warranted by symptom or impairment scores on DPS (including obtaining information from treatment providers and other sources)
2. OV #2: On young person becoming a participant in QUEST Futures, parent consent to:
    a. share assessment with service providers and child's school and have ongoing exchange of information with them;
    b. inform attorney for the child about parent's decision to participate in QUEST Futures, describe components of treatment plan (type and frequency of services), and provide general periodic report on engagement in services;
    c. share information about assessment, treatment plan and engagement with DJJ if child should be detained while case is pending, and receive similar information from DJJ upon the child's subsequent release to the community;
    d. at the I&R stage, if asked by Probation, inform Probation that the child has been a participant in QUEST Futures (this consent will only be sought if parent has consented to informing the attorney for the child that the child is participating in QUEST Futures); and
    e. at the I&R stage, if the judge orders an MHS report, provide MHS with a current assessment report and a summary of treatment engagement.
5. Dispo-OCFS
6. Dispo-Probation

Appendix E
Bio-Psycho-Social Assessment

CONTACT INFORMATION

Name _____ JCA No. _____
Parent's/Guardian's name/s: _____
Current address: _____
Home Phone: _____ Work: _____
Other phone _____

Alternative contact in event of emergency: _____
Phone: _____
Home school contact: _____
Phone: _____

CLIENT INFORMATION

Date of Intake: _____Tier:_____
Referral Source:_____
Home school: _____
Grade level: _____Credits to date: _____Special Ed: Y____ N_____
D.O.B.: _____Age: ____ Birthplace:_____
Student's nickname (or AKA): _____
Please circle:
Sex: Male Female
Religion:
Attends: Weekly Occasionally Rarely
Primary language: English Spanish French
Other: _____
Race/ Ethnicity: _____
Height:_____ Weight:_____

FAMILY INFORMATION

Are the client's natural parents:
Living together? Yes _____ No _____
Separated? (How Long)_____
Divorced? (How Long) _____
Parent/s deceased? (How Long)_____
Name/Address of non-custodial parent: _____

Please provide the following information about the adults who live with participant:
Name: _____ Relationship: _____

D.O.B. _____ Birthplace: _____
Occupation: _____

Siblings (Include any deceased child):
Name: _____Full:_____ Half: _____ Step: _____
School or occupation: _____ Grade: _____
Address (if different):_____

Name: _____Full:_____ Half: _____ Step: _____
School or occupation: _____ Grade: _____
Address (if different):_____

Other people living in household with student:

Name: _____ Relationship: _____
Age: _____ Occupation: _____

Name: _____ Relationship: _____
Age: _____ Occupation: _____

Have there been or are there currently any major changes or stresses in the family?
If YES, please mark all that apply:

In Past:	Current (6 months or less):	
_____	_____	Financial problems
_____	_____	Change of residence
_____	_____	Job changes / job loss
_____	_____	Drinking / drug problems
_____	_____	Arguments between parents
_____	_____	Separation or divorce of parents
_____	_____	Remarriage of parent(s)
_____	_____	Separation of sibling(s)
_____	_____	Separation of other family member
_____	_____	Frequent physical punishment
_____	_____	Physical confrontations between parents
_____	_____	Separation from significant non-family member(s)
_____	_____	Mental illness in family
_____	_____	Physical illness in family
_____	_____	Psychiatric hospitalization of a parent
_____	_____	Death in the family
_____	_____	Sexual promiscuity or incestuous behavior in the family
_____	_____	Legal problems
_____	_____	Other family problems

Please provide details:
Can the family cope with the student's current behavior?:

_____ Yes, quite well
_____ Yes, if support is made available
_____ Yes, if student is hospitalized
_____ Not at all

How serious do you think your child's problems are?
_____ Very serious
_____ Moderately serious
_____ Not serious

How hopeful are you that he/she will get better?:
_____ Very hopeful
_____ Moderately hopeful
_____ Not hopeful at all

Additional comments/observations:
_____
_____

SCHOOL INFORMATION

Current functioning – (Academic performance, relationship with teachers and peers, special classes or special help, clubs and sports, self-assertion):
_____
_____

History – (Past academic performance, school changes, separations, relationships with teachers and peers, extra-curricular activity, marked changes in performance, honors, suspensions):
_____
_____

EMPLOYMENT/SOCIALIZATION

Employment history – (Job types, performance on the job, attendance patterns):
_____
_____

Peers and neighborhood – (Relationships with peers, number and length of close relationships, type of friends, frequency and type of social activity, dating, performance in neighborhood, hobbies, play patterns):
_____
_____

HEALTH INFORMATION

Type of insurance: _____

Date of last physical exam: _____

Pre-school developmental history – (Include pre-natal, birth and neo-natal history, birth weight, feeding, sleep, remarkable deviations in developmental milestones, general behavior, training, habit disturbances, speech, parent's attitude toward student):

_____

_____

A. Medical Health

Allergies: _____

Medical condition/s: _____

Name of medication: _____

Dosage:_____

B. Mental Health

Therapy history: Yes:_____ NO:____ Where:_____

If yes, approximate dates:_____

History of medication: Yes_____ NO_____

If yes, has medication been helpful? YES _____ NO _____

Has any professional ever recommended medication? YES ___ NO ____

HEALTH INFORMATION (continued)

Please circle:

Smokes cigarettes:

No Sometimes Often

Drinks alcoholic beverages:

No Sometimes Often

Uses illegal drugs:

No Sometimes Often

If yes, what types?

LEGAL INFORMATION

Legal history:

CASE WORKER: _____

SIGNATURE: _____

COMPLETION DATE: _____

SUPERVISOR: _____

REVIEW DATE: _____

Appendix F
List of Referral Agencies

AGENCY	PROGRAM	PROGRAM DESCRIPTION
Child Center of New York	HALE – FFT	Family Functional Therapy: Intensive Home-Based therapy
	Family-Based Treatment	Outpatient Substance Abuse Treatment
	Outpatient Mental Health Clinics	Individual/Family Psychotherapy, Medication Management
	School-Based Mental Health Clinics	Individual/Family Psychotherapy, Medication Management
	Single Stop	Entitlement Assistance
	JobNet	GED/Vocational Program for Special Needs Youth
Jamaica Hospital	Outpatient Mental Health Clinic	Individual Psychotherapy and Medication Management
Flushing Hospital	Outpatient Mental Health Clinic	Individual Psychotherapy and Medication Management
FEGS	Outpatient Mental Health Clinic	Individual Psychotherapy and Medication Management
Bleuhler Center for Psychotherapy	Outpatient Mental Health Clinic	Individual Psychotherapy and Medication Management
Advanced Center for Psychotherapy	Outpatient Mental Health Clinic	Individual Psychotherapy and Medication Management
Long Island Consultation Center	Outpatient Mental Health Clinic	Individual Psychotherapy and Medication Management
Western Queens Consultation Center	Outpatient Mental Health Clinic	Individual Psychotherapy and Medication Management
Joseph Addabbo Mental Health Clinic	Outpatient Mental Health Clinic	Individual Psychotherapy and Medication Management
Glendale Mental Health Center	Outpatient Mental Health Clinic	Individual Psychotherapy and Medication Management

Jewish Board of Children and Family Services	Pride of Judea	Individual Psychotherapy and Medication Management
Upper Manhattan Mental Health Clinic	Outpatient Mental Health Clinic	Individual Psychotherapy and Medication Management
Kings County Hospital	Outpatient Mental Health Clinic	Individual and Family Therapy, Medication Management
Elmhurst Hospital	Inpatient Psychiatric Services	Inpatient Psychiatric Services
	Outpatient Clinic	Individual and Family Therapy, Medication Management
	Partial Hospital	Short-Term Day Treatment for Adolescents
Queens Children's Psychiatric Center	Dialectical Behavioral Therapy (DBT) Program	Short-Term Day Treatment
Nurse Family Partnership	Nurse Family Partnership	Pre-and Post-Natal In-Home Care for Adolescents
Liberty Management	Holliswood Hospital	Short-Term Acute Care Inpatient Psychiatry
	Arms Acres Residential	28 Day Substance Abuse Program
	Arms Acres Outpatient Clinic	Outpatient Substance Abuse Clinics
Daytop Village	Daytop Village	Outpatient Substance Abuse Clinic
Phoenix House	Phoenix Academy	Residential Substance Abuse – long term
Dynamite Youth	Dynamite Youth	Residential Substance Abuse
Far Rockaway Treatment Center	Far Rockaway Treatment Center	Outpatient Substance Abuse Clinic
Outreach Project	Outreach House	Residential Substance Abuse
		Outpatient Substance Abuse

		Middle-School Outpatient Program – only for court-involved youth
Elmcor	Elmcor	Substance Abuse Prevention
South Asian Youth Action	SAYA	Truancy Prevention Program
Transfer Schools (DOE-CBO Partnerships)	North Queens Community Prep	High School
	Renaissance Academy	High School
	Queens Satellite Academy	High School
	Community Prep High School	High School – only for court-involved youth
	Bronx Haven High School	
Martin de Pores	Martin de Pores	NYSE Special Needs School – Residential and Day
Jamaica Learning Center	Jamaica Learning Center	Pre GED and GED
Safe Space	Entitlement Program	Health Insurance assistance
	Domestic Violence	Counseling
Family Resource Centers	Parent Advocacy	Parent Support Groups, Peer-to-Peer Advocacy
United We Stand	Parent Advocacy	Parent Support Groups, Peer-to-Peer Advocacy
EXALT	EXALT	Vocational/Academic support and trainings – internships
Summer Youth Employment	SYEP	Paid employment
Young Adult Internship Program	YAIP	Vocational/Academic support and trainings for disconnected youth

Job Corps	Job Corps	Vocational/Academic support and trainings for disconnected youth
Southern Queens Park Association	Southern Queens Park Association	Preventive Services
Hispanic Aids Forum	Hispanic Aids Forum	Support and Peer Groups for GLBTQ Youth
Youth Enrichment Services	YES	Support and Peer Groups for GLBTQ Youth