Administration for Children's Services
150 William Street - 18th Floor
New York, NY 10038
Jess Dannhauser, Commissioner

Residential and Aftercare Services for Adjudicated Youth (Close to Home) Concept Paper

Background

The New York City Administration for Children's Services (ACS) is responsible for child welfare and juvenile justice services in New York City. ACS' Division of Youth and Family Justice (DYFJ) provides citywide juvenile justice services with a focused strategy of promoting public safety and improving the well-being of youth, families, and communities by ensuring quality care, and creating youth-centered opportunities to help young people become positive, contributing members of society.

DYFJ oversees a continuum of juvenile justice services for youth and families in New York City that includes:

- Community-based preventive and alternative services for youth who are at risk of delinquency or placement, and their families;
- Secure and non-secure detention services for youth who are arrested and awaiting court resolution; and
- Rehabilitative, therapeutic residential services for all youth placed within New York City as adjudicated juvenile delinquents, as well as aftercare services upon their return to the community, as part of the Close to Home initiative.

In 2012, the Governor signed Close to Home legislation, transferring responsibility for all but the highest risk/needs youth placed by the New York City (NYC) Family Court to ACS. Close to Home mandated treatment and supervision services near youths' families and communities. In 2017, New York State passed the legislation known as Raise the Age, raising the legal age of adult criminal responsibility from 16 to 18 and shifting care for older youth into the juvenile justice system. Young people adjudicated in the NYC Family Court and placed in the custody of ACS receive services and supports in or close to the communities where they live through the Close to Home (CTH) initiative. Residential and aftercare services are provided to youth placed in Non-Secure Placement (NSP) or Limited Secure Placement (LSP)[1].

Youth involved with the juvenile justice system experience a myriad of social and family problems that compound the challenges they face when they become systems-involved, such as

[1] https://ocfs.ny.gov/programs/rehab/close-to-home/

See NY CLS Family Ct Act § 353.3

unreliable permanency resources, poor family bonds or attachments, disengagement from school or remedial supports, lack of positive peer relations as well as attitude and orientation (e.g., distorted perceptions of criminogenic behavior). Without proper structure, supports, exposure and access to activities and resources that help these young people acquire and develop skills and resources that enable them to address their need, better self-regulate, cultivate and reinforce their interest in learning and employment, they risk deeper involvement in the juvenile and criminal justice system. Close to Home builds on successful New York City and State reforms and best practices from across the country aimed at improving outcomes for young people and their families by strengthening services, resources, and opportunities.

The Close to Home mission is to develop, support, and maintain permanent connections for youth and families while fostering opportunities for youth to be socially connected, feel safe, and develop prosocial skills to change behavior. Family support and contacts are essential to each youth's growth and success.

While developing CTH, ACS engaged national leaders to ensure that evidence-based models, contemporary research findings, and best practices were woven into the program design. All efforts to improve outcomes for youth are grounded in the following principles:

Public Safety: Consistent with the Family Court's determination that each youth requires supervision and treatment within the least restrictive setting possible, intensive supervision and monitoring is provided by well-staffed residential and community-based aftercare programs.

Accountability: Data are used to drive programmatic decisions and to ensure that CTH is effective, efficient, and responsive.

Evidence-based/evidence-informed treatment: CTH operates along a trauma-informed continuum of care that empowers and supports youth by responding to individual treatment needs and skills development with services that have a proven track record of achieving positive outcomes.

Educational Continuity and Achievement: Individualized educational services through the NYC Department of Education (DOE) allow youth to earn transferrable academic credits, while assigned Educational Transition Specialists ensure academic continuity upon return to community schools.

Community Reintegration: Youth make and maintain connections to positive adults, peers, and community supports embedded in their neighborhoods well past CTH placement.

Family Engagement and Collaboration: Family support and contact are essential to each youth's well-being; CTH minimizes dislocation in order to nurture frequent and meaningful opportunities to participate in treatment and engage with families.

Permanency: CTH is structured to develop, support, and maintain permanent connections for youth and families.

Purpose of the Concept Paper

The purpose of this concept paper is to announce ACS' vision for an upcoming RFP intended to identify qualified contractors to provide both residential and aftercare services to youth who have been adjudicated as juvenile delinquents. Through the RFP, which will be released later in 2022, ACS will seek appropriately qualified contractors/organizations that are skilled and experienced in delivering programs for justice involved youth, achieving DYFJ's desired outcomes to reduce recidivism, reduce or eliminate delinquent behaviors, and support reintegration in their communities. ACS seeks contractors who are committed to treating all youth and families with respect and dignity and who can develop and deliver high-quality services that recognize the diversity of youth and families in terms of race, ethnicity, sexual orientation, gender identity, religion, immigration, and mental health and physical ability. ACS seeks contractors who recognize the impact of social systems, racial disparities, and other forms of discrimination on youth and families, and who deploy strategies that mitigate these inequities.

Each selected provider will manage two components of the CTH program: residential care and aftercare. Residential care is offered in a Non-Secure Placement (NSP) or Limited Secure Placement (LSP) setting. Aftercare is required for both NSP and LSP youth.

***Residential Care**:* ACS contracts with not-for-profit providers to operate NSP and LSP group homes in or right outside of the five boroughs of New York City. A key component of the NSP group homes is the lack of secure perimeter hardware such as barbed wire fences. Typically, each residence houses 12 or fewer youth, and is designed to look and feel like a home environment. While in an NSP program, youth attend school taught by DOE teachers in a standalone building or at the NSP home. They also receive medical, dental, mental health, and/or substance abuse services as needed. LSP group homes have more restrictive security features compared to NSP group homes, such as fencing and doors managed by a control room to ensure the safety of residents, program staff, and local communities. Young people who are placed in an LSP setting generally present higher public safety risks compared to those who are placed in an NSP setting. They also receive all of their services directly on-site at the LSP facility.

Aftercare: After successfully completing their NSP or LSP residential term, providers transition youth back to the community and provide intensive aftercare support and supervision while the youth is on aftercare status. Aftercare planning begins on the first day of CTH placement, as the same provider is responsible for both residential care and aftercare. Aftercare supervision is essential for a youth's successful reintegration into the community following placement. Services are community based and support the youth's ongoing reintegration into their home community which include, but are not limited to, educational/vocational, behavioral health, positive youth development activities, etc. Aftercare community supervision involves a designated aftercare worker seeing and being in contact with the youth regularly to monitor compliance with conditions of release, the ability to maintain the youth safely in the community, and managing crises at any hour of the day, any day of the week. The aftercare worker engages with the youth during the residential care period and has partnered with the youth and family to plan for the transition to aftercare. These services aim to create smooth transitions from residential settings to community settings. This will allow clear communication among the different agencies and individuals involved in the re-entry process (e.g., residential facility staff, mental/behavioral

health service providers, community-based treatment providers, schools, and family members and other adults who can support returning youth).

ACS welcomes feedback on this Concept Paper from stakeholders.

Population(s) to be served

The target population is youth between the ages of 11-23 who are placed on a juvenile delinquency petition into a Non-Secure Placement (NSP) or Limited Secure Placement (LSP) facility.

ACS anticipates awarding up to 23 contracts for Close to Home residential/aftercare services citywide. Facilities should be located in or in close proximity to the New York City communities in which the youth and families live, so that family and family resources can easily travel to participate in youth treatment. The expectation is that the agencies awarded the contracts will be able to provide services regardless of which borough or surrounding counties the youth and family resides.

Service	Location of Facility	Number of Youth to be Served	Anticipated Number of Contracts (Capacity of Homes)	Available Funds Annually
Female NSP	Bronx	8	1	$2,805,000
	Queens	8	1	$2,805,000
	Brooklyn	8	1	$2,805,000
Male NSP	Bronx	32	4 (8 youth in each home)	$11,220,000
	Brooklyn	32	4 (8 youth in each home)	$11,220,000
	Queens	32	4 (8 youth in each home)	$11,220,000
	Manhattan	8	1	$2,805,000
Male NSP Problematic Sexual Behavior (PSB)	NYC or surrounding area	6	1	$2,915,000
Male NSP Intellectual and Developmental Disabilities (IDD)	NYC or surrounding area	6	1	$2,915,000
Female LSP	NYC or surrounding area	6	1	$2,915,000
Male LSP	Bronx	6	1	$2,915,000
	Brooklyn	6	1	$2,915,000
	Queens	6	1	$2,915,000

Transitional Residential Care	NYC or surrounding area	8	1	$2,805,000

Goals and Objectives of the RFP

ACS's goals and objectives for this RFP are to provide a continuum of evidence-based or proven interventions for youth 11-23 years old who have been adjudicated juvenile delinquent by the family court. CTH strives to improves outcomes for youth by achieving the following goals:

- Prevent further involvement in the juvenile/criminal justice system.
- Afford youth the opportunity to experience innovative and research-based programming that includes therapeutic services, safe and secure custodial care, responsive health and behavioral health care, supportive reentry services, and opportunities for educational achievement.
- Reduce/eliminate criminogenic behaviors.
- Promote positive behaviors, healthy relationships, and problem-solving skills that allow youth to remain in the community safely.
- Support families in problem-solving and conflict resolution in order to avoid future involvement with the court system.
- Connect youth and families to viable and sustainable community supports.
- Promote successful school completion and vocational options for youth.

Proposed Program Approach

While ACS is not requiring a specific approach, we are seeking contractors who will provide continuity of services throughout the youth's placement in CTH; provide case planning services from the date the youth is placed with their agency and aftercare until the end of disposition; and work with ACS to determine the types and anticipated duration of services. Although the length of stay for an individual youth may differ depending on their behavior and other factors, all young people placed with CTH (regardless of classification or docket length) will have a presumptive length of stay of six months in residential care and a presumptive length of stay of an additional six months on aftercare. A determination of longer (or shorter) length of stay will be on a case-by-case basis, in collaboration with ACS. Contractors must maintain a no-reject/eject policy for referrals of youth during the term of contract award; and recognize that the flow of intakes may vary from month to month but will be based on the population of youth adjudicated in the NYC Family Courts and placed in CTH.

I. Residential Care

a. General Residential Care. While a youth is in residential care, ACS envisions short-term treatment and stabilization focused on reducing criminogenic behaviors. In addition, all agencies contracting with CTH will have the necessary capacity to effectively serve children with a range of needs, including youth who have substance misuse challenges, severe emotional or behavioral problems. This is a change from existing contracting practice in which only some agencies had the capacity and expertise to serve these specialized populations.

b. Specialized Programs:

ACS is maintaining two specialized programs for youth with Intellectual and Developmental Disabilities and youth who exhibit Problematic Sexual Behaviors.

i. Youth with Intellectual and Developmental Disabilities (I/DD).

Youth placed in I/DD settings should receive all the support, treatment, and understanding necessary to meet their broad range of physical, emotional, and developmental needs, in a manner that maximizes their chances for reintegration and success in the community. Youth with such diagnoses require a highly structured, closely supervised therapeutic environment and a program that helps to empower them to achieve their highest potential. Providers serving the I/DD population must ensure that all staff receive training on I/DD and are capable of supporting this population.

ii. Problematic Sexual Behavior (PSB).

PSB treatment is effective in reducing deviant sexual interest and/or inappropriate behaviors, justice involvement, and non-specific mental health disorder symptoms as well as improving social connectedness, educational achievement, and family cohesion. Through PSB specialized services, the youth will learn impulse control; guidelines for appropriate sexual behavior; how to respect privacy and understand boundaries; and how to improve/increase their self-esteem. The youth will be held accountable for their actions and learn to fundamentally change their harmful behaviors.

Youth that present with PSB should be treated with evidence-based models such as Multi-Systemic Therapy Problem Sexual Behaviors (MST-PSB) for justice-involved youth.[2] PSB treatment incorporates intensive family therapy, individual therapy, parent training, cognitive-behavioral therapy, skills building, and interventions in school and other community-based systems.

c. Transitional Residential Care (TRC):

ACS is seeking to establish a short-term (six to twelve months) transitional residential program for males who are preparing to leave CTH facilities and/or the child welfare system without a permanent living arrangement. On a case-by-case basis, consideration will be offered to youth needing placement during or beyond their dispositional order. Youth entering a TRC will be provided with supports which encourage personal growth, development, and empowerment to make mature and healthy decisions. TRC will also offer youth case management, educational/ vocational services and will help them connect with a variety of community resources to enhance their co-designed personal development plan. TRC will support the goal of serving youth in the least restrictive, most home-like setting possible. TRC will serve youth age 17-23 who have demonstrated readiness for independent living and

[2] https://www.mstservices.com/

who can function independently in the community, but do not yet have a clear and committed permanency resource. Since the implementation of Raise the Age, CTH has seen an increase in older youth. The TRCs would be beneficial in serving this population. ACS is particularly interested in input from external stakeholders on models of transitional residential care.

II. Aftercare Services

As stated previously, aftercare development begins once a youth is placed in a residential setting. The aftercare team will participate in treatment team and planning conferences from day one. Providers will facilitate transitions from residential settings to community settings, with clear communication among the different agencies and individuals involved in the re-entry process (e.g., residential facility staff, mental/behavioral health service providers, and other community-based treatment providers, schools, and family members and other adults who can support returning youth). Providers will use best efforts to provide continuity and consistency for youth throughout the placement and aftercare process.

To support this vision, ACS is seeking to incorporate the following components into programs:

Case Planning*:* ACS utilizes the Youth Level of Service/Case Management Index (YLS/CMI)[3], which is a structured assessment instrument designed to facilitate the effective intervention and rehabilitation of youth who have committed criminal offenses. Case planners will ensure that youth and family are provided with services that are tailored to best address the family's strengths and needs. They will be required to incorporate the Risk Need Responsivity (RNR) framework in all case planning activity. Plans should match the level of service to the youth's risk to re-offend, assessing criminogenic needs and targeting them in treatment. Intervention and behavioral treatment should be tailored to each youth's learning style, motivation, abilities, and his/her strengths.[4] Family members and youth should be included in treatment planning. They should participate in identifying expected outcomes and setting timelines to achieve the plan.

Assessment and Treatment Planning: Providers will design a model of integrated practice with a special emphasis on coordinating treatment plans between provider staff (including on-site clinical staff) and other community service providers. The treatment will include a full range of health, mental health services, and appropriate recreational activities. Providers will also utilize and complete the YLS/CMI to inform the development of individualized treatment plans that address the criminogenic areas. All youth must be assessed for past and present trauma.

Evidence-based/Promising Practice/Innovative Model*:* Providers will implement program models that have been proven to be successful in working with youth in juvenile residential and aftercare settings. These models should be guided by an overall treatment philosophy, restorative

[3] Case Planning Handbook- YLS/CMI Version 2015.

[4] https://www.publicsafety.gc.ca/cnt/rsrcs/pblctns/rsk-nd-rspnsvty/index-en.aspx

justice approach, may rely on a theory of change, and generally involve a "package" of case management, psychosocial, and educational elements. All services should be rooted in evidence-based, promising/innovated and best practices that effectively meet the needs of the youth and families that are placed in residential care and aftercare.[5]

***Permanency Planning and Family Engagement*:** ACS understands that families have complex needs and dynamics; we also know that youth have a better opportunity of becoming successful when they are with their families. Therefore, the expectation is that all reasonable efforts will be made to preserve and reunify a youth with his/her caregiver prior to being released to the community. Providers will work with youth and families to facilitate reunification. Parents should be engaged throughout the planning process and provided necessary services and supports that will facilitate safe and timely reintegration to families and communities.

ACS envisions a strong linkage to aftercare services for youth leaving residential settings. Agencies should utilize a Family Finding model[6] to ensure that family resources have been exhausted. ACS is also requesting that all programs be staffed with resource specialists. Resource specialists will assist families with practical needs such as housing, budgeting, job attainment, prosocial recreational activities, school adjustments, and most importantly, generalizing all the skills and progress the youth made in placement within the home. Resource specialists will partner with the agency's case planner and serve as a liaison between program staff and youth's caretaker.

Incentives: ACS seeks agencies to use incentives to increase youth and family participation in treatment. Incentives can be tangible or intangible rewards used to motivate a youth or a family. Family participation in treatment team meetings, family therapy, school meetings, family day, medical/mental appointments, etc. are examples of areas that could qualify as incentive-based interventions. ACS encourages agencies to use incentives broadly and creatively to maximize outcomes for youth and families, while reserving the right to approve new uses.

Social Justice: Placement and aftercare services will provide a high quality of service and care that is inclusive of, but not limited to, the history; traditions; values; family systems; race and ethnicity; immigration and refugee status; religion and spirituality; sexual orientation; gender identity or expression; social class; and mental or physical abilities of client populations. Providers will be aware of the impact of social systems, policies, practices, and programs on multicultural client populations, advocating for, with, and on behalf of multicultural clients. Services will recognize and work to redress the historical legacy of current racial inequities that results in differences in application of practices, policies, and experiences of families. Services will examine factors that drive these differences among children and families involved in juvenile justice and deploy strategies to correct them.

Medical and Mental Health Services: Residential care staff will provide comprehensive medical care to youth including the identification and treatment of emergency and/or serious acute health and mental health conditions. Providers will be responsible for the interim management and

[5] https://www.blueprintsprograms.org/

[6] https://www.familyfinding.org/core-concepts overview.

treatment of chronic/serious health and mental health conditions and ensure that a medical professional is always on-call and available for consultation by telephone.

As part of the overall assessment process, staff will review and incorporate into the youth's juvenile justice service plan all information available from youth's time in detention and from other sources (e.g., probation, providers, prior placement, parents and foster parents, etc.). Agencies will complete an initial review of all existing documentation (e.g., assessments, recommendations, safety plans, and medications, etc.). This should include history of problematic substance use, trauma exposure, depression, commercial sexual exploitation, medical, dental, psycho-social, and YLS information immediately and no later than 24 hours after the youth's admission to the facility. Additionally, providers will obtain any clarification or additional information needed of existing documentation.

Family First Prevention Act: CTH will need to offer all youth in care a minimum of six months of aftercare services. The Family First Prevention Services Act (FFPSA) allows for additional support and services that assist families for children to remain at home, reduce the unnecessary use of congregate care, and build the capacity of communities to support children and families.[7]

Educational/Vocational: Providers will partner with youth to develop individualized plans that are informed by and reflect each youth's educational, vocational, career, and social-emotional goals. Providers will staff an educational/vocational specialist that focuses on helping youth learn skills that will help them find and maintain gainful employment and provide them with opportunities to deter them from reoffending.[8] The educational/vocational specialist will be responsible for providing technical assistance and support to case planners by advocating for services available through the NYC Department of Education, assisting youth with the development of educational and vocational plans, and making referrals to appropriate supplemental services, such as ACS' Fair Futures program that provides mentorship, tutoring, and housing supports.

Youth Voice in Facility Operations: Providers will establish a formal Youth Council specifically designed to support and empower youth voice in the operations of the facility. The Youth Council will meet regularly to provide input into food, recreation, therapeutic services, milieu, staffing, and other aspects of residential life.

Transportation: Providers will provide transportation to families to ensure and encourage visitation and scheduled meetings at the location that youth is placed. They will also transport youth to and from home passes, court appearances, school, and medical appointments.

---

[7] https://ocfs.ny.gov/main/sppd/family-first.php

[8] https://network.aia.org/blogs/stacey-wiseman/2016/07/22/opportunity-and-engagement-vocational-programs-in-juvenile-facilities

Staffing/Supervision: Providers will have qualified and trained staff to meet the needs of youth in their programs. Agencies will maintain a level of staffing to manage intake, youth in the facility, aftercare services, etc. Providers will employ and supervise staff who are well-trained and prepared to adhere to ACS child welfare and juvenile justice goals, including assessing the safety of children throughout the life of a case. Direct service staff and supervisors will participate in the ACS-mandated onboarding core training and will also fulfill the annual training requirements outlined in ACS policies, standards, and guidance. Providers will document mandated trainings in staff personnel files and in Cornerstone, the ACS learning management system.

Providers will conduct weekly supervision with all case planning and clinical staff, which must include case-specific support coaching and supervision of casework. This includes progress towards case milestones and completion of required documentation while reinforcing and reminding staff of best practice. Supervisors will have the ability to assess the professional development needs of their staff and provide opportunities for growth. Supervisors will conduct quality assurance case reviews with staff and provide staff with reflective supervisory support and regular performance evaluations.

Contract Management

Providers will be accountable for programmatic outcomes, fidelity to program models, and compliance with all ACS policies and standards. All adherence and fidelity reports from program models will be submitted and reviewed on a quarterly basis. ACS will engage in consistent monitoring activities and feedback loops to understand provider progress and compliance with programmatic and fiscal contract requirements. Both parties will endeavor to identify and build on what works and share best practices.

ACS currently focuses on the following key metrics to measure performance of CTH: placement stability while in residential care, incident rates including youth-on-youth assaults and altercations, absences without consent (AWOCs) while in residential care, time spent in residential care and aftercare community supervision, revocation rates, and readmission rates. Additional outcomes/outcomes measures are outlined in the ACS Quality Assurance Standards for NSP and LSP.[9]

Technology

Providers will maintain case and program data in the in the New York State Office of Children and Family Services (OCFS) system of record, CONNECTIONS (CNNX), for all child welfare cases and use the dashboard provided by ACS to monitor staff activities and program performance. Providers will also use the CNNX Placement module to respond to all placement referrals from ACS and work collaboratively with ACS to keep pace with new technological innovations and continuously seek to utilize technology to improve service delivery and access. Providers will maintain adequate case files, fiscal and personnel records, and ensure that staff follow appropriate, confidential record-keeping practices and procedures in a manner which

[9] CTH QAS

adheres to all existing federal, state and city laws, rules and regulations, and is consistent with policies, procedures, and standards promulgated by ACS.

Proposed Method of Evaluating Proposals

Upon receipt, all proposals will be reviewed for responsiveness. Proposals determined by ACS to be non-responsive will be rejected. All responsive proposals will be evaluated pursuant to criteria specified in the forthcoming Request for Proposals. These criteria will include but may not be limited to:

- Proposed program approach.
- Organizational structure and capacity to support quality implementation and sustainability, including past performance in delivering human services, fiscal oversight, and data collection.
- Experience in the juvenile justice, criminal justice, or child welfare systems.
- Evidence of commitment to family/community voice and choice, inclusivity, social justice, and racial equity.
- History of use of evidence-based models and of serving the proposed constituent population/geographic community effectively.

Awards will be made to the highest-ranked proposal(s) within each Competition Pool. If a proposer is eligible for an award in multiple Competition Pools, ACS will determine which Competition Pool the proposer will be recommended for. ACS will make awards starting with the highest-ranked proposer in each Competition Pool and proceed down each list until all service needs are covered. However, ACS reserves the right to skip one or more proposals, or select a partial proposal for award, to ensure that contracts will meet all service needs. ACS also reserves the right to limit the number of boroughs it awards to a proposal that includes multiple boroughs.

Proposed Term of Contract

It is anticipated that the terms of the contracts awarded from this RFP will be from July 1, 2023 to June 30, 2026 with the option to renew for two additional three-year terms. Renewal is subject to availability of funds and evaluation of contractor performance.

Total Funding Available/Anticipated Payment Structure

The total available funding for this program is approximately $195,525,000 ($65,175,000 annually). Funding will be divided between Limited Secure Placement and Non-Secure Placement as follows:

Placements	Available Annual Funds	Total Available Funding
Limited Secure Placement (LSP)	$11,660,000	$34,980,000
Non-Secure Placement (NSP)	$50,710,000	$152,130,000

Transitional Residential Care	$2,805,000	$8,415,000

Procurement Timeline

It is anticipated that an RFP associated with this Concept Paper will be released in the summer of 2022. A pre-proposal conference will be held approximately two weeks after the release of the RFP. The proposal due date for the RFP will be approximately eight weeks after the pre-proposal conference. It is anticipated that the contractor(s) will be selected/recommended for award by the winter of 2022 with a contract start date of July 1, 2023.

Contractor Performance Reporting Requirements

Contractors will be required to submit all program and case-related documentation, including but not limited to electronic case records, court reports and other documents, educational and vocational records, case conference reports, abuse/neglect reports, personnel files, program logs associated with supervision, and critical incident reports or activities as requested by ACS.

Use of PASSPort

Health and Human Service (HHS) RFPs will be released through New York City's Procurement and Sourcing Solutions Portal (PASSPort).

To respond to this RFP and all other Human/Client Services RFPs, organizations must have an account and an approved HHS Prequalification Application in PASSPort. Proposals and Prequalification applications will ONLY be accepted through PASSPort. If you do not have a PASSPort account or an approved HHS Prequalification Application in PASSPort, please visit www.nyc.gov/passport to get started.

Contact Information

All comments and feedback regarding this concept report must be received no later than June 24, 2022 by 5:00 PM. Comments should be sent via email to: CTH-CP@acs.nyc.gov.