Disconnected Youth:
An Answer to Preventing Disengagement

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Executive Summary

There is a crisis of disconnected youth in New York State. Young adults with no care, no connections, and no hope for the future are a population on the rise. A number of past reports and studies have focused on reconnecting youth. This white paper will focus on preventing disconnection in the first place and on engaging children and youth before it is too late.

The issue of disconnected youth is too broad and complex to take on all at once. For our purposes, the term "disconnected youth" refers to individuals between the ages of 16 and 19 who are not in school and not employed. In addition, this paper will focus on those youth who will eventually "age-out" of foster care or leave the children's mental health system.

In 2001, an estimated 3,700 children nationwide entered the child welfare system explicitly to receive mental health care.[1] This number does not take into account the children who were placed for other reasons but had, indeed, a mental health problem. Clearly, there is an overlap between these two systems. There is also an overlap with the educational system but, due to its complexity and a belief that the State Education Department (SED) is already focused on children through its "Closing the Achievement Gap" work, we will only briefly touch on that. (These initiatives include creating P-16 Regional Education Alliances that will link school districts with colleges, libraries, and community service organizations; and increasing parent and family involvement.) However, we are mindful that school should be a constant in the lives of all children and youth, and that the state must utilize the educational system as both the site for early interventions and as a safety net for youth who have slipped through the cracks of other systems.

The Process: Disconnected Youth Workgroup

Beginning in early 2007, the Schuyler Center for Analysis and Advocacy (SCAA) started pulling together research on disconnected youth both nationally and at the state level. SCAA then held two informal meetings of key stakeholders—agency representatives, advocates, and youth. Attendance at the second meeting was greater than at the first because participants at the first meeting added to the list of who should be at the table.

During the summer, SCAA conducted one-on-one meetings with the Office of Mental Health (OMH), the Office of Children and Family Services (OCFS), the Office of Temporary and Disability Assistance (OTDA), and the Office of Alcoholism and Substance Abuse Services (OASAS). Staff asked the commissioners and representatives of those four agencies to brainstorm a "wish list" of things that could be done to better provide services to children and youth, to prevent them from becoming disconnected. The "Principles of Prevention" that are laid out later in this white paper are a direct result of the work group's effort, while the recommendations came mainly out of the small group sessions. SCAA plans to interview other small groups, including SED and the NYS Department of Criminal Justice Services, as this project progresses.

Background

In 2005, 8% of all youth aged 16 – 19 were not working and not in school in New York State. The state was ranked 19th nationally in terms of numbers of disconnected youth.[2]

So who are the individuals that our society considers "disconnected youth"? Many disconnected youth have been or are involved in the child welfare, juvenile justice, mental health, and substance use systems. Many are homeless. They are often high school dropouts, teen parents, or runaways.

In New York City alone, there were 200,000 disconnected youth in 2005. Numbers there are higher than average. For example, 16.2% of young men in New York City are disconnected, compared to 7.7% nationally.[3] Perhaps even more daunting is the information, according to a 2005 report by the Young Adult Taskforce, that less than 10,000 disconnected youth received City-based services.

For our purposes, we will examine the needs of children in the child welfare and children's mental health systems—those children who will transition or "age-out" of those systems at some point, and who require supports to do so successfully. We will attempt to answer two questions. First, how do we work within these systems to keep children and youth engaged, address their needs, and tailor services to fit those needs? Second, how do we coordinate care across systems and state agencies?

An Overview of Adolescent Brain Development

Let us begin with a different approach than the norm, which generally treats children and youth involved in the child welfare and mental health systems as though they were completely separate entities from peers who have had no contact with those systems of care. Let us imagine that they are not so different at all. Let us imagine ourselves at age 18, perhaps with supportive families and communities, with financial and educational resources, with job skills, with *opportunities*—and then let us strip those things away and picture ourselves as basically abandoned, with no supports, no money, no place to stay and no home to return to if things get rough. Let us face the fact that without the supports and advantages

most of us are accustomed to, we are all just one step away from disconnection ourselves.

Now let us imagine that we are all alone in the world—and that we have a mental illness or have just left foster care following a traumatic childhood. Due to these experiences we may, in fact, be more resilient. Or we may instead be more lost.

Consider these facts. The brain of a typical adolescent has much of its focus on autonomy. Adolescents test limits, experiment, take risks, and resist authority in an attempt to maintain control. They are egocentric, exhibiting a normal amount of narcissism and self-centeredness. They tell themselves personal fables—that they are invincible and that nothing bad can happen to them. They also have an imaginary audience—the sense that everyone is looking at them, around whom the world revolves. Still, for most typical teens, being listened to is more important than actually getting their way.[4] For all their provocative testing of boundaries, most truly crave security and understanding, and often push the limits to prove that those boundaries exist. In that, they are not so different from adults.

As adults and even as children our pasts are important, in particular because our memories embed prior experiences in the neural connectors within our brains. The brain is an associational organ that matches those past experiences with present firing patterns. It is also an anticipation machine that links the past with what it expects will happen in the future, based on past experiences.[5] Therefore, it makes sense that we sometimes jump to conclusions or form opinions that appear unfounded. And it stands to reason that we act and react in certain ways, according to conditioned responses to particular triggers.

Experience or neural activation shapes connections in the brain via synapse formation and neural growth, resulting in neural plasticity.[6] Neural plasticity is necessary for the function of activity-dependent circuits; it allows us to learn through repeated movements. Likewise behavior, once thought to be set at a very early age by genes and DNA, is now known to alter through repeated efforts at change. According to recent research, the ability to change behavior has no age limit—and cognitive techniques have proven effective in the treatment of diseases and disabilities such as depression, obsessive-compulsive disorder, and dyslexia.[7]

In a nutshell, intervention works—and the earlier, the better. To ensure healthy behaviors and reactions, we must decrease exposure to trauma; increase protections for those at-risk; promote competence; provide opportunities, mentors, and second chances; and strengthen supports during periods of transition and change.[8] As a society, we should do this for all children and youth, with particular attention paid to those with special needs or circumstances. As adults, it is our responsibility to prepare youth for the real world.

With all this in mind, picture yourself or your own child at age 16 or 18. For that matter, picture yourself, or your child, at 25 or even 30. Remember how often you or your child requested financial assistance and emotional support. Recall how many times you, or they, returned home after college, a lost job, or even a failed marriage. Think about the societal supports that made the transition to adulthood easier (at 18, or 25, or 30…). Then picture yourself without those supports and ask yourself the question: do our most vulnerable children and youth deserve any less than the smoothest transition possible?

An Overview of State Systems

This paper will concentrate on two systems, child welfare and children's mental health, but will take into account the service overlap that occurs between state departments and agencies dealing with educa-

tion, social services, and substance use. Cross-system coordination is critically important to treating children holistically and as part of a larger family unit.

In addition, this paper will briefly address kinship care and what are referred to as child-only cases. Children and youth in both groups should be considered high-need in terms of early intervention and transition planning.

► *Child Welfare*

From July 2005 to June 2006, 229,900 children were in families reported to Child Protective Services in New York State. In addition, 46,000 received Preventive Services, 47,000 received Foster Care and Article 10 Direct Placement with Relatives Services, and 5,500 received Adoption Services. Federal law requires the state to start proceedings to terminate parental rights if a child has been in state custody for 15 of the last 22 months.[9] With that in mind, consider the outcome—a life in foster care with an eventual exit out into adulthood.

In New York State, a youth may remain in foster care if (s)he consents to remain in care past his or her 18th birthday and is:

- a student attending a school, college or university;
- regularly attending a course of vocational or technical training designed to prepare him or her for gainful employment; or
- lacks the skills or ability to live independently.[10]

In 2004, there were 18,875 youth between the ages of 18 and 21 who left foster care and the child welfare system. In 2005, there were 17,261; in 2006, there were 16,141.[11] The number of youth leaving the system ("aging-out") at age 18 has declined—1,080 in 2004; 991 in 2006—while the number leaving at age 21 has increased from 438 in 2004 to 614 in 2006.[12] Youth are staying in the system longer, allowing them more time to prepare for "the real world"—even if it's only an extra year.

This increase in stay is positive if it means that more of these youth are in school. However, it may also mean that too many of these youth are unable to live independently and that may be a direct result of the system itself. Since the children and youth in this system have had traumatic experiences and difficult lives, sympathy for their circumstances can translate into coddling by those around them, leading to helplessness on the part of the youth. While they are certainly deserving of empathy, these youth also deserve a fair shot at success—which can only happen if they are empowered to learn, grow, and live productive, responsible lives.

► *Children's Mental Health*

The children's mental health system is separated from the adult system. They are often two completely autonomous entities—right down to their different philosophies about mental illness. For some, this is an opportunity to provide or receive specialized treatment. For others, it results in fragmented services.

In general, New York State programs are state-funded, county-administered. The mental health system is no exception. While county systems all operate differently, they appear to have similar experiences and challenges. A spring 2007 survey of county mental hygiene directors and commissioners found some divergent approaches but similar concerns. Twenty of the 57 local directors responded to the survey, which began by asking at what age children were considered adults by the mental health system. The response by 19 counties was unanimous—age 18; unless, as one county said, the youth in question was disabled and in school prior to their 21st birthday. In that case, the youth was still technically considered a child even after age 21.

When asked if youth automatically aged-out at 18, 15 counties replied in the negative. Another three replied in the affirmative, but said that youth did so with transition plans. Most counties surveyed see age 18 as a year of transition, particularly if the youth is still in

high school. Sixteen counties surveyed provide either direct referrals to the adult system, transitional case management, or wrap-around teams to ease transition. Nineteen counties said that transition was also eased by coordination and continuity of services between schools and the county mental health system. They cited clinic staff in schools, meetings with school administrators, and cross-system planning groups as beneficial mechanisms.

Interestingly, 11 counties said they do not track youth as they transition between systems, while eight counties said that they do track. When asked if there were advantages to having separate mental health systems, the responses were overwhelmingly favorable. Fourteen counties cited the availability of age-appropriate services, necessary separation from adults in the system, and the ability to provide specialized services. However, one county responded that they would like to see a comprehensive "family system", as opposed to a children's system. Another said that while children require specialized services, these services could continue as needed after age 18, instead of having "two different systems with different eligibility standards that do not normally connect." Curiously, while generally supportive of the two-system approach, responses also confirmed that problems and barriers arise from that separation. Sixteen counties said this resulted in greater fragmentation, long wait lists, or "little recognition in the adult system of children's mental health."

► *Child-Only Cases*

Temporary Assistance for Needy Families (TANF) provides cash assistance and work opportunities. Child-only TANF cases are cases where no adult recipient is present in the TANF cash grant. Currently, 47% of TANF cases in New York State are child-only. In some of these cases, there is no parent present and the child lives with a relative or legal guardian. In others, the parent is ineligible for TANF. One reason that a parent would be ineligible is if they are a recipient of Supplemental Security Income (SSI), which provides cash assistance to the elderly, blind and disabled. Children whose parents receive SSI are subjected to the health and, often, mental health issues of those parents.

► *Kinship Care*

Children in kinship care arrangements are often child-only cases and are therefore dependent on TANF cash assistance, which is significantly lower than foster care payments. The grandparents or other relatives who have taken custody of these children are sometimes ill-equipped to do so. They are often elderly, in ill health, or financially unable to shoulder the burden of another mouth to feed and body to clothe. Like their peers in foster care, these children have usually suffered poverty, abuse or neglect. However, while youth in foster care receive clothing allowances and an educational subsidy, youth in kinship care do not. While they have the benefit of remaining connected to family, they do not have the financial or educational advantages (however small) of youth in foster care.

The Problem: How Do We Lose Children in the First Place?

Consider a few questions:

- Why do half of the counties surveyed in the previous section report that they do not track youth as they move between mental health systems?
- Would tracking be welcomed, or is it the case that youth are simply so glad to be free from court- or parent-ordered care that they distance themselves from supports once they age-out?
- Have state systems, and the larger society, failed those youth by forcing them out of care with no follow-up and no foundation to fall back on?

The easiest question to answer may be the last: of course youth should be better prepared than they are to leave care, and should be supported following the conclusion of care. The recommendations made in this paper will address ways to do this.

The other two questions are harder to answer. According to the aforementioned survey, the counties that did not keep track of the youth exiting the children's mental health system did so primarily because of the separation (funding and otherwise) between the two systems. Those that provided transition services felt it was necessary in order to garner positive outcomes.

"A child is simply referred to the adult system. There is no follow-up, tracking or case management to make sure that the child and the knowledge of the child follow to the adult system. This could be fixed, if the children were as important as maintaining the silos."

—County mental hygiene director

Interviews conducted during the research phase of this paper found that some youth were simply so happy to be out of care that they basically cut themselves off from the supports that were offered. Some found supports elsewhere, in family, friends, or mentors. Others became disconnected. This latter eventuality begs the question—how can the systems change so that youth, while eager to transition, are also comfortable seeking assistance from those same systems post-transition? How do we make those systems accessible?

Planning is key. Youth should be involved in developing a success plan from the moment they enter care. This plan should be created with the guidance of human service staff (all staff involved in the youth's care, across agencies), as well as the significant adults in the youth's life. Staff should ensure that there are supportive adults in the picture. Staff should also be culturally and linguistically sensitive so that youth can relate to them, and should be trained to understand what constitutes normal adolescent behavior, as opposed to what manifests as symptoms of mental illness or other problems. Working together, youth, their families, and the human service staff that manage and provide their care can lay the foundation for not only successful transitions and outcomes, but for positive and ongoing relationships. In effect, the state will not have created a revolving door, but rather a shelter in the storm.

The Solution: Prevention v. Remediation

We are not a society that values prevention. Our culture is reactive and supports a "band-aid mentality" of quick fixes. This ensures that we will continually deal with fallout. Although, as discussed earlier, there must be better supports in place for those youth transitioning out of care or between systems, it is also critical to preventively serve youth as a deterrent to disconnection.

New York State is currently addressing the need for prevention, as well as for better cross-system collaboration and coordination of services within the children's mental health system, by implementing three initiatives. The first, the Children's Mental Health Act of 2006, charges the commissioners of OMH and SED to create a children's mental health plan that school districts statewide will voluntarily implement. The plan will contain both short- and long-term recommendations to provide comprehensive, coordinated services, including prevention, early intervention, and treatment, for children through age 18. The Act also directs SED to develop and implement regulations to incorporate social-emotional development into educational standards and programs in every school district across the state. Again, implementation by those districts will be voluntary.[13]

The second, Child and Family Clinic Plus, will offer mental health and wellness screening and assessment of children in normative settings such as child care centers, preschools, schools, and after school programs. It is the first policy initiative in the state that addresses the mental health needs of children when they are very young, and that makes the connection between mental health, wellness, and a child's overall well-being. Both of these initiatives should serve to catch more children with mental health issues early, allowing for intervention and better rates of recovery.

The third, the Children's Cabinet, is a Governor-created group of 18 agencies that are charged with collaborating to strengthen the systems that address children's issues, and to address some of those issues. While the Cabinet's first two initiatives include early care and education issues such as the expansion and implementation of prekindergarten, and the expansion of the Children's Health Insurance Program, it is expected that they will tackle a wide range of others. As an issue that spans a number of agencies, disconnected youth should be a priority on the Cabinet's agenda.

Principles of Prevention

An ideal system would include strategies targeted in a number of areas. These "principles of prevention" provide the foundation for the recommendations that follow. They include:

- **Family-centered system of care.** In an ideal system, children are seen as being one part of a larger dynamic. They are raised, taught, and cared for by their families, potentially the most powerful force in their young lives. When members of the family have health or emotional issues, are unemployed, or have housing difficulties, the community supports them as part of an overall plan for assisting the child. Families are also supported by receiving help to navigate the various systems they come in contact with. Families and children drive the decision-making around their own treatment and education.

- **Preparation for problem-solving.** Youth should be empowered to take control of their lives within the context of the world around them, and should be mentored in regard to leadership, power, and negotiation.

- **Care coordination**. In an ideal system, care between mental health and other child-serving systems would be better coordinated. As noted earlier, nationwide in 2001, approximately 3,700 children entered the child welfare system specifically to access mental health services. These children were not served in their community because they did not have insurance or had exhausted their insurer's mental health coverage. They are just a sampling of the children who enter the child welfare system each year with mental illness.

  In an ideal system, care would be coordinated between all agencies that come in contact with children and youth—such as social services, education, substance use, juvenile justice, housing, and employment. This coordination would begin at first contact with the creation of a system of care for each child. The case workers and providers in the system of care would communicate with each other regarding treatment, would coordinate benefits, and would work together with the youth on developing goals for the future.

- **Concurrent planning.** An ideal system would start planning for a child leaving the system the moment that they enter it. Call it "discharge", "aging-out" or "graduation"—children who enter these systems will leave them someday, either still children or as young adults. Along with the care (or case management) plan, there would be a concurrent plan that outlines different scenarios—such as the youth returning home, the youth being adopted, or the youth going out on their own at 18. Society is responsible for the children and youth who leave these systems, and if we fail them many will end up in jail or on the streets, repeating a cycle of unemployment, teen pregnancy, inadequate education, and ill health that benefits no one.

- **Constancy of relationships.** An ideal system would ensure that the children and youth in these systems have at least one adult in their lives whom they can count on. The concept of social capital applies to all of us. We are aided, influenced, and supported by those around us. Those relationships—in particular with siblings and with their community of origin—should be encouraged and nurtured. Children need consistency, and ongoing relationships are imperative to their sense of security, safety, and self.

- **Integrating mental health services and addressing stigma.** An ideal system would fully integrate mental health services into schools and primary care settings, in order to increase early intervention. Stigma is the proverbial elephant in the room. Children and particularly young adults often do not want to acknowledge that they need help, in general, let alone help with a mental health issue. Stigma must be addressed head-on, and service providers must make it easier for youth to access services by making it more acceptable for them to do so. Mental illnesses should be treated as the public health issue and chronic diseases that they are—as treatable disorders where recovery is often possible.

- **Early and effective intervention.** An ideal system would catch and treat mental illnesses early—and sometimes lessen their severity because of this intervention. Evidence-based early intervention can prevent years of uncertainty and needless suffering. Providing services to children in the early years would help keep them connected and prepared as they age and encounter other obstacles and challenges.

- **Youth involvement.** An ideal system would include culturally competent, age-specific care for teenagers and young adults. Such care would address and nullify the stigma that youth often feel about continuing treatment as adults. Youth would have a voice in their care, and that care would build off existing principles for youth development.

Recommendations

The following recommendations describe the specific steps that New York State should take to prevent the disconnection of children and youth involved in the child welfare and children's mental health systems. These recommendations are a direct result of conversations with the commissioners and staff of OMH, OCFS, OTDA, and OASAS.

- **Educate policymakers and the public about the basic science of prevention.** As noted previously, we are not a society that values prevention. New York needs to increase awareness of a number of health and human service issues, including child abuse and neglect, domestic violence, mental illness, and substance use. The state should launch a multi-agency awareness campaign focused on preventing those problems and encouraging early intervention.

- **Develop and adopt a prevention framework.** A logic model that outlines in detail the population to be served, service approaches (including evidence-based practices and environmental strategies), performance targets, measurement methods, and desired results—across all appropriate agencies—could serve as a tool in planning and developing all future initiatives and activities. This framework would increase coordination and eliminate duplication of effort, and should be adopted by all youth-serving agencies.

- **Develop and implement a statewide risk and protection survey.** The Youth Risk Behavior Surveillance System (YRBSS), produced annually by the Centers for Disease Control and Prevention, provides a snapshot of youth behaviors in New York State. However, the YRBSS is not comprehensive. The state should develop and implement its own survey to gather data that could be shared across agencies and used to inform practice.

- **Focus on public health.** There must be a culture shift toward public health, with all health and human service issues viewed through the public health lens. There must also be a concurrent shift in the media portrayal of mental health issues and reporting. Mental illness must be de-stigmatized. To that end, Child and Family Clinic Plus is a step in the right direction. Bridging the divide between the mental health and educational systems is imperative. Providing early intervention in normative settings is critical to creating a new culture.

- **Add disconnected youth to the Children's Cabinet agenda.** Since this is such a cross-cutting policy issue that impacts all youth-serving agencies, the Cabinet should make it a high priority. By bringing all of the key policymakers to the table, it has the power to make things happen at the agency level.

- **Create a central coordination point.** The Children's Cabinet, with its representation from youth-serving agencies, should examine the need for an Office of Youth Services that would coordinate all services targeted to this age group. All too often, state agencies end up fighting over whose responsibility it is to provide services. This entity would coordinate that responsibility, thereby decreasing competition and increasing appropriate and timely action.

- **Create a Children's Budget.** This document would detail all of the funding spent across the state on children's services. It would be used to identify gaps, streamline and share funding, and prevent duplication of services. It could also be used as a tool to increase funding where it is lacking.

- **Address the family as a whole, not as separate pieces.** Many youth will return (or attempt to return) to their families after leaving care. We cannot expect them to succeed in transitioning if the climate to which they return is not a healthy, supportive one. The state should treat the family holistically, addressing all issues that affect family life and the ability to provide a safe, stable, nurturing home. In addition, the state should address the issue of sibling separation and should follow the recommendations outlined in OCFS' white paper *Keeping Siblings Connected*.[14]

- **Examine the practice of symptom-reduction versus what is developmentally-appropriate.** This paper discussed adolescent brain development early on. All systems that deal with teenagers should look at whether certain behaviors are a result of mental health issues, or simply developmentally-appropriate behavior for that age group. Instead of immediately medicating youth to reduce "symptoms", kicking them out of school for behavior problems, or shuffling them between systems they don't belong in, entities that deal with youth (whether state agencies or schools) should conduct comprehensive reviews before taking action, and all parties should broaden their understanding of what constitutes "normal" adolescent behavior. The state should develop a consistent measure across systems.

- **Guarantee Medicaid benefits past age 18.** Youth should not lose their health insurance because they turn 18. The time required to apply and wait for new coverage is a deterrent to applying, especially for youth who have not been taught how to fill out the necessary paperwork. Loss of this benefit results in youth who stop taking necessary medications or seeking treatment, as well as more youth presenting in emergency rooms for care. Medicaid should be extended for as long as recipients require this type of assistance. At the very least, human service workers should assist youth in re-applying for Medicaid long before they turn 18, so that there is no gap in coverage.

- **Waive college tuition for youth in foster care.** The state must encourage these young people to continue their education so that they are better situated to find well-paying jobs. Since these youth generally do not possess the means to finance their education, the state should provide tuition waivers that would allow them to pursue degrees. In addition to resulting in a

well-educated workforce, waivers would allow youth to remain in the child welfare system longer, giving them more time to prepare for entry into the workforce and taking care of some of their other needs while they pursue an education.

- **Utilize common identifiers.** As children and youth move between systems, or as foster children move between homes and schools, medical and educational records are often lost. SED is in the preliminary stages of creating a student identifier system; the state should use those numbers, or a similar system, to track youth as they maneuver the child welfare and children's mental health systems. OCFS is currently looking at connecting children to data within 30 days of entering the system.

- **Utilize multiple points of entry.** Again, Child and Family Clinic Plus is a start. The state should co-locate services wherever possible—using the previously-mentioned prevention framework to coordinate programs.

- **Create and implement services for child-only and kinship cases.** Youth in these arrangements are at high-risk for disconnection. They and their families should be supported with appropriate wrap-around services. Youth in kinship care should be given the same financial and educational supports that youth in foster care receive.

- **Train human service workers.** Frontline staff need to ask the right questions regarding transition. Who is the significant individual in your life; your primary support? Where will you go when you leave here? What are your plans for the future? The state must also examine the cultural and linguistic disparities that exist within the human service workforce. Staff are not necessarily reflective of the youths' background and are therefore harder to trust. Every attempt should be made to ensure that youth are comfortable and subsequently candid.

- **Begin transition readiness earlier.** Transition planning should begin at intake. The children's mental health and child welfare systems should develop and administer a youth-driven success plan that outlines goals early on, and should routinely check to see that these goals are being met. Beginning planning six months before aging-out or transitioning is too late. In addition, skills such as job readiness that are not currently taught by the child welfare system until age 14 must be included as part of the success plan.

- **Ensure significant support systems.** Every youth needs just one person they can count on. Human service staff should ensure that success plans include a parent, sibling, mentor, teacher, caseworker, or older friend who has the youth's best interests at heart. Such a connection is invaluable.

- **Stress forgiveness over failure.** Transition plans should build in a level of fluidity, much like a relapse model for those in recovery. Youth are not all going to make successful transitions the first time out. The state should institute a grace period for returning to the child welfare system after age 18, with supports in place to help the youth revise his/her success plan. Alumni networks are a good way to build communities of youth with similar experiences.

- **Empower youth to advocate for themselves.** New York State's YOUTH POWER! has a saying—"Nothing about us without us." As demonstrated by the Youth in Progress (YIP) members who shared their experiences with the work group, youth are their own best advocates. They should be encouraged and trained to promote their interests. They should also be included in all decision making that affects them.

Conclusion

There is a lot of work to be done in order to decrease the number of youth who become disconnected each year in New York State. A focus on prevention would be a proactive way to address the issue, instead of picking up the pieces after the fact and attempting to "re-engage" these youth. SCAA will continue to bring key stakeholders and policymakers to the table while taking this project to the next level and advocating for serious reform.

Endnotes

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