NEW YORK STATE OF OPPORTUNITY.

Justice Center for the Protection of People with Special Needs

ANDREW M. CUOMO
Governor

DENISE M. MIRANDA
Executive Director

February 8, 2019

Sheila J. Poole
Commissioner
Office of Children and Family Services
52 Washington Street
Rensselaer, New York 12144

Dear Ms. Sheila J. Poole:

The Justice Center for the Protection of People with Special Needs (Justice Center) is charged with protecting people receiving services in facilities under its jurisdiction from abuse, neglect and other conduct that may jeopardize their health, safety and welfare pursuant to Article 20 of the New York Executive Law. To that end, the Justice Center conducts systemic reviews in order to identify risks to the health, safety and welfare of people receiving such services.

On November 28, 2018, the Justice Center issued a draft of our review of residential treatment centers entitled *Review of Young People Leaving Care without Consent at Residential Treatment Centers*.[1] The Justice Center received a response from the New York State Office of Children and Family Services (OCFS) dated February 4, 2019, outlining actions your office has taken in response to the review findings as well as plans for additional corrective measures to be implemented in the near future. The final review findings, including the response from OCFS, is attached.

This review was conducted by the Justice Center and would not have been possible without the cooperation and professionalism that staff from the residential treatment centers and OCFS provided during the review. We appreciate and join you in your continuing commitment to the care of vulnerable people in New York State.

Sincerely,

Denise M. Miranda, Esq.
Executive Director

[1]This Review was performed pursuant to the Justice Center's authority as set forth in the Protection of People with Special Needs Act, Chapter 501 of the Laws of 2012.

Cc: Lisa Ghartey Ogundimu, OCFS
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NOTE: All correspondence related to this matter will be available for public inspection under Article 6 of the Public Officers Law. Material which will be required to be kept confidential or which is protected from disclosure under the Public Officers Law or other laws will be redacted prior to such disclosure.

NEW YORK STATE OF OPPORTUNITY.

Justice Center for the Protection of People with Special Needs

Prevention and Quality Improvement

Review of Young People Leaving Care without Consent at Residential Treatment Centers

February 2019

161 Delaware Avenue, Delmar, New York 12054
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The Justice Center's Promise to New Yorkers with Special Needs and Disabilities

OUR VISION

People with special needs shall be protected from abuse, neglect and mistreatment. This will be accomplished by assuring that the state maintains the nation's highest standards of health, safety and dignity; and by supporting the dedicated men and women who provide services.

OUR MISSION

The Justice Center is committed to supporting and protecting the health, safety, and dignity of all people with special needs and disabilities through advocacy of their civil rights, prevention of mistreatment, and investigation of all allegations of abuse and neglect so that appropriate actions are taken.

OUR VALUES AND GUIDING PRINCIPLES

Integrity: The Justice Center believes that all people with special needs deserve to be treated with respect and that people's rights should be protected.

Quality: The Justice Center is committed to providing superior services and to ensuring that people with special needs receive quality care.

Accountability: The Justice Center understands that accountability to the people we serve and the public is paramount**.**

Education: The Justice Center believes that outreach, training, and the promotion of best practices are critical to affect systems change.

Collaboration: Safe-guarding people with special needs is a shared responsibility, and the Justice Center is successful because it works with agencies, providers, people who provide direct services, and people with special needs to prevent abuse and neglect.

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Executive Summary

Purpose

This systemic review was conducted by the Justice Center for the Protection of People with Special Needs (Justice Center) with assistance from the Office of Children and Family Services (OCFS). The review was initiated in response to the high numbers of young people in care who are absent without consent (AWOC), often referred to as AWOL, from OCFS Residential Treatment Centers (RTCs). OCFS defines a young person who is AWOC as "a child who has been placed by an authorized agency in foster care in a certified foster boarding home, an approved relative foster home, or a licensed foster care facility and who disappears, runs away or is otherwise absent voluntarily or involuntarily without consent of the person(s) or facility in whose care the child has been placed."[1] In 2017, the Justice Center's Vulnerable Persons' Central Register (VPCR) received almost 2,500 reports from OCFS licensed programs, involving a young person who was AWOC.[2]

Research

There is a significant risk of harm to young people in residential care who leave their program without consent. The National Center for Missing & Exploited Children has found that of the 25,000 runaways reported in 2017, one in seven were possible victims of sex trafficking. "Of those, 88% were in the care of social services when they went missing."[3] Young people leave care without consent at nearly every facility at some point in time. Developing effective strategies to prevent and respond to AWOC is paramount to the health and safety of youth in care.

In 2016, OCFS issued an Administrative Directive (ADM) 16-OCFS-ADM-09 *Protocols and Procedures for Locating and Responding to Children, and Youth Missing From Foster Care and Non-Foster Care.* The ADM defined "absent without consent" or AWOC and outlined the procedures voluntary agencies must follow when a young person is absent without consent, and when they return to the program. The ADM directed agencies to consider the level of risk posed to the young person while in the community unsupervised and to immediately notify law enforcement when a young person in care was in a high-risk category and absent without consent.

Direct care staff are the first to respond when a young person leaves the program without consent. Their competency is vital to the management of the therapeutic milieu. Research has shown that when direct care staff were minimally trained and not engaged

[1] 16-OCFS-ADM-09 *Protocols and Procedures for Locating and Responding to Children and Youth Missing From Foster Care and Non-Foster Care.*
[2] Data from the VPCR as of 5/30/2018.
[3] "Child Sex Trafficking," National Center for Missing & Exploited Children, http://www.missingkids.org/content/dam/ncmec/en_us/documents/cst1in7infographic.pdf

with the young people in care, incidents of young people leaving without consent were more likely to occur. Additionally, more restrictive and punitive programs have been shown to contribute to young people leaving without consent. Boredom and a lack of activities are also known to contribute to this problem. [4] Well trained direct care staff that are engaged in therapeutic programming have been found to help prevent incidents of young people leaving without consent by maintaining a supportive and positive environment with activities and incentives to meet the needs of young people in care.[5]

Review

The Justice Center completed site visits to five RTC programs and reviewed:

- program descriptions
- policies/procedures
- program documentation
- staffing ratios, schedules, patterns, and levels
- behavioral support plans
- programming and program scheduling

The Justice Center also interviewed over 30 young people in care and over 80 RTC staff. Staff interviewed included direct care staff, clinical staff, supervisory staff and program administrative staff.[6]

Recommendations are provided to promote the health, safety, and welfare of young people in care and the remediation of contributing factors to young people leaving the program without consent.

Program Description

Residential treatment centers predominantly consist of OCFS licensed congregate care institutions. OCFS regulation defines an institution as "a facility established for the 24-hour care and maintenance of 13 or more children, operated by a child care agency."[7] The young people in care in RTC programs are the focus of this review because they have an array of clinical and behavioral needs that require increased supervision and services, and therefore face increased risks when they are absent without consent. Additionally, many RTCs also contain Hard-to-Place programs, which are "special

[4] Finkelstein, M., Wamsley, M., Currie, D., & Miranda, D. (2004). *Youth who chronically AWOL from Foster Care. Why they run, where they go, and what can be done.* New York: Vera Institute.
[5] Ibid
[6] The Justice Center conducted site visits at Northeast Parent and Child Society's Children's Home Residential Treatment Center on August 2 and August 16, 2017, Cayuga Centers Residential Treatment Center on August 21-22, 2017, Villa of Hope Residential Treatment Center from September 25-27, 2017, The House of the Good Shepherd Residential Treatment Center on November 29, 2017 and William George Agency Residential Treatment Center on January 23-24, 2018.
[7] New York State, Office of Children and Family Services, *Standards of Payment for Foster Care of Children Program Manual*, September 2006.

programs with enriched child care staffing for children with more severe behavior and emotional disorders than those served by regular programs."[8] Young people in care at RTCs typically have multiple diagnoses that may include trauma, depression, conduct disorder and history of substance abuse. Many times, these young people have had unsuccessful placements at lower levels of care.

Key Findings

1. **Policies and Procedures**
   - **A.** None of the RTCs visited had policies and procedures that were consistent with the OCFS administrative directive.[9]
   - **B.** Supervision standards were not clearly defined for direct care staff.

2. **Program Activities**
   - **C.** RTCs were using consequences that had no therapeutic value and behavioral modification techniques that encouraged young people to leave without consent.
   - **D.** At one RTC, substance abuse prevention programming was not provided to all young people in care, and they were not consistently screened for substance use upon their return to care.
   - **E.** RTCs lacked programming options and consistent opportunities for young people to participate.
   - **F.** Corrective Actions to address young people leaving without consent were not always implemented.
   - **G.** Essential documentation was missing or incomplete.

3. **Staffing**
   - **H.** Staff lacked training, guidance, and support to:
     - **a)** interact with young people in a therapeutic manner;
     - **b)** meet the specialized needs of young people in care; and
     - **c)** ensure the safety of young people in care.
   - **I.** Staffing shortages impacted:
     - **a)** provision of clinical services;
     - **b)** supervision of young people in care; and
     - **c)** regular participation in recreation activities.

Key Recommendations

1. **Policies and Procedures:**

[8] Ibid
[9] 16-OCFS-ADM-09 *Protocols and Procedures for Locating and Responding to Children and Youth Missing From Foster Care and Non-Foster Care.*

A. Ensure policies and procedures are consistent with the OCFS administrative directive and that direct care staff follow these policies and procedures.
B. Clearly define supervision standards and train direct care staff on supervision standards.

2. **Program Activities:**
   C. Ensure RTCs use therapeutic consequences and effective behavioral modification programs to address young people in care who have left without consent and other behaviors.
   D. Educate all direct care staff on substance use by young people in care, prevention strategies and how to screen young people in care when they return from being absent without consent.
   E. Ensure RTCs have an array of programming options and they are provided regularly to the young people in care.
   F. Ensure corrective actions are fully implemented.
   G. Ensure essential program documentation is completed and maintained.

3. **Staffing**
   H. Provide training, guidance, and support to direct care staff on how to:
      a) engage and support young people in a therapeutic manner;
      b) meet the specialized needs of young people in care; and
      c) meet the safety needs of young people in care.
   I. Address staffing shortages and turnover to ensure that:
      a) young people in care are receiving appropriate clinical services;
      b) management and staffing resources meet the supervision needs of the young people in care; and
      c) young people are able to participate in recreational activities on a regular basis.

Review Findings

Background

The Justice Center for the Protection of People with Special Needs (Justice Center) is charged with protecting individuals in the care of facilities under its jurisdiction against abuse, neglect and other conduct that may jeopardize their health, safety and welfare pursuant to Article 20 of the New York Executive Law. To that end, the Justice Center conducts systemic reviews to identify risks to the health, safety and welfare of people receiving such services.

The Justice Center's VPCR received more than 2,500 reports of a young person leaving Residential Treatment Centers (RTC) programs in 2017. As a result, the Justice Center

initiated this review of five RTCs with high or increasing reports of a young person leaving care without consent

Scope and Methodology

Site visits were conducted at:

1. Northeast Parent and Child Society's Children's Home - Residential Treatment Center (RTC #1)
2. Cayuga Centers – Residential Treatment Center (RTC #2)
3. Villa of Hope – Residential Treatment Center (RTC #3)
4. The House of the Good Shepherd – Residential Treatment Center (RTC #4)
5. William George Agency – Residential Treatment Center (RTC #5)

Interviews were conducted with over 30 young people in care and 80 direct care staff. Additionally, a sample of documentation from each program was reviewed which included:

- AWOC Policies and Procedures
- Supervision Policies and Procedures
- Census
- Schedules of direct care staff
- Staff training schedules
- Behavioral support plans for young people in care
- Behavioral modification systems
- Programing and programing schedules
- Communication logs
- Incident reports

Documentation was requested for all other program specific guidance, policies, procedures, and for responding to and preventing young people from leaving without consent.

2018 Residential Treatment Center AWOC Survey Results

On March 12, 2018, the Justice Center issued a voluntary and anonymous survey to all RTCs certified by OCFS. The purpose of the survey was to gather information to help in the development of resources to prevent and reduce the number of young people leaving care without consent and support the staff who provide care in these programs. The survey was completed by 26 of the 48 RTCs, resulting in a 54% response rate.[10] Over 90% of the RTC programs responding to the survey reported that young people had left

[10] The Justice Center worked with OCFS regional office staff to identify 48 RTC from across the state

their program without consent. Results of the survey are incorporated into the review findings.[11]

Findings

The Justice Center's review findings are outlined below. Letters detailing specific findings at each RTC visited were previously issued to the agency executive director, and OCFS.

RTC Policies and Procedures

A. Policies and procedures were not consistent with the OCFS administrative directive on responding to and locating young people who are absent without consent.

OCFS defines a young person who is AWOC as "disappears, runs away or is otherwise absent voluntarily or involuntarily without consent of the person(s) or facility in whose care the child has been placed."[12] 84% of respondents to the Justice Center's survey stated that they had a formal definition for when a young person was considered absent without consent. However, 33% considered a young person to be absent without consent if they leave the RTC campus, though the administrative directive does not make this distinction, and 24% of respondents stated that they considered a young person absent without consent only after they are missing for a set period of time (for one program it was more than 24 hours).

All five RTCs visited for this review had policies or procedures that were not consistent with the administrative directive from OCFS. RTC #4 was using a policy that was last revised in August of 1998 and did not reflect several aspects of the administrative directive issued in May 2016, including consideration of the risk level of the young person at the time of going AWOC and the completion of the screening for sex trafficking upon return to the RTC.

RTC #1 and RTC #2 had a time limit that a young person could be out of supervision before they were considered absent without consent, regardless of the young person's risk level. RTC #1 would file a Missing Person Report (MPR) "on the average of about one (1) hour after the youth had run away." RTC #2 defined absent without consent as "a youth walks away from supervision without authorization for 30 minutes or more."

RTC #3 and RTC #5 did not identify the need to make notifications to authorities immediately when a young person in a high-risk category was absent without consent.

[11] Not all programs responded to each question. All response percentages are based on the number of programs which responded to that question.

[12] 16-OCFS-ADM-09 *Protocols and Procedures for Locating and Responding to Children and Youth Missing From Foster Care and Non-Foster Care.*

Further, RTC #3 had several young people identified with high risk safety concerns such as substance abuse, physical aggression and self-harm, but did not designate them as high risk.

Additionally, staff at RTC #1 were using the additional term "out of program" and staff at RTC #2 were using the term "wandering" to describe a young person who was out of the direct supervision. Staff at both RTCs were using these terms interchangeably with absent without consent and appeared to not understand how they differed. At both RTCs the direct care staff did not appear to use the program's absent without consent policy or procedure for a young person considered to be "wandering" or "out of program". Further, neither program provided a formal definition in a policy or procedure for either term.

B. RTCs had supervision standards and expectations that were not defined for direct care staff.

Three RTCs used supervision standards that were not defined for direct care staff. RTC #5 had an intervention in Individual Behavior Management Plans (IBMP) called "AWOL STOP status". This intervention included placing young people in TCI approved holds to prevent them from leaving without consent.[13] However, this status was not defined for staff in any policy.

Two RTCs had implemented enhanced supervision standards for certain young people but did not provide staff with a definition of these standards. RTC # 3 policy stated that young people in care upon admission to the RTC "must be provided with closer supervision at all times", but did not provide a definition of this level of supervision. RTC #4 used "one-to-one supervision" for some young people when they returned from being absent without consent. However, there was no written definition of "one-to-one" supervision in their policies.

Program Activities

Program activities at RTCs were found to contribute to young people leaving without consent and failed to address unsafe behaviors they may have engaged in while gone.

C. RTCs were using consequences that had no therapeutic value and behavioral modification techniques that encouraged young people to leave without consent.

In response to questions in the Justice Center survey about the use of consequences for young people in care leaving the RTC without consent, 85% of the RTCs responded that they used discipline and/or consequences, 41% limited or restricted privileges and 55% would stop off grounds/campus trips for a period, some up to 30 days.

Interviews and review of documentation revealed that punitive consequences that lacked therapeutic value were used at four RTCs.

[13] Therapeutic Crisis Intervention

- RTCs #2, #4 and #5 were using a consequence they called “table time”. When a young person displayed unsafe behaviors, including leaving without consent, they were required to sit at a table for a period, an hour or more, without engaging peers or participating in RTC activities.

- Additionally, RTC #2 would restrict visitation or revoke family visits as consequence for leaving without consent. RTC #1 disciplined the entire group of young people instead of determining who was responsible. In response to this group consequence, one young person tried to leave the program without consent and then had several instances of self-harm.

At two RTCs, both staff and young people in care believed some policies or procedures contributed to or encouraged young people to leave without consent.

- Staff at RTC #2 did not consistently implement a phase system for young people in care to earn privileges and community time. Young people found it too difficult to earn privileges to go off campus unsupervised, so young people would leave the RTC without consent.

- At RTC #1 the young people interviewed stated that they understood the modified skills program and knew how to manipulate it to limit consequences after they engaged in high risk behaviors on and off campus. Staff who were interviewed reported that the RTC was also holding young people back from school after returning from being absent without consent until their clinician could speak with them. During this time in the dorms youth were permitted to sleep, watch TV and play video games and this may have been viewed by some young people as an incentive to leave without consent.

D. Substance abuse prevention programming was not provided to all young people in care, and young people were not consistently screened for substance use upon returning to care.

The Justice Center Survey showed that 27% of RTCs provided no information or training for direct care staff on substance use by young people in care. The majority of programs 81%, said they provide assessment and referral and/or counseling for young people in care when a need was indicated, while 65% provided educational materials.

During interviews at two RTCs direct care staff and young people stated that, young people were engaged in unsafe behaviors including smoking marijuana and drinking alcohol when AWOC. Review of the policies and procedures at RTC #4 showed that nursing or direct care staff screen young people in care upon return from being absent without consent, however, direct care staff did not recall if they had received any training or education about how to screen for substance use. The same RTC only provided

counseling, training or educational materials about the dangers of substance use to young people who had a noted history of substance use.

E. RTCs lacked programming options and consistent opportunities for young people to participate in these activities.

Only 58% of the RTCs responding to the Justice Center Survey said they have a council, advisory committee or structured meeting to provide young people the ability to provide input into programming.

At RTC #3, several staff felt young people in care would benefit from more options for community engagement, like volunteering or bringing community resources onto campus. Young people in care were limited to trips into the community for shopping or recreation but had few resources for deeper involvement in the community. Staff at RTC #2 stated that the previous administration viewed programming options as rewards that had to be earned and not as an integral part of treatment. Management at RTC #4 said that incentive programming for good behavior "take place spontaneously" without any consistency for the young people in care.

F. Corrective Actions to address young people leaving without consent were not implemented.

Two RTCs had previously identified corrective actions to help prevent young people in care from leaving without consent, but did not fully implement them. RTC #2 had made procedural changes in 2015 with a goal of "rebuilding peer culture on campus." Changes included having young people in care hold themselves and each other accountable through a group process. Interviews of young people and direct care staff revealed this process had not been implemented or followed. RTC #4 had previously identified a need to improve the assessment of protective factors at intake including the risk of the young person to leave without consent. The same RTC identified the need to analyze each occurrence of a young person leaving without consent to better understand the reason for the behavior. However, none of these plans were fully implemented due to staff turnover.

G. Essential program documentation was either missing or incomplete.

Essential documentation was either missing or not completed at all five RTCs. RTCs #1, #3, and #5 had communication logbooks missing staff entries for multiple shifts and some with whole days that were incomplete. At RTC #4 direct care staff who were not fully cleared to work with young people in care unsupervised were not consistently identified according to established agency procedure.[14]

RTC #2 was not documenting or consistently holding specialized meetings (aka Red Flag meetings) used to process the circumstances of each occurrence of a young person

[14] A staff safety plan contains safeguards that are put in place to protect young people in care by addressing safety concerns that may exist with a staff member.

leaving without consent and to establish a plan to mitigate this risk in the future. This lack of documentation made it difficult to keep direct care, clinical and administrative staff aware of what was happening in the RTC and with young people in care.

Staffing

H. Staff lacked training, guidance, and support to:

a. interact with young people in a therapeutic manner.

Direct care staff and young people in care at two RTCs, gave examples of a lack of positive and therapeutic engagement by staff that at times contributed to a negative environment. At RTC #4, several staff stated that they saw coworkers engaged in power struggles with young people which led to further behavior issues and disruptions. Young people stated they felt "talked down to" by staff and if staff were more engaged there would be "less time to plan" leaving without consent. In RTC #1, young people in care stated that staff mockingly encouraged them to leave, going as far as to open doors for them. They stated that young people leaving without consent was "non-stop" and staff were tired of them leaving, so staff did not respond as they should.

b. meet the specialized needs of young people in care.

Several direct care staff at two RTCs stated that additional training on the special needs of young people in care was needed. Some staff at RTC #1 were concerned about their co-workers' ability to understand the mental health needs of the young people or how to speak to them in a supportive manner. Young people in care at RTC #2 stated that they viewed staff as fearful of them, and as a result, reluctant to administer consequences or the agency's phase system. During interviews, several staff stated that the needs of the young people in care were too high for staff to meet and did not appear to understand that the program was serving young people "considered as ungovernable or incorrigible and require heightened supervision due to behavioral dysregulation, emotional dysregulation, substance use, stealing, self-injurious behaviors, etc."

RTC #1 and RTC #3 provided minimal training to newly hired staff before they began working with young people in care. Staff at RTC #1, said that newly hired staff were "thrown in" and "given keys and a badge" with limited knowledge and resources to perform their job duties. Staff felt this led to the newly hired staff "hiding" in the staff office to avoid managing behaviors of the young people. RTC #3 had newly hired staff that were not required to complete essential trainings like Mandated Reporter, TCI, Supervision of Youth Policy, and AWOL Policy and Procedure prior to working in the cottages with the young people in care.

c. ensure the safety of the young people in their care.

Results from the Justice Center RTC survey showed that 73% of respondents stated that their program permitted the use of physical restraint to prevent a young person from leaving without consent, and 84% of those programs that permitted the use of restraints monitored the use of physical restraints to prevent future use of those restraints. Only

32% of respondents stated that their program used training to help direct care staff know when physical restraint can be used to prevent young people from leaving without consent.

Direct care staff at RTC #1 and RTC #2, expressed that they lacked confidence with using physical restraint due to fear of repercussions from the Justice Center. Both RTCs used physical restraint to prevent young people from leaving without consent. RTC #1 encouraged staff to prevent young people from leaving by blocking doors when possible. However, at times this action triggered a physically aggressive response from young people towards staff and led to a physical restraint.

I. Staffing shortages and turnover impacted:

a. provision of clinical services.

Management at two RTCs had identified the turnover in the clinical staff as a concern. During interviews at RTC #3, management and direct care staff expressed concern that all the clinicians in the program had been working there for less than a year, some for only a few months. At RTC #1 the turnover in clinicians was so high that many of young people in care had multiple clinicians in one year.

Additionally, the clinical staff at RTCs #1 and #3 stated that case management duties prevented them from providing clinical services to the young people in care and from working collaboratively with direct care staff. Case management duties were explained as transportation to appointments, facilitation of visits and coordination of collateral service providers in addition to documentation requirements of the clinical program.

b. supervision of young people in care.

At four RTCs, deficient management and staffing resources contributed to occurrences of young people leaving without consent. RTC #5 was not meeting its required ratio of two young people to one direct care staff. During interviews, staff indicated that the number of young people in care who attempted to or successfully left without consent increased during times of high staff turnover.

At RTC #2, the agency administration reported that in the past staff were hired solely to support required staffing ratios, regardless of work experience. Staff and young people both identified lack of employee experience and knowledge as a contributing factor to the increase in young people leaving without consent.

Two additional RTCs had staffing levels that were inadequate to fulfill safety protocols necessary to prevent young people from leaving without consent. At RTC #3 while the program provided staffing to meet the base ratio defined in regulation, this ratio was not adequate to meet the behavioral needs of the young people in care. This led to one staff in a cottage with two young people identified as “High Risk Alerts” due to risk of leaving without consent. When the solitary direct care staff member was distracted, the two young people left the cottage. Several direct care staff at RTC #4 stated in their interviews that the program was using a physical intervention behavioral support referred to as “Stop

AWOL" which required staff to implement a physical intervention to prevent a young person from leaving without consent. Staff stated that when multiple young people with this intervention designation participated in activities together they would frequently take advantage of the lack of staffing to leave without consent.

c. regular participate in recreation activities.

Four RTCs were not providing regular participation in recreation activities for the young people in care due to inadequate staffing. At RTC #3 several young people in care and staff stated that the lack of staffing and increased turnover of staff, led to activities being cancelled on most weekends. RTC #4 had similar issues with staffing which directly led to young people leaving without consent and activities being cancelled for the remaining young people.

RTC #1 and RTC #2 had issues with managing behavioral challenges of the young people in care while still maintaining recreation activities. Both RTCs met the required staff to young person ratio, however when staff had to address behavioral issues of a single young person, the activities of all the young people in the cottage would be canceled.

Recommendations

The Justice Center's specific recommendations are detailed below. While this review focused on five residential treatment centers, the Justice Center recommends that OCFS apply these recommendations to all residential treatment centers that would benefit from them.

Policies and Procedures

A. Ensure RTC policies and procedures and direct care staff follow the requirements outlined in the administrative directive.

1. Review policies and procedures in place at RTCs to ensure they fulfill the requirements of the OCFS administrative directive.
2. Ensure the definition of "absent without consent" provided in the administrative directive is used by RTCs.
3. Identify programs using additional terms to describe absent without consent, ensure these terms are in accordance with the definition provided in the administrative directive and are clearly defined for direct care staff.
4. Ensure that direct care staff are following the required actions outlined in the administrative directive for a young person who has left without consent.

B. Develop clearly defined supervision standards for direct care staff.

1. Review the current supervision standards in place at each program to ensure they:

a. are clearly defined in policy and procedures.
b. meet the supervisory needs of the young people in care.
c. are feasible based on staffing of the program and the supervisory needs of the young people in care.
d. require direct care staff are trained on and understand the standards.

Program Activities

C. Use therapeutic consequences and effective behavioral modification programs to address young people in care who have left without consent and other behaviors.

1. Limit practices that take young people in care away from programming, daily living activities and family visitation and ensure that more individualized, therapeutic consequences are used.
2. Evaluate all behavioral modification programs in use to determine the therapeutic value and effectiveness in addressing young people in care leaving without consent.
3. Ensure programs have supervisory and clinical oversight processes to monitor the consistency and effectiveness of consequences and behavioral modification programs for young people in care.

D. Educate direct care staff on substance use by young people in care, prevention strategies and how to screen young people upon returning to care.

1. Ensure programs fulfill requirements in the administrative directive regarding follow up with young people in care upon returning to care including:
   a. an immediate assessment of the health needs of the young person performed by a trained staff member.
   b. clear expectations and procedures to follow when it is suspected a young person requires medical attention.
   c. regular training for direct care or medical staff to perform this assessment and training on substance use among young people in care.
2. Consider training direct care and medical staff in the use of Naloxone and have it readily available.

E. Ensure RTCs provide an array of programming options which are provided on a regular basis to the young people in care.

1. Ensure programs provide opportunities for young people to have meaningful input into the development of programming.

F. Fully implement all corrective actions.

1. Ensure RTCs can identify if corrective actions are fully implemented and are effective.
2. Make sure that the implementation plan for corrective actions is available to various levels of management and administration so that the plan is not lost with staff turnover.

G. Ensure communication logs and important program documentation are completed.

1. Ensure programs have clear expectations and standards for direct care staff who are completing logbooks and program-specific documentation.
2. Ensure programs are providing training to direct care staff on the procedure and expectations for program documentation.
3. Ensure programs develop and implement regular and ongoing supervisory review of program documentation for compliance with procedures.

Staffing

H. Ensure staff have training, guidance and support on how to:

a. interact with young people in a therapeutic manner.

1. Ensure direct care staff are provided additional trainings on engagement, trauma, mental health and special behavioral needs; and receive regular and consistent supervisory feedback on their engagement of young people in care.

b. meet the specialized needs of young people in care.

1. Ensure direct care staff are provided essential training prior to working with young people in care. Review training schedules for newly hired direct care staff to ensure essential trainings like mandated reporting, supervision of youth policies and procedures, and crisis prevention and intervention are provided prior to working with young people in care.
2. Ensure direct care staff receive continuing education and training on all specialized needs of young people in care at least annually and are provided with related educational materials.

c. ensure the safety of the young people in their care.

1. Ensure direct care staff understand the appropriate use of physical restraint.
   a. Conduct ongoing monitoring of physical restraint used to prevent young people from leaving without consent, to ensure: programs are using physical restraint in accordance with TCI guidance, that direct care staff understand TCI

guidance, and expectations for staff to implement physical restraint are as prescribed and feasible.

b. Ensure programs continue to educate staff and young people in care on the Justice Center and provide additional annual training and support to help alleviate staff anxiety about the Justice Center.

I. Ensure staffing is adequate to:

a. ensure young people in care are receiving appropriate clinical services.

1. Aid programs in identifying the causal factors associated with the high turnover in clinical staff and address these factors.
2. Assess the non-clinical tasks required of the clinical staff in programs and assist programs in identifying additional resources available to help complete these tasks.

b. ensure RTCs implement management and staffing resources that meet the supervision needs of the young people in care.

1. Review the current staffing levels to ensure they are in accordance with state regulations, the agreed upon program description, and the behavioral needs of the young people in care.
2. Monitor hiring practices of the RTC programs to ensure appropriately skilled and qualified people are hired.

c. allow young people in care to participate in recreation activities on a regular basis.

1. Ensure programs are not only meeting the required staffing ratios but the necessary staffing to meet the changing behavioral support needs of the young people in care.
2. Provide ongoing monitoring of program recreation activities to ensure these opportunities are provided to young people in care and that they occur.

NEW YORK STATE | Office of Children and Family Services

ANDREW M. CUOMO
Governor

SHEILA J. POOLE
Acting Commissioner

February 4, 2019

Denise M. Miranda, Esq.
Executive Director
Justice Center for the Protection of People with Special Needs
161 Delaware Avenue
Delmar, New York 12054

Dear Executive Director Miranda:

This letter is in response to the "Residential Treatment Centers' Response to Young People Leaving Care without Consent" report issued on November 28, 2018.

The New York State Office of Children and Family Services (OCFS) is charged with providing oversight, monitoring and technical assistance to New York's residential voluntary agency providers. OCFS is always exploring opportunities to provide additional resources through technical assistance, training, and monitoring to support voluntary agencies as they address significant incidents within their residential programs, most notably, the occurrence of youth absent without consent (AWOCs).

As you may know, our new enhanced Raise the Age (RTA) Model is specifically designed to reduce the risk of AWOLs and improve safety outcomes. OCFS has also implemented a centralized automated incident tracking system which will require agencies to report incidents to an OCFS centralized call unit. This system has been launched with a few providers, to go statewide by Fall 2019. It is our expectation that this system will drive consistency in AWOL reporting and tracking which will allow us to analyze at the agency and state level the underlying factors contributing to AWOLs. Additionally, OCFS has requested agency specific data from the Justice center regarding increased reports, particularly those concerning AWOLs.

Below is a response to each of the findings in the November report. Please note however that the report was based on responses from five agencies, which is not a representative sample of the vast residential treatment sector of child welfare which includes approximately 17,000 children in 101 programs including institutions, group homes, and foster boarding homes.

RTC Policies and Procedures:

- In response to inconsistent AWOC polices, OCFS reviewed the policies of each of the four agencies noted (#4 - Cayuga Center no longer operates residential treatment and is therefore excluded from this response) as compared to 16-OCFS- ADM-09. Each of the programs was required to update their policies to be consistent with the directive. OCFS continues to review policies and work with agencies to address inconsistencies as needed.
- Regarding supervisory standards, agencies are communicating expectations through a variety of methods. Agency #3 agreed that their policies lacked clarity and have since updated their Supervisory Policy. Agency #4 documents supervision in pre-shift logs, enhanced supervision plans and individual youth documents, as well as through regular staff meetings. Agency #5 communicates standards through training and the Individual Behavior Management Plans for youth

Program Activities:

- OCFS works closely with agencies to foster therapeutic milieus and as issues are noted, agencies have responded promptly. Both Agency #4 and Agency #5 issued agency-wide directives and training to discontinue the use of "table time." OCFS conducted a review of Agency #4 and confirmed that the practice has discontinued.
- Regarding procedures that may contribute to AWOCs, Agency #1 has discontinued their practices related to youth who are not in school.
- Given the significance of substance abuse services for youth in care, OCFS partnered with OASAS in the fall of 2018 to provide statewide training for voluntary agencies regarding "Teen Intervene," an evidence based program to reduce and eliminate substance abuse.
- Programming options are essential for youth in care, although staff resources influence the extent of community programming offered. Agency #3 is continuously pursuing community connections and has recreational staff assigned to each cottage. During our recent agency review there were an abundance of community activities available for youth. Agency #4 has a Youth Council which has been empowered to provide input into youth programming. OCFS concurs that consistency is important as it relates to all aspects of care, particularly incentives.
- OCFS concurs with the identified documentation deficiencies. All three agencies have begun to transition to electronic logging to remedy this issue.

Staffing:

- OCFS emphasizes staff training and support through oversight and monitoring. The administrative team of Agency #1 reset expectations with all residential staff regarding risk and safety concerns for youth who AWOC and emphasized appropriate interventions to redirect youth. Agency #4 recently underwent a TCI Fidelity Assessment, conducted by Cornell University, to review and address these issues individually and systemically.
- Each of the agencies has core, mandated training requirements for all staff. As gaps are identified, agencies are required to respond promptly. Agency #1 recently developed a new residential staff orientation and onboarding process. They now conduct weekly team meetings with standard agenda items to promote consistent messaging for all staff. Regarding Agency #3, our findings have been that all staff attend core training upon hiring and are required to complete annual trainings. We have not identified deficiencies in their practice. During our most recent agency review staff did note that they would like more training opportunities. This issue was identified by OCFS as an area of improvement and included in the agency's Program Improvement Plan (PIP) which is monitored regularly.
- Promoting safety for all the youth in residential care is the primary focus of OCFS' licensed residential providers. The use of a physical restraint is the action of last resort, after all means of non-physical de-escalation have been attempted. Restraint training and refreshers are core components of each of the agencies training regimen. Specifically, regarding the Therapeutic Crisis Intervention (TCI) training, all staff must demonstrate competence in the techniques during the training to remain in compliance.
- OCFS is working diligently on numerous initiatives related to recruiting and retaining competent staff. Staff shortages have negatively impacted many service sectors. OCFS has convened a workgroup of providers and other stakeholders to address workforce issues and is collaborating with sister-state agencies and other child welfare stakeholders to assist agencies in identifying promising strategies to recruit and retain highly qualified and motivated staff.

OCFS is committed to promoting strong, consistent programs that provide high quality services to the vulnerable youth in our system of care. We appreciate your partnership in this mission and are confident that the findings noted in your report are being addressed. Please do not hesitate to reach out to discuss these issues further.

Sincerely,

Lisa Ghartey Ogundimu
Acting Deputy Commissioner