THE
LEGAL AID
SOCIETY
JUVENILE
RIGHTS

199 Water Street, 3rd Floor
New York, NY 10038
(212) 577-3300
www.legal-aid.org

John K. Carroll
President

Janet E. Sabel
Attorney-in-Chief
Chief Executive Officer

Dawne A. Mitchell
Attorney-in-Charge
Juvenile Rights Practice

Lisa Freeman
Assistant Attorney-in-Charge
Special Litigation and Law Reform Unit

January 12, 2020

Ms. Leslie Robinson
New York State Office of Children and Family Services
52 Washington Street,
Rensselaer, NY 12144
Via email: regcomments@ocfs.ny.gov

Re: Comments on Proposed Regulations

Dear Ms. Robinson:

The Legal Aid Society of New York provides comments on amendments to the Office of Children and Family Services (OCFS) proposed regulations published in the New York State Register on November 13, 2019. These proposed regulations include 18 N.Y.C.R.R. §§ 441.4(a), 441.17, 441.22, and 442.2.[1]

The Legal Aid Society is the nation's largest and oldest provider of legal services to low income families and individuals. The Legal Aid Society's Juvenile Rights Practice provides comprehensive legal representation to children who appear before the New York City Family Court in abuse, neglect, juvenile delinquency, and other proceedings affecting children's rights and welfare. Our perspective comes from our daily contacts with children and their families, and also from our frequent interactions with the courts, community-based programs, social service providers, and a variety of State and City agencies. We represent the majority of youth placed in foster care in New York City's Family Courts. Through our ongoing representation of our clients for the duration of their time in care as well as the work of our Special Litigation and Law Reform Unit, our lawyers, social workers and paralegals routinely meet with young people in foster care, including those placed at residential treatment centers.

In addition to the below comments, please note that we have made an effort to address some of the below concerns by placing line edits into the proposed amendments in the attached word document (Appendix A).

Subdivision (a) of section 441.4 of 18 N.Y.C.R.R.

As reflected in Appendix A, we propose subdivision (a) be amended to include a requirement that policies pertaining to discharge mandate that discharge planning be individualized and begin on day one. In addition to the other policies noted, subdivision (a) should be amended to require "[e]ach

[1] A child in care is a child who is cared for away from his or her home 24 hours a day in a foster family free home; a duly licensed, certified, or approved foster family boarding home; child care institution, or health care facility; or any combination thereof. See 18 N.Y.C.R.R. § 441.2.

child care agency and facility operated by such agency" include a "de-escalation room" policy consistent with the requirements of 18 N.Y.C.R.R. § 442.2.

Section 441.17 of 18 N.Y.C.R.R. Restraint of children in Care

It is well known that physical restraints come with "inherent risk to both youth and staff due to the hazardous circumstances in which restraints are applied."[2] Restraints traumatize youth and expose them to serious physical injury or death.[3] Staff must be adequately trained and supported to be able to effectively de-escalate situations in order to ensure that restraints are an intervention of last resort and only done to prevent imminent harm.[4] We are pleased that the regulation echoes this sentiment, however, we propose that § 441.17 be strengthened in the following ways. The regulation should be amended to establish that restraints are "exceptional interventions" and that only OCFS-approved restraint techniques may be used. While we are pleased to see that OCFS prohibits the use of room isolation as a restraint, due to the harms associated with such isolation, we believe the regulation should include an express prohibition against the use of isolation upon children in care. For example, §§ 441.17(6) and 442.2(a) should be amended to include the following language, "[r]oom isolation shall never be used for children in (foster) care."

As you can see from our proposed edits in Appendix A, we support an absolute ban on the use of prone restraints. Prone restraints are explicitly *prohibited* by the NYS Office of Mental Health (OMH), the NYS Office for People with Developmental Disabilities (OPWDD), and the Administration for Children's Services (ACS) for its pre-placement facility for foster care youth.[5] OCFS-operated Division of Juvenile Justice and Opportunities for Youth facilities and ACS secure and nonsecure detention facilities further prohibit face down positioning during a restraint except under very narrow circumstances, such as during a transitional hold and for no more than 3 minutes.[6] ACS limited secure placement facilities also prohibit prone restraints.[7] Further, the U.S. Department of Education prohibits prone restraints and cautions that "[p]rone restraints should never be used because they can cause serious injury or death."[8] Despite this widespread disfavor, many of our clients who are placed at residential treatment centers (RTCs) report to us that they are subject to harmful prone restraints. It is past time for OCFS to acknowledge that the use of prone restraints conflicts with current prevailing professional standards and to ban prone restraints for children in all

[2] "Behavior and Management: Coordinated Standards for Children's Systems of Care," Final Report to the Governor September 2007, developed by the Committee on Restraint and Crisis Intervention Techniques, p. 11.
[3] *Id.*
[4] *Id.* at 19.
[5] 14 N.Y.C.R.R. § 526.4 (OMH); 14 NYCRR §§ 624, 633 and 681 (OPWDD) and ACS Policy No. 2016/09, Safe Intervention Policy for the Children's Center dated October 7, 2016.
[6] OCFS Crisis Prevention Management (CPM) policy (PPM 3247.12); ACS DYFJ Safe Intervention Policy in Secure and Nonsecure Detention Policy 2014/10.
[7] 18 N.Y.C.R.R. §450.7.
[8] U.S. Department of Education Restraint and Seclusion: Resource Document (May 2012) p. 16.

foster care placements, just as OCFS and the other aforementioned agencies have banned their use in residential facilities for youth.

Further, the regulations should be amended to require agency staff to ensure that the individualized treatment or behavior plan for each youth address permissible and precluded means of restraint for each youth, consistent with their particular needs. Additionally, we note that the permitted justification for the use of a restraint is overbroad as currently written, and urge that it be amended. The phrase "otherwise jeopardize the safety of any person" in the current definition of acute physical behavior is vague and, because it lacks a requirement of imminent risk, may lead to more liberal use of restraints. We urge OCFS to remove it from regulation § 441.17, and to define "acute physical behavior" as "behavior that poses an imminent risk of serious physical injury to oneself or others." Variations on this standard are used in a variety of other settings, for example in facilities overseen by OMH[9] and OPWDD[10].

Given the dangers associated with physical restraints, we urge OCFS to require a post restraint medical review immediately following every restraint, regardless of whether "it appears that [the] child may have sustained an injury." Moreover, we request that the post restraint medical review take place no more than one hour after the restraint. A one hour window would be consistent with the requirements of both OCFS limited secure placement and ACS secure detention policies. The OCFS Crisis Prevention Management (CPM) policy requires (in a facility with health staff on duty) "the youth must be examined as soon as possible but in no event more than one hour following the use of the physical the restraint."[11] The ACS Safe Intervention Policy IX(A) requires youth to be taken to the Health Services Unit "within one hour unless circumstances require quicker medical intervention."

Consistent internal oversight of restraint use is integral to the safety of youth. Subsection 441.17(j) should include a requirement that all restraints be followed by a timely administrative review to ensure compliance with policies, trainings and regulations. In addition, as the attached line edits show, we urge OCFS to amend §441.17(k) to include a requirement that the agencies notify the attorneys for the children following a restraint. Further, § 441.17(l) should be amended to include a requirement that the authorized agency provide OCFS with monthly reports on the number of children restrained in each institution during the previous month, the duration of the restraint, the nature of and the reason(s) for the restraint and whether the restraint resulted in an injury and or a report of maltreatment.

[9] "For behavioral management purposes, seclusion and restraint are interventions to be used only as a measure of last resort to avoid imminent injury to the patient or others." OMH, Official Policy Manual Directive, PC-701, "Seclusion and Restraint," dated May 15, 2017, and 14 N.Y.C.R.R. § 526.4, Restraint and Seclusion ("Restraint and seclusion are safety interventions which may be used for purposes of managing violent or self-destructive behavior only in emergency situations if such intervention is necessary to avoid imminent, serious injury to the patient or others….").
[10] See 14 N.Y.C.R.R. § 633.16 ("The use of any restrictive physical intervention technique must only be in response to a person engaging in behaviors that pose an immediate health or safety risk to the person or to others.").
[11] OCFS CPM 3247.13.

Although the proposed amendments do not address the use of mechanical restraints, we believe the regulations should be amended to prohibit the use of mechanical restraints. We strongly object to the use of mechanical restraints (otherwise known as handcuffs or shackles) on any child in care. The use of mechanical restraints on children in care should never be authorized by OCFS. Indeed, the American Bar Association has recognized,

> The use of shackles on children . . . is degrading. . . . [T]reating children in this way leads to shame and humiliation. . . . Public shackling is an inherently humiliating experience for children to endure. . . . [C]hildren and adolescents are more vulnerable to lasting harm from feeling humiliation and shame than adults. The nature of shackling necessarily signals that the child is dangerous, thereby increasing the likelihood that the child will be treated as dangerous by others.[12]

Subdivision (a) of section 441.22 of 18 N.Y.C.R.R.

We are pleased to see that proposed OCFS regulation explicitly requires agencies to provide comprehensive and consistent behavioral health services to all youth in congregate care settings in addition to medical and health services. We are particularly encouraged to see that OCFS now requires screening with a "validated, industry accepted instrument" given the importance of screening children in congregate care upon admission for a number of emergent issues. However, we propose the following changes to strengthen the proposed behavioral health regulations. The admissions process should be required to include the following key components: (1) a comprehensive evaluation prior to admission to congregate care conducted by a licensed graduate-level provider, indicating the need for congregate care placement; (2) youth should not be admitted to congregate care unless they present with a documented current DSM diagnosis and evidence of significant distress/impairment that requires placement in a congregate care setting; and (3) youth admitted to congregate care should have a(n): (a) discharge plan, (b) medical assessment and physical examination within the first 24 hours of admission, unless a physician determines that an examination within the week prior to transfer to the facility is sufficient; (c) review and approval of the admission by a psychiatrist for appropriateness and safety of the program; and (d) opportunity to identify family resources for planning and participation in treatment and discharge.[13]

It is imperative that youth "and their families participate in the development and ongoing review of [the youth's] comprehensive service plan."[14] The regulation should be amended to require agencies to develop an initial service plan within one week of admission, and a more comprehensive service plan within 30 days of admission.[15] Subsection (a)(2)(c) should be amended to require "[w]ithin 30 days of a child being placed within an agency's congregate program, the agency, utilizing a qualified

12 American Bar Association Criminal Justice Section report to the House of Delegates. ABA Resolution 107A (2015).
13 See, e.g., Council on Accreditation https://coanet.org/.
14 *Id.* at https://coanet.org/standard/rtx/5/
15 *Id.*

mental health professional, must utilize validated industry accepted instruments to assess each youth for service needs related to *medical*, mental, behavioral, *educational, social, family connections, and* developmental health, substance use/abuse, and sexual assault/trafficking. These assessments/evaluations must be documented in the child's case record and *explicitly* inform treatment planning for the youth and family." The *italicized* language should be added to this subsection of the proposed regulation.

With respect to "ongoing services", referred to in § 441.22(e)(iv), the regulation should require that mental and behavioral health services be provided to all youth in congregate care on a regular basis, and substance use/abuse services where indicated. Moreover, the regulation should require that these services be offered and delivered in both individual and group modalities, and, at a minimum, include daily and weekly programming, informed by trauma and brain science methods.[16] Such programming should: allow for coaching, modeling, reinforcing, and fortifying prosocial behavior, positive self-concept awareness, and asset development; employ proven strategies for managing challenging emotions and behaviors, and appropriate leisure and recreational activities; and offer positive health and wellness techniques and strategies for optimal functioning.

With regard to the frequency of ongoing services, the regulation should require at a minimum that weekly therapy be offered and delivered to all youth in congregate care. The frequency of such treatment should be driven by the needs of the child as determined by a qualified mental health professional using a validated industry accepted instrument rather than by the type of placement.

Subdivision (b) of section 441.22 of 18 N.Y.C.R.R.

We understand that the proposed changes to subdivision (b) of § 441.22 are intended to conform the process for HIV testing of children in foster care to the standards set forth in Article 27-f of the Public Health Law and the regulations of the New York State Department of Health set forth at 10 N.Y.C.R.R. Part 63. However, the proposed changes raise some questions.

In paragraph (b)(5), "[a]dditional assessments of a child under the age of thirteen in foster care," subparagraph (ii) is confusing insofar as it seems to require an assessment by agency staff as part of a medical examination. As such, subparagraph (ii) seem somewhat redundant of subparagraph (i), except that (i) refers to the service plan review and (ii) refers to the periodic medical examination. This provision should be clarified to specify whether the periodic medical examination is intended to include *a review of* an agency staff assessment, or whether an assessment by designated agency *medical* staff is intended, or something else.

In subparagraph (b)(7)(ii), the reference to the determination of capacity to consent as defined in paragraph (b)(1) should be deleted because the corresponding language regarding assessment of the

[16] See: https://www.cebc4cw.org/. See also https://www.casey.org/media/Group-Care-complete.pdf.

capacity to consent has been removed from (b)(1). In addition, it appears that under the proposed regulations, if a child is determined to have capacity to consent under the Public Health Law, that child's written consent to the disclosure of HIV-related information to a birth parent or guardian is required, but that such written consent would not be required before HIV-related information is disclosed to a foster parent or prospective adoptive parent. While it is important for a foster parent to understand the health needs of a child in her care, that need should be balanced with the right of a child who has the capacity to consent. We urge OCFS to develop guidance for the appropriate sharing of information with foster or adoptive parents when a child has been determined to have capacity to consent under the Public Health Law.

Section 442.2 of 18 N.Y.C.R.R. De-Escalation rooms[17]

We are pleased that, as noted in the Regulatory Impact Statement, the proposed regulations recognize the risk of trauma to children when they are placed in foster care. Because room isolation is an intervention that poses a grave risk of trauma, we are gratified to see that the proposed regulations prohibit room isolation. According to the Regulatory Impact Statement, "[i]n the alternative, the proposed regulations would authorize … an institution to permit a … child, consistent with the child's treatment plan, to be cared for with the consent of the … child in a room to calm escalating behavior."[18] However, we are concerned that although the intent appears to be to replace room isolation, which can be traumatic, with de-escalation rooms, which should be therapeutic, much of the language in the proposed regulation remains punitive and restrictive. In addition, we are concerned that the proposed regulation does not include sufficient protections to ensure that the use of de-escalation rooms is truly voluntary. Accordingly, we suggest the following changes, which are also reflected in the attached line edits in Appendix A.

First, in § 442.2(a), we propose adding that a de-escalation room can be included, with the consent of the child, in the child's crisis intervention plan. In addition, we suggest adding language to emphasize that a de-escalation room is intended to be a soothing environment and not simply one where a child is separated from the people or circumstances that are causing agitation. This notion is consistent with best practice guidance from the NYS Office of Mental Health relating to comfort

[17] We note that the substance of the regulation regarding de-escalation rooms is proposed to be at 18 N.Y.C.R.R. § 442.2, which is currently the room isolation regulation. Because room isolation is referred to and prohibited in § 442.2, but also defined in the restraint regulation, § 441.17(a), we suggest adding the definition of de-escalation room to § 441.17(a), along with language clarifying that neither room isolation nor a de-escalation room is permitted as a form of restraint in § 441.17(a) & (b). Our changes would clarify that room isolation and a de-escalation room are distinct and different interventions, and that room isolation is not permitted, while de-escalation rooms may be an appropriate therapeutic intervention in certain cases. To further highlight that room isolation and de-escalation rooms are distinct interventions, we suggest removing the parenthetical "(use of room isolation)" from the heading of § 442.2. These changes are also reflected in the attached line edits in Appendix A.
[18] NYS Register, November 13, 2019.

rooms.[19] In Appendix A, we also propose adding language to the physical description of de-escalation rooms to ensure that they are not only safe, but also offer soothing sensory stimuli.

Next, the proposed regulation must be strengthened to ensure that both children and staff understand that the child's consent is required to use a de-escalation room. To emphasize the voluntariness of de-escalation rooms, we propose a new subdivision (b) which states that a de-escalation room may not be used as a form or restraint or as a punishment. In addition, because the concept of "being placed" suggests an involuntary event, we propose changing the language in what would become subdivision (d) to "[u]se of de-escalation rooms must be voluntary in nature; any child *entering* a de-escalation room must agree to this intervention." We also propose adding the "continued consent of the child" to the showing of necessity prerequisite to a child remaining in a de-escalation room longer than two hours. In what would be subdivision (g) as reflected in the attached line edits, the language "but shall not prevent the child's departure from the room" again emphasizes the voluntariness of this intervention and provides further guidance to staff about their role in the use of de-escalation rooms. To address the inherent power imbalance between children in care and staff, we propose that each de-escalation room be required to contain a poster advising residents of their right to refuse to enter or remain in a de-escalation room.

Finally, to ensure that de-escalation rooms are used appropriately and effectively, we suggest enhancing the criteria in the proposed regulation for daily recording of the use of de-escalation rooms, and recording the relevant information in the progress notes of the individual child's uniform case record in addition to the authorized agency's daily records. These measures, which are reflected in the attached line edits, will help to evaluate practice for continuous improvement and ensure safety.

[19] Facilities are strongly encouraged to consider alternatives to seclusion, such as the use of sensory modulation and comfort rooms. A comfort room is a designated space that is designed in a way that is calming to the senses and where the user can experience visual, auditory, olfactory, and tactile stimuli. Furnished with items that are physically comfortable and pleasing to the senses, comfort rooms offer a sanctuary from stress and are a useful tool to teach individuals calming techniques in order to decrease agitation and aggressive behavior. In this regard, comfort rooms (which may also be utilized by staff, as appropriate) have great utility in fostering a safe and therapeutic environment. More information about comfort rooms can be obtained from OMH's public website: www.omh.ny.gov.

https://www.omh.ny.gov/omhweb/guidance/implementation-guidelines.pdf

Thank you for your consideration of our comments. We believe that such changes will better ensure children in care are treated safely and appropriately. If you need any further information, please feel free to contact me.

Sincerely,

Dawne A. Mitchell
Attorney-in-Charge

cc: Acting Commissioner Sheila J. Poole