CITY COUNCIL
CITY OF NEW YORK

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TRANSCRIPT OF THE MINUTES

Of the

COMMITTEE ON GENERAL WELFARE JOINTLY WITH THE COMMITTEE ON JUVENILE JUSTICE AND THE COMMITTEE ON MENTAL HEALTH, DEVELOPMENTAL DISABILITY, ALCOHOLISM, DRUG ABUSE AND DISABILITY SERVICES

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February 28, 2014
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HELD AT: Committee Room
City Hall

B E F O R E:
FERNANDO CABRERA
STEPHEN LEVIN
ANDREW COHEN
Chairpersons

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Maria del Carmen Arroyo
Inez Barron
Rory Lancman
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Annabel Palma
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CHAIRPERSON CABRERA: Thank you so much. Good morning. Alright, good morning and welcome to today's joint oversight hearing examining the pre and post-release mental health services available to youth detained and placed in ACS Juvenile Justice Facility. I am Council Member Fernando Cabrera, chair to Juvenile Justice Committee. I would like to thank Council Member Levin, chair to the General Welfare Committee and Council Member Cohen, chair to the Committee on Mental Health, Developmental Disability, Alcoholism, Drug Abuse and Disability Services for holding a hearing today on this very important topic. I would also like to recognize the newly appointed members of the Juvenile Justice Committee who are here or will be joining us shortly: Council Member Vacca from the Bronx; Council Member Arroyo from the Bronx; Council Member Barron from Brooklyn and Council Member Lancman from Queens. As most of you already know, this is my first hearing as the chair of the Juvenile Justice Committee. I would like to take a moment to express to everyone here today how excited I am to take on the responsibility of overseeing New York

City's Juvenile Justice System. The committee has an important job here; to make sure young people who are involved in the justice system receive the help that they need in order to turn their lives around. Having served on the committee last session, I am aware of the administration's various reforms, including efforts to decrease the juvenile detention rate and to place our youth in facilities within New York City through our Close to Home Initiative, all of which are making positive impacts on the lives of young people. I look forward to working with ACS Commissioner Carrion and representatives from its Division of Youth and Family Justice as we continue with this reform.

With that said, today we are here to examine the pre and post-release mental health services available to juveniles who are detained and placed in ACS Juvenile Facility. Studies have shown that about 20 percent of children age five to 17 suffer from a mental health disorder. The numbers are even more staggering for young people who are involved in the justice system. Nationally, 65 to 70 percent of youth who are involved in the juvenile justice system have been

diagnosed with at least one mental health disorder. The prevalence of mental health needs among this population is not surprising since mental and emotional conditions are often the underlying reasons for why juveniles engage in delinquent behavior in the first place. In addition, many of the youth who are involved in the city's juvenile justice system have experienced trauma in their lives. In fact, of youth assessed for secure detention in New York City, approximately 85 percent reported having experienced one or more traumatic events in their lives, such as sexual or physical abuse. One in three screened positive for depression, post-traumatic stress disorder or both, and in the year 2013, 58 percent of juveniles in ACS custody were referred and received mental health services while in detention. With so many juveniles demonstrating the need for mental health care, we need to make sure that young people who are in need of services are receiving adequate care. The committees are here today to examine how ACS administers mental health services to juveniles who are in its detention and placement facilities, as well as to gain a better understanding of how it

ensures that young people who are in need of such services will continue to receive them as they transition from residential settings back to the community. In addition, the committees are excited to learn that ACS has received a federal grant to partner with Bellevue Hospital to improve its trauma-informed care and we would like to find out more about this work. These services that are being discussed today are extremely critical to the success of young people's reintegration back into the community, as well as their long-term mental health. I would like to thank representatives of the administration for being here today. I will now turn the microphone over to Chair Levin for opening remarks, but first, let me acknowledge my staff from the Juvenile Justice Committee: Peggy Chan, Wesley Jones, Lillian Hogash [phonetic], Nora Ayaya [phonetic]. Thank you so much. Co-Chair.

CHAIRPERSON LEVIN: Thank you very much, Chair Cabrera. Good morning, everybody. My name is Stephen Levin and I'm chair of the General Welfare Committee. I want to start off by thanking Council Member Cabrera, chair of the Juvenile Justice Committee and Council Member Andy Cohen,

chair of the Committee on Mental Heath, Developmental Disabilities, Alcoholism, Drug Abuse and Disability Services. And I want to thank the staff of each of these three committees here today. I want to give special acknowledgement to the General Welfare staff, with whom I work closely and for their preparation on this hearing, as well as my colleagues on the General Welfare Committee, Council Member Cabrera, Gibson, Johnson, Menchaca, Palma, Richards, Torres and Wills.

Given the high percentage of youth in the juvenile justice system who have mental health illnesses and conditions, it is very important that we are here today to discuss the mental health services provided for detained and placed youth. Mental illnesses and conditions affect a significant portion of our youth and affect an even greater portion of those in the juvenile justice system. As Chair Cabrera pointed out, and this is an important number that you will hear throughout the hearing today, approximately 65 to 70 percent of youth in the juvenile justice system have mental health needs. That is nationwide. Youth may be diagnosed with a variety of illnesses or

conditions, including depression, anxiety, attention deficit disorder, bipolar disorder, conduct disorder and more. No matter what illnesses or conditions they are diagnosed with, however, and no matter what stage of the juvenile justice system they are in, we must be working to ensure that we are providing the best quality care for our youth throughout. Their success at each stage in the juvenile justice system, including their reintegration back into school and society depends on it. We must always be looking out for the interests and development of our youth, so I am interested today to hear more about the mental health services ACS provides, and I am specifically interested to hear more about their medication policy and the availability of medications to youth in ACS's care. Thank you very much to the administration, the advocates and everyone else who is here today for providing testimony, and I'll now turn it over to Chair Cohen for his opening remarks.

CHAIRPERSON COHEN: Thank you and good morning. I'm Council Member Andrew Cohen, chair of the Council's Committee on Mental Health,

Developmental Disability, Alcoholism, Drug Abuse and Disability Services. I am pleased to be joined today by Council Member Cabrera, chair of the Juvenile Justice Committee and Council Member Levin, chair of the General Welfare Committee.

As you know, we are here today to discuss pre and post-release mental health services for young people in ACS's Juvenile facilities. My co-chairs have already given a thorough background on this topic, so I don't have much to add; however, as this is my first Mental Health hearing, I would like to say a few words regarding mental health issues among young people.

Research has shown that the onset of major mental illness may occur in children as young as seven years of age, and half of all lifetime cases of mental illness begin by age 14. Nationwide 20 percent of young people have experienced a mental health disorder which interfered with their ability to function. Tragically, if young people in need of mental health treatment do not receive such treatment, the effect can be dire. Mental health issues have a negative impact on academic performance, retention

and graduation rates. Mental health issues also lead to delinquent behaviors and involvement in the juvenile justice system. I'm sure we all wish that every young person in need of mental health services was able to receive such services. Unfortunately, research suggests that 75 to 80 percent of youth in need of mental health services do not receive them. Thus, for some young people the first opportunity to receive mental health care may occur at entry into the juvenile justice system.

Today, I look forward to learning more about how ACS administers mental health services to young people in detention and placement facilities. I'd also like to learn more about how ACS ensures that these young people continue to receive such services after they have been released from ACS custody. At the moment I'd like to acknowledge that we have been joined... well, I don't know if we've been joined, but I guess we will be joined by my colleagues on the Mental Health Committee, Members Elizabeth Crowley, Ruben Wills is here, Council Member Corey Johnson and Paul Vallone, and

I'd also like to thank the staff for their help in preparing me for today.

CHAIRPERSON CABRERA: Thank you so much, co-Chair. Let me just acknowledge before I turn it over to ACS, we been joined by Council Member Gibson, Wills, Richards and Vallone. Thank you much. Let me turn it over to ACS and if you could identify yourself.

CHARLES BARRIOS: Good morning, Chairs Cabrera, Levin and Cohen and members of the Committees on Juvenile Justice, General Welfare and Mental Health, Disability, Alcoholism, Drug Abuse and Disability Services. I am Charles Barrios, Senior Advisor for Juvenile Justice Clinical Services with the Division of Youth and Family Justice at the New York City Administration for Children's Services. With me is Jennifer Romelien, Executive Director for Detention Programs and Sarah Bass, Executive Director of Residential Programs. Thank you for providing us with the opportunity to share our work related to the mental health services provided to youth in ACS's Juvenile Justice Programs.

The Administration for Children's Services oversees an array of services and programs for youth at every stage of the juvenile justice process. The agency's Division of Youth and Family Justice works to promote public safety and improve the lives of youth, families and communities by providing services that are child-centered and family focused, including therapeutic treatment, safe and secure custodial care, responsive health care, effective re-entry services and promotion of educational achievement. We and our contracted partners provide these services to use in secure and non-secure detention facilities, non-secure placement residences and community-based alternative programs. Each year, the Division provides secure and non-secure detention services to juvenile delinquents and juvenile offenders whose cases are pending adjudication. While in detention, residents receive a number of services such as education, health services including mental health services, recreation and case management. In calendar year 2013, DYFJ served approximately 3,300 youth in our 13 non-secure and two secure detention facilities. As of December 2013, 128

youth were in secure detention; 60 youth in Crossroads Juvenile Center and 68 in Horizon Juvenile Center. A total of 92 youth were in the 13 non-secure detention residences.

On September 1st, 2012, New York City launched Close to Home, a juvenile justice reform initiative that allows New York City youth who are found by a Family Court Judge to have committed a delinquent act to receive services in or close to the communities where they live, rather than hundreds of miles upstate. Under Close to Home, young people who are adjudicated as juvenile delinquents in New York City Family Court are placed into the custody of ACS and receive rehabilitative and therapeutic services at one of 31 small resource-rich residential program in or near the five boroughs. ACS in partnership with the New York State Office of Children and Family Services has collaborated with nine local non-profit agencies to implement Non-Secure Placement, Phase I of Close to Home. Since September of 2012, ACS has provided NSP services to approximately 750 young people. Of this total, nearly 270 youth have successfully completed their court order, which ACS

divides into two components: residential care and aftercare.

ACS also oversees two community-based alternative programs that offer juvenile justice involved youth the opportunity to receive services while remaining at home with their families. The Juvenile Justice Initiative, otherwise known as JJI, links juvenile justice involved young people and families with intensive evidence-based therapeutic interventions aimed at diverting youth from residential placement. The goals of JJI are to reduce recidivism, improve youth and family functioning and reduce the number of delinquent youth in residential facilities. Treatment is provided as a preventive service and youth must comply with the program as a condition of probation. JJI is currently serving approximately 180 youth.

The Family Assessment Program, otherwise known as FAP, serves families seeking to file PINS, Persons in Need of Supervision petitions in the New York City Family Courts. PINS youth are those under the age of 18 who are charged with offenses unique to their status as juveniles,

including truancy, ungovernability and running away from home. FAP is a court-based effort in which ACS works closely with PINS adolescents and their families to provide a continuum of services within their community. In 2013, FAP served more than 6,700 youth.

Young people in detention facilities receive preliminary mental health intake and screenings upon admission. Around the clock mental health services are provided to young people, both in secure and non-secure detention and all youth receive an initial health screening, which includes a brief mental health screening within 24 hours of admission. A comprehensive health assessment, including a complete health history, physical examination and laboratory tests is conducted within 72 hours after a youth arrives. Young people in non-secure detention receive mental health and health services at the secure detention center closest to their group home residence.

The mental health and psychiatric services available to youth in delivered by ACS contracted providers, Addiction Research Treatment Corporation, otherwise known as ARTC, which was

renamed START, and Charles Jin Medical Service, PC, respectively. Mental health services are therapeutic in nature and they're provided in both individual and group modalities. Psychiatric services include assessment, evaluation and medication management.

Over the past three years, approximately 40 percent of the youth population screened by ACS's mental health clinicians in detention were identified as needing additional mental health evaluation and mental health services on-site. Te number of youth referred to psychiatric services increased from an average of 35 per month in 2012 to 48 per month in 2013. Currently, 25 percent of youth who received psychiatric services at Crossroads Juvenile Center and 36 percent of youth who received psychiatric services at Horizon Juvenile Center are prescribed psychotropic medications to address mental health conditions.

In 2012, ACS set out to explore ways to leverage additional services, components, assessment tools, elements and staffing that would better inform our intake process, create options

for deeper, more clinical assessments of youth when needed and further and better identify mental health needs while still in detention and in anticipation of placement.

That same year, Bellevue Hospital Center and NYU Langone Medical Center, in partnership with ACS, was awarded a four-year grant by the Substance Abuse and Mental Health Services Administration as part of its National Traumatic Stress Initiative to create and conduct trauma-informed screening and care in secure detention. Developed to train frontline residential staff in dealing with the various types of trauma that up to 90 percent of our young people in the juvenile justice system have experienced, the trauma-informed care project strives to establish evidence-based trauma-informed mental health screening in ACS's two secure detention facilities; develop evidence-based skills groups to reduce trauma related problems among youth in detention; train staff about the effects of trauma and how to mitigate them in a juvenile justice population and build collaborative partnerships with the child-serving systems associated with juvenile detention

to increase trauma responsiveness in those systems. ACS, in conjunction with our partners at Bellevue and NYU, is the first secure detention system in the country to implement trauma-informed practices and training, which is complementary to the work that we are doing to create an integrated intake process for detention and placement and establish a therapeutic milieu to provide targeted reentry and treatment recommendations for youth as they transition into placement, alternatives to placement programs or back into the community. We are proud to say that our excellent staff at DYFJ is at the forefront of this groundbreaking work.

Beginning last winter, Bellevue's team held a series of training with staff at Crossroads Juvenile Center to increase the staff's ability to identify trauma exposure and work effectively with traumatized youth, as well as reduce secondary trauma issues among staff. By the end of the four week curriculum, the trauma-informed training was provided to all 200 Crossroads Juvenile Center staff, including housekeeping and kitchen staff. During August 2013, 126 Crossroads residents were screened for trauma history; Post Traumatic Stress

Disorder, depression and problematic substance abuse. Of those screened, 107 or 85.2 percent reported experiencing at least one potentially traumatic event, such as sexual abuse, physical abuse and domestic violence. Overall, residents reported experiencing an average of 3.2 potentially traumatic events and 43 of the 126 screened positive for PTSD and/or depression. According to a sampling conducted by Bellevue in 2013, the predominant psychiatric diagnoses of youth screened in our secure and non-secure detention facilities included Attention Deficit Hyperactivity Disorder and impulse control 36 percent, followed by mood disorders at 32 percent.

ACS is committed to ensuring continuity of care for all young people in our detention settings. Our continuity of care policy reinforces this expectation with respect to a youth's previously provided mental health and psychiatric care, including medications prescribed to a youth prior to their entering detention. In the event that a medication is cost prohibitive, ACS may prescribe a comparable generic equivalent, as is widely practiced in the community.

Non-secure placement providers are responsible for delivering care that meets the full range of mental health needs of youth, either by offering a comprehensive array of mental and behavioral health services on-site or establishing referral and treatment arrangements with community-based mental health providers. NSP providers that link to community-based mental and behavioral health providers must ensure that services are readily available.

All NSP mental health services are delivered by qualified mental health providers, who develop and update consistent diagnoses of the young people they treat. The majority of the NSP providers use the Missouri Approach, a highly regarded therapeutic approach for juvenile justice involved youth. This unique multi-layer treatment is designed to help young people make lasting behavioral changes that will prepare them for successful transitions back into home communities. The approach stresses close supervision and features a group treatment process in which each young person is held accountable to his or her actions by the other young people in the group.

New York City's NSP services are divided into general and specialized residential programs. The majority of non-secure placement residences have service-rich programs and are considered appropriate for a general population of youth. The non-secure placement system also includes programs designed to serve youth with specific high level needs, including mental health diagnoses, intellectual and developmental disabilities, fire setting behaviors, problematic sexual behaviors, history of commercial sexual exploitation and substance abuse treatment. Of the 31 NSP sites, 10 are dedicated to serving youth with specialized needs.

Youth who are placed in Close to Home follow a placement matching process that relies on a careful, synthesized review of their clinical and behavioral needs. Our placement staff incorporate information about the young person from the Department of Probations Investigation and Report assessment tool, educational records and Family Court Mental Health Services. ACS intake and assessment specialists update these records by obtaining information about youth from ACS

contracted medical and mental health staff at our secure detention facilities.

Within 14 days of a young person's arrival at the NSP residence, providers conduct a mental health screening. At minimum, the screening ascertains the youth's current mental status; history of present illness; current medications and response to them; history of treatment with medications and responses; social history; substance abuse history; interviews with parents and guardians; a review of prior records and an explanation of how the youth's symptoms meet diagnostic criteria for the proffered diagnosis or diagnoses. Where the initial screening or history indicates a need for mental health services, the NSP provider ensures that qualified staff or a qualified contracted mental health professional performs a full assessment. Youth who have severe developmental and/or mental health needs may be referred to appropriate New York State Office of Mental Health Services or to the Bridges to Health Program. The Bridges to Health Program is a home and community-based services Medicaid waiver program that provides support and healthcare

services for young people with disabilities while they are in and once they are discharged from NSP residences. When assessments indicate a need for mental health services, the staff arranges for the prescribed services. If a psychiatric referral is needed, it is made promptly upon indication.

Similar to the youth in detention, young people served in our non-secure placement system have been diagnosed with a host of mental health conditions, including conduct disorder; anti-social personality traits; bipolar disorder; depression and Post Traumatic Stress Disorder. There are currently 140 youth in the entire NSP system who are prescribed medication for their mental health conditions.

Following six to seven months of residential placement, youth are discharged to their families and their community on aftercare status, the next step in the continuum of care for adjudicated juvenile delinquents, which is a critical component to the successful reentry of youth. Prior to leaving residential placement, each youth has a structured aftercare service plan in place, which may include mental health services.

200 young people are currently on aftercare status. It is Children's Services' expectation that the majority of youth transitioning out of residential placement will be served by ACS contracted NSP aftercare service providers through the provision of Functional Family Therapy, the Boys Town Model or the Family Connections Model, as well as linkages to community-based organizations.

The Juvenile Justice Initiative's Alternative to Placement Program provides home-based services for youth prosecuted on juvenile delinquency charges in Family Court and to their families. The program is a condition of probation for youth who would otherwise be placed in institutional settings. Through JJI, therapists provide comprehensive services to all family members in the home to address a range of issues, including mental health; substance abuse; peer difficulties; school-related challenges and family troubles. These intensive services usually take place in the home when it is most convenient for the family. Therapists see families many times a week and remain on call 24 hours a day.

Following a court ordered exploration of alternatives, court intake staff assess youth and their families by using the Department of Probations Investigation and Report assessment and/or a mental health study. Young people determined to be JJI eligible and their families are directed to one of three evidence-based therapeutic modalities; Blue Sky, a continuum of Functional Family Therapy, Multi-systemic Therapy and Multidimensional Treatment Foster Care that serves the Bronx and Manhattan; Multi-systemic Therapy, which serves Brooklyn, Queens and Staten Island and Multi-systemic Therapy Psychiatric Services, which serves Brooklyn and Queens.

In 2012, ACS partnered with the Medical University of South Carolina and New York Foundling to evaluate the Blue Sky modality and compare it to other juvenile justice programs, including placement in community-based alternatives to placement. The researchers will collect data on the 211 youth participating in the project's randomized clinical trial and compare recidivism outcomes one year post-treatment between youth who received Blue Sky services and those who

participated in other juvenile justice programs. This project marks the first randomized clinical trial conducted in New York City of any evidence-based treatment modality that targets delinquency behavior and prevention.

The Family Assessment Program, ACS's PINS diversion program, is completely voluntary; however, a family must participate in FAP before a PINS petition can be filed. In the fall of 2010, FAP launched a new continuum of five service interventions targeted and prioritized for families that access services from FAP. Services range in intensity from in-home therapy to the placement of youth with a specially trained foster family who becomes, alongside a family therapist, part of the youth's therapeutic team. Additionally, ACS has a memorandum of understanding with the New York City Department of Health and Mental Hygiene, which provides funding for two clinical consultants to assess youth in FAP who have serious mental health needs. Last year, the consultants accepted 152 referrals to work with these types of young people.

In 2010, FAP redesigned its approach in order to ensure that staff had the ability to

identify and differentiate between low and high needs families. With the aid of a new screening instrument, staff are able to direct families and young people who score in the low range to FAP counseling services and neighborhood-based preventive services and to offer those who score in the high range a more comprehensive assessment and a referral to partner agencies, many of which specialize in intensive therapeutic approaches to stabilize families in crisis. Although the options vary in scope, duration and technique, all of these programs are proven to work specifically with young people to promote family cohesion over the long term.

In closing, I'd like to thank you for the opportunity to share with you the important work that we are doing to address the mental health needs of youth in our juvenile justice programs. We are grateful for all of the support of the Council and as we continue to strive to improve services for the city's most vulnerable young people. I now... [disruption in tape]

CHAIRPERSON CABRERA: Thank you so much. I have a few questions. Appreciate the

information you reported. It's very helpful. I want to get right into it. You know, some of the advocates have come to us with a huge... in my estimation, a huge concern. It has been reported that some medications are not prescribed to juveniles because of their cost. So for example, a youth may be suffering from ADHD and they're given antipsychotic medication instead of Ritalin because of the cost. Can you address that?

CHARLES BARRIOS: I'm going to defer to Jennifer Romelien.

CHAIRPERSON CABRERA: Thank you.

JENNIFER ROMELIEN: Good morning. We do have a continuity of care policy so if the young person...

[crosstalk]

CHAIRPERSON CABRERA: Could you speak a little closer to the mic? Thank you so much, and if you can identify yourself.

JENNIFER ROMELIEN: We do have a continuity of care policy that the agency must follow; our contracted psychiatrics must follow, so if a young person comes into the facilities and they are on... currently on medication such as

Ritalin, we look to continue that medication unless there's a medical reason why we cannot. So that's absolutely not... we are not looking to cut costs.

CHAIRPERSON CABRERA: But...

[crosstalk]

JENNIFER ROMELIEN: In any...

[crosstalk]

CHAIRPERSON CABRERA: Okay so...

[crosstalk]

JENNIFER ROMELIEN: By any means.

CHAIRPERSON CABRERA: That might be true for those who came in with a condition.

JENNIFER ROMELIEN: [interposing] Correct.

CHAIRPERSON CABRERA: But according to your own statement presentation here, there has been an increase to referrals for psychiatric care, so I would imagine as we find in schools you know, kids fall through the cracks; diagnoses are not made properly sometimes; they're misdiagnosed. So whenever you get... you identify a youth it's... I mean the potentiality is there, and Ritalin is the most used medication. Why would they be taking

antipsychotic medication when really it should be Ritalin?

JENNIFER ROMELIEN: We do have young people that are in both non-secure and secure detention at this time that are prescribed Ritalin, and the increase of referrals to psychiatric or psychiatrists is the result of the new screening process that we have through our grant with Bellevue. But we are prescribing Ritalin to young people if the doctors deem that that's the medication that the young person needs.

CHAIRPERSON CABRERA: Are they... let me ask in a different way. Are there young people in your facilities who have ADHD and they're given antipsychotic medication?

CHARLES BARRIOS: So we do have youth that are in detention that are being prescribed antipsychotics, but keep in mind that oftentimes when a diagnosis is made, sometimes it's made in correlation with another diagnosis; it could be a mood disorder. We do have in detention, in fact, approximately I would say 3,750 prescriptions... I'm sorry, 3,750 approximate number of tablets were

dispensed to kids who were diagnosed with ADHD in 2013. The other thing that I would like to...

[crosstalk]

CHAIRPERSON CABRERA: I'm sorry the last... I couldn't hear the last thing that you just made after you mentioned the number. So 3,000 you said what? I'm sorry.

CHARLES BARRIOS: That were administered to kids with a diagnosis of ADHD.

CHAIRPERSON CABRERA: Okay.

CHARLES BARRIOS: But back to your question about why are we using antipsychotics. Again, I would refer to point that we have kids who have other corresponding diagnoses to whom that medication is, according to the psychiatrist, the best medication to prescribe them.

CHAIRPERSON CABRERA: I'm very familiar with the diagnosis. I'm a licensed mental health counselor, so I'm very familiar with this. Do you have youth that are not going... do you have youth that are not in a psychotic state that should be getting Ritalin and are not getting Ritalin? Well, let me ask you in a different way. Maybe this will be helpful. Do you have someone who don't... do

you have young people who don't have a dual diagnose and are getting the antipsychotic medication?

CHARLES BARRIOS: That is not correct. If the diagnosis is ADHD, then that youth is not prescribed an antipsychotic.

CHAIRPERSON CABRERA: Okay, very well. Have you had advocates speak to you regarding these concerns; any other advocates? Have you been approached to your knowledge?

CHARLES BARRIOS: No, we have not received any direct communication from advocates on this matter.

CHAIRPERSON CABRERA: Okay, very well. My other question was regarding your assessment tools. What assessment tools are you using?

CHARLES BARRIOS: Oh, for detention we are administering the UCLA PTSD Reaction Index for DSM-IV. We are also administering the PHQ-9 Depression Scale, as well as the CRAFFT Screening Tool for Substance Abuse. In addition to that, mental health... our contracted mental health provider in detention is administering a mental health intake, which consists of a comprehensive

evaluation, which includes presenting problem; history of social problems; history of prescribed medication and other diagnoses, as well as information from the family or caregiver.

CHAIRPERSON CABRERA: And who is specifically administering the assessment tools? Is this a psychiatrist? Is this a licensed social worker; licensed clinical psychologist; licensed mental health counselor? Who do you have?

CHARLES BARRIOS: So it’s both licensed master social workers, as well as licensed mental health counselors.

CHAIRPERSON CABRERA: Very good. No, I just... go ahead.

CHARLES BARRIOS: Alright. Who are administering the screening tools.

CHAIRPERSON CABRERA: Okay, great. I mentioned that you had an increase; a significant increase of referrals. What would you attest that to for psychiatric care?

CHARLES BARRIOS: So as Jennifer alluded to earlier, because we are systematically screening youth in detention for trauma, there’s been an increase in the number of referrals made

for ongoing mental health services in psychiatry. Previously, a lot of those conditions were unrecognized as PTSD wasn't often used as a diagnosis for the youth population in detention.

[Pause]

CHAIRPERSON CABRERA: Okay, my last question, as I don't want to be selfish with time here, my last question is regarding when you have young people coming in have you had cases where you had a diagnosis that you couldn't handle within house that... and if you have such cases, where these young people end up at?

CHARLES BARRIOS: So we contract with a provider that has a very qualified team of child and adolescent psychiatrists, who are available to conduct forensic evaluations as well as comprehensive psychiatric assessments. To the extent that the psychiatrist believes that a child is suffering from a condition that may warrant possible in-patient hospitalization or observation to an acute hospital setting, those arrangements will be made, but to my knowledge there hasn't been a situation where a kid has been assessed or

evaluated and a psychiatrist was not able to render an appropriate diagnosis.

CHAIRPERSON CABRERA: Thank you so much. Council member... co-Chair Levin, before I do that, I want to recognize Council Member Menchaca; Council Member Barron; Council Member Lancman and Council Member Palma. They have joined us today, and I'll turn it over to my co-chair.

CHAIRPERSON LEVIN: Thank you very much, Chair Cabrera. Thank you very much, all, for your testimony and for being here today. I wanted to ask a little bit about... and I apologize for having to run out for a moment during your testimony to another hearing... about the limited secure placement programs and what model in terms of mental health services the limited secure programs we're going to have, are they more in line with non-secure or secure placements?

CHARLES BARRIOS: So in terms of mental health services, similar to non-secure placement, ACS is planning to give the providers a per diem to provide on-site mental health services, which are generally provided through staff that they recruit on their own. In this case it would be licensed

master social workers or maybe licensed mental health counselors. In terms of psychiatry services, with the change in the administration we are currently consulting with newly appointed Deputy Commissioner Felipe Franco to try to determine what's the appropriate way to address psychiatric services for LSP, whether it be by assigning providers a per diem to do their own psychiatry or whether it would be by contracting with a psychiatry services provider to offer those services to the LSP population.

CHAIRPERSON LEVIN: Is there a timeframe in terms of... if you'd just actually speak to the timeframe in terms of the rollout of LSP and then timeframe in terms of psychiatric services or when that decision will be made and whether it's going to be made prior to full implementation or after full implementation.

CHARLES BARRIOS: So the decision about which path to take in terms of psychiatry services will be made sometime within the next four weeks. In terms of the timeframe for the start of LSP, that's been projected to start sometime around late summer, early fall of 2014.

CHAIRPERSON LEVIN: Late summer or early fall of 2014.

CHARLES BARRIOS: That's...

[crosstalk]

CHAIRPERSON LEVIN: Okay.

CHARLES BARRIOS: Yeah.

CHAIRPERSON LEVIN: And that's... is that... I had thought that we were looking at rolling out in the spring of 2014. That's been moved back at this point?

CHARLES BARRIOS: Yes, that is currently pending final decision by the Commissioner.

CHAIRPERSON LEVIN: And do you anticipate that the need for mental health services is going to be greater in LSP than in NSP? Is that... is that an anticipation or is that something that you're looking at and factoring that into budgetary decisions and program decisions?

[Pause]

JENNIFER ROMELIEN: The expectation is that for the LSP population we will see more significant mental health and certainly behavioral issues than we do in an NSP population.

CHAIRPERSON LEVIN: Okay, but going along the same model as NSP in terms of you're not going to be changing anything in terms of the structure of services or that's still to be determined?

JENNIFER ROMELIEN: Still to be determined, but we're working closely with OMH to make sure that we have a full continuum of care.

CHAIRPERSON LEVIN: I wanted to ask about youth that are diagnosed with... while they're in placement with more severe mental health needs, so say a young person is diagnosed who's 17 years old with schizophrenia. What is the process for somebody that has a more severe diagnosis that's... and if you could walk us through that in terms of secure placement and non-secure placement as it is now and then potentially limited secure placement.

CHARLES BARRIOS: Council Member, you're asking both in terms of secure and non-secure?

CHAIRPERSON LEVIN: Correct. If they're diagnosed while in placement and then

actually if you can't answer that question if they come in with a diagnosis.

CHARLES BARRIOS: So for detention if a young person comes in with a prior diagnosis of schizophrenia, that person receives ongoing psychiatric interventions immediately, which will include an immediate evaluation of the youth, a determination about medication, ongoing mental health service needs and to the extent that the youth requires additional services beyond what the provider in detention can provide, then accommodations are made to have that kid transported to the appropriate hospital setting.

CHAIRPERSON LEVIN: So it'd be to an HHC hospital or somewhere in the city?

CHARLES BARRIOS: That's correct.

CHAIRPERSON LEVIN: And that would be the same for secure placement and for non-secure placement. Is that correct?

SARAH BASS: For placement we're in a slightly better position because we've had the benefit of all the assessments and the services that have been provided in detention. So when we're doing our intake process, we can place them

in a program that serves severely emotionally disturbed youth so they have specialized services; they have more individual group and other services that can be provided there. However, even in our severely emotionally disturbed programs we've had kids who had such significant mental health needs, we have needed to utilize HHC hospitals for emergency rooms and even some state hospitals, but while they're there we're working continually with them because they're still in our care so that we can figure out what to do once they come back to the community or come back to one of our placements.

CHAIRPERSON LEVIN: And then...

CHARLES BARRIOS: [interposing] Just remember... I just wanted to clarify that we will not be doing state secure placement. It's only limited secure placement that we will be taking over as well.

CHAIRPERSON LEVIN: Say that again. I'm sorry?

CHARLES BARRIOS: That it's only limited secure placement that we'll be taking over

as well as part of Phase II of Close to Home, not state secure placement.

CHAIRPERSON LEVIN: Right, and then just if you could speak for a moment to if somebody is diagnosed while in placement; if the youth is in the system without a diagnosis and then it becomes clear at a certain point that their diagnosis is warranted to the mental health services, what would be the process then for that child?

JENNIFER ROMELIEN: As everyone said, the number of youth that come in that are highly traumatized I mean it’s quite large, so the expectation of even our general providers are to have mental health services on-site so that they can deal with those situations, so every... even the general providers have the infrastructure to deal with the youth to diagnose and to treat someone with a mental health disorder. And if it’s determined that the need is higher than can be handled in a general provider, then we would work with intake to find a specialized bed for that youth.

CHAIRPERSON LEVIN: Thank you, and then, sorry, just speaking... going back to Council

Member Cabrera's discussion before about... I just want to be totally 100 percent clear that if somebody... if a child has just an ADHD diagnosis that they are not receiving psychiatric drugs as a treatment for that condition. Is that correct?

CHARLES BARRIOS: The question I believe was whether kids with...

CHAIRPERSON LEVIN: [interposing] Antipsychotic drugs, excuse me.

CHARLES BARRIOS: Right. Whether kids with a diagnosis of ADHD are prescribed antipsychotic drugs?

CHAIRPERSON LEVIN: Right.

CHARLES BARRIOS: And the answer to that is if ADHD is the only diagnosis, then they are not.

CHAIRPERSON LEVIN: Okay, if they are diagnosed with ADHD and also a condition that warrants an antipsychotic medication, are they prescribed the antipsychotic medication plus another medication to treat the ADHD or are they just prescribed the antipsychotic medication?

CHARLES BARRIOS: So in that instance, a psychiatrist may make a determination to prescribe the antipsychotic drug.

CHAIRPERSON LEVIN: And not another drug to treat the ADHD.

CHARLES BARRIOS: In some cases yes.

CHAIRPERSON LEVIN: Because the antipsychotic drug is supposed to take care of the ADHD or because the ADHD is not warranting medication?

CHARLES BARRIOS: Yes, it’s on a case-by-case basis. It depends on a number of factors and in addition to that, in some cases the other diagnosis may be the predominate diagnosis, but that is a decision that is left at the discretion of the psychiatrist.

CHAIRPERSON LEVIN: Okay, so there could be an instance where a child as or a young person has a diagnosis of ADHD in addition to another diagnosis, which is a predominant diagnosis and they’re getting treated for the predominant diagnosis, but they’re not getting treated for the ADHD. Is that correct?

CHARLES BARRIOS: No, they would also be treated for ADHD. You were asking me whether if they're placed on antipsychotic drug for another diagnosis, is it possible whether the youth would also receive medication to treat the ADHD, and my response to you was yes, they would.

CHAIRPERSON LEVIN: Right and then my question was actually is it possible that they wouldn't receive another medication to treat their ADHD?

CHARLES BARRIOS: So again, that would be case-by-case, but we can certainly look into that matter further.

CHAIRPERSON LEVIN: 'Kay, thank you very much.

CHAIRPERSON COHEN: Good morning again. Thank you for your testimony. Just to follow up on that line and then I'll move on, the decision is made based on the determination of the psychiatrist and it's not a question or function of cost. It's just whatever the psychiatrist is medically appropriate. Right, just so I'm clear on that, and just in the bigger picture in regard to your testimony, if a drug that is a proprietary drug,

you will seek to do generic if it's available. If it's not available, you'll provide the... and cost is not going to be a factor in the... is that the testimony?

CHARLES BARRIOS: Yes.

CHAIRPERSON COHEN: Okay, thank you very much.

CHARLES BARRIOS: I mean I'd also like to add, Council Member, that medication costs in detention stabilized in early 2013 largely due to several psychotropic medications patents expiring during late 2012 and 2013, as well as new FDA regulations imposed on pharmaceutical companies for ways in which they can market their medications. As a result, we have seen fewer detention youth who came into our care taking newer, expensive medications.

CHAIRPERSON COHEN: Just taking a step back so I sort of understand the big picture, everybody we're talking about today has been referred or found their way into the system by way of Family Court; that they've been adjudicated as juvenile delinquent?

CHARLES BARRIOS: The majority of the youth are, but there are some youth who go into placement from the community, very small number of youth.

CHAIRPERSON COHEN: Come in by way of what?

SARAH BASS: Everyone who's in placement has been adjudicated as a juvenile delinquent in Family Court, but that's placement. Right.

JENNIFER ROMELIEN: Detention also we serve juvenile offenders as well as juvenile delinquents who are processed through the adult court system in detention.

CHAIRPERSON COHEN: Okay, I guess what I'm concerned about just hearing your testimony is I wonder how many people here you know like I don't want to see people criminalized who you know, who their main problem is that they have mental health issues. I mean you mention in your testimony that they have behavioral issues. I guess sort of by definition everybody there has behavioral issues or they wouldn't be there.

CHARLES BARRIOS: Right, so we have often said to our providers that it's important for them to conduct a comprehensive assessment of every youth that is admitted to their programs and to take into account that there are other contributing factors that, in fact, may make someone arrive to the conclusion that a kid does not have a mental health condition. We tell people that it's important for them to have an understanding of when teenagers exhibit high risk behaviors; that those often reflect reactions to some of their experiences; social stigmas and relationships with family and peers. So I wouldn't necessarily say that all the kids that come into placement have mental illness. We have a process in place that allows for clinicians to determine whether or not there is a mental health condition, but it's always important for us to try to distinguish between what is considered mental illness and what's considered behavioral.

CHAIRPERSON COHEN: Could you just help maybe by giving me an example of something you think that might fall into the column...

[crosstalk]

CHARLES BARRIOS: Sure.

[crosstalk]

CHAIRPERSON COHEN: Of behavior versus a mental health issue?

CHARLES BARRIOS: Right, so you might have a young person in the placement facility who is having a difficult time responding to rules and norms and...

CHAIRPERSON COHEN: [interposing] And governability I guess was a factor in a determination of being a juvenile delinquent.

CHARLES BARRIOS: Who makes the determination?

[crosstalk]

CHAIRPERSON COHEN: Well, I think you testified about ungovernability as being one of the factors in...

[crosstalk]

CHARLES BARRIOS: Right, so while they’re in the placement facility it’s the providers that are making the assessment; conducting the observations of youth and they’re making the determination about whether or not something is behavioral versus something that may

warrant a psychological psychiatric evaluation or intervention. But they're also doing that in consultation with ACS and our placement and permanency staff to ensure that everyone will arrive at a consensus about what may be the possible... the most beneficial service or intervention for that kid at that point in time.

CHAIRPERSON COHEN: And then just briefly you've mentioned that were only 200 people in aftercare at the moment. Is that correct?

[Pause]

CHAIRPERSON COHEN: Page eight I think, the top of page eight. Yes?

CHARLES BARRIOS: Yes, that's correct.

CHAIRPERSON COHEN: It seems like a small number. What... why... why...

CHARLES BARRIOS: [interposing] Oh, I'm sorry. No, Council Member, correction. There are approximately 200 kids currently on aftercare status.

CHAIRPERSON COHEN: There are 200 currently on aftercare status. That...

CHARLES BARRIOS: [interposing] That is correct.

CHAIRPERSON COHEN: That seems like a small number.

[Pause]

JENNFIER ROMELIEN: The youth are only in aftercare for the length of their placement, so if they were in residential for say seven months, they only have about three months left if they were extended in aftercare so while there may be more services in place for the families, technically in our aftercare it's only for the length of the dispositional order, so that may... that's why the number.

CHAIRPERSON COHEN: I understand. Thank you.

CHARLES BARRIOS: Thank you.

CHAIRPERSON CABRERA: Thank you so much. Let me recognize we've been joined by Council Member Arroyo and Council Member Crowley. We'll have now Council Member Barron followed by Council Member Vallone.

COUNCIL MEMBER BARRON: Thank you, Mr. Chair. Thank you for your testimony and I'm sure that you can appreciate the questions. I know we're talking about the juvenile justice, but I'm

sure you can appreciate the questions about medications that are being prescribed, especially in light of the situation several years back where ACS was found to have children involved in receiving medications without having the approval of those parents that were involved, so I'm sure you can appreciate our concern about medication. As children are brought into this system and being evaluated, you said there are periodic evaluations while they're in the program? Are there assessments made after initial intake as to a child's mental state?

CHARLES BARRIOS: I just want to clarify it, Council Member, we're talking about placement?

COUNCIL MEMBER BARRON: Mm-hm.

CHARLES BARRIOS: Okay.

SARAH BASS: So all youth are assessed when they come into placement. The groups in placement are rather small. We have homes that are generally like six to 12 beds, so it's a small group so they're constantly being assessed by the staff that are around them and if there was an

issue that came up they certainly could be treated at any time if an issue came up.

COUNCIL MEMBER BARRON: So the staff is trained to make those assessments as to the mental state?

SARAH BASS: There are clinicians at every facility and they're trained to make those assessments and certainly the line staff receive... all of our staff, whether they're ACS staff or whether they're provider staff, have rigorous training on a number of things like trauma or adolescent functioning, so that even the line staff have an idea of what they should be looking out for and they certainly can also alert the mental health staff, but there is mental health staff in all these facilities.

COUNCIL MEMBER BARRON: If a child is diagnosed as having a need and they're in the placement system for a designated length of time, after they've completed their time in the system, the juvenile system, what follow-up is there or what provisions are there that maintain the medications that they need?

SARAH BASS: We work hard in Close to Home with discharge planning starting at day one, which is really keeping in mind what do we think when this kid goes home from the minute they come in they're going need when they go to the community, be it that they're going to need medication management or whether their needs are too great to even go straight home from a facility; whether perhaps they need to spend time in an OMH facility. So we're looking to those. We have a lot of partners. We have contracted aftercare teams that can do functional family therapy. We work with Bridges to Health to do wrap around services for families. We've had some youth that have gone to RTFs because their mental health needs really needed that level of care, so we really are working very hard to make sure that when youth go home they have the services in place that they need. In addition, we have aftercare staff that meet with the youth to make sure that families are being compliant; that youth are doing what they need to do. If the youth isn't doing what they need to do, we have the ability to revoke a youth,

but we would be very... to bring them back into care.

COUNCIL MEMBER BARRON: Oh.

SARAH BASS: But we would be very loathe to do that if it was simply because of a mental health issue, but that is something that we can do if we feel that the youth is a danger to others and may need a higher level of care.

COUNCIL MEMBER BARRON: So you used the term revoke meaning to bring them back? So you can bring them back even though they have completed whatever their time is?

SARAH BASS: They would still be within their dispositional...

[crosstalk]

COUNCIL MEMBER BARRON: Oh.

[crosstalk]

SARAH BASS: Of 12 months.

COUNCIL MEMBER BARRON: So it’s only within the disposition...

[crosstalk]

SARAH BASS: Right.

[crosstalk]

COUNCIL MEMBER BARRON: Time.

SARAH BASS: And a placement could be extended, but that's only if it feels that it's safety reason. We wouldn't extend someone for a mental health reason.

COUNCIL MEMBER BARRON: And one last question. In terms... you made reference to state secured placements; that you would not have any involvement with them.

SARAH BASS: We are just not taking over the... we're not running state. We're only doing non-secure and limited secure placement will remain with the state, with OCFS.

COUNCIL MEMBER BARRON: Okay, thank you.

CHAIRPERSON CABRERA: Council Member Vallone?

COUNCIL MEMBER VALLONE: Thank you and good morning and thank you for coordinating with all three agencies. I echo Council Member Barron's concerns about the timeframe. I spent a numerous amount of years on the Board of Corrections and it was clearly shown that the most traumatic time for any child or inmate is the first 24 hours, and there is testimony today about an initial screening

within 24, more comprehensive within 72 and a follow-up in a non-displacement 14 days later. I'm not happy with the timeframe there and with a child's trauma in that very first hour of their life possibly changing forever. I'd like to know what is done in those first 24 hours if there is a warning sign that someone is triggering these mental health issues so that the process can be expedited or additional care so not to scar for the rest of their life.

CHARLES BARRIO: So we'll start with detention.

COUNCIL MEMBER VALLONE: 'Kay.

JENNIFER ROMELIEN: So the first 24 hours that Charles alluded to is when a child comes into the detention facility they are seen by the health clinician; whether that's going to be a physician assistant or a pediatrician and part of that intake includes a mental health screening. If that...

[crosstalk]

COUNCIL MEMBER VALLONE: But that's the same screenings for anyone.

JENNIFER ROMELIEN: I'm sorry?

COUNCIL MEMBER VALLONE: That's the same screening for any child that comes...

[crosstalk]

JENNIFER ROMELIEN: That's any child that comes into the detention facility.

COUNCIL MEMBER VALLONE: Okay.

JENNIFER ROMELIEN: Prior to them going onto their orientation hall, they must be seen by the medical clinician, and if that clinic...

[crosstalk]

COUNCIL MEMBER VALLONE: How much time is that?

JENNIFER ROMELIEN: Generally that happens immediately, but their contract is within the first 24 hours, but I can say overall that they see those kids before they are moved onto the hall. If the child presents with an issue when they meet with they meet with the physician assistant or the pediatrician, they immediately alert the clinician that's on-site or if the clinician is not on-site, we have on-call availability 24 hours a day to assess the needs.

[crosstalk]

COUNCIL MEMBER VALLONE: So there seems to be a gap there between the initial screening and 24 hours, so that's where my concern is, so I mean 23 hours goes by before they have someone... if a clinician has to be brought or...

JENNIFER ROMELIEN: For a mental clinician? The 24 hours is just in the contract with our floating... the floating hospital and medical provider; however, like I said, whenever a child is brought into detention they're immediately seen by a physician assistant or a pediatrician to assess their medical needs, as well as their mental health needs.

COUNCIL MEMBER VALLONE: So that part I'm clear on. It's the next part...

[crosstalk]

JENNIFER ROMELIEN: 'Kay.

[crosstalk]

COUNCIL MEMBER VALLONE: That I'm concerned about from that initial screening to the 23 to 24 hours after. That's a very long period of time for a child to wait.

[Pause]

CHARLES BARRIOS: So between the time that the youth being admitted into detention receives that initial medical screening or health screening and the time that a mental health clinician sees the kid, the medical staff are still on-site and also there are facility staff that are on-site that should there be a reason why that child needs to be seen immediately we have the resources that can automatically deployed so that the kid would not have to wait until that 24th hour to be assessed by a mental health clinician. We have psychiatrists that are on-call and available 'round-the-clock.

COUNCIL MEMBER VALLONE: How many psychiatrists are there?

JENNIFER ROMELIEN: There's one full-time psychiatrist and we have five per diem psychiatrists. The full-time psychiatrist is on-call 24 hours a day.

COUNCIL MEMBER VALLONE: Well, that was also a major concern with the Department of Corrections. There's not enough medical staff to handle the demand of what's happening, so is this more of a contractual issue or something that we

can look at down the road to focus on this initial 24 hours ‘cause I’m telling you through many, many years of testimony on this, the first 24 hours is the most critical part of the child’s... possibly the rest of his life or her life and whether it’s youth or an inmate on Rikers Island, it was a serious, serious issue and we constantly went back to it to make it better I mean ‘cause we all realize there’s limitations within the contract providers; the budget that’s there, so now we want to make it better for you to make sure you have those resources to do that. So if there’s anything there that we can come back on a later hearing or if additional resources and if I urge my fellow council members that is the most traumatic time, that first 24 hours. I also wanted to mention upon the completion, whether it’s release or discharge, is there a coordination with the family doctor or a physician upon release so that the continuation of medical services can continue in the private sector?

JENNIFER ROMELIEN: With detention or with placement? Well, I’m going to speak to...

[crosstalk]

COUNCIL MEMBER VALLONE: Yeah.

JENNIFER ROMELIEN: Detention.

COUNCIL MEMBER VALLONE: Yeah.

JENNIFER ROMELIEN: When a child is released from detention, there is a process where our medical providers as well as our psychiatric providers are to contact the family and give them the necessary information for them to proceed in the community.

COUNCIL MEMBER VALLONE: Well, that’s a process with the family. Is there any requirement that the family physician... their records be forwarded to the physician so that he or she can see what was actually administered for treatment?

CHARLES BARRIOS: So under our current psychiatry services and mental health contracts in detention there is the expectation that those providers reach out not only to family and guardians, but also to prior treating psychiatrists and physicians to the extent that they’re available to provide information.

COUNCIL MEMBER VALLONE: Expectation is the difference between actually happening though, so can... is that something also that we have to

revise so that we can make that requirement; that it actually is a requirement and not an expectation?

CHARLES BARRIOS: Well, it's part of their scope requirements in their contract, so they are required to follow-up; however, they have no control over the physician who was treating...

[crosstalk]

COUNCIL MEMBER VALLONE: That's different.

[crosstalk]

CHARLES BARRIOS: The kid. Yes.

COUNCIL MEMBER VALLONE: Yeah well, I think one, our responsibility is to get that information and I think...

[crosstalk]

CHARLES BARRIOS: Right.

[crosstalk]

COUNCIL MEMBER VALLONE: At that point we can say we did the best we could to keep the continuity of the treatment going, but I want to make sure that that information's being released. That was another issue in the Department of

Corrections we had. It was stopping upon release. So is that something we can... we can...

[crosstalk]

CHARLES BARRIOS: Yes, that would be very helpful. The other thing Jennifer wanted me to mention is that sometimes the families will voluntarily reach out to the child's physicians to try to get that information as well.

COUNCIL MEMBER VALLONE: And the last point I'd make, if I may, is just if unfortunately that child does wind up one day as an inmate on Rikers Island are those same records available so that the same process; the evaluation that's now being done at Rikers they would have a heads up a to what had happened in the youth detention?

SARAH BASS: With the placement youth, if one of our youth were on aftercare saying got arrested, we would work to ensure that we had some communication with Rikers so that they know sort of the needs of the youth and we could try to figure out how to get them whatever they need in order to do a proper assessment and so they're not starting from zero; that they know the background on the youth.

COUNCIL MEMBER VALLONE: That's not... it's not a requirement yet? It's just your hope that that's happening or is that just... is that actually policy and procedure or is it...

[crosstalk]

SARAH BASS: Oh, no, it's... sorry, I didn't mean to say... I mean that's... the expectation is that they do it, yes. They go... I mean we have our staff, the Placement and Permanency staff and the community support specialists go into Rikers and meeting with youth and the... I will say the collaboration with records we can improve on, so we'll work more on getting them the records.

COUNCIL MEMBER VALLONE: I may suggest as a follow-up at a future hearing as to the discharge planning and where we can continue the continuity of services to the children in their private homes versus also the possibility of subsequent facilities. Thank you very much for your testimony.

CHAIRPERSON CABRERA: Thank you so much. Council Member Menchaca, followed by Council

Member Levin, and we have been joined by Council Member Johnson.

COUNCIL MEMBER MENCHACA: Thank you so much, Chairs, for this joint hearing and I am very interested in rebuilding on what I think you're hearing here is understanding what resources are required, but beyond the resources I think there's also a sense of competency for different populations that are coming in. And so my two different populations, and I want to get a good sense from you all, while youth are in detention are youth that don't speak English... and I'm trying to figure out how that's communicated and get a good sense, and the LGBT community, specifically the transgender community. Oftentimes, the transgender community comes... or members of the transgender community come in with medical supervised hormone intake for example, and how does that continue through detention? I'd like to hear from you on that process and specifically on the hormones as a medication.

[Pause]

JENNIFER ROMELIAN: And with response to your first question in regards to young people

that come in and may not... do not speak English, we do have language line providers that can be able to translate for those young people, as well as translators that can come into the facilities to translate for that young person.

COUNCIL MEMBER MENCHACA: And that falls within the 24 hours that Council Member Vallone was talking about?

JENNIFER ROMELIEN: Correct.

COUNCIL MEMBER MENCHACA: Okay.

JENNIFER ROMELIEN: All staff have the availability to use the language line immediately and then we would have someone come in as a translator if that child needed that service.

COUNCIL MEMBER MENCHACA: Okay.

[Pause]

CHARLES BARRIOS: So ACS has a senior advisor for LBGTQ Policy and Practice and over the course of the past year and a half, almost two years, we've undertaken a major effort to ensure that all our staff within our juvenile justice continuum are trained in ASC LGBTQ Policy and Practice. We have also distributed information to all of our staff in detention in the way of palm

cards that are used to educate youth about their rights and expectations. In addition to that, we have incorporated questions in our revised case management intake tool that contains a list of SOGIE questions. Does everyone know what SOGIE is or should I...

COUNCIL MEMBER MENCHACA: Explain it everybody.

CHARLES BARRIOS: Sexual orientation, gender identity and expression. So these were questions that were incorporated into the assessment tool in order to help case management staff appropriately identify youth who identify as LBGTQ, as well as identify what their health needs are with respect to their identification.

COUNCIL MEMBER MENCHACA: It sounds like this program is new and so it'd be great to get numbers about the training and how far you've kind of impacted the entire system. These things are not easy for any system and so it'd be great to have a better sense of where you are. It doesn't sound like you have the numbers now.

[Pause]

JENNIFER ROMELIEN: So Charles wants me to mention with regards to young people who identify as transgender, we have and we will continue to house that young person on the hall that they identify with, so we... a young person who identifies as female will be housed on a female dorm and provided all of the female undergarments and so on and so forth.

COUNCIL MEMBER MENCHACA: Okay and what about the hormones specifically and how that gets incorporated into the care and...

JENNIFER ROMELIN: So we do have a continuity care policy that applies to that as well if a young person was receiving hormone treatment in the community.

COUNCIL MEMBER MENCHACA: Mm-hm.

JENNIFER ROMELIN: Our physicians will continue that care in detention if they were receiving that.

COUNCIL MEMBER MENCHACA: And in cases... ‘cause we’ve heard of cases where that doesn’t happen where medication is removed. Is there an ombudsperson structure that allows for that?

JENNIFER ROMELIEN: Absolutely. There is an ombudsperson structure within detention.

SARAH BASS: And just to mention, that placement in our general population continuum we do have a house specifically for LGBTQ youth. SCO runs it. They have a very long history of dealing with this population. They are fantastic and they're very affirming and I think we've had a really good experience and the youth in that program have had really good experiences.

COUNCIL MEMBER MENCHACA: Okay well, I'll... colleagues have more questions, but know that we're going to be engaging in this conversation soon too. Thank you.

CHAIRPERSON CABRERA: Council Member Crowley?

COUNCIL MEMBER CROWLEY: Good morning. I want to talk about the population from 16 to 18. There's been a lot of support now if kids that fall in that age group are arrested for a felony, the court wants to start delaying the process of treating them as an adult, but right now, once they're 17 they're no longer ACS's responsibility

if they commit a crime? Is that a question? That's a question I asked.

CHARLES BARRIOS: That is correct. Yes, it's 16 and under.

COUNCIL MEMBER CROWLEY: Right, but in other ways like when you have youth that are in foster care you go until 21 or 24?

CHARLES BARRIOS: Yeah, that's correct.

SARAH BASS: If the...

CHARLES BARRIOS: [interposing] But...

SARAH BASS: Oh, sorry.

CHARLES BARRIOS: No, go ahead.

SARAH BASS: If a youth is placed before... say they are 15 years old and then they get placed, we... in placement clearly they're treating them past the age of 16. We'll treat them for the amount of time that the court placed them and that's all we're allowed legally to do, but we do in placement have youth that are older. We have 18 year olds; we have 19 year olds just because of AWOL time and needing to extend youth, so we're certainly going to treat youth and work with youth for the amount of time that the court allows us to, but it's determined by the court, not by us.

COUNCIL MEMBER CROWLEY: And have you had difficulty with the court for that group, 17, 18...

[crosstalk]

SARAH BASS: Well...

[crosstalk]

COUNCIL MEMBER CROWLEY: 19?

SARAH BASS: We don't... they wouldn't be placed with us over 16. The only youth that we're dealing with are the ones that were placed before that that are still serving their time.

COUNCIL MEMBER CROWLEY: Do you see issues with that? It seems as if there are a lot of people that are entering into the criminal justice system as what I would perceive as a youth, right; 16, 17, 18 committing crimes, but they're treated as adults. Does ACS see that as a problem because your agency works with people in that age group if they're in foster care or if they've been in your care prior to them being 16?

CHARLES BARRIOS: There is currently a proposal out there about raising the age and at this time ACS is currently reviewing that proposal.

COUNCIL MEMBER CROWLEY: I say this because I chair the Criminal Justice Committee and a lot of the violence that is happening at Rikers is youth when they're 16, 17 and 18, and then the vast percentage of incidents happen with people under 24 and a great population is under 18 and a significant number of that population also has mental health issues and I just don't think that there's proper oversight and intervention in helping these youth and I'm afraid if they don't get the proper attention at a young age that then they're just going to have a lifetime of being within the criminal justice system. And so I think if the city starts looking at that population under 21 and provides more and more services to that population, especially the population between 16 and 18, that we could prevent the lifetime of involvement within the criminal justice system. Is there any initiative that we could support as a council that is moving towards doing such an action where you would stay involved or get involved with 16 and 17 year olds?

JENNIFER ROMELIEN: The way the court system currently works we can't... I mean we're

not... we're... it's not in our hands. I share your concerns, but unfortunately, that's not the way our system's currently set up.

COUNCIL MEMBER CROWLEY: But if this administration... you know, the court systems are within the state's jurisdiction, so if the city of New York said that they wanted to work more with ACS to work with this population, do you see that that would have a positive impact? Do you think that your agency is available to do that?

[Pause]

CHARLES BARRIO: Council Member, I'm going to ask Sara Hemmeter, Associate Commissioner of Youth Justice Programs to respond to that question.

COUNCIL MEMBER CROWLEY: Thank you.

ASSOCIATE COMMISSIONER HEMMETER: So sorry. Hi, I'm Sara Hemmeter. One of the programs that we do run is the Family Assessment Program, which Charles spoke about in the testimony, and that program does provide service to young people up to the age of 18; therefore, kids who are... parents want to file a PINS petition so kids who are not arrested, but have some issues in the home

or in the community, a parent can bring them in and they can receive services there, and we view that program as kind of a prevention or it is a prevention program to try to prevent the young person from entering either the juvenile justice or the criminal justice system. We don't have any outcome data on that right now, but that is one area where the families can come to ACS and receive services up to the age of 18.

COUNCIL MEMBER CROWLEY: Okay, but is ACS working with the Young Men's Initiative at all?

ASSOCIATE COMMISSIONER HEMMETER: Well, we have... we've had conversations with the Young Men's Initiative, but we don't have any direct link with them I mean in terms of service provision. There's a lot of overlap between those two programs, and actually the person who runs YMI used to work at ACS in the Family Assessment Program, so there are... you know, we talk a lot about different programs and how we can link better.

COUNCIL MEMBER CROWLEY: Okay, no further questions.

CHAIRPERSON CABRERA: One last question by co-Chair Levin before we move onto the next panel.

CHAIRPERSON LEVIN: Thank you all very much. Thank you, Chair Cabrera. I just had a question and it's not really yours to answer, but I wanted to put it on the table. In the previous term, Council Member Koppell and Council Member Brewer and I had really encouraged the Department of Education to expand mental health services in our school, and we had gotten the commitment from them to expand it in terms of the capital allocations for mental health facilities and community–based health facilities in our schools, but what we focused on was providing more mental health services. Do you coordinate with the Department of Education because the thought being that if we have more mental health services in our schools, particularly in schools where there are maybe a number of high risk youth that we may be able to head off kids going into the system in the first place, and so that's one area that's an area of preventive measures that we should... it would make a lot of sense for there to be some

coordination with DOE in terms of getting resources in there; real resources that even if it's ACS or DJJ and encouraging the Department of Education to allocate those resources kind of working in a more holistic fashion.

CHARLES BARRIOS: So we have an ongoing relationship with the Department of Education. Recently, we have been meeting with the State Office of Mental Health to look at the way that educational services are provided through the DOE's Passages Academies. Those are the two schools, the one in the Bronx and the one in Brooklyn over at Belmont, and so we are having conversations about the behaviors of kids, the needs of kids, additional resources that might be leveraged offered through OMH in the way of training, as well as looking at whether there are other services that can be adapted to the schools to better support youth in NSP.

CHAIRPERSON LEVIN: Right and not just in those specific schools, but also in all the other high schools. I mean we have you know, I don't know how many high schools in New York City, but a lot and you know, kids... there are at-risk

kids in every high school, so it would I think make sense to just look kind of broadly at what services are provided throughout the system and if we can kind of get at least a kind of minimum level of services and care and then we can kind of look to build on that and kind of just see how that's working throughout the system.

CHARLES BARRIOS: And I certainly support that. It would be great to be able to establish a baseline of what the mental health service needs of kids are throughout our city and what those services should look like in schools.

CHAIRPERSON LEVIN: Thank you very much. I appreciate that.

CHAIRPERSON CABRERA: I said it was going to be the last question, but my co-Chair had another question and then we're going to go to the advocates and I promise you we'll have you altogether at the same time.

CHAIRPERSON COHEN: Just to follow up on a point made by Council Member Vallone, you said we have one full-time psychiatrist, five per diems. You know, do you think that is adequate and why is that adequate? Too, why do we use per diems if

there's a need for full-time... you know, if you need five per diems is there a need for more full-time and lastly, is there... the access to social workers. How many social workers are there and what is the access to the social workers?

CHARLES BARRIOS: So I'll answer the first part of your question, then I'll defer to Jennifer for the second part. I think Council Member Levin asked a similar question about whether the services that are currently available in detention are desirable or enough and is that due to contractual issues and whether it's something that we are looking at. So to respond to your question, it is due to the existing contract and we are currently looking at ways in which to enhance our psychiatry services so that we can provide more robust services to kids while they're in detention. In terms of the clinicians...

JENNIFER ROMELIEN: With respect to the clinicians, we currently have 13 clinicians throughout the system, two supervisors and a mental health director.

CHAIRPERSON LEVIN: Thank you.

JENNIFER ROMELIEN: You're welcome.

CHAIRPERSON CABRERA: Thank you so much. We appreciate your time, your information and now we're ready for the next panel. I'm going to ask for... yeah, we're going to need an extra chair if the Sergeant-at-Arms can help me there and Nancy Ginsburg from the... [background voice] Lisa Freeman; Dr. Jeremy Kohomban; Carol Fisler and Dr. John Shaw.

[Pause]

CHAIRPERSON CABRERA: You can begin your testimony, whoever would like to go first. If you can introduce yourself, appreciate it.

DR. KOHOMBAN: Good morning, Honorable Chairs Cabrera, Levin, Cohen and members of the committee. I am Dr. Jeremy Kohomban and I'm the President and CEO of the Children's Village and Harlem Dowling. We work with about 15,000 children in the Greater New York City area and also in the Netherlands, Baghdad, Iraq and Australia and most recently in Haiti. I won't go through my testimony word by word because you went through a lot of detail, so I'm going to try and highlight on the things that we believe are important.

When our Deputy Commissioner described Close to Home and he spoke about the specialized children, we serve about 98 percent of those specialized children, so the sex offenders; the problematic sexual behavior; the fire setters; the substance abusers. Those children are in Close to Home with the Children's Village, and I would like to describe to you what we see and share with you some opinions about our experience.

When we talk about mental health, it is very... we believe that it's extremely important to distinguish between what is considered situational mental illness and chronic and persistent mental illness, and the reason for this is that the system is disproportionate. It's disproportionately a system of color, predominately black and brown kids. That's the system and it is very easy to walk away sometimes thinking that all these kids who are predominately black and brown have mental health issues because those are the statistics that you hear, right; 80 percent plus. What we know for a fact, and our teams, by the way, are made up of medical doctors, psychiatrists, social workers and psychologists along with the cottage staff. What

we know for a fact is that when it comes to situational mental illness there's great hope, great, great hope. The drivers there are abject poverty; lack of opportunity; violence, the kind of trauma that we most closely associate with the 15 or 16 neighborhoods where most of our children come from that are predominately poor and of color. The secondary driver is hopelessness and despondency. Kids who have been part of child welfare are now in juvenile justice; kids with no belongings. At the Children's Village we believe firmly that the magic bullet for that group in addition to treatment is one caring adult relationship, just one. We see it every day, every day and the transformation is incredible.

We also believe that as we talk about medication that in addition to having appropriate medication at the right time, it is critically important that we take kids off medication again, because we need to be sensitive to the disproportionality in the system. We don't want kids on very strong psychotropics indefinitely. Medication management is difficult at best, especially when you are poor. I mean at the

Children's Village we have five psychiatrists and pediatricians, so it's very easy for us to do daily blood tests if we need to do that, but when kids are discharged and they're in the community, to have that kind of access is not always possible and to avoid the risk that kids will grow up into adults who are dependent on psychotropics, we believe that part of the treatment is also removing kids from psychotropics at the right time.

And finally, I want to highlight on what we believe are the most important recommendations in mental health. When you get past the psychiatrists, the psychologists and all of us who are embedded in mental health issues, relationships are incredibly important. It doesn't matter what the credential is. If you don't have people who can bond and engage with kids who feel disenfranchised and outside the system and feel hopeless and despondent, then we've failed. Flexibility is critical. There is no one medication and no one strategy that meets all needs. You need to be absolutely ready to be flexible at very short notice.

Three, among the kids who are in this situations on mental health, substance abuse is often a coping mechanism and I believe that to screen and treat for drugs and to rule out substance abuse is important as a first step because in the absence of ruling out substance abuse, you'll never get to the issues of you know, does this child have a chronic and persistent mental health issue that we also need to deal with. Robust psychiatric services, as you heard, are important if not for making sure that we have the right medication, to making sure that we take kids off medication when they don't need to be on that.

And finally, there is no government funded system that takes care of kids forever. Rikers Island is probably the other place where our kids end up too often. Family, when available and when safety is not an issue, is the key health support system that exists for our children and working with families and making sure that families know how to deal with either situational mental illness; the triggers or the persistent; you know, the child that's schizophrenic. Yeah, kids with schizophrenia can go on to live normal lives if the

family has the right education and support. Thank you.

LISA FREEMAN: Good morning. My name's Lisa Freeman. I'm the Director of Special Litigation and Law Reform in the Juvenile Rights Practice of the Legal Aid Society. I'm here along with Nancy Ginsburg, who's the Director of our Adolescent Intervention and Diversion Practice in the Criminal Practice. I want to thank you for giving me the opportunity to testify this morning and for holding this hearing regarding these issues that we think are so important. I also won't go through the testimony; the lengthy prepared testimony that we've provided to you, but I do encourage you to read it. I think it has important points in it that I'm sure I won't get the opportunity to speak about.

Obviously, I think we all recognize that this population has tremendous needs and it is absolutely the belief of the Legal Aid Society that these needs are not being absolutely met at this point. These needs can be addressed both in a preventative way so that services in the community are enhanced to help prevent kids from coming into

the criminal justice system, and we would encourage the Council to use its resources to try to make that possible, particularly because it's obvious that most of the kids that come into juvenile justice system come from very specific communities and those communities have been identified repeatedly over and over again and those communities should be targeted for services either through school system integration of mental health services or through other community-based efforts. Once the kids are in the system, the kids that are held in secure detention, it has been our unfortunate experience that the provider that's been in place that is a contractual provider that ACS, as we understand, did award it to the lowest bidder, is really inadequate to the task of providing the services. I think the efforts that ACS has made to bring Bellevue in and to provide trauma-informed care and training to staff has been a tremendous move forward. We encourage that to be continued and we think that, in part, as ACS testified, the increase in referrals and the increase identification of needs of the population shows how inadequate what was going on before that

was. So we are hopeful that a new contract will be awarded and that there will be a better ability to identify the needs of the population and address those needs through a future contract.

As far as kids that are... well, one additional thing. There's been a tremendous change that's taking place in the juvenile justice system, in part, due to Close to Home and other efforts to adjust and reduce the population of kids that are in detention, but one of the results of that is that the kids that do remain in detention have become a needier population. A few years ago, there were about 90 percent of the kids in detention were kids that were there as a result of juvenile delinquency were placed there through Family Court and only about 10 percent were juvenile offenders who were placed there through adult court. Now it's almost 50/50, so almost 50 percent of the kids are there as a result of adult court placement and often are there for much longer periods and are facing some significant potential sentences. So the needs of that population are much greater. There's an opportunity for a much more intensive treatment because those kids are

often there for years and so that adds to the importance of this issue really.

In addition, one of the things that came to our attention is there is really virtually no budget for programming in the secure detention system and it's I think well accepted that keeping kids busy basically is one of the best ways to reduce misbehavior and that we think that's one of the contributing factors to some of the problems that do take place in secure detention. One of the other factors that was not mentioned this morning is that ACS... the secure facilities are under a Corrective Action Plan from the State Office of Children and Family Services related to the use of restraints; of physical restraints and room confinement and there are very high rates of use of both of those things in the detention system and we again, think that that's, in part, a reflection of inadequate mental healthcare and inadequate programming; that essentially if you aren't providing those kinds of services, the staff are going to resort to other mechanisms to try to control the population that really are not appropriate and that are being abused. One

additional piece of that is that ACS has yet to finalize a restraint policy or room confinement policy or really develop a final set of policies for the Division of Youth and Family Services... I'm sorry, yes, for the secure facilities and we think that's absolutely essential; that essentially if the staff don't know what the rules are how can anyone expect them to abide by them, and that really that needs to be developed and needs to be developed immediately.

Finally, with regard to children that are in placement under Close to Home, which we think has been a fabulous development, and we do think that the work that's being done on that front needs to be continued so that there's a better transition and better communication because we don't believe that the information that does get gathered in detention is being adequately communicated in a timely fashion to the placement facilities, so they're at a loss as to what the needs of the kids are and it really should be a much smoother transition. And really, the same thing going from the placement back into the community; that if you don't... the whole goal of

Close to Home is to take advantage of being in the community, but it seems that in many instances that transition is not taking place as well as it could because the kids are not being linked to community services in a timely way, so they're being discharged and a new provider's being put in place to provide them with mental healthcare, where the whole idea is that whatever relationships they develop they should be able to continue once they're transitioning back into the community, so we would really encourage ACS and the oversight of ACS to address that, and that's essentially it. I'm happy to answer questions, as is Miss Ginsburg. Thank you.

[Pause]

CAROL FISLER: Thank you. I'm Carol Fisler from the Center for Court Innovation and I thank you for this opportunity to speak. I can be very brief because the main focus of what I wanted to talk about is really on what precedes the young people going into detention or placement. I want to just bring to your attention some of the work that we've been doing with young people who are in Alternative to Detention programs to identify

mental health problems and start the process of providing comprehensive strength spaced family focused services to prevent detention and ultimately to prevent placement.

The Center for Court Innovation has been running a very intensive mental health juvenile justice program in Queens since late 2008, and in the Bronx since 2011 and we just a couple months ago launched our program in Staten Island. We call this the Futures Program. We have served over 360 kids in Queens. We have served about 60 kids in the Bronx. What's critical about the program is that we're trying to again, identify you know, the broad-based screening of young people who are participating in ATD programs and then provide services for as long as kids are involved in the juvenile justice system, so we'll stay involved with the kids if they go into detention and when they come out of detention; when they come out of placement.

We have published an evaluation. The full report is available on our website. It's a very rigorous quasi-experimental design where we took kids going through the QUEST Futures program

who were enrolled in the Queens Alternative to Detention program and compared them to comparable kids who were in the ATD programs in Brooklyn and Staten Island and what's really most significant is that the kids who were identified with mental health problems who received these intensive case management and family support services had significantly lower rates of re-arrest, including lower rates of felony re-arrests than the kids who had similar clinical needs, similar juvenile justice profiles, but who were not receiving the services. So we've recognized that for kids who have not yet entered detention; not yet been placed by screening, assessing and providing appropriate mental health services we really can improve public safety and keep kids from deeper penetration into the system.

I also just wanted to point out a companion study that we did, which is also accessible on our website. We looked at the prevalence of mental health disorders among 800 young people who enrolled in the Alternative to Detention programs in Brooklyn, Queens and Staten Island over about a two-year period. Of those 800

young people, fully 50 percent of them endorsed signs of mental health disorders on a nationally validated mental health screen. So while that is somewhat lower than the rates of disorders that you will see among the young people who are in placement, it is significantly higher than the rates of mental health disorders that you see among the general population. So we recognize that you know, the kids who are arrested and you know, identified as being at low and moderate risk of reoffending do have very significant mental health needs. And just to pick up on an issue that I know is important to a lot of you, and ACS is really trying to address it, we saw very high rates of Post Traumatic Stress Disorder. In our Bronx Futures program where we're working you know, with kids who have flagged for disorders and who have agreed to receive our case management services, 70 percent of those young people have experienced significant trauma in their lives, either as witnesses to it or as the recipients, and that's both interpersonal trauma and community trauma. So we really strongly support the efforts that ACS has

described to really do a lot more trauma-informed care.

And I'll just make one last note because a lot of what you were asking questions about earlier; a lot of what ACS was talking about is the importance of coordinating care as young people move into detention; into placement; back out into the community. One of the biggest challenges that this group of juvenile justice and mental health stakeholders had in designing the Futures program was figuring out information sharing protocols that could strike the right balance between respecting the confidentiality of young people and their families and keeping the information about their mental health disorders as confidential as possible, especially at the early stages of the juvenile justice process. It's a big disincentive to receiving care while under juvenile justice supervision. If the families or their lawyers believe that the presentment attorneys or the judge will receive information about mental health disorders that might be used in prejudicial ways. So I just want to you know, raise that as a cautionary tale, but it's not an insurmountable

challenge. Thank you. I'm happy to answer any questions.

DR. SHAW: Hi, good morning. I'm the last speaker. I'll try to be brief. I'm Dr. John Shaw, clinical psychologist, psychoanalyst and I've been practicing in the child welfare system for more years than I'd care to mention, but it's well over 30. In preparing for today's testimony, I reflected that if I included my college days as a childcare worker at a now closed childcare institution, it would be well over 40, so I offer that, although I still have self-consciousness about the numbers.

I'm from the Episcopal Social Services. I'm currently the administrative mental health for those programs and under my clinical direction are the mental health services for our none-secure placements. We have three non-secure placement homes. We opened up the first one in July 2012 in New York City and we've had, and I think ACS would support this, remarkable success in achieving the benchmarks of the program. One of the reasons I believe this is true is that ESS has already had, at this point, eight years of working with non-

secure detention, so the programmatic philosophy, the training of the staff, the expectations, the focus on a safe, secure environment first I think has led to a lot of success that we have had in transferring this to an ACS-run placement program.

I won't comment too much more about the stats on the mental health needs of the kids in care. They've already been covered. I do want to echo a couple of things though. Yes, Post Traumatic Stress Disorder is way underdiagnosed in this population. Even when it is diagnosed, it's above the norm, but the focus of the system on behaviors, on attitudes, on how the kids are doing in school has led to a high number of diagnosis of both ADHD and conduct disorders. I'm not saying they're not valid diagnoses, but the systems tend to therefore not pay attention to some of the severe trauma the kids will talk to you about, and in my experience in this population, very, very high numbers of violent deaths of siblings and friends witnessed, much more so than I've ever experienced in the foster care or prementive [sic] populations working with them. So it's really a condensed population of very severe multiple losses

and trauma that often don't get paid attention to, and I will be getting to one way that we've been paying attention to this that has been very, very fruitful.

We deliver services at ESS through a team approach. We have a clinical social worker on each of the teams, as well as psychiatry and psychology services available for all of the children. The psychotherapists that are assigned to the houses are present at intake when the child comes into the house. A screening is done at that point and if there's any markers on that screening that require additional attention, an immediate call is made to me and we either will transport to our psychiatrist or if the need deserves it enough we'll go to a psychiatric facility. We have not had the need to go to any psychiatric facilities, but on a few occasions we have arranged either that day or the next day to transport the child or bring the psychiatrist to our facility, but it is not a high number. These kids that we're getting have already had the blow of detention and are now adjusting to it and some of the kids we're getting

we already know from our non-detention facilities. They're coming into our NSPs.

I also wanted to mention and echo the importance of engagement as for the bottom line for any of the professions, and I would also like to add that my view of mental health services in these programs should be shaped and molded to support the engagement and the relationships that the kids develop with the youth specialists who are there 24/7, who the kids open up to regularly far more than they'll open up to a therapist who are there when the kids are in pain or in struggle or having conflict, and our work with them is to support them understand the system and to support the Missouri model, which we are using within our facilities as mental health professionals. This is in addition to the expectation that all of the kids are seen for individual psychotherapy. All of our kids receive psychiatric evaluations within a month. All of children receive full psychosocials within two weeks, so we very much at the beginning try to get a clear picture of the mental health services needed for the kid.

In my opinion, mental health services in all of the systems really should be molded to the system of care providing services for the child. If it operates as a standalone on a traditional mental health model, you'll be coming up with issues that have nothing to do with the failure of the public system in the first place that brought the kid into care and can even extend care in some cases if too much is generated of non-essential critical mental health issues. As correct as they might be, they don't necessarily at all address what went wrong a few years back at the public sector treating and trying to help the family as any of us would receive services didn't work. So we really try to focus on whatever mental health issues we in a very open situational need to have to be put into place to support the kid entering that transition. The Close to Home Initiative I very much appreciate the early family involvement and the support; the financial support the agencies get for transportation for delivery of families to make that easier for them. It makes our job much, much easier.

What I really like today to talk to the Council about today and to share very happily and enthusiastically is the success we're having using creative arts as a treatment form within the agency. Many of the agencies will have teaching artists come in, drama or music therapy come in and do performances for the kids. What we have begun is to use licensed creative arts therapists who are mental health licensed by the state of New York since 2004 in conjunction with our therapists, and our initial focus has been mostly music. That's what the kids have been most responsive to, but we have also taken on dance and visual artists for the kids who like to draw. Engagement is immediate. It's user-friendly psychotherapy for the kids. We have waiting lists and most of the kids... most teenagers find it rather weird to go in and just talk about what's on their mind if they can find it. What happens here is that you're providing a medium other than verbal that the kids are immediately responsive to. The lyrics; the raft the poems; what the kids put forth allow immediate access into those severe traumas, whereas if we were waiting around for them to talk about it, we

might never get to... and I'm pretty scared that it might take me four or five months before I get some of the stuff I would get with a kid who comes in because he wants to record a rap song. So we've really geared up with a lot of instruments, a lot of... on the production guide for music at this point and the creative arts therapist that we're using, a very talented artist and singers who are used to working with adolescents, and applying creative arts as a mental health treatment form. Unfortunately, it's not funded through the per diem currently, so we cannot hire them as therapists per se and we're pursuing other avenues to get the foundation funding. The testimony contains a couple of stories; success stories that are actual and real. I was involved with both of them with the kids and the amount of transformation that you do see in the kids, of course, is not just due to the fact they're in creative arts therapy, but they go back to the house and they talk about the rap songs. The staff can come and see them perform. We've had performances of the entire system of care with over 200 kids. Families come; take the videos; watch the kids; the parents are beaming, so

we're also providing experiences that many of the families and many of these kids would never get, as normal as doing a performance at high school kind of production where your whole family is there. So the reverberations of this has been stunning for me as a psychologist at this point, and I just wanted to put that on board and to add that we're adding dialectical behavior therapy, which is a nationally recognized evidence-based model used in many juvenile reform efforts and in residences, which can be conjoined with creative arts so that we have the engagement, we're sharpening the therapeutic process and making it more focused and eventually want to use it as a program platform in some of the houses within the Missouri model. So I thank you for... and this is my second time before the Council. I don't think any of you people were here the last time. Una Clarke was presiding many, many years ago. I testified mental health needs in foster care, so I'm very grateful to be back again and testifying for the needs of these kids. Thank you.

CHAIRPERSON CABRERA: Thank you so much. That was... for the panel. That's very

informative. You have confirmed... we have some questions by the council members; my colleagues, but I just have to make this one comment because you know, in our field, and I say our field because I'm still part of it, that in the mental health field there is a tendency to go towards the medical behavior cognitive approach. The DSM-5 is designed to be that way and I always feel that a lot of the young people, if I may, in these detention centers they're treated like specimens. They're treated like patients rather than human beings and we talked... you know, what I gather from the doctors and what I heard from the other guys you know, just the whole idea on normal lives in life, relationships and I was going to bring it up with ACS, but for the sake of time, but you brought it up, the whole issue of Post Traumatic Stress Disorder. I'm wondering if we are focusing really... well, maybe we're missing the issue here and you brought up something, Doctor, but I think what's happening is that Post Traumatic is really an outcome; an effect from grief. You have a generation of young people that are grieving. They're grieving parents getting divorced or

they're grieving the loss of family; they're grieving you know, friends getting shot you know, and so forth and maybe we're not really targeting. The problem is that a lot of this funding, a lot of the reimbursement does not target this area. You know, there is no reimbursement you know, for grief therapy you know, so to speak, as you would have with clinical depression. Oh, you're clinically depressed. Let me give you some medication, you know. I'm not a big fan of medication. Sometimes I feel that we're overmedicating our young people as a form of control. Having said that, let me turn it over to Council Member Barron, followed by Council Member Vallone and Council Member...

COUNCIL MEMBER BARRON: Thank you to the chairs. I have a question for the first presenter and you talked about situation over chronic as the situation that we're looking... as the types that we're looking at. Would the clinical protocols be different for situational versus chronic?

DR. KOHOMBAN: We think it should be. Ma'am, I think when you look at situational impacts like issues of race, poverty, failing in school,

families being socially isolated, grief of losing siblings, grief of families incarcerated, I mean these are realities among our populations of color. Those conditions need to be recognized early so that we can come in with a non-medical model that wraps ourselves around kids at times like that because that's what happens in our own families. If you look at middle-class and upper middle-class families all across the United States that face similar situations, we don't see disproportionate numbers of those children ending up in juvenile justice or even foster care for that matter. It's because we've created family supports. We know how to address grief. We know how to give our children, my own children, positive peers when we worry that their peer group that they are a part of is not working. If a misdiagnosis there where you identify situational behavior and mental illness as significant and chronic could easily trap a kid further into the system as a candidate for medication and all sorts of complicated conditions.

COUNCIL MEMBER CROWLEY: Can situational evolve into chronic if it's...

[crosstalk]

DR. KOHOMBAN: It...

[crosstalk]

COUNCIL MEMBER CROWLEY: Not addressed and...

DR. KOHOMBAN: We believe it can and we have seen that. When you look at Close to Home right now, about 40 percent of our young people were also in foster care or they were touched by the foster care system. Now they're entering the juvenile justice system and eventually if untreated they will enter the adult correction system and the homeless population. Every step of penetration will make that sense of despondency greater and at some point, young people lose their sense of efficacy. No matter what opportunities we present, they don't feel that they can complete.

COUNCIL MEMBER CROWLEY: Thank you and to the second presenter, I'm sorry, your name?

LISA FREEMAN: Lisa Freeman.

COUCIL MEMBER CROWLEY: Okay.

LISA FREEMAN: Lisa Freeman.

COUNCIL MEMBER CROWLEY: Miss Freeman, when you talked about the providers that ACS had been using were inadequate, shouldn't there be a

certain minimal standard that program should have to meet so that a program that's inadequate is not refunded over and over and over? How do you think that happened that they have a history in the longevity of getting contracts but they're inadequate?

LISA FREEMAN: I'm going to let Nancy Ginsburg respond to this.

NANCY GINSBURG: I'm really glad you asked that question 'cause that's the one question we're dying to answer. There was an RFP I'm not sure how many years ago that was issued by ACS and to ACS's credit, I think they tried very hard to get a high quality provider, but apparently there was a decision made by someone, and we don't know who that was, that the contract was going to be awarded to the low bidder and then we got what we paid for and sadly, that is the situation we are in and I think that the current administration of ACS recognizes that the level of provision is less than they desire; certainly it's less than we desire and I think when there are conversations about children being diagnosed with one thing or another, it's our position that they are often misdiagnosed in the

facilities and that is a big reason why there is a discrepancy on our feeling about what kind of medication or if any medication should be prescribed to those kids. So we are... I think part of the fact that ACS sought federal funding; grant funding...

COUNCIL MEMBER CROWLEY: [interposing] Mm-hm.

NANCY GINSBURG: To pay for the Bellevue trauma services is a sign of significant good faith on behalf of the agency; that they recognized that the level of service they were providing was not meeting the need and the fact that those issues are being identified now is good, but we need a better provider in there to actually treat those identified issues.

COUNCIL MEMBER CROWLEY: And back to the question of no formalized policy regarding the use of restraints. Isn’t that something that we can do? I mean do we have to wait? Is it a state issue or can’t we have a policy that indicates what the protocols would be for restraints and for room confinement?

NANCY GINSBURG: I mean I think again, to ACS's credit, they decided you know because ACS had not been overseeing the juvenile justice system before I think 2010...

COUNCIL MEMBER CROWLEY: [interposing] Mm-hm.

NANCY GINSBURG: There were policies in place; they decided to review them, but they have not finalized those policies. I actually reviewed one of the drafts; I mean I think it was over a year ago. They need to be finalized, so I mean they should be improved, which I mean certainly a review is appropriate, but they need to be finalized so that they're in place and staff can be trained on them and understand what the rules are. So I think they are... with regard to restraints, the draft that I saw was certainly a step forward as compared to where it had been previously.

COUNCIL MEMBER CROWLEY: And finally, to Dr. Shaw, you talked about how impactful it is when students or when the children who are in these situations have the ability to express themselves through rap and spoken word and other kinds of expression, I think it bodes well for us to look at

as we look at the New York City school system making sure that we have the time for teachers to have the arts, the expressive arts, the performing arts and all other kinds of expressions because I think it talks about mitigating those kinds of conditions that lead to students not being able to express themselves. I think that's really very critical and a part of our totality in an educational system.

DR. SHAW: I would agree. I think that the lack of the arts or the gradual diminishing of the arts in the public school system is in essence depriving kids of the power that is in the will to create and express. When that's oppressed, you get rage with many other reasons and I had a comment from someone who saw a performance a few weeks ago with the kids that we put on for the program. They said it was incredible because they're looking at the kids, they know their history and they know what they're capable of doing and said, "You've got rage on stage performing what they're about and they love it." The other benefit to the entire community is that it pulls families, staff across all professional lines together when the kids

perform. Naturally, we will break in some chicken noodle soup dance for the entire community and it's a lasting kind of positive experience that people just don't forget, so I've been very pleased by the effects of it. The rage is one of the major targets I have understanding it because inside of that rage is very positive potential; an insistence on being known, an insistence on not giving up, on insistence on being heard. When it gets into a negative cycle, it'll cycle down into violence, but if you can help the kids just find one door where that's recognized and acclaimed in a positive way, they will keep going toward it.

COUNCIL MEMBER CROWLEY: Thank you.

CHAIRPERSON CABRERA: Council Member Vallone, followed by Council Member Levin and Council Member Cohen.

COUNCIL MEMBER VALLONE: Well, after hearing Council Member Barron rap in the Stated hearing, I think you should be in charge of the new media. I think that would go great. I think you're hearing what we hear; the frustration as you are and I think even during this process we'd sometimes rather have your panel before any of the

agencies ‘cause we can use your questions for them before they leave, and I think that’s why we also appreciate when you do the bullets of the testimony ‘cause reading a 15 minute statement of the record just unfortunately, council members have to leave and it’s not conductive. I think a lot of the limitations you mentioned today were contractual; the vendor, RFP and we’re going to have to revisit that upon the new issuance of RFP or a contract. So I’m urging you to continue this dialogue as to what can be made different upon the next RFP and is there any other models that we can look at in other municipalities that you feel offer something a little bit different or beyond that we can use going forward and it’s something else if you have answers to that now, and the last question was you had mentioned limitations in providing this new media therapy. What are those limitations? Are they not provided in the contract? Can you not hire those who provide those services?

DR. SHAW: When the Medicaid dollars are given to the agency through the traditional per diem, there are cost centers with allowable providers within those cost centers, and I believe

that to this day they haven't been changed by the Department of Health in over 25 years, so I'm not even sure... I heard LMHC so I don't know whether would technically allow them, the DMT to hire an LMHC. There have been a number of... the relicensing of mental health professionals in 2004 created at least three or four new licenses and as far as I know none of them are reimbursable under the cost assignment categories for the per diem, so when you report to the state...

COUNCIL MEMBER VALLONE: [interposing] The cost assignment categories that we have to amend...

DR. SHAW: [interposing] Yes.

COUNCIL MEMBER VALLONE: For the recertification.

DR. SHAW: Yes, but they are licensed. They are licensed mental health professionals, but we are not allowed to report back to the state that we used the per diem Medicaid dollars directed at that.

COUNCIL MEMBER VALLONE: And is there another different municipality or another program

out there that we could model for future use for ACS?

LISA FREEMAN: In terms of the provision of mental health care?

COUNCIL MEMBER VALLONE: Mm-hm.

LISA FREEMAN: Is that what you're saying? I mean I don't know offhand. I do know that in the correctional context that's in with the Department of Corrections in the city they struggle in some ways with the same issues because you know, it's really you don't tend to attract necessarily for the provision of particularly incarcerated people. You don't necessarily have...

[crosstalk]

COUNCIL MEMBER VALLONE: Well, with the Department of Corrections they didn't even have any choices. There was only one vendor that stepped up and that was it, so.

LISA FREEMAN: Right, but I know that there had been a model at one point in time in the Department of Corrections, which was some time ago, where they were working with Montefiore you know, where you're working with an institutional provider that may have access to a broader range of

services, but I'm sorry, Nancy, you wanted to add to something.

NANCY GINSBURG: I actually spoke to some of our colleagues on a national level who track the various mental health providers around the country and sadly, there are not many models for us really to look at, although I think there are many models being used in New York City that are very successful. They're just not necessarily available to kids who are court-involved or who are in detention type settings, and so I think we do have a wealth of very high quality providers in this city and I think that we need to be looking at how to open those doors so that high quality providers can reach these kids. I think you know, one of the other issues that have come up through the Bellevue project, and I wish that they had... ACS had talked about it a little bit, is that the trauma training that is going on in the facilities is not just for the kids; it's also for the staff and that's a really, really big issue when you do this work, particularly when you're in a locked facility with these kids all day because it's not just the kids who have lots of grief issues.

Many... most of the staff come from the same community as where the kids come from and they leave their communities that are filled with grief and enter buildings that are filled with grief and it is very complicated to negotiate their own lives and then to come in and try to help those kids, and the staff has reported that they've found that trauma training to be very, very helpful for them to try to manage their own emotions and to try to take a different approach to the kids and I think that's something historically that has really not been looked at; secondary trauma for staff and I think a lot of the agencies are really looking at secondary trauma issues when working with these populations 'cause it's very hard to address these issues day in and day out. You know, the other thing that really needs to be looked at is the staffing issues of the detention facilities because they are not adequately staffed and lots of the staff member work double shifts. They are physically exhausted. It's hard to be mentally on top of your game when you're physically exhausted, and...

[crosstalk]

COUNCIL MEMBER VALLONE: I...

[crosstalk]

NANCY GISNBURG: So all of that is interrelated.

COUNCIL MEMBER VALLONE: Thank you and thank you to the chairs for allowing me the questions. Thank you.

CHAIRPERSON LEVIN: Thank you, Council Member Vallone. Thank you very much to this panel for your testimony. I wanted to first off, Dr. Shaw, I wanted to thank you for bringing up the importance of arts therapy. My mother was an arts therapist in a high school 30 years and I know I remember from that time just how important that was to those young men's lives...

DR. SHAW: Mm-hm.

CHAIRPERSON LEVIN: And it's something to think about that you know, 30 years ago we knew that that was the case, and it seems that it would be further along maybe in implementing a stronger, more robust program than we currently have, but I do appreciate your testimony and I think it's something that we're going to focus on and encourage ACS to prioritize and fund. I mean a lot

of it is funding, as when my mother lost her position as an arts therapy teacher due to a lack of funding, so I know what that means. I wanted to ask about... this panel what I had asked the last panel about mental health services in schools and if you see there being a value in broader citywide protocol or programs in all of the schools, particularly high schools, and if through your experience you see any particular hot spots or particular parts of the city that could use greater resources; mental health resources in schools and also whether you see a correlation at all between youth that have been in the homeless shelter system and mental health issues. We chaired a hearing yesterday... I chaired a hearing yesterday through the General Welfare Committee on family shelters and you know, there are 22,000 youth; children in the shelter system at any given night...

DR. SHAW: [interposing] Mm-hm.

CHAIRPERSON LEVIN: And you know, there are tens and tens of thousands of young people that have lived through that experience throughout their lives, and so I was wondering if you see any correlation there and if you have any ideas about

maybe adding more mental health resources to our family shelter system.

DR. SHAW: I think... I've worked and continued to do consulting in preventive programs and many of the families in the preventive programs are currently living in shelters or entered shelter care. There are usually in most of these shelters at least case planners. Some of the shelters have on-site mental health services coming on. I think that the problem, and I do not have an answer for this, that often exists is a mismatch between the envisioning of what mental health is all about and what the service is with the needs of the program they're servicing. The training... and the more you go toward the medical model, the more rigorous the training and thinking medically, and in medical thinking, of course and I'm glad, but it's a big threat to think out of the box. You don't want doctors thinking too much out of the box, particularly when it comes to physical medicine. So you always... you would be getting the services there, but how effective the services can be really depends on the provider and the relationship the provider has with the facility itself. So I think

when staff and management really get to know the providers they get to relate to each other as folks and really have conversations, the needs that are specific to that facility as far as mental health goes are better met, but that's a very hard thing to dictate, but my experience has always been when it's just not working; it's just an add on or a plug in there's such a gap between the expectations and feelings and the needs of the clients and staff and what the provider is actually trying to do. And there have been cutbacks in school mental health. Going back two or three years, there were some serious ones in the Bronx. I know VNS sending folks out to the schools that they had to cut back on and it provided a network of services back to the clinic and the community. That was cut off at that point, so that kind of model in the schools itself I think is a very useful when it's outsourced from a community mental health clinic.

DR. KOHOMBAN: I had a comment, Mr. Chair, and it's slightly different. It's that we should be careful about net widening. You know, we don't want to go into these same poor communities and throw out a broader net under the doctrine of

greater mental health. I think we need to focus on making sure that these kids in these communities have the things that you and I take granted in our own lives; good recreation, good after-school programs; you know, positive peer groups. In Harlem in the Polo Grounds where we do most of our work making sure that our girls have a Girls Club; that our boys have midnight basketball so that they're off the streets because otherwise behaviors... when kids are bored they do stupid things. I was one of those kids. I was arrested at 17, so I know and you can easily come out with the mental health diagnosis when what you really needed were the things that kept you out of trouble, kept you busy, kept you occupied and kept you at home.

CHAIRPERSON LEVIN: Thank you.

CAROL FISLER: I'll just add a couple of quick comments. The kids who we're working with in this you know, Alternative to Detention context have a host of educational issues. Many of them are in special education. They need assistance getting new IEPs. They need school safety transfers. They are way behind academically and we

work with them on those kinds of issues. I think if you're... you know, we could always improve outcomes for kids by having more mental health services available, but it's not a question of just putting more into the schools. The question really is what are the environments that the kids are in when they're in school? It's very sobering to realize that arrests are actually lowest during the summer months when the kids are out of school. Arrests go up when kids are in school because of incidents arising in the schools. So some of the efforts that are currently underway to look at collaborative problem solving within a school community to bring together multi-service collaboratives across the school community and the larger community so that we're providing the kinds of healthy, positive supports that kids need where mental health services are an integral part of that, but not simply something that's plunked into an environment that already is creating a lot of potential for juvenile justice involvement.

CHAIRPERSON LEVIN: So you're saying on its own mental health services as a standalone

service don't achieve the desired effects. 'Kay, thank you.

CHAIRPERSON CABRERA: Council Member Cohen?

CHAIRPERSON COHEN: Thank you and thank you for taking your time to come in and testify before the committee. I appreciate it. I don't know if this is directed toward Legal Aid or to the Center for Court Innovation, but I mean I have to say that you know, having sat through this hearing, I am really concerned about the... you know, the juvenile justice aspect of... you know, the criminalization of all of these... what appear to me to be mental health issues; that in order for young people to get access to mental health care they somehow have to get dragged into you know, a criminal system or a quasi-criminal justice system. It doesn't seem to make sense and also I would think it would add another layer of problems onto young people who already have problems. You know, like I was earlier... like if truancy is... you know, if there's a correlation between truancy and learning disabilities or... I mean obviously you know, addiction has all sorts of negative behaviors

associated in addition to just having a dependency or... and I'm not really what the behavior elements are of people who have Post Traumatic Stress Syndrome, but I suspect that there are negative behaviors associated with it, and these people as a result of having mental illness are getting... you know, young people particularly who are getting dragged through, like I said, a quasi-criminal justice system or a criminal justice and I think that that's deeply concerning.

LISA FREEMAN: Well, I think maybe this will address both your concerns and Chair Levin's concerns. We've been working really hard collaboratively with the groups at this table and many groups who are not at this table and with city agencies to try to address this very problem. I think since the Student Safety Act numbers have become public it's become clear that we have a serious to prison pipeline problem in this city. I will say that the NYPD has responded favorably and that the number of arrests have gone down, although they're not quite as low as we would like to see them. But the number of suspensions are still quite high and suspensions are often the first step

in kids being pushed out of school and if you are suspended enough kids quickly get the message that they shouldn't... they are not really wanted in the school and that's really where we, as a society, want the kids to be. The Department of Education has created a multi-service collaborative, which we have been participating in, and that multi-service collaborative is addressing the parts of the city where juvenile justice kids feed into the juvenile justice system most, and when I say juvenile justice, I include 16 and 17 year olds because I don't happen to agree with our state definition that 16 and 17 year olds are not juveniles. And so primarily, we are looking at the South Bronx, the Rockaways, Jamaica Queens. We had our first meeting in Staten Island yesterday and part of that multi-service collaborative... the goal of that multi-service collaborative is to try to get the schools and the providers... all types of providers; ACS, foster care, mental health; just family service providers in those communities talking to each other early in the process and trying to identify problems of kids; just problems, not necessarily mental health problems, just

issues. Kid comes into school and is sad. Why are you sad? I mean just learning how to have those conversations with kids because lots of kids who are sad act angry. It's always better to be you know, bad than mad and kids often behave that way, and so trying to get the first point of contact to be a counselor or a teacher rather than school safety or having school safety when they identify a kid bringing that child to a school administrator so that the issue can be addressed and it's not addressed by school safety agents. And when Carol was talking about collaborative problem solving, the Department of Education and the NYPD have started to spend a lot of money to bring in a psychologist from Massachusetts General Health, Dr. Stuart Ablon, to train all of the NYPD SSAs and the Uniformed Task Force officers who are assigned to the schools have been trained in collaborative problem solving. We are hopeful that they are going to receive ongoing more intensive training in that model and we are hopeful that the DOE will dedicate more funding so that more people from more schools can receive that funding. The research shows that you need about 60 percent of a school

community to receive that training for there to be actual change, so that needs to be paid for.

[Pause]

CHAIRPERSON CABRERA: I have one more question and then I'll close with a comment. You heard me addressing the issue of medication, especially when it came to a hyperactive attention disorder. Are you familiar; are any of you familiar or have you... has it been brought to your attention any of the issues that I've brought up regarding the suggestion that the psychiatrist is even substituting medication or any of those combinations that I brought up before?

DR. SHAW: Yeah, I can't respond to where it came from, but I can tell you some of our experiences within clinical services at ESS. We've had no problems... the children have a Medicaid per diem and a case identification number, which is the billing vehicle for medications, so we have had no problem whatsoever with any of the ADH medications going through. Occasionally there have been shifts in some of the antipsychotic medications in terms of Medicaid acceptability; what's a pass for what the agency has to pay for, so we may have to take a

couple of extra steps to get it, but no, it's been quite the opposite. The only place that's ever been ever a glitch has been in obtaining the antipsychotics. In our 36 kids we have about 15 on psychotropics and one on antipsychotic medication. Almost all the other kids are on ADHD medication and what we picked up as one of the very prevalent problems, which does not require a psychotropic to help, is sleep; that many of the kids even if they're reported by the staff as appearing to sleep well, when you begin talking to them, they may not be sleeping well. They may be tossing and turning. They may not get up, so that the staff who are there who make the rounds to know it, but they are just not sleeping well, so the psychiatrist has started in addition to sleep hygiene prescribed melatonin at very low doses, below what you and I would get at the drugstore over the counter and that's been successful and a lot of the kids have asked for that. But we certainly would not use any medication at nighttime to induce, in essence, a chemical restraint. They are very, very mild, so it's been quite the opposite and I think in most of the system the number of kids on three, four

medication cocktails for this system is blessedly low and I was very happy to see such a low incidence of use of you know, new generation antipsychotics in our population.

CHAIRPERSON CABRERA: Anybody else? Anybody else heard? [background voice]

[Pause]

DR. KOHOMBAN: I agree. We see the same. We have had no problems. They have medications. When a certain medication was not approved by Medicaid and we needed to go out and get it privately, but we did so and there hasn't been one instance in our population where we denied the prescribed medication.

LISA FREEMAN: It's been our experience... our greatest problem comes in the secure detention facilities. We do not have direct contact with the mental health provider other than when we request a psychiatric for residential placement. That's the only actual contact we have. We have no ongoing day-to-day conversation about treatment that goes on. They don't speak to us, even though we have often loss of history about a child. We may have represented the child in foster

care proceedings. We... often if a child has been psychiatrically hospitalized, we have those records. We can speak to ACS and hope that ACS gets those records to the mental health provider, but we're not aware of what the substance of those conversations are. We often see in those facilities our kids being misdiagnosed, so almost every kid who's in a detention facility can be diagnosed with conduct disorder. That's how they get there. I don't really even know... I'm not a clinician, but my layman's feeling about conduct disorder is almost every teenager could at some point be diagnosed with conduct disorder. There's no way to treat it anyway. There's no way to treat oppositional defiant disorder and so I think there's a big tendency, and I am saying this purely as a layperson and not as a clinician, to try to control those kids and to try to control their behaviors. Often if an actual real assessment was done of many of those kids, many of those kids do have other issues that are not identified and then they are given medication that does not match their actual diagnosis because nobody actually gets to their actual diagnosis. I will also say that we...

my unit represents the kids who are prosecuted in Supreme Court and so they do stay there for a much longer period of time and they are much deeper end kids and they are not necessarily the kids that Jeremy is addressing. That is not a net winding population. Those are kids who have often touched many, many systems before they have reached Supreme Court and have had many issues missed and needs missed along the way and had those issues been identified and treated, they may have never [disruption in tape] the system.

CHAIRPERSON CABRERA: Well, we have literally run out of time. We have another hearing right after this one and they need to set up, but I want to thank you for your work, for your effort, for advocating for young people, especially those who are the most vulnerable. I am really encouraged by the testimony that came forth. I think we need to refocus back on community, developing healthy families, working with parents and for those who unfortunately go through the system to be able to... even in the meantime while they are in this detained settings, we could be working with the parents. I think parents are the

key, the key, the key and so I'm really encouraged by something that I have always believed, but I'm glad to see it here. Those in the mental health field seeing eye-to-eye and the Legal Aid, the work that you do is fantastic. Keep up the good work and we're looking forward perhaps in the future to have a follow-up regarding this issue. Thank you so much. Have a good day, everyone.

[gavel]

C E R T I F I C A T E

World Wide Dictation certifies that the foregoing transcript is a true and accurate record of the proceedings. I further certify that I am not related to any of the parties to this action by blood or marriage, and that I am in no way interested in the outcome of this matter.

Date: 03/22/2014