David A. Hansell, Commissioner

Testimony to the New York City Council

Committee on General Welfare

June 25, 2019

"Oversight—The Nicholas Scoppetta Children's Center"

Good morning Chair Levin and members of the Committee on General Welfare. I am David Hansell, the Commissioner of the New York City Administration for Children's Services (ACS). With me are Julie Farber, the Deputy Commissioner of Family Permanency Services; Winette Saunders, the Deputy Commissioner for Administration; and Dr. Suchet Rao, ACS's Medical Director for Psychiatry and Behavioral Health. As Commissioner, I have no greater responsibility than to make sure that the children who are entrusted into ACS's care are safe and well-cared for in an environment that reduces the negative impact of trauma, allowing them to begin to heal. Over the past few months, building on the foundation put in place over many years, we have made significant progress in strengthening the work we do at the Children's Center and to more expeditiously find placements for the children and youth. While there is still more work to be done, and some of our initiatives take time to implement, we are proud of the progress we have made. We appreciate the opportunity to discuss ACS's ongoing quality improvement and enhancements at the Nicholas Scoppetta Children's Center with you today.

Our work on behalf of the children who come to the Children's Center focuses on three key goals: First, to provide a safe, trauma-informed welcoming environment for the children and youth. Second, to provide all of the services and supports children and youth need while they are at the Children's Center including health, mental health, education, programming and other supports for children and youth experiencing trauma. And third, to find a safe and supportive foster care placement setting that meets the child's needs until he or she can return home or another permanency arrangement is

finalized. .The Children's Center serves as the entry point for many of the children and youth who come into New York City's foster care system. This includes children and youth who have been abused or neglected, youth who are placed on Persons in Need of Supervision (PINS) petitions when parents are struggling with their youth's behavior, youth leaving the juvenile justice system who do not have an identified resource to care for them, and children and youth whose parents voluntarily place them in foster care because they are struggling to care for their children.

As you know, ACS provides prevention services and supports so the overwhelming majority of children we come into contact with can remain safely at home with their families. When children and youth come into foster care, ACS makes every effort to identify a safe kinship placement with family or close friends known to the child. When a kinship placement cannot be immediately identified, ACS identifies a foster home or other appropriate foster care setting based on the child's needs.

The Children's Center is a 24/7 setting that provides medical clearances for children and is a temporary placement for children when there is no appropriate foster care setting immediately available. Nearly half of the children are at the Children's Center for 1 day or less and more than two-thirds of the children leave the Children's Center within 4 days. The Center serves NYC's most vulnerable children and youth—a total of 2,773 unique children last year, ages newborn to age 21.

From the first day that a child enters foster care in New York City, ensuring their safety, permanency and well-being is crucial. In recent months, ACS has undertaken a

comprehensive, deep analysis of the Children's Center including a close examination of how we are meeting the needs of children, as well as programmatic and operational requirements.

In March 2019, I ordered a number of immediate steps that included:

- An intensive case review of every child with special needs by our Chief Medical Officer, which ensured that these children and youth were safe and healthy, and that their needs were being met;
- Security enhancements to maintain the safe environment for youth and staff that is necessary to create a therapeutic milieu, and enhanced collaboration with the NYPD on both youth enrichment opportunities in the Children's Center and safety in the surrounding community;
- Expanded high-level leadership support at the Children's Center, including leveraging Deputy Commissioner Winette Saunders' expertise in youth programming, safety, and security protocols.

In addition to those immediate actions, we have continued to make enhancements in the past three months, which I will detail more thoroughly in my testimony today. These include:

- Onboarding a new Assistant Commissioner to the Children's Center, David Bauer, who brings more than 20 years of clinical experience and expertise working with children in residential care.
- Developing a new staffing plan for the hiring of 95 additional staff for the Children's Center, across multiple program and operational functions.

- Significantly expanding programming for the children and youth at the Children's Center.
- Enhancing safety for youth and staff by putting in place additional peace officers, and renovating the entry screening area to allow for easier identification and removal of potentially dangerous contraband.
- Creating and implementing a plan for short-term and long-term renovations to the facility, which will move non-essential functions out of the building and expand the space available for youth programming.
- Expanding the number and range of placement options available throughout our foster care system for high-need youth, and enhancing case planning and family-finding services onsite, all with the goal of expediting placement of young people from the Children's Center to more appropriate settings.

I will now provide you with more information about the work we have done to add new resources and enhancements in these core areas: staffing and training; therapeutic milieu and clinical services; education; programming; safety; facilities enhancements; and initiatives to decrease the census and length of stay at the Children's Center.

Therapeutic Milieu and Clinical Services:

We know that children who have experienced abuse and neglect, removal, and other separations from their families are experiencing some of their moments of greatest trauma. At the Children's Center, it is our job to minimize trauma and help children begin the healing process. Continuing to enhance the therapeutic milieu at the

Children's Center is a top priority. In April, we added an Assistant Commissioner to the Children's Center, David Bauer, who is implementing new therapeutic models to best meet the needs of children and youth. ACS also partners closely with the Bellevue Department of Child and Adolescent Psychiatry to meet children's clinical and mental health needs. An onsite team that include professionals in psychiatry, psychology, and social work provide assessments, counseling and crisis intervention, as well as training and consultation for ACS Children's Center staff.

We are implementing more community meetings with youth, as a way to consistently check in, allow youth to express ideas and concerns, and problem-solve around challenges. While our goal is for youth to feel safe and empowered to express themselves, we have also instituted a feedback/suggestion box where youth can anonymously share any concerns or suggestions they may have. ACS is also working with Save Our Streets (S.O.S.) to bring credible messengers and restorative justice practices to the Children's Center, and to implement a Youth Council—all with the goal of reducing incidents on and offsite and engaging youth in positive activities and behaviors. These practices are crucial to incorporate youth voice into our practices and build community with the young people who are with us, even if only for a short time.

Programming:

The Children's Center provides a wide range of educational, recreational and social-emotional programs that are delivered both on-site and off-site in partnership with community organizations, the NYPD, the Department of Education and other partners.

The goals of our programming are to reduce the impact of trauma, provide enrichment and recreation, meet children's social and emotional needs, provide life skills and social skills, and to enhance safety by reducing idle time.

We have long-standing trauma reduction programs with Culture for One, the Pajama Program, and others. Many new programs have been added during the past few months, including collaborations with the Lower East Side Girls Club and the National Arts Club.

We hold celebrations for holidays and special occasions, including our Second Annual LGBTQ Pride event and Puerto Rican Heritage Month celebration this month. Programming is key to helping reduce trauma and provide connection and enrichment, and we greatly appreciate the assistance of the community and the local elected officials in our program development efforts. This summer, youth at the Children's Center are participating in DYCD's Summer Youth Employment Program (SYEP), participating in an NBA Basketball Camp at Chelsea Piers, attending summer school, participating in Creative Art Works, and spending time at the Asser Levy swimming pool and gym and the Tony Dapolito Recreation Center. Many of our providers will continue programming over the summer, including Planned Parenthood, Culture for One, New York Road Runner, the Good Dog Foundation, and Beautiful Me. We will continue our Friday Movie Night, Saturday Bingo Night and Sunday Karaoke/Dance Night, and also organize basketball tournaments and ping pong tournaments. We have a number of trips already organized including FDR State Park, Splish Splash Water Park, Great Adventure, Playland Park, Coney Island, and the Bronx Zoo.

ACS is also leveraging an additional $1.0 million in funding to expand programming at the Children's Center in the coming year. Again, we thank our partners at OMB and the Mayor's Office for working with us to achieve this important priority. We are looking forward to expanding onsite and offsite programming to engage children and youth while they are at the Children's Center.

Staffing and Training:

I am deeply grateful to the staff who dedicate each day to caring for children at the Children's Center. The team at the Children's Center includes child care staff, social workers, a pediatrician and a team of nurses, staff that design and implement programming for children and youth, placement specialists, and an onsite team of mental health professionals from Bellevue Hospital. Their jobs are incredibly challenging and rewarding, and I want to be sure to use this opportunity to thank them for all that they do.

We are focused on building our workforce of highly-trained, dedicated individuals who meet children at their most vulnerable moments. In addition to Assistant Commissioner Bauer, we also added a new Deputy Director for Programming to join the dedicated team of staff who are working to continually expand and target programming opportunities to meet the needs of children and youth.

We regularly assess the staffing needs at the Children's Center to maintain the correct staffing ratios as the census fluctuates, and to minimize the use of temporary staff. As a result, and given the high priority of the Children's Center and the children

we serve there, ACS worked with our partners at OMB and the Mayor's Office, who authorized the hiring of an additional 95 staff for the Children's Center over the coming months. This will include 49 positions in the Child Care Department, 12 social workers, 9 positions in the Office of Placement, 3 positions in our Programming and Wellness Department, and 22 positions in the Intake Department including engagement specialists and visiting specialists.

We are also working hard to enhance training and professional development for the Children's Center workforce, to equip staff with the tools they need to keep children safe and help minimize trauma. As such, we are now adding two new dedicated positions within the ACS Workforce Institute to exclusively focus on providing training and professional development for Children's Center staff.

In addition to training on Safe Crisis Management, a trauma-informed de-escalation and crisis response protocol, Children's Center staff participated in 19 different training sessions from January through May on other topics. These included safe sleep, suicide prevention, working with children with autism, trauma and its effect on brain development and providing culturally competent services for Lesbian, Gay, Bisexual, Transgender, Queer and Questioning youth. We also work with partners including Safe Horizons, Bellevue, and others to offer training for staff on important topics like human trafficking prevention and engagement with youth exposed to trauma.

Medical Care:

Tending to the medical needs of children who come to the Children's Center is a critical component of our work. We have on-site or on-call pediatric physicians or nurse practitioner and nursing coverage 24 hours a day, 7 days a week. In addition to medical care, children and youth at the Children's Center are evaluated and provided with dental care and vision care.

The Medical Director and the Nursing staff are able to identify medical needs of the children by conducting a physical examination, and reviewing information from the caseworker, previous medical records, and the school as these become available. A comprehensive care plan is then developed and medical needs are addressed throughout the child's stay at the Children's Center. The Medical Director has daily check-ins with nursing staff, communicates daily with the Child and Family Specialists regarding the appropriate level of care, and attends weekly meetings with the Office of Placement Administration to provide advice on the placement of children and youth with complex medical needs. In addition, the Medical Director updates ACS's Chief Medical Officer on any child or youth at the Children's Center with complex or acute needs.

Education:

When children have experienced trauma and disruption, school is a crucial thread of continuity. This is why we are intensely focused on making sure that children at the Children's Center are able to attend their home schools when in their best interest, and that youth who have been disconnected from school prior to coming to

ACS are reengaged and supported to continue their education. For younger children and those with special needs, ACS transportation services accompanies the children to and from school each day. We have implemented a shuttle service to the 14th Street subway hub so that older youth can more easily get to their needed destination. Our local Neighborhood Coordination Officers (NCOs) have been incredible partners in this effort by meeting with older youth on site and providing mentorship about the importance of education.

To better serve our young people who require alternate education pathways, we established an on-site high-school equivalency program with our partners at the NYC Department of Education where older youth can meet with a guidance counselor, take the high school equivalency tests, and attend classes to get their education back on track.

Safety:

ACS is committed to a safe environment for every child who comes to the Children's Center and every staff member who works there. It is critical that children and youth who come to the Children's Center, at what is often one of the most traumatized moments in their lives, feel safe in our care. Safety is an essential component to creating a therapeutic milieu to begin to address trauma, so children and youth can begin to heal and to thrive.

To do this, we increased the number of peace officers at the Children's Center, which has enabled them to spend more time on the floors where children and youth

reside, interacting with youth and staff and making them feel safer. Peace officers, as well as the other Children's Center staff, have been trained in Safe Crisis Management.

ACS has also renovated the entry screening room so that it has more space and can enable staff to better find and confiscate any potentially dangerous contraband. We completed construction to expand the screening room last month, and it is fully operational. We have an invaluable partnership with the local 13th Precinct, which involves both youth enrichment activities and security support in the external environment, and I cannot thank our NYPD colleagues enough for their dedication to our efforts to help ACS remain a good neighbor in the community.

Facilities Enhancements:

Given our changing needs at the Children's Center, ACS has been making some short-term facility enhancements, as well as developing a longer-term renovation plan. We recently renovated the security screening room and installed additional security cameras. This summer, new recreational furniture, new beds and dressers, and wi-fi will be in place, and we are moving some unrelated administrative operations out of the building, which will allow us to expand the space available for programming for children.

We are also working with DDC on a longer-term capital plan, which will include creating an additional intake area, relocating the nursery to the first floor, renovating the second floor and turning the auditorium into a gymnatorium.

Reducing the Length of Stay and Census at the Children's Center:

Our immediate and longer-term efforts to enhance services, supports and safety for everyone at the Children's Center are critically important. Of equal importance and focus, ACS has been identifying additional ways to reduce the length of stay for children at the Children's Center and to establish more options within our care continuum to serve older youth. While nearly half of all of the children who come to the Children's Center are there for less than 24 hours, and two-thirds leave within 4 days, there is a relatively small number of high-need children and young people for whom placement is more complex and can take longer. We are in the process of recalibrating our system to best serve the full range of young people who reside at the Children's Center, and expedite the process of identifying the most appropriate placements for all of them. We have already taken key steps in this area and more are on the way, including:

- Added case planners to the Children's Center to focus on finding kin or other foster care placements.
- Enhanced proactive case planning and home finding for youth in detention who are likely to be discharged soon and who do not have a family resource.
- Instituted a Family Finder pilot with three of ACS's foster care providers who will help find kin resources and provide prevention services for long-stayers at the Children's Center and Youth Reception Centers.
- Created 144 new therapeutic family foster care slots, which is a family-based foster care setting where the child receives specialized services for youth with

moderate to severe behavioral or emotional issues, while living with a specially trained foster parent.

- Added residential care capacity, including 8 new beds already in use with our provider Abbott House and 11 new beds through our provider Cardinal McCloskey.
- Collaborating with DOHMH on interventions for high needs youth 18 and older who have serious mental health issues, by referring these youth to the DOHMH Intensive Mobile Treatment (IMT) and Forensic Assertive Community Treatment (FACT) programs.

In addition to these efforts already underway, ACS is continuing to explore and identify additional placement options. We have recently identified a new residential care site within ACS's portfolio that is planned to open in the coming months to serve eight high-needs youth. We are working closely with the State Office of Mental Health (OMH), state OCFS, and NYC DOHMH to pursue the development of a new program tailored to youth who need higher levels of care. We are also continuing to work and advocate with the State Office of People with Developmental Disabilities (OPWDD) to enable our youth who reach age 21 to be placed into the OPWDD system if their long-term care needs can best be met in that system.

Community Engagement

Building our relationship with the neighbors, tenant associations, community-based organizations and elected officials in the Children's Center Manhattan

community, has helped us develop important collaborations with community members and the many programs and services nearby.

In the Fall of 2018, we created a Community Advisory Board because we wanted to engage all of the stakeholders in supporting the critical work at the Children's Center. I want to be sure to use this opportunity to thank the members of our Children's Center Advisory Board, which includes elected officials, the local Community Board, Bellevue, the NYPD, program partners, neighbors, tenant associations, and other leaders from the Children's Center neighborhood. These members have been committed to helping us problem-solve issues in the community, provide ACS with connections to local assets including programming in the nearby parks, at the Lower East Side Girls Club, the National Arts Club, and more. They have been ambassadors to help demystify our work at the Children's Center and to carry important messages, like foster parent recruitment, to the community. A special thank you to Council Members Powers and Rivera, and your incredible staff, for your work with us on the Advisory Board.

Int. 1358-2019

ACS appreciates the City Council's interest in data regarding the prescribing of psychiatric medication to children in foster care. We are well-aware of the national trends showing high rates of psychiatric medications being prescribed for children in foster care. During my service in the federal Administration for Children and Families in

the Obama Administration, I became familiar with this disturbing national pattern, and came to NYC ACS determined to address it.

Because of ACS's deep concern about these problematic prescribing trends, we have drafted a new policy, and issued guidelines while the policy goes through the finalization process, that aim to make NYC a leader in this area. The policy was released for public comment and is now with OCFS for final approval.

This new policy, and the interim guidelines, seek to ensure psychiatric medication is used sparingly and judiciously with children and youth in foster care with a well-established medical need. To do this, the policy seeks to ensure psychiatrists document a clear indication for use of medication (as an element of a comprehensive treatment plan) based on a recent psychiatric examination, after having first considered and implemented other treatment options including trauma-informed therapeutic services. When medication is recommended, no more than one medication should be prescribed at a time (except in extreme circumstances), the child should be monitored regularly, and medications adjusted so that the minimum effective dose is used at all times. Clinically speaking, there are good reasons that a medication may be necessary at a certain point in time, but we want to ensure that prescribers are routinely checking whether the minimal effective dose is being used (or if the medication is required at all). Efforts should be made to taper off/discontinue medication after a certain period, so that youth receive the lowest effective dose.

ACS's foster care providers are also required to get parental consent whenever possible, and ACS has a stringent oversight and approval process for any parental

over-rides in instances where necessary for children's well-being and we are legally authorized to do so. When youth are over 18, married, or parenting, the youth is able to make the decision to consent on his or her own. ACS psychiatrists also regularly provide consultations to foster care agencies and parents regarding psychiatric medications, their impact, and the alternatives.

Our new policy aims to strengthen parental engagement in the decisions around the use of these medications. The new policy will require more detailed written consents for parents, strict time limits on the provision of these medications before the need for a new consent and review, and additional steps to prevent the prescription of multiple psychiatric medications. We are eager to implement this policy as soon as it is approved by our state oversight agency, OCFS.

Like the Council, ACS believes that having data about the systemic use of psychiatric medications would be valuable. Currently, in addition to our oversight in individual cases, ACS has a Medical Audit Unit, which conducts annual reviews of the health and mental health care the children in foster care receive. But while the prescription of these medications needs to be individualized, data about aggregate use and trends would provide us with insight into our system as a whole.

Currently, ACS does not have access to the data that the Council is requesting, but we are advocating for access to aggregated data about the use of psychiatric medications in our foster care system. The data are currently collected in the Medicaid data system, overseen by the State Department of Health (DOH). These data, like all health data, are protected by strong privacy laws and regulations. Given our

responsibilities, ACS believes that it is critical for us to have this information to ensure that medications are being appropriately administered, so we have requested access to the information from our state partners, OCFS, OMH, and the DOH.

One of the recommendations of the Foster Care Task Force was to advocate to the State to provide ACS with access to the Psychiatric Services and Clinical Knowledge Enhancement System (PSYCKES), which is a web-based portfolio of tools that uses data from the NYS Medicaid claims database to generate data about diagnoses and treatment, including psychiatric medications prescribed. ACS has been in conversations with OMH and OCFS about getting access to the information in this system, and we are optimistic that this will be resolved. Once we gain access to PSYCKES, we believe that we would have much of the information the City Council is looking for in this bill. We would welcome the opportunity to talk more at that time about what data we can publicly report and provide to the City Council.

In addition, children in foster care are due to transition into Medicaid Managed Care in October 2019. As part of our conversations with the state about this transition, we have also been advocating to get access to more aggregate-level data regarding the health and mental health of children in foster care. It is our understanding that after the transition to managed care there should be additional linkages to medical data in the system of record, Connections. We are continuing to advocate for this as well.

Conclusion

Thank you for the opportunity to discuss our work at the Children's Center, the ways in which we are enhancing the services that we provide when children first come into foster care, and our efforts to ensure psychiatric medications are prescribed as judiciously as possible for children in foster care. I thank the Council for your leadership and steadfast support, and I look forward to our continued partnership. I am happy to answer your questions.

We see what can be.

Testimony of Good Shepherd Services
Before the NYC Committee on General Welfare
Chair: Council Member Stephen Levin
Re: Oversight: Nicholas Scoppetta Children's Center and Residential Care
Michelle Yanche, Associate Executive Director, Good Shepherd Services
June 25, 2019

Good Morning. I am Michelle Yanche, Associate Executive Director for Government and External Relations at Good Shepherd Services. My testimony today will focus on the need for investment in residential care.

Good Shepherd Services goes where children, youth, and families face the greatest challenges and builds on their strengths to help them gain skills for success. We provide quality, effective services that deepen connections between family members, within schools, and among neighbors. We work closely with community leaders to advocate, both locally and nationally, on behalf of our participants to make New York City a better place to live and work.

Good Shepherd Services has been operating residential group programs since the 1930s and has extensive knowledge and experience running residential programs throughout New York City. We currently operate three group residential programs, all funded through ACS. Our General Residential program is for 30 young women in an open setting, where the young women are able to come and go to school or jobs in the community, maintain regular contact with their families and participate in social activities, while still being in a safe and structured environment where they are provided with comprehensive services to resolve the problems that led to placement and prepare them for independent adulthood; the Rapid Intervention Center which houses 16 young women provides a comprehensive psychological, psychiatric, medical and educational evaluation by professional staff to fully assess their needs and determine the best possible long-term solution for ongoing care; the Youth Reception Center which is for 10 young women provides a short-term placement with educational, health, and mental health services, while youth wait for placement in other settings.

CRISIS IN RESIDENTIAL CARE

We are all aware, as we have seen in media coverage and today's testimony bears out, that steps were needed to bolster the Children's Center to ensure that the children who pass through it do so as briefly as possible and, while there, receive the care they need, a proper assessment and a smooth connection to a next step where their needs can be better addressed. But the struggle to serve these young people well is not contained by the walls of the Children's Center – it also extends to our programs. We providers are struggling with some of the same challenges and with the same youth and our capacity to do this well is equally strained. What is needed is a <u>systemic solution</u> and a <u>systemic investment</u> for these kids, who also come to us. We are hopeful about ACS efforts to create an immediate plan to address this urgent situation, as it has been at an urgent level for over two years.

Part of what is needed is to provide additional staff and supports at the Children's Center, to better diagnose and treat the youth and to move more of the kids, especially the older ones, out of the Children's Center and into longer-term stable settings including our programs. We stand ready to partner in this effort with ACS, and with OMH, Bellevue and other mental health service providers, but in order to do so effectively we also must be better and more-fully resourced to meet the needs of the youth with the highest needs.

We are already struggling in our residential programs with this same population of very high-need youth at the same time that we have seen our capacity become increasingly strained by staff loss to ACS, which is able offer much higher salaries ($15,000 more) and better benefits than we can. We too often are unable to hire and keep staff due to contract funding constraints that drive low wages and the incredibly challenging conditions, including violent behavior at times, our staff face as this is an intrinsic part of working with this population. We have been working with ACS and raising this issue for almost two years, and add our voices to the call for the investment of resources in the residential system. Without a solution to address the situation, it will only become more urgent.

The youth who walk through our doors come only from the Children's Center, and we know from our initial assessment that they come to us with highly complex trauma histories. This plays out in behavioral, mental health and substance abuse disorders that require a high level of services and trained staff. Additionally, we are seeing high rates of girls who are being commercially sexually exploited, which we have limited resources to curtail and few resources to which to refer them. To provide the services these young people need, we providers need additional resources. We need the State

and City to work with us to explore models, interventions and in invest the necessary funding to ensure that the children in our care are receiving the essential services they need for success.

We and our fellow providers are at a tipping point and as you may know some have shifted capacity to provide a Raise the Age (RTA) program as the funding, staffing and program model for that program better addresses the very issues we have raised. With planning of Phase 2 of RTA beginning this summer, it is quite possible that additional residential beds may be shifted towards this model in lieu of any concrete steps being taken to invest in this system and address the issues outlined above.

We are firmly in support of ACS providing their staff at the Children's Center what is needed to ensure a safe, nurturing and short-term stay for the children who must reside there. But a systemic response to this crisis requires that all staff – both ACS's and ours – serving these youth must be properly qualified, properly trained AND properly recompensed for this important work. We cannot do this without changes to the way our contracts and our work are resourced. Like the Children's Center, we also need to provide better staffing ratios, a higher level of services, and stronger support from ACS when youth are posing a threat to other youth, to our staff and to the community.

Thank you.

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TESTIMONY

The New York City Council
Committee on General Welfare
Stephen T. Levin, Chair

The Nicholas Scoppetta Children's Center
& Int. 1358-2019

June 25, 2019

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The Legal Aid Society thanks Chair Levin and the members of the Committee on General Welfare for this opportunity to share our perspective on the conditions for children in foster care at the Nicholas Scoppetta Children's Center and to express support for Int. 1358-2019, a bill that would improve oversight of psychiatric medication for children in ACS custody. We are gravely concerned about the dangerous mix of problems occurring at Children's Center, including holding too many children at the facility, keeping them there for far too long, failing to provide of adequate services and supervision, and engaging in an overreliance on police surveillance and arrest. We urge the City Council to do everything in its power to ensure that children brought to the Children's Center do not exit the Center's doors more traumatized than when they arrived.

As you are aware, The Legal Aid Society is the nation's largest and oldest provider of legal services to low income families and individuals. The Society operates three major legal practices – Civil, Criminal and Juvenile Rights – providing comprehensive legal services throughout New York City. The Legal Aid Society's Juvenile Rights Practice provides legal representation to children who appear before the New York City Family Courts in all five boroughs, in abuse, neglect, juvenile delinquency, and other proceedings affecting children's rights and welfare. Last year, our staff represented some 34,000 children. Our perspective comes from daily contact with children and their families, and frequent interactions with the courts, social service providers, and State and City agencies whose practices impact our clients and their families. In addition to representing many thousands of children each year in trial and appellate courts, The Legal Aid Society pursues impact litigation and other law reform initiatives on behalf of our clients.

Persistent Problems at the Children's Center

The Children's Center is intended as a temporary residence for children coming into foster care until a permanent placement is found.[1] Most of the children entering the doors of the Children's Center have just been removed from their parents or families. This forcible separation of children from their parents can cause irreparable harm and bring lifelong consequences to the health and wellbeing of both the children and their parents.[2] Put simply, it can be terrifying for a child to be torn from all that they know and thrust into an unfamiliar institution away from their families. Because of this vulnerability, it is imperative that the Children's Center is a friendly, safe, supportive and temporary stop for children coming into foster care. Unfortunately, the Children's Center is failing on all fronts.

We focus our testimony on four main areas of concern. First, the alarmingly high number of children at the Children's Center is compounded by anecdotal evidence that children are held at the Children's Center for weeks, months and even over a year. The Children's Center, intended to be a "temporary, short-term residence for children awaiting long-term placement," is not designed to serve the long term needs of any children. Second, we remain concerned about the interaction and involvement of law enforcement at the Children's Center, including increased number of youth arrests and police access to youth while they reside at the Center. Third, we continue to hear about the inappropriate use of restraint and inadequate supervision provided to youth at the Children's

[1] https://www1.nyc.gov/site/acs/about/acs-divisions.page
[2] See, e.g., American Psychological Assn, Parents and Caregivers are Essential to Children's Healthy Development, available at http://www.apa.org/pi/families/resources/parents-caregivers.aspx; Sankaran, Vivek, Church, Christopher, "Easy Come, Easy Go: The Plight of Children Who Spend Less than 30 Days in Foster Care," 19 U. Pa. J. L. Soc. Change 207 (2017).

Center. Fourth, we are concerned about youth's access to educational services and support while residing at the Children's Center. Any one of these issues is alarming; taken together, this multitude of issues occurring in a place where vulnerable children enter the foster care system calls for immediate action.

High Population and Long Stays

The Children's Center, designed to house fifty-five children,[3] has been over capacity consistently since at least December 2017 and most likely throughout 2016 and 2017. ACS's own data indicates that since at least December 2017, the average number of children at the Children's Center has been 70 or higher.[4] In February 2019, the average number of children reached a high of 87. In March 2019, the last month for which data is available, there were 78 children at the shelter, including 13 babies and toddlers and 21 children under 10 years old.[5] The issue is not simply a surge in children at the Children's Center, but a corresponding dramatic increase in the length of their stay.

As former ACS Commissioner Gladys Carrion stated, the Children's Center is "designed [as a place] for children to be for a couple of hours, not even days."[6] It certainly is not the least restrictive, most homelike setting to which children are entitled. Yet youth, particularly those with higher needs and adolescents generally, are languishing at the Children's Center and suffering as a result. As an example, one 11 year old client with multiple diagnoses, including severe autism,

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[3] https://www.nbcnewyork.com/investigations/i-Team-Exclusive_-ACS-Children_s-Center-Beyond-Capacity_New-York-397146051.html
[4] https://www1.nyc.gov/site/acs/about/flashindicators.page
[5] https://www1.nyc.gov/assets/acs/pdf/data-analysis/flashReports/2019/04.pdf
[6] https://www.nbcnewyork.com/investigations/i-Team-Exclusive_-ACS-Children_s-Center-Beyond-Capacity_New-York-397146051.html

remained at the Children's Center for almost 4 months because ACS reportedly could not locate an appropriate foster home for him. Given this child's condition, it was imperative that he be immediately placed in an appropriate home with a caretaker that could provide him with individual attention and structure. While at the Children's Center, our client did not receive any evaluations nor was he provided with any therapeutic treatment. He was also denied adequate care to manage his health needs, including appropriate nursing services he is entitled to receive and had been receiving while in the care of his mother. Unsurprisingly, our client regressed significantly during his stay. His school reported that he was exhausted and had poor personal hygiene. Even though our client had been successfully toilet trained for several years, he began wearing diapers. He was harassed and spat at by other residents and had his jacket and Christmas gifts stolen. After repeated requests from his attorney, ACS's Office of Placement (OPA) reported on their attempts at finding a home for our client. The OPA reports indicated that after five agencies reported no vacancies in their Medical Foster Boarding Homes, OPA also sought placement in Treatment Family Foster Care. It is not clear that the determination regarding his needed level of care was based on a comprehensive assessment of his needs, since, if anything, his needs increased while at the Children's Center. Regardless, of the 17 agencies that provide therapeutic foster homes, 11 reported no vacancies at all and the six remaining indicated they did not have a therapeutic foster home that could meet his needs. Finally, after almost 120 days, ACS placed our client in a foster home. Unfortunately, assessments needed to implement his service plan and determine his eligibility for additional supports had not been completed before the move, delaying critical services to meet his needs.

In addition to this egregious example, we have several clients at the Children's Center and other pre-placement reception centers that have been there for at least 30 days, and some as long as 16 months, waiting for placement. While some of these youth have higher needs, many are simply waiting for an available foster home. For example, one of our 14 year old clients remained at the Children's Center for 16 months waiting for a foster home. And as these children wait, many are not provided with proper case management services, adequate medical and mental health care or educational services.

These issues become even more urgent in light of the recent, incredibly troubling experience of another client. This 11 year old was removed from her grandmother due to alleged sexual abuse. ACS has reportedly been unable to find a foster home for her because of concerns regarding her own problematic sexual behavior. Despite Bellevue Hospital staff assessing our client and recommending treatment by a particular therapist, ACS has failed to authorize payment and our client has not had the recommended therapy nor, to our knowledge, any other therapy while at the Children's Center. After more than 100 days at the Children's Center, apparently without treatment, she attempted suicide. While no longer there, this client's experience highlights how dangerous ACS's practices are for the vulnerable children in its care.

ACS has taken steps to implement new procedures at the Children's Center in order to identify children with special needs at intake and ensure a service plan is created. We applaud these measures, however, more must be done to address the significant delays in foster care placement for **all** children at the Children's Center. Although ACS has made some progress in identifying

children's needs, there must be improvements in the placement process and in the placement array so children do not languish at this facility for weeks and months.

Law Enforcement Approach

One immediate repercussion of housing so many children, each of whom are in crisis, acutely experiencing the trauma of family separation and or a failed placement elsewhere in one facility is that it becomes significantly more difficult for ACS to manage the children housed in the Children's Center. We obviously agree that it is essential for all children to feel physically secure at the Children's Center and we appreciate that ACS is seeking to reduce the serious harms that some children are experiencing there. Nonetheless, we remain concerned that ACS appears to be relying heavily on law enforcement to address some of these issues and that such an approach undermines the well-being of the children in their care. As reported in the press recently, several anonymous ACS staff members came forward to describe overcrowding and unsafe conditions at the Children's Center. In response, ACS' official statement, published on March 16, 2019, emphasized that ACS is "increasing the number of peace officer[s] on-site, installing additional security cameras, and working even more closely with NYPD."[7] Increasing the involvement of NYPD represents an outdated and dangerous approach to handling supervision issues or addressing challenging behaviors of children in foster care.

We have also received anonymous reports from ACS staff that express outrage at what is viewed as a culture shift at the Children's Center – from "protecting" to "celebrat[ing]" and

[7] *NYC Moves to Protect Children at Foster Care Intake Center After I-Team Report*, NBC New York, Mar. 16, 2019.

"track[ing] when a child is arrested" while residing at the Center. We have been told that 60 youth have already been arrested from the Children's Center this year and ACS security officers are being trained in arrest procedures and identifying and gathering gang intelligence. An increased police presence has also been reported at the Center. These reports paint a picture of a facility desperate to control and lower its high population through measures to the detriment of the children in its care.

Anecdotally, we have also seen an increase in the number of clients who have been arrested, either directly from the Children's Center or while placed there, for actions directly connected to their needs and disabilities and to the lack of appropriate supervision and treatment available to address their needs. For example, one of our clients has been repeatedly arrested at the Children's Center after being there for over a year. With no other available placements for this older youth, who had been in foster care for eleven years, ACS contended that the Children's Center – which is not a placement – was the only place for her. After one arrest while at the Center, the prosecuting attorney was persuaded to file higher charges after staff insisted that the young person "be taught a lesson." This troubling attitude toward young people is consistent with that reported by anonymous ACS staff.

Beyond arrest, we are concerned that the Children's Center unduly allows police access to children in its custody. To our knowledge, ACS does not have a Children's Center policy with regard to warrantless access by police or questioning of youth by law enforcement. We are concerned that law enforcement is permitted to enter the building and have access to and question youth without ACS first contacting the youth's parent or attorney. As children in their legal custody, ACS has the responsibilities of a parent and must act in the best interest of the children in its care.

First, ACS should require a warrant before allowing police to enter the building in search of a young person. The Children's Center is considered the youth's residence and as such ACS should not allow warrantless entry. Second, ACS should not permit police to question youth unless and until the youth's attorney has given permission.

This is especially important because children are fundamentally different from adults and there must be additional protections against any waiver of the right to be silent that is not "knowing, voluntary, and intelligent." As ACS is aware, it is firmly established that brain development continues past age 21.[8] As a result, youth are not yet able to consider the long-term consequences of their actions or to resist environmental pressures as well as adults. Adolescents especially struggle to process information and make sound decisions in stressful situations, such as during police questioning.[9]

Leading professional organizations with expertise about children agree that children should speak with an attorney before agreeing to be questioned by police due to children's developmental limitations. ACS is not qualified to waive *Miranda* rights on behalf of youth. And the presence of ACS staff does not adequately ensure that a child makes a knowing, voluntary and intelligent decision with respect to his or her *Miranda* rights. ACS staff often have conflicting interests and may misunderstand the meaning and nature of the rights the youth is being asked to waive. A youth's attorney would offer expert, objective advice to young people about their right to remain

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[8] Linda B. Chamberlain, *The Amazing Teen Brain: What Every Child Advocate Needs to Know*, 28 A.B.A. CHILD. L. PRAC. No. 2 at 17-18 (April 2009).
[9] See Goldstein et al., *supra*.

silent and their ability to waive this right and speak to the police. ACS must prohibit questioning unless and until the youth has consulted with an attorney and agreed to waive their *Miranda* rights.

The overreliance on law enforcement at the Children's Center will only serve to fuel the pipeline of children of color from child welfare into the justice system. Moreover, ACS cannot ignore that the acts precipitating law enforcement's involvement are often a manifestation of the youth's trauma and disabilities and that these interactions could be averted if youth were offered stability through a timely foster care placement. ACS must instead respond by increasing case work staff, ensuring timely access to needed services and treatment, improving training and making certain that the Children's Center is a short-term stay for youth.

Supervision and Training

Finally, while we appreciate that ACS has made several improvements to the staffing and programming at the Children's Center, we continue to hear about a lack of adequate supervision by and training of Children's Center staff that places all children there at risk of physical and psychological harm. Our clients report dangerous restraints and excessive force by untrained staff, as well inadequate supervision leading to fear of or actual harm from staff and other children at the facility. For example, one nine year old client reported multiple restraints by a male staff member, one of which resulted in the child face down on his stomach on the floor with his hands behind his back. Prone restraints like this are prohibited at the Children's Center, as they are in virtually every other child-serving setting in New York State. On another occasion, the same staff member, while holding a stick, reportedly told children around him that "somebody is about to start getting hurt." Finally, another client reports being repeatedly punched in the head by a staff member after reacting

to that staff member saying "if you have a mother, why are you here?" These are just some examples of clients' experiences with the inappropriate supervision and abuse and misuse of restraints by staff resulting in their physical, mental and emotional injury.

Although we recognize ACS has increased staff training opportunities, there may be little impact on actual practice without additional training requirements and quality assurance measures to confirm that training principles and practices are adhered to. ACS must do more to ensure basic safety of children at the Center, including increasing case work staff, increasing training requirements, and providing appropriate oversight over restraint procedures.

Educational Services and Support

When youth enter foster care and are separated from their families, school can be a source of great stability and comfort. Under the federal Fostering Connections to Success and Increasing Adoptions Act, youth in foster care (including youth at the Children's Center) are entitled to remain in their school of origin if it is in their best interest to do so. In recent years, ACS has started to provide transportation services to facilitate school attendance for youth at the Children's Center. We hear concerns, however, that there are sometimes delays in setting up transportation and that children are not transported to school during the first few days of their stay at the Children's Center. We also hear complaints that children are sometimes dropped off late in the morning and therefore miss important instructional time.

In some circumstances, clients have told us that the Children's Center has prohibited them from attending school. Anecdotally, this seems to happen most often when the client has a history of school truancy, but ACS does not seem to have firm procedures or standards for making a

determination that a youth should not be permitted to attend their school. Further, ACS does not have adequate arrangements in place to provide alternative educational services to these youth, or to youth at the Children's Center who do not attend public school (e.g., youth who are home-schooled by their parents or who are not enrolled in school at all).

Finally, the conditions at the Children's Center are not conducive to supporting children's academic success. Youth must have access to homework help, including computers, research materials and other supplies they need in order to complete their assignments. Placement in foster care should not lead to school absences and academic failure.

Int. 1358-2019

We strongly support Int. 1358-2019, a bill which would require ACS to collect and report data about the prescription of psychotropic medication for children in its legal custody. The bill fills a critical gap in systemic oversight over the prescription of these medications to this vulnerable population and will more closely align NYC child welfare monitoring practices with national standards.

Psychotropic Medication and Children in Foster Care

Psychotropic or psychiatric medications are prescribed to treat symptoms of a mental, emotional, or behavioral disorder. These powerful drugs directly affect the central nervous system. There are several types of psychotropic medications, including antipsychotics, antidepressants, stimulants and antianxiety drugs. When prescribed appropriately and monitored closely these drugs can have significant benefits for those with mental health conditions.

Studies consistently reveal significantly higher rates of psychotropic medication use for children in foster care than in the general population. For example, one study estimated that the rate of psychotropic medication use for youth in foster care varied by state from 13 to 52 percent, compared to about 4 percent for youth in the general population.[10] Another study found that children in foster care were prescribed antipsychotic medication almost nine times more often than children not in foster care (12.37% versus 1.4%).[11] This study further found that one in five children were prescribed two different antipsychotics, and more than one in ten children received four or more psychotropic medications.[12]

Many children in foster care exhibit behaviors related to the abuse and trauma they have endured, either prior to or as a result of their placement in foster care. All too often, these children are denied adequate therapeutic counseling and mental health support to treat underlying issues, but are instead given powerful psychotropic medications without any additional services.[13] Although these medications can have significant benefits when prescribed appropriately, they can conversely cause profound and at times permanent adverse effects including psychosis, suicidal thoughts, development of diabetes, irreversible movement disorders, rapid weight gain and other life-threatening conditions. These drugs can be even more harmful if improperly used or combined with

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[10] *Multi-State Study of Psychotropic Medication Oversight in Foster Care*, Tufts Clinical & Translational Science Institute, Sept. 2010.

[11] Data based on the states studied. *Antipsychotic Medication Use in Medicaid Children and Adolescents: Report and Resource Guide From a 16-State Study*, Medicaid Medical Directors Learning Network/Rutgers CERTs, June 2010.

[12] *Id.*

[13] Indeed, the New York State Office of Children and Family Services has stated the importance of trying "a variety of alternative interventions before prescribing medication. Medication should not be the sole component in the behavioral plan." *The Use of Psychiatric Medications for Children and Youth in Placement*, OCFS Informational Letter (2008).

other medication.[14] Moreover, there is little research on the impact of these drugs on the developing brains of children and many of these medications have not been approved by the U.S. Food and Drug Administration as safe and effective for children.

These risks are amplified for children in foster care for several reasons. First, they are often living with caretakers who do not have full information or detailed knowledge of their trauma history, mental health needs or medical records. Children are moved frequently between placements and even the agencies employing the foster parents often lack complete medical histories. At the same time, foster parents may lack timely access to therapeutic services for the children in their care and be more inclined to seek a "quick fix" through medication. Similarly, biological parents and youth are not always provided with full information on the benefits and risks of a medication or alternative treatments. In addition, parents may be coerced to consent to medication by virtue of the Family Court proceedings against them. As a result, youth are routinely placed on psychotropic medications without appropriate exploration of alternative forms of treatment, and without proper attention to potential drug interactions, over-medication, and adverse side effects.

It is also problematic when children in foster care are given these powerful drugs without any other supports or services in place. Psychosocial services, mental health treatments and therapies can be used instead of, or in conjunction with, psychotropic medication. Combined treatment of psychosocial therapy and psychotropic medication can be more effective than either treatment alone

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[14] *Promoting the Safe, Appropriate, and Effective Use of Psychotropic Medication for Children in Foster Care*, U.S. Department of Health and Human Services, Administration for Children and Families, ACYF-CB-IM-12-03, April 11, 2012 ("ACF Memo").

for certain conditions.[15] Moreover, for children in foster care who have been removed from their homes, trauma informed therapy can be particularly useful.

Problematic Prescribing Practices

In 2012, the U.S. Administration for Children and Families (ACF) issued guidance to states on implementing effective oversight of psychotropic medications for youth in foster care.[16] Included in that guidance were descriptions of "[p]atterns that may signal that factors other than clinical need are impacting the prescription of psychotropic medications." Referred to as "outlier practices," these practices include "instances where children are prescribed too many psychotropic medications, too much medication, or at too young an age." New York's Office of Children and Family Services (OCFS) has also enumerated specific circumstances that warrant review.[17]

One outlier practice, polypharmacy (the use of multiple psychotropic medications at once), is increasingly prevalent in the foster care population, despite "the lack of supporting evidence and the potential for adverse effects."[18] There is "scant evidence" that using multiple psychotropic medications at once is effective and safe in children. Another potential outlier practice identified by

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[15] *Foster Care: HHS Has Taken Steps to Support States' Oversight of Psychotropic Medications, but Additional Assistance Could Further Collaboration*, U.S. Government Accountability Office, January 2017, at 11 (citing, for example, J. Walkup et al., "Cognitive behavioral therapy, sertraline, or a combination in childhood anxiety," *New England Journal of Medicine*, vol. 359, no. 26 (2008)).

[16] ACF Memo at 8.

[17] Circumstances that OCFS identifies as possibly warranting independent review include: (1) a child prescribed more than three psychiatric medications; (2) a child prescribed more than one psychiatric medication from the same class of medications (e.g., two anti-psychotics); (3) psychiatric medication prescribed for a child younger than 5 years of age; and (4) medications needed to manage target symptoms are causing significant side effects. *The Use of Psychiatric Medications for Children and Youth in Placement*, OCFS Informational Letter (2008).

[18] A 2008 study of children in foster care taking psychotropic medication found "21.3 percent are receiving mono-therapy (one class of psychotropic medication), 41.3 percent are taking three or more classes of psychotropic medications. 15.4 percent are taking medication from four or more classes, and 2.1 percent are taking five or more classes of psychotropic drugs." ACF Memo at 8 (citing Zito, JM, et al., Psychotropic medication patterns among youth in foster care, *Pediatrics*, 121(1):e157 (2008)).

ACF is the prescription of these medications in dosages that exceed recommendations. A lack of specific evidence-based prescription guidelines "reinforces the need for close supervision and monitoring" of children on off-label medication dosages.[19] Finally, ACF identified the outlier practice of prescribing psychotropic medication to very young children, since they are especially vulnerable to adverse effects of psychotropic medications.[20]

Oversight and Monitoring

As a result of these potential dangers, it is imperative that ACS take an active role in both individual and systemic monitoring of these prescriptions for children in its custody. The vital need for rigorous and effective oversight of psychotropic medication use for children in foster care is well established in federal law and best practice. The Fostering Connections to Success and Increasing Adoptions Act of 2008 requires states to develop a plan for the ongoing oversight and coordination of health care services for children in foster care, including mental health care and prescription medications.[21] The Child and Family Services Improvement and Innovation Act amended this provision to require that these plans include protocols for the appropriate use and monitoring of psychotropic medications.[22] Outlining the changes in the law, the federal ACF stated that "oversight of psychotropic medication use is necessary in order to responsibly and effectively attend to the clinical needs of children who have experienced maltreatment" and urged "close supervision and

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[19] ACF Memo at 9-10.
[20] *Id.* at 10.
[21] Pub. L. No. 110-351, § 205, 122 Stat. 3949, 3961-62.
[22] 42 U.S.C. § 622(b)(15).

monitoring" and "careful management and oversight" in the use of psychotropic medications for children.[23]

Additionally, the American Academy of Child and Adolescent Psychiatrists (AACAP) has recommended practices for child welfare agencies in overseeing the mental health treatment of children in foster care, including active monitoring to assure safe utilization of psychotropic medications.[24] AACAP explained that children in state custody "often have no consistent interested party to provide informed consent for their treatment, to coordinate treatment planning and clinical care, or to provide longitudinal oversight of their treatment." Thus, "[t]he state has a duty to perform this protective role for children in state custody."

A variety of quality assurance methods must be used to oversee medication practices "at the client *and agency* level."[25] These methods include a system of tracking medication and all medical history/records for children in foster care, a mechanism for automatic flagging of certain problematic prescribing practices, system strategies to improve the oversight of prescriptions, and other internal quality assurance initiatives.[26] OCFS similarly recommends that local agencies perform system-wide oversight and have the capacity for independent review of psychotropic medication prescriptions for children in its care.[27]

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[23] ACF Memo at 11.
[24] *AACAP Position Statement on Oversight of Psychotropic Medication Use for Children in State Custody: A Best Principles Guideline*, American Academy of Child and Adolescent Psychiatry, 2005.
[25] ACF Memo at 12 (emphasis added).
[26] *Id.*; Leslie, et al., *Multi-State Study on Psychotropic Medication Oversight in Foster Care, Tufts Clinical and Translational Science Institute*, 2010, p. 7; *Recommendations about the Use of Psychotropic Medications for Children and Adolescents Involved in Child-Servicing Systems*, American Academy of Child and Adolescent Psychiatry, 2015, pp. 30-31.
[27] *The Use of Psychiatric Medications for Children and Youth in Placement*, OCFS Informational Letter (2008).

To ensure compliance with federal law, child welfare standards, and OCFS guidance, ACS must develop systemic oversight and monitoring of children in foster care who have been prescribed psychotropic medication. ACS is currently developing procedures to improve its oversight of certain individual prescriptions for children in foster care. Because these plans—as we understand them—fail to ensure comprehensive system-wide oversight, we believe action by the City Council is necessary.

Int. 1358-2019 would address this issue directly by requiring ACS to collect data from each of its contracted foster care provider agencies about the use of psychotropic medication by children in its legal custody. By collecting this data, ACS and City Council will be able to observe prescribing trends for each foster care agency, with the data disaggregated to show trends by gender and ethnicity. The data collected will allow ACS to track problematic prescribing practices on a systemic level and provide feedback to and require corrective action from agencies that demonstrate high rates of these dangerous practices. The bill will facilitate the proper systemic oversight of the prescription of these powerful drugs to this vulnerable population of youth. We urge the Committee to vote in support of the bill and push this important piece of legislation forward.

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Children are languishing at the Children's Center. While there, children are at increased risk of further trauma, encounters with police, school failure, and deterioration due to lack of appropriate services. The Children's Center lacks a family structure preventing children from developing healthy attachments with a parental figure. The issues highlighted in our testimony today are not new; but as

the population at the Center has increased, pressure has built and these problems have become more acute. These problems must be addressed now. We urge ACS and the Committee to recognize that these issues require significant, system-wide reform to ensure that the Children's Center serves as a very brief stop prior to placement with an appropriate resource, as it was intended.

And finally, we strongly support Int. 1358-2019 and its goals of a more robust system of oversight of the prescription of psychotropic medication for children in ACS custody. We hope the Committee will also support the bill and move it forward for a full vote. We thank you once again for this opportunity to address these important issues.

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TESTIMONY OF LAWYERS FOR CHILDREN

To the New York City Council Committees on General Welfare

"Oversight: The Nicholas Scoppetta Children's Center"

June 25, 2019

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Thank you Chair Levin and the Committee for holding this hearing about the ACS Children's Center and providing us with the opportunity to testify.

Founded in 1984, Lawyers For Children is a not-for-profit legal corporation that represents individual children in voluntary foster care, abuse, neglect, termination of parental rights, adoption, custody and guardianship proceedings in family court, and advocates for system-wide reform to improve the lives of children in foster care. This year, we will represent children and youth in more than 6,000 court proceedings. Based on our experience in individual cases, we have also successfully participated in numerous class-action lawsuits and helped to effectuate change in City and State policies and practices to promote good outcomes for all children in foster care.

We are pleased that the Council has chosen to focus on issues at the Children's Center and hope that this hearing will lead to greater accountability for the care and treatment of children who are placed there.

Kenneth's Ordeal at the Children's Center: What No Child Should Endure

The plight of our client Kenneth, (whose case gained the attention of the media this past March[1]), highlights many of the most serious problems that have arisen because ACS operates the Children's Center completely unchecked. Kenneth, was 17 years-old when he entered foster care. He was placed at the Children's Center because ACS failed to find an appropriate foster care placement for him.[2] He remained there for a year, in conditions that are hard to believe actually exist in 21st Century New York City. Kenneth, who is not ambulatory, was without an operable wheelchair for the better part of the year, was not given proper medical treatment, and was not provided with necessary services, including occupational, speech and physical therapy. Kenneth described sitting in his own urine on his broken wheelchair and, wearing clothes and shoes that did not fit him. ACS failed to provide Kenneth with the most basic services despite numerous court orders directing the agency to meet his needs. ACS' failures were so egregious and so inexcusable that a Family Court judge took the rare step of holding the agency in contempt.

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[1] Melissa Russo, Kristina Pavlovic, ACS Held in Contempt for Neglecting Wheelchair-Using Teen Soaked in His Own Urine (March 14, 2019), https://www.nbcnewyork.com/news/local/ACS-Held-in-Contempt-for-Failing-to-Care-for-Wheelchair-Bound-Teen-Soaked-in-His-Own-Urine-506827971.html; Michael Fitzgerald, Is New York State Responsible For Some Long Stayers at the City's Temporary Foster Home? City Child Welfare Commissioner Thinks So, *The Chronicle of Social Change*, (March 29, 2019) https://chronicleofsocialchange.org/featured/new-york-childrens-center-child-welfare-commissioner/34364.

[2] Matter of Kenneth R., 2019 NY Slip Op 29042 at 4 (Family Ct. NY County. Jan. 28, 2019), available at: http://nycourts.gov/reporter/3dseries/2019/2019_29042.htm)

Kenneth's experience highlights many of the systemic problems with the Children's Center, and we urge the Council to enact stronger oversight mechanisms so that no child will ever experience the kind of horror that Kenneth was forced to endure.

Children's Center Licensing & Oversight

Operating without a regulatory framework, oversight, or accountability has greatly contributed to the Children's Center's ongoing problems and has resulted in its failure to meet the needs of too many children entrusted to its care.

When the Children's Center opened in 2001, it was mostly heralded as a welcome relief from its predecessor facilities. According to a *New York Times* report on the occasion of the Children's Center opening, however, the problems we are facing today were predicted from the very beginning. The reporter explained, "Some child welfare veterans see dangers in the very spaciousness and beauty of the new building, that it will become a place where too many children will be kept for too long." But Commissioner Scoppetta "vowed that the new shelter will not become a shelter or orphanage. 'We are absolutely, unequivocally opposed to that,' Mr. Scoppetta said. 'If a kid stays more than 24 hours, it's only because it's a very difficult placement.'"[3]

Of course, those skeptics were incredibly prescient. Staying longer than 24 hours is no longer unusual. Rather, 72 hours is the time by which "most young people" are discharged, according to Commissioner Hansell's March testimony before the Counsel.[4] Even so, ninety children or more regularly spend the night in the Children's Center. Many of those children stay for weeks on end. Some, like Kenneth, stay for more than a year.

While the Children's Center functions as both a shelter for children who stay for just a few days and as an orphanage for children like Kenneth, it does not appear that it is required to comply with the regulatory framework governing either shelters or residential placements. It does not appear that New York State Office of Children & Family Services (OCFS) has licensed this facility or that OCFS or any other agency has any oversight over the Children's Center's operations.

Furthermore, whether our clients are placed in foster homes, group homes or residential treatment centers, Lawyers For Children attorneys and social workers are regularly welcomed to meet with them in their placements. They are invited

[3] Nina Bernstein, New Center for Foster Children Echoes Changes in an Agency, *The New York Times*, June 1, 2001, p. B3.
[4] *New York City Council Budget and Oversight Hearings on the Fiscal Year 2020 Preliminary Budget* Before the City Council Committee on General Welfare, March 25, 2019 (Statement of Commissioner David A. Hansell, Administration for Children's Services)

into our clients' homes and permitted to see where they are living, where they are sleeping, and whether they have appropriate clothing in their closets. These visits allow us to inform the courts that our clients' needs are being met in their homes. At the Children's Center, however, children's attorneys and social workers are routinely denied access to our clients' living spaces. This further limits opportunities for oversight and hampers our ability to represent our clients.

Lack of Placements

Earlier this year, Commissioner Hansell and Deputy Commissioner Farber explained to the Council that there is a shortage of foster care placements for older children, children with developmental disabilities and children with serious mental health challenges, which has led to those children staying at the Children's Center for extended periods of time.[5] ACS has expressed its frustration, asserting that many of these children's needs should be met in either the New York State Office of Mental Health or the New York State Office of People with Developmental Disabilities systems.[6] This is not a new argument. More than ten years ago, ACS filed a lawsuit seeking to force OPWDD to provide care and services for developmentally disabled children who had been placed with ACS. For more than ten years, ACS has been litigating that case to no avail.

Children should not be caught in a turf battle. It is now time for ACS to stop denying responsibility for these children and start providing them with appropriate placements and services.

Today, there is no reason to think that there is a greater number of older children, developmentally disabled children or children with complex mental health needs in foster care compared to when the Children's Center first opened. And, yet, approximately the same number of children spend the night at the Children's Center when there were 31,000 children in foster care[7]. Where have all of those placements gone?

Inadequate Services

Children who spend extended periods of time at the Children's Center are not only deprived of a home. Unlike other children in foster care, they have not historically been assigned a case planner, whose job is to ensure that all of the child's educational, medical, mental health and physical needs are being met. Without a case planner, there is nobody assigned to make diligent efforts to work with the child's family or other resources to try to effectuate the child's discharge from foster care.

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[5] *Id.*
[6] *Id.*
[7] *Id.* at 3

New York State regulations spell out the staffing requirements for group homes and residential placements serving children with higher needs. The regulations set minimum standards for child to staff ratios, required professional personnel, and staff qualifications. The regulations are designed to ensure that placements serving children with higher needs employ a sufficient number of clinicians and professional staff who meet regularly with the children and provide coverage when a crisis occurs. They also set forth the required minimum contacts that the case planner must make with the child and the child's parent each month, to ensure that the child's needs are being met and that appropriate plans are being developed to address the causes of the child's foster care placement. The Children's Center does not seem to be bound by those requirements, despite caring for some of the highest needs children in foster care.

Because of this, children like Kenneth are not getting the attention they require and languish without receiving desperately needed services. It is imperative that every child at the Children's Center be assigned a case planner who is trained to identify service needs, arrange for appropriate evaluations, ensure that the child (and the child's family) is connected to therapeutic interventions, and who will work with the family toward an appropriate permanency goal.

Preventing Criminalization of Young People

We are particularly concerned that in order to address some of the problematic behaviors of children at the Children's Center, ACS has chosen to increase the presence of "ACS special officers to provide additional security,"[8] rather than to increase the use of social workers and other therapeutic staff. We share the goal of ensuring that the Children's Center is a safe place for all children and young people who reside there. However, we want to ensure that law enforcement is not unnecessarily involved in situations that can and should be handled by quality social work practice. "When law enforcement is brought into a non-life-threatening situation with a foster child, the caregivers and the already traumatized children are likely to see the crisis escalate rather than stabilize."[9] Studies have shown that police intervention in non-criminal matters involving foster children "only worsened their precarious situations."[10] Unfortunately, youth in foster care do not easily recover from being detained by the police. An in-depth report on the criminalization of youth in foster care found that "the experience of being arrested, handcuffed and jailed, even briefly, can have lasting impact, from deepened trauma to greater odds of a criminal future."[11]

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[8] *Id.* at 4

[9] County Welfare Directors Association of California, *Family Urgent Response System for Foster Youth and Caregivers* (Apr. 2018), https://www.cwda.org/sites/main/files/file-attachments/ab_2043_fact_sheet_ website.pdf.

[10] Karen de Sá, *et al.*, *Chronicle Investigation: Fostering Failure Dubious Arrests, Damaged Lives,* San Francisco Chronicle (May 18, 2017), https://projects.sfchronicle.com/2017/fostering-failure/.

[11] *Id.*

For these reasons, ACS must only be permitted to invoke security personnel and law enforcement to address issues at the Children's Center when absolutely necessary.

Recommendations

We urge the City Council to exercise its oversight authority over ACS to impose a measure of accountability upon the agency. To that end, we suggest that the City Council exercise its oversight authority by requiring ACS to provide the City Council with the following:

1. Data, including but not limited to:
   - Numbers of children at the Children's Center each night;
   - The length of stay for each child at the Children's Center;
   - The number of children placed at the Children's Center who are non-ambulatory;
   - The number of children placed at the Children's Center who have been diagnosed with an autism spectrum disorder and other developmental disabilities;
   - The number of children placed at the Children's Center who have been diagnosed with complex mental health needs;
   - The steps being taken to develop additional foster care capacity for developmentally disabled children, children with complex mental health needs; and older youth; and,
   - The staff employed at the Children's Center, including job title, minimum qualifications and responsibilities.
2. A policy outlining how case planning and medical, educational and other therapeutic services are to be provided for children who spend more than 24 hours at the Children's Center;
3. A protocol for involving law enforcement/security personnel only when absolutely necessary.
4. A protocol for permitting children's attorneys and social workers to observe their clients' living quarters.

We further urge the City Council to provide ACS with additional funding to ensure that ACS properly cares for all children there by employing a sufficient full-time staff with the training and expertise appropriate to care for developmentally disabled children and children with complex mental health needs. This would include, for example, case planners, certified social workers, behavior modification specialists, and education specialists.

Conclusion

Thank you for your attention and commitment on this issue and to young people in foster care. We are happy to follow-up with you on any questions you may have about our testimony and to assist the Council in developing legislation that will help create oversight/accountability measures for ACS.

Council of Family and Child Caring Agencies
Testimony Presented by Lisa Gitelson, Associate Executive Director
City Council Hearing/Committee on General Welfare Oversight
The Nicholas Scoppetta Children's Center
Use of Psychiatric Medication for Youth in Foster Care
June 25, 2019

Good morning, Chairperson Levin, I am Lisa Gitelson and I am the Associate Executive Director, Downstate, of the Council of Family and Child Caring Agencies (COFCCA). Our member agencies include over fifty not-for-profit organizations providing foster care, adoption, family preservation, and juvenile justice services in New York City and over 100 agencies providing the same services Statewide. On behalf of our member agencies, their thousands of employees, and mostly on behalf of the tens of thousands of children and families that our agencies serve, we thank you for the opportunity to testify before you today.

The Children's Center is intended to provide shelter for children and youth upon entry into foster care. It must be a safe place and children should be there for a matter of days at most. Our foster care residential providers are designed to work with the youth placed with them to allow them to return to community family based settings – their own family or a foster family and to be successful in those homes, in the community and in school. Safety is always paramount but so is treatment.

High Needs Youth/Children Center

COFCCA joins in support and in appreciation of the changes made by ACS for the Children's Center. The ability to do our work with all that is needed is what makes the difference at this critical moment in the life of a child. The addition of intensive case reviews for every child with special needs, security enhancements, expanded high level leadership, additional staff and training of the staff and expanded programming options, allows for meaningful and planful work.

Similarly, the agencies providing services to youth in residential care face the same challenges working with these highest-needs youth once they leave the Children's Center and come to our programs. And, similarly, the agencies need these exact same enhancements to do the meaningful work with our youth. Our residential care centers and the YRCs are doing the same work or are continuing the work started at the Children's Center. For the continuum to be successful, all of the supports must be equal.

We are working with youth that have entrenched trauma-based behaviors, some presenting as a danger to themselves and others. We have youth recently released from incarceration. We care for youth with extraordinarily serious mental health diagnoses, many not treated until entering care. Amongst our youth we have those engaging in criminal activity while in our care. We have youth repeatedly engaging in extremely dangerous, risky and violent behaviors. Our youth living lives marked by intense trauma of different degrees. Just to have entered foster care is a major trauma for any youth.

The same enhancements that have been added to the Children's Center, in addition to many others, are needed by the voluntary foster care to serve these same youth as they transition from the Children's Center to foster care. Most notably, there needs to be the staffing appropriate and necessary to work with these youth. This requires contracts

that are budgets to pay a fair wage in order to hire and retain qualified staff. Our review of the staffing challenges show that for CY18 our nonprofit NYC agencies experienced a 32% turnover rate in Direct Care Worker staff. Additionally, the average starting salary for the Direct Care Workers in NYC hovered right at the $15 an hour mark. We cannot properly serve and make change for the high needs youth in our care when we lose a third of our staff every year and are paying the same base rate as McDonalds. In fact, for many of our youth who have jobs, they are making more than the staff that care for them.

As we approach a new RFP for providing foster care for youth in NYC we are at a moment in time to take action and provide all that we should for these youth. Our agencies have decades of experience working with very challenging youth and would very much welcome an opportunity to share suggestions as well as brainstorm new ideas to meet the needs of today's youth. These efforts would be in residential care, family foster care, and perhaps even a new preventive services model. These efforts would also include structuring funding for the Children's Center to support the Children's Center as it is functioning now, not as it was originally envisioned. There must be funding to support the census that now is regularly at 70+, with youth whose needs are substantial.

We see all of this work in partnership with ACS and with a goal shared with ACS to provide the most meaningful services to the most traumatized youth. We do believe that in partnership there exists meaningful opportunity to bring change. We are certain that we need this partnership to be funded immediately in order to protect and serve these youth.

Psychiatric Medication Data Collection Regarding Youth in Foster Care

COFCCA supports the position of ACS with regard to this proposed bill and does not take a separate position.

The members of COFCCA take seriously the psychiatric/psychological needs of the youth in our care and the need for psychotropic medication to address these needs. With regard to the collection of data we believe that it needs to be contextualized for a full understanding of reasons for the use of the medication. A straightforward collection only will not paint a picture of the youth, their needs and the situation requiring the medication.

I would be happy to answer any questions the Council members may have.

I thank you for allowing me to submit testimony.
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SHELTERING
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Children and Family Services

Embracing Hope *and* Building Futures *for* Generations

Testimony Delivered by Theodora Diggs, LMSW
Program Director of the Sheltering Arms Reception Center Annex
Prepared for the New York City Council Committee on General Welfare
Oversight Hearing – The Nicholas Scoppetta Children's Center
June 25th, 2019

Good morning. My name is Theodora Diggs, I'm the Program Director of the Sheltering Arms Reception Center annex of the Nicholas Scoppetta Children's Center. Thank you to Chair Levin, and members of the New York City Council Committee on General Welfare for the opportunity to testify before you today.

Sheltering Arms is one of the City's largest providers of education, youth development, and community and family well-being programs in the Bronx, Manhattan, Brooklyn, and Queens. In addition to serving nearly 500 youth in foster care, and more than 2,000 children in preventive services over the course of a year, we have operated the Sheltering Arms Reception Center (sometimes called the Children's Center annex) since September 2017. Our Reception Center, located in the north Bronx, is one of four Reception Centers citywide that serve children and youth awaiting an appropriate foster care placement. The Sheltering Arms Reception Center is unique in serving young children ages 0-12 years old, while the Youth Reception Centers serve adolescents in need of placement.

I am testifying before you today to ensure that the needs of children and youth in the Reception Centers are highlighted, and that the systemic lack of appropriate support and therapeutic foster care placements for these children and teens with serious behavioral and mental health challenges is addressed.

Lack of Resources for Children with Severe Behavioral and Mental Health Issues

When Sheltering Arms launched our Reception Center a year-and-a-half ago, neither we nor ACS anticipated the severity of mental health challenges and behavioral issues we would encounter serving this very young population. We have seen children as young as 4-, 5-, and 6-years-old with serious diagnoses such as oppositional defiant disorder (ODD), mood disorder, and psychotic disorders. We have received children from psychiatric hospitals, and have had to refer several children for psychiatric hospitalization because they became a risk to themselves and/or other children and staff in the facility:

- Sarah* is a 10-year-old girl diagnosed with ODD, ADHD, PTSD, and Reactive Attachment Disorder. She was transferred to our Reception Center from Kings County Children's Psychiatric Hospital. Sarah remained in our program for four months, during which she

*Names have been changed to protect privacy.

was hospitalized two times. She was placed in a therapeutic foster home, but has continued to require hospitalization.

- James* is a 6-year-old boy who was placed with us for only two days before having to be hospitalized due to aggressive and self-harming behavior. He was hospitalized at Jacobi Hospital for one week before being transferred to Bronx Children's Psychiatric, a State hospital. James remained there for one month and was discharged back to our Reception Center, where he stayed with us for five days before being re-admitted to Bronx Children's Psychiatric. He stayed there for another month before being released to his birth mother.

Children like Sarah and James, who struggle with severe mental health issues and require intensive support, are not unusual in our Reception Center. Dozens of the children we serve each year come to us with severe mental health and behavioral challenges.

It is clear that when these needs are not appropriately addressed in the young population we serve, the symptoms and trauma they experience compounds as they wind their way through the foster care system. One child in our Reception Center, diagnosed with a mood disorder, had been in nine different placements before coming to our Reception Center at 8-years-old because even therapeutic foster parents were not equipped to address his intensive needs.

While our average length of stay at the Reception Center is three days, children in need of therapeutic placement end up staying with us for 3-4 months due to a lack of available and appropriate therapeutic foster care placements. Sometimes therapeutic foster homes, while a great resource for some children, are not even sufficient to meet the needs of children we serve. The training that is currently required to be certified as a therapeutic foster home, while useful, does not address the specific and intensive needs of each child, or the severity of the needs of some of the children we have served.

Considerations and Recommendations for the General Welfare Committee

As an increasing number of children enter foster care with serious behavioral and mental health issues, New York City must ensure that providers and foster parents have the resources to appropriately and meaningfully meet the needs of these children. **We urge the General Welfare Committee to continue to push ACS to expand services for children who need intensive therapeutic support, as well as the foster parents who care for them.**

1. **Salaries:** As additional supports have been added to the Children's Center, the Reception Centers and voluntary foster care agencies need similar supports. Most notably, we must be able to recruit and retain the appropriately qualified staff necessary to work with these youth**. This requires contracts with budgets that allow for salaries at the level needed to attract and retain qualified staff.**

2. **New Models of Therapeutic Care:** It's clear New York City needs to explore new models of therapeutic foster care to meet the needs of the children that are currently entering care. Staff at the Reception Centers, and the therapeutic foster homes available for

placement, need training that specifically addresses the individual needs of the children being placed in their care. Providers and states across the country are considering a "professional foster parent" model for therapeutic foster care, which creates the opportunity for foster parents to be more thoroughly trained, and appropriately supported, to meet the needs of the children in their care.

3. **Training and Support for Staff and Foster Parents:** Even before a new model is put in place, resources are needed to provide staff at the Reception Centers with comprehensive trauma training now so they can better support the children and youth with severe behavioral and mental health issues that are coming into care. Both Reception Center Case Workers and the foster parents accepting these high needs children into their homes should receive regular trauma-informed training. Evidence-based models like Trauma-Focused Cognitive Behavioral Therapy (CBT), among others, would be a good place to begin to offer more support to foster parents. We also recommend that Case Workers and foster parents be trained together when possible, so that Case Workers can support foster parents and also ensure foster parents are able to effectively execute the parenting techniques.

Thank you again for the opportunity to testify about these important gaps in support for both children and staff. I am happy to answer any questions you may have.

TESTIMONY OF JULIA L. DAVIS
DIRECTOR OF YOUTH JUSTICE AND CHILD WELFARE

Committee on General Welfare
Stephen T. Levin, Chair
Members: Vanessa L. Gibson, Barry S. Grodenchik,
Brad S. Lander, Antonio Reynoso,
Rafael Salamanca, Jr., Ritchie J. Torres and Mark Treyger

June 25, 2019

The Children's Defense Fund's (CDF) *Leave No Child Behind* mission is to ensure every child a healthy start, a head start, a fair start, a safe start and a moral start in life, and successful passage to adulthood with the help of caring families and communities. CDF provides a strong, effective and independent voice for all the children of America who cannot vote, lobby or speak for themselves. We pay particular attention to the needs of poor children, children of color and those with disabilities.

In New York (CDF-NY), we are dedicated to improving conditions for children across the State, based on research, public education, policy development, organizing and advocacy activities. Our priorities are health, education, early childhood, child welfare and juvenile justice.

Thank you to the Chair and members of the City Council Committee on General Welfare to offer this written testimony concerning the Nicholas Scoppetta Children's Center, and Int 1358-2019, legislation in relation to information about the use of psychiatric medication for youth in foster care.

1) *Nicholas Scoppetta Children's Center*

We are concerned by reports of extended lengths of stay at the Children's Center, police presence and arrests within the facility, and delays in services for youth placed there. Data from April 2019 shows that the average number of children in the Children's Center on any given day was 70.[i] Half of these youth are adolescents, 14-18 years old (47.1%), and nearly a quarter are children aged 11 to 13 (22.9%).[ii] The remaining 30% are children aged 10 and under.[iii] Because there is limited public reporting on conditions and incidents that occur at the Children's Center, we encourage the Committee to

exercise its oversight role by inquiring from the Administration about the following policies and practices:

Contact with Law Enforcement

- Incidents involving youth the facility, and the guidance for ACS staff in calling NYPD or engaging police in response to such incidents;
- Police presence and activity in the facility, including arrests of facility residents and the filing of juvenile reports;
- What, if any, internal monitoring or reporting ACS maintains with regard to police contact with youth in the facility.

Length of Stay / Information on Youth Needs

- Data on average length of stay within the facility;
- Data on the number of youth in the facility who do not leave within 7 days who have mental or behavioral health conditions.

2) *Int 1358-2019, legislation in relation to information about the use of psychiatric medication for youth in foster care*

Children in foster care are prescribed psychotropic medications at a rate nine times higher than children who are not placed in foster care.[iv] Studies have shown that psychotropic medications, which include mood stabilizers, antipsychotics, anti-anxiety medications, and stimulants, are prescribed to children in foster care as young as one year old.[v] Powerful antipsychotic medications, designed to treat adults with schizophrenia and bipolar disorder[vi], are the most frequently prescribed medications for children in foster care and are used for conditions from anxiety to attention disorders.[vii]

Many children in foster care experience abuse, neglect, exposure to violence, poverty and systemic racism[viii], and disrupted attachments with parents and other adults, which make them more likely to have emotional and behavioral challenges including mental health disorders.[ix] It is also true that for children with mental health disorders, medication can play a key role in treatment.[x] However, when children in foster care are prescribed psychotropic medication, best practices for prescribing and monitoring treatment[xi] are often ignored.[xii] In some cases, children are prescribed psychotropic

medications so that they are sedated and easier to manage in foster care settings.[xiii] Medical histories are not obtained, children are not actually diagnosed with a specific condition, and often, alternative treatments, such as psychotherapy, are not included in their care.[xiv] As a result, psychotropic medications are often over-prescribed and can make children's emotional and behavioral challenges worse.[xv]

The perils of over-prescribing in the foster care setting are significant. Children are incorrectly prescribed medications rather than obtaining the treatment and support they need to address underlying trauma.[xvi] Children experience unwanted side effects and foster care placements lack protocols to monitor these side effects and effectively intervene.[xvii] Side effects include interference with sleep and appetite, tics, hearing voices, significant weight gain[xviii] and suicidal thoughts or attempts.[xix] A 2006 analysis showed that at least fort-five children died between 2000 and 2004 due to the side effects of these medications.[xx] Further, in many cases, the long term effects of these medication on children are unknown.[xxi]

In light of these risks, best practice in child welfare requires diligent monitoring and data collection around the use of these drugs.[xxii] We strongly support Int. 1358-2019, a bill which would require ACS to collect and report data about the prescription of psychotropic medication for children in its legal custody. The bill fills a critical gap in systemic oversight over the prescription of these medications to this vulnerable population and will more closely align NYC child welfare monitoring practices with national standards.

CONCLUSION

Thank you for the opportunity to offer this written testify before the Committee. I am sorry that my schedule will not permit me to attend the hearing, but I would welcome the opportunity to address any questions of concerns.

Julia L. Davis
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[i] ACS Flash Report, May 2019, slide 12 of 33, available at: https://www1.nyc.gov/assets/acs/pdf/data-analysis/flashReports/2019/05.pdf.
[ii] *Id.*
[iii] *Id.*
[iv] ABA Psychotropic Medications, Feb. 16, https://www.americanbar.org/content/dam/aba/administrative/child_law/psychtropicmed_res_feb16_report.pdf, 1.
[v] ABA Practice & Policy Brief: Psychotropic Medication and Children in Foster Care: Tips for Advocates and Judges, October 2011, https://www.americanbar.org/content/dam/aba/administrative/child_law/PsychMed.authcheckdam.pdf, 8, 16.

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[xvii] ABA Psychotropic Medications, Feb. 16, https://www.americanbar.org/content/dam/aba/administrative/child_law/psychtropicmed_res_feb16_report.pdf, 8.
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[xix] ABA Psychotropic Medications, Feb. 16, https://www.americanbar.org/content/dam/aba/administrative/child_law/psychtropicmed_res_feb16_report.pdf, 7.
[xx] ABA Psychotropic Medications, Feb. 16, https://www.americanbar.org/content/dam/aba/administrative/child_law/psychtropicmed_res_feb16_report.pdf, 7.
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[xxii] Case Family Programs, Is there an effective policy framework for oversight and monitoring of the use of psychotropic medication by youth in out-of-home care? (2018), available at: https://www.casey.org/is-there-an-effective-policy-framework-for-oversight-and-monitoring-of-the-use-of-psychotropic-medication-by-youth-in-out-of-home-care/.

Center for Family Representation (CFR)
Submitted Testimony for the Committee on General Welfare

Hearing Date: June 25th, 2019

Int. 1358-2019: A Local Law to amend the administrative code of the city of New York, in relation to information about the use of psychiatric medication for youth in foster care

CFR is grateful for the opportunity to submit testimony to the Committee on General Welfare on the proposed legislation requiring the collection of information on psychiatric medication prescribed for foster care youth. We thank the Committee for their focus on this important issue.

Overview of CFR

CFR is the New York City county-wide assigned indigent defense provider for parents who are respondents in Family Court Act (FCA) Article 10 proceedings in Queens and New York counties. CFR was founded in 2002 to support indigent parents in raising their children safely and to minimize the City's reliance on foster care. Currently, pursuant to a contract with the New York City Mayor's Office of Criminal Justice (MOCJ), CFR represents on average 1,300 new clients each year in Article 10 proceedings, and in supplemental proceedings like custody, guardianship, visitation and termination of parental rights cases. We also represent clients in criminal court and have recently begun representing children in juvenile delinquency proceedings. CFR has served over 9,000 families since our founding in 2002. We employ an interdisciplinary model of representation, marrying in court litigation to out of court advocacy: every client is assigned an attorney and a social work staff member at intake,

which is generally the first day the client is summoned to court, and these teams are supported by parent advocates, paralegals and supervisors. Our goals are always to prevent foster care or, where foster care is unavoidable, to shorten the time children spend in care and to prevent re-entry.

Information on Psychotropic Medication Prescribed to Foster Care Youth

It is widely acknowledged that youth in foster care are prescribed psychotropic medications in vastly higher rates than non-foster care youth[1]. Youth in foster care are particularly vulnerable to dangerous prescribing practices given the likelihood that they will experience multiple life stressors, become exposed to a variety of systems, and lack access to a consistent caregiver who can advocate and monitor their healthcare needs and treatment[2]. While many foster care youth will require and benefit from mental health treatment, in our observation, these youth are often prescribed powerful psychotropic medications over therapeutic treatment modalities like trauma-focused psychotherapy and psychosocial services because these services can be difficult to access and require more time to see results. Information and data related to psychotropic medication prescribed to youth in care should be collected and made available to the public so that problematic prescribing practices can be monitored and corrected.

[1] *State Prior Authorization Parameters for Psychotropic Medication for Children and Youth in Medicaid*, Center for Health Care Strategies, Inc, Technical Assistance Tool, March 2018.
[2] *The Use of Psychiatric Medications for Children and Youth in Placement; Authority to Consent to Medical Care*, New York State Office of Children & Family Services, Strategic Planning and Policy Development, 08-OCFS-INF-02, February 13, 2008.

Current Practices:

New York State and federal child welfare standards require medication monitoring at the client and agency level[3]. Despite promising to revamp their current policy, the Administration for Children Services (ACS) does not have a plan for monitoring and collecting data on psychotropic medication use for youth in care. This has resulted in a lack of clear information on prescribing trends across ACS-contracted foster care provider agencies and types of foster care placements.

More often than not, when children enter the foster care system, they are separated from their primary caregiver, school of origin, community and any services they were linked to prior their removal. As a result, many children struggle with the transition into foster care. They are sometimes placed in settings or homes ill-equipped to address their unique needs, placing them at greater risk of becoming diagnosed with a mental health disorder or emotional disturbance. Our clients frequently express that their child never had these challenges prior to entering foster care, or that their child's symptoms worsened once they entered care. We have found that our clients are not always meaningfully included in conversations about their child's mental health treatment planning, and may not learn about the severity of their child's challenges until they reach a state of crisis. For example, foster care provider agencies do not always inform them about scheduled evaluations or meetings with their child's psychiatrist, so our clients frequently learn about their child's diagnosis and treatment plan second

[3] *Promoting the Safe, Appropriate, and Effective Use of Psychotropic Medication for Children in Foster Care*, U.S. Department of Health and Human Services, Administration for CHildren and Families, ACYF-CB-IM-12-03, April 11, 2012.

hand. Our clients are not always immediately informed if their child is hospitalized, and sometimes do not learn of the hospitalization until after their child is discharged.

In our experience, once a child is in crisis, parents are often urged and pressured to consent to psychotropic medication. At this stage, a child's placement in their foster home or their ability to attend school and prosocial activities may be at stake if their behavior doesn't improve. If a parent affirmatively objects, or requests more information on the medication and risks, and the agency feels the child is in immediate need of the medication, they can ask the court to override the parent's consent. If the agency makes the request for parental consent during a regular court appearance, parents often feel pressured to consent while on the record, even if they haven't received adequate information on the medication to make an informed decision. We have found that agencies sometimes resort to this option before taking the time to schedule a meeting with our client and their child's mental health providers, which is a common barrier to a parent providing their consent.

One example of this practice occurred during a Permanency Hearing for our client Ms. C. While on the record, the foster care agency asked Ms. C to consent to her child taking the medication Guanfacine to treat symptoms related to Attention Deficit Disorder. Ms. C was not prepared to consent at that time. She had previously been informed that her child needed an Electrocardiogram before he could be medically cleared to take the medication. The court directed the agency to invite Ms. C to the appointment with the cardiologist, which had not been scheduled. Unfortunately, after the court appearance, the agency scheduled the cardiologist appointment with the

foster parent and did not inform Ms. C about the appointment. Ms. C was not able to make an informed decision about whether the medication was appropriate for her child because the foster care agency failed to involve her in his medical appointments.

Benefits of Public Information on Prescribing Trends for Foster Care Youth

Private and public healthcare systems regularly collect data on medication prescribing trends and implement relevant procedures to protect their patients from inappropriate and dangerous prescribing practices. Since ACS does not have a system in place to collect information on the prescription of psychotropic medication for children in care, and no current plans to create one, it is nearly impossible to understand the current prescribing practices and address the problematic and inappropriate use of psychotropic medication for NYC youth in care. Children in foster care and their families, as well as the providers and agencies that serve them, are entitled to this information.

The City Council and the public need access to information on psychotropic medication prescribed to youth in care so that these youth can be protected from problematic prescribing practices, including polypharmacy and the prescription of psychotropic medication without the informed consent of a parent or legal guardian. New York City can use this data to identify problematic prescribing practices within specific ACS-contracted agencies and settings, across age groups, gender, and ethnicity. We believe this information will shed light on many of the concerns that our clients have shared, and prevent agencies from prematurely prescribing psychotropic

medication to children when non-pharmacological treatment modalities should be explored. ACS must develop a system for collecting and reporting this information immediately, as required by federal and state regulations and child welfare standards and best practices. Once these trends are identified, procedures for preventing these problematic practices can be developed and implemented.

Recommendations and the Impact on NYC Children and Families

CFR supports the passage of **Int. 1358-2019.** This proposal establishes clear expectations for the type of data ACS must collect and make available to the public with respect to psychotropic medications prescribed to children in care. This includes information on the perceived problematic prescribing trends including polypharmacy, prescriptions to children under five, prescriptions for more than one medication from the same class of medications, and prescriptions without any other therapeutic service. The legislation calls for ACS to compile and publish quarterly and annual reports with this data, disaggregated by foster care provider agency, gender, ethnicity, age, placement type, prescriber type, and whether additional therapeutic services are provided. The report will also include the number and percentage of foster care youth who are currently prescribed medication or medication(s), whether the medications are from the same class of medication, the number and percent of cases where an ACS override of parental consent was requested, and the number and percent of cases where the override was approved. ACS will be required to identify problematic prescribing trends at each foster care provider agency and report on what corrective action has been taken

to address the practice. This information will be made available to the public on the ACS website.

CFR urges City Council to pass **Int. 1358-2019** in its current form. We recommend that ACS be directed to monitor and collect data on whether medications prescribed to foster care youth were FDA approved for the diagnosis and/or age of the child. ACS should also collect data on the number of clinicians who worked with the child and prescribed medication in a given time period. In our view, the collection of this additional information will help to illuminate the problematic practices that **Int. 1358-2019** seeks to identify and resolve.

Conclusion

New York City's children and their parents deserve transparency from ACS and it's contracted agencies. The collection of data on the prescription trends for New York City youth in foster care is essential to protecting vulnerable children from harmful and inappropriate prescriptions for psychotropic medication. Child welfare-involved parents are often hindered from accessing information and participating in their child's mental health treatment and **Int. 1358-2019** would provide much needed oversight and accountability for agencies responsible for children in care who are often overprescribed medication. CFR is confident that our clients and their children would benefit from the collection of this information by ACS and the City Council, and the resulting institutional changes regarding psychotropic medications for children in care.

CFR is grateful for the opportunity to submit testimony on the alarming lack of oversight on psychotropic medication for youth in care and we thank Councilman Levin for introducing this important legislation. Please contact Charlotte Baughman, Senior Staff Social Worker, or Jennifer Feinberg, Senior Staff Attorney at 646-634-2699 or 646-276-6385 with any questions or concerns.

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. ________ Res. No. ________
☐ in favor ☐ in opposition

Date: ________

(PLEASE PRINT)

Name: Michelle Yanche
Address: Good Shepherd Services
I represent: ________
Address: ________

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. ________ Res. No. ________
☐ in favor ☐ in opposition

COFCCA
Council of Family + Child Caring Agencies
Date: ________

(PLEASE PRINT)

Name: Lisa Gitelson
Address: ________
I represent: COFCCA / Council of Family + Child Caring
Address: 254 W 31st

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. ________ Res. No. ________
☐ in favor ☐ in opposition

Date: 7/25/19

(PLEASE PRINT)

Name: THEODORA DIGGS
Address: ________
I represent: SHELTERING ARMS Children and Family Services
Address: re: Reception Center needs

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THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. 135-B Res. No. ______
☒ in favor ☐ in opposition

Date: 6/25/19

(PLEASE PRINT)

Name: Kate Wood

Address: 199 Water St

I represent: The Legal Aid Society

Address: 199 Water St. NY NY

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. ______ Res. No. ______
☐ in favor ☐ in opposition

Date: June 25, 2019

(PLEASE PRINT)

Name: David Hansell, Commissioner

Address: ______

I represent: Administration for Children's Services

Address: 150 William Street

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. ______ Res. No. ______
☐ in favor ☐ in opposition

Date: ______

(PLEASE PRINT)

Name: Dr. Suchet Rao

Address: ______

I represent: Administration for Children's Services

Address: 150 William Street

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THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. ________ Res. No. ________

☐ in favor ☐ in opposition

Date: June 25, 2019

(PLEASE PRINT)

Name: Winette Saunders, Deputy Commissioner

Address: ________

I represent: Administration for Children's Services

Address: 150 William St

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THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. ________ Res. No. ________

☐ in favor ☐ in opposition

Date: June 25, 2019

(PLEASE PRINT)

Name: Julie Farber, Deputy Commissioner

Address: ________

I represent: Administration for Children's Services

Address: 150 William Street

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