

# The Measure of a Society: Protection of Vulnerable Persons in Residential Facilities Against Abuse & Neglect

Report submitted to  
Governor Andrew M. Cuomo

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*“The secret of care of the patient is in caring for the patient.”*

Dr. Francis Peabody, "*The Care of the Patient*", JAMA, March 19, 1927



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This report would not have been possible without the assistance of the many individuals and organizations who contributed their knowledge, wisdom and experience to shaping my understanding of the strengths and weaknesses in the systems developed for the safety and protection of the vulnerable people entrusted to the care of the state or its agents. Many of them are listed in Appendix A to the report, but there are countless others who have added their contributions through comments on Governor Andrew M. Cuomo's website, or through letters and emails, some of them sent anonymously.

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CJS  
Albany, New York

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## **Executive Summary**

This report addresses the problem of abuse and neglect of vulnerable people in residential programs operated or supported by agencies of the state of New York. As of December 31, 2010 there were approximately 273,600 children and adults with disabilities or other life circumstances that make them vulnerable who were in residential facilities under the auspices of one of six separate state agencies which operate, license, certify or fund such programs. In total, these programs cost approximately \$17.9 billion and encompass approximately 11,700 provider sites.

Although all of these programs share a common obligation to protect residents and keep them safe from abuse and neglect, the execution of that obligation varies widely among the state agencies and the programs they operate or authorize, with major gaps and inconsistencies (Figure 4, p. 25). These variations include:

- whether they require that provider agencies have an incident management program to identify and respond to unusual incidents;
- whether and how they define the terms “abuse” and “neglect” to encompass specific behaviors by employees and others;
- whether they require that providers investigate reported allegations of abuse or neglect;
- whether they establish time frames for the completion of such investigations;
- whether they require that persons conducting investigations be trained to do so;
- the standard of proof used in such investigations (Figure 5, p. 27);
- whether they require that reports of such investigations be sent to the state supervising agency;
- what types of crime and under what circumstances they must be reported to law enforcement agencies (Figure 6, p. 28);
- the obligation of the state agency itself to conduct investigations;
- whether they require providers to analyze patterns and trends in reported incidents; and
- the availability of independent oversight over the residential providers’ operations (Report, §IV, A).

These gaps and inconsistencies expose vulnerable people to needless risk of harm and complicate the challenge of teaching and training direct service staff, especially at the 112 provider agencies which have licenses from multiple state agencies (Figure 9, p. 32).



There are formidable barriers to reporting abuse and neglect by the two groups of people who are most knowledgeable about such incidents – direct support staff and the residents themselves. These barriers include the failure to adequately differentiate between serious incidents of staff personal culpability, and lesser incidents caused or contributed to by deficient workplace conditions; poor articulation of "zero tolerance" policies, which discourage reporting; ineffective investigations when incidents are reported; and unsuccessful disciplinary actions in state agency programs (Report, §§ V). There are wide variations in the rates of reported incidents between different types of residential programs and among the same types of facilities (Report, § III).

This report recommends sweeping reforms of the system for reporting and investigation of incidents of abuse and neglect in residential programs. Many, if not most, of these reforms are equally applicable to non-residential programs and would need to be extended to these as well in order to ensure a consistent set of standards and expectations both as to protection of service recipients and training of staff of such programs. Among the key elements of the reforms are:


- In place of the multiple and varying definitions of abuse and neglect among the several state agencies, or the lack of any definitions at all, adopting a common set of definitions that are easily understood.
- Implementing a statewide, centralized, 24-hour hotline for reporting abuse and neglect of vulnerable persons in residential care, in much the same manner as is currently done for cases of child abuse, including the ability to accept anonymous reports.
- In place of the multiple and varying standards for reporting criminal behavior to law enforcement agencies from the approximately 11,700 provider sites, shifting the responsibility for screening and making referrals to law enforcement agencies to trained staff at the hotline who would have access to a unit of the state police or experienced law enforcement personnel to bring consistency, experience and judgment to this decision-making, as well as the capacity to follow up on referrals and offer investigative assistance.
- Instituting common standards for investigations and requirements to use trained investigators.
- Creating transparency of the investigative process by including independent actors on incident review committees, and requiring an annual system wide public report on outcomes by the Commission on Quality of Care and Advocacy for Persons with Disabilities.

- Differentiating the treatment of serious and repeated acts of abuse and neglect from lesser offenses, and from incidents that are caused or contributed to by workplace conditions.
  - The former would be addressed by a Table of Penalties calling for termination of employment (included in the state collective bargaining agreement), referrals for criminal prosecution as appropriate, placement on a Central Register banning future employment in positions having contact with vulnerable persons.
  - The latter would be addressed by progressive discipline, and individual rehabilitation and re-entry plans for the employee. Workplace conditions would be addressed through non-punitive reviews and implementation of corrective actions.
- Creation of an interagency Statewide Central Register for abuse and neglect of vulnerable persons as a repository for substantiated cases of serious or repeated abuse and neglect (and banning persons on the register from employment in positions requiring contact with vulnerable persons) (Report, §§ VIII and IX).

This report contains recommendations for legislative action to implement the reforms identified above, as well as recommendations addressing prevention, consistent standards and practices regarding background checks of prospective employees, staff recruitment and training, career ladders, incident reporting and investigation, employee discipline, provider discipline, independent oversight and other issues (Report § X).

While this report focuses specifically on my assignment to examine the problem of abuse and neglect in human service systems in the state, its findings regarding the numerous inexplicable gaps and inconsistencies in the legislative and regulatory framework are sobering and have broader implications. Many of the underlying laws have been added piecemeal over the years by the work of separate legislative committees of jurisdiction over a particular system in response to specific concerns. The patchwork quilt of laws is compounded by the proliferation of inconsistent regulations adopted by agencies, sometimes pursuant to the same laws. The findings in this report should prompt a broader re-examination of how the state manages the vast resources that it devotes to the support of these multiple systems of human services, and the consistency of its policies and practices in doing so.

Over the past 35 years, the role of the state as a direct provider of services has diminished dramatically as state institutions have been closed or drastically downsized and services transferred to the community. These community-based services are predominantly delivered by private organizations licensed, certified, regulated and funded by the state. Although the state is primarily a purchaser and funder of services delivered by such organizations, in this area as well there are major and inexplicable inconsistencies in how common functions are carried out, sometimes resulting in multiple processes by different state agencies to accomplish the same objective with the same provider.



At the same time, several state agencies continue the direct delivery of services similar to those provided by private agencies with which they contract. Yet, there is no common set of performance expectations or a Code of Conduct to hold accountable the employees engaged in this work on behalf of the state or the private providers. Unless grounded in a compelling rationale for a difference, inconsistent policies and processes among state agencies to accomplish the same goals are inefficient and wasteful of scarce state resources, and also create unnecessary difficulties for provider organizations – especially those that interact with multiple state agencies in delivering services to different groups of people.

In the time since the submission of my report to the Governor, there have been ongoing discussions with the Governor and members of his staff about how to implement the recommendations contained in the report and to sustain the focus on developing and maintaining a robust set of protections for vulnerable persons. Out of those discussions has emerged the initiative to create a Justice Center for protection of vulnerable persons in the Executive Department that would serve as the focal point of the state's efforts to implement major reforms across all of its human service systems, as described in this report. As envisioned, the Justice Center would:

- Establish a Hotline and Statewide Central Register for vulnerable persons across human service systems to:
  - receive reports of abuse and neglect involving vulnerable persons, including anonymous reports, 24 hours a day;
  - screen and classify reports of abuse and neglect, with the assistance of experienced law enforcement officers, and ensure their prompt investigation and remediation, as well as referral of criminal conduct to appropriate law enforcement agencies as warranted;
  - maintain a registry of all persons who have been found substantiated for serious or repeated acts of abuse or neglect of vulnerable persons, as described in this report, and who would be barred from continued employment in positions requiring direct contact with vulnerable persons.
- Establish a Division of Investigation & Prosecution to:
  - directly investigate all serious cases of abuse and neglect, as well as any other cases it deems warranted;
  - delegate other cases to trained and certified investigators in accordance with policies and procedures it develops for doing so, and receive and review the reports and outcomes of such investigations, as well as investigations into other serious incidents, and take any further action it deems warranted (using sampling, spot-checks, reviews of outliers and other techniques);
  - have the authority to prosecute abuse and neglect crimes against vulnerable persons as it deems warranted;

- represent the state in disciplinary cases seeking termination of state employees for abuse or neglect of vulnerable persons.
- Establish a Division of Fair Hearing to conduct all fair hearings relating to reports of abuse or neglect.
- Establish a Training Academy which would:
  - develop investigation standards and a training curriculum for investigators;
  - certify trained investigators who may be assigned to investigate reports of abuse or neglect and other serious incidents;
  - work with human service agencies and constituency groups to develop a common core curriculum for direct support workers and a system for credentialing such workers; and
  - promulgate a code of conduct applicable to all employees in human service agencies consistent with principles to be established by law.
- Establish a clearinghouse for background checks of all direct support workers across human service agencies, as described in this report, in order to promote consistency and reduce duplicative background checks.
- Establish a Division of Monitoring and Oversight to assume the existing monitoring and oversight responsibilities the Commission on Quality of Care and Advocacy for Persons with Disabilities under state law, which will be expanded to cover other human service systems currently lacking independent oversight.
- Submit an annual report to the governor and legislature, and such other reports as it deems warranted, reviewing and analyzing patterns and trends in the reporting of and response to incidents of abuse and neglect, and other serious incidents, and recommending appropriate preventive and corrective actions to remedy individual or systemic problems.

The recommendations included in this report will, when implemented, help insure the safety and well-being of those vulnerable persons entrusted to the care of the state and its authorized agents. However, true system reform must be broader than the agenda set forth by this report. The expansion of home and community based services that has occurred over the better part of the last four decades has not yet achieved the original vision of enabling people with disabilities to live in fully integrated settings; families of people in need continue to have to negotiate a complex and frustrating maze of services; and there has yet to evolve a truly accountable provider network whose success is measured by the success of the people it serves.

The recommendations in this report complement other major reform initiatives announced by Governor Cuomo. These include the recommendations of his Medicaid Redesign Team, including the development of health homes, care management for all Medicaid


enrollees, and the repatriation of individuals with disabilities who are being served out-of-state. The development of behavioral health organizations for those with behavioral health needs and implementation of the People First Waiver models of care envisioned for people with developmental disabilities, are intended to promote person care planning and assure greater provider accountability.



## **I. Introduction**

This report responds to Governor Andrew M. Cuomo's concern for the protection and safety of vulnerable people served in state operated or state supported residential programs. Recent revelations about the failures in reporting serious incidents of abuse, in making timely referrals to law enforcement agencies, in effective responses by law enforcement when serious apparent crimes have been reported, in removing employees responsible for egregious acts of abuse through use of the state employee disciplinary process, and in excluding persons with histories of abusive behavior from being re-employed in similar positions – all underscore the need for a fresh examination of the functioning of the safety net for vulnerable people. The broad public concern spawned by these revelations, including several legislative oversight hearings by the Assembly Committee on Mental Health, Mental Retardation and Developmental Disabilities (Chaired by Assemblyman Felix Ortiz), the Committee on Codes (Chaired by Assemblyman Joseph Lentol), and the Committee on Oversight, Analysis and Investigation (Chaired by Assemblyman Jonathan Bing), provide a unique impetus for re-examining not only the underlying policies of state agencies dealing with abuse and neglect in residential settings, but also how these policies are implemented in the hundreds of programs across the state. The goal of this effort is simply stated: to create a durable set of safeguards for vulnerable people in residential settings, which are consistently implemented and provide protection for the residents against abuse and neglect, and fair treatment for the employees upon whom they depend.


This report addresses primarily vulnerable persons in residential programs as the first order of priority because the responsibility of the state for safety and protection is the greatest towards those who are in its custody or that of the providers it has authorized. Nevertheless, most of its recommendations would be equally applicable to non-residential programs operated by the state and such providers, as there needs to be a set of standards and expectations both as to the protection of service recipients in all systems and as to the training and supervision of staff of the programs that serve them.



These human service systems did not arrive overnight to the point at which they find themselves, nor will they get to a dramatically better level of performance immediately. But there is a need to begin the process of reform with a sense of urgency. This report ends with recommendations for administrative actions that can and should be taken immediately. It also proposes for consideration by the Governor and legislature the enactment of new laws for the prevention and remediation of abuse and neglect in residential facilities. It recognizes that some of the systemic changes that must be implemented across large, complex and decentralized service systems will require carefully thought out plans for implementation of the recommendations made and recommends the development of such implementation plans.

While many of the recommendations in this report propose streamlining, simplifying, coordinating or eliminating inconsistent, duplicative, or overlapping functions among different human service systems, there are also new obligations to be placed upon service providers and state agencies to strengthen the systems for reporting and investigation of abuse and neglect, and to create a more effective and accountable set of protections for vulnerable persons. These obligations may provide an impetus for collaborative arrangements between state agencies, consistent with the approach of the Governor's Spending and Government Efficiency (SAGE) Commission and among private providers to share resources.

Since March 2011, with the assistance of the very capable staff listed in the acknowledgments, I have met with a wide cross-section of primary consumers, family members, providers, direct support staff, advocates and state agency staff including commissioners, policy analysts, investigators and administrators (see Appendix A for a complete list). We have interviewed staff at all of the state agencies involved in the reporting, investigation and resolution of reports of abuse and neglect, gathered data on the volume of reports and substantiation rates in each system, and interviewed investigators and other staff involved in these processes. We have received almost 1700 comments and suggestions offered by a diverse cross-section of New Yorkers on the Governor's website (<http://www.governor.ny.gov/AdvisorVulnerablePersons>) and in letters and emails. In addition, we have gathered data from each of the state agencies



describing their residential programs and services, and their systems for reporting, investigation and response to incidents of abuse and neglect.<sup>1</sup> The data contained in this report regarding the number of beds in each system, the types of facilities, the occupancy rates, and the volume of reported incidents have been provided by each of these state agencies. Cost data have been provided by the Division of the Budget.

These meetings and correspondence with various constituency groups has led to an outpouring of a broad array of concerns dealing with everything from the overall levels of funding for the services provided, rate-setting practices, staffing levels in state agencies and at the service sites, and a variety of issues dealing with the management, governance and internal policies of state agencies and provider organizations. I have been candid in informing all those with whom I have communicated that while I do not minimize the importance of these issues, this report will focus primarily on the task at hand which is the protection and safety of vulnerable children and adults in residential facilities.

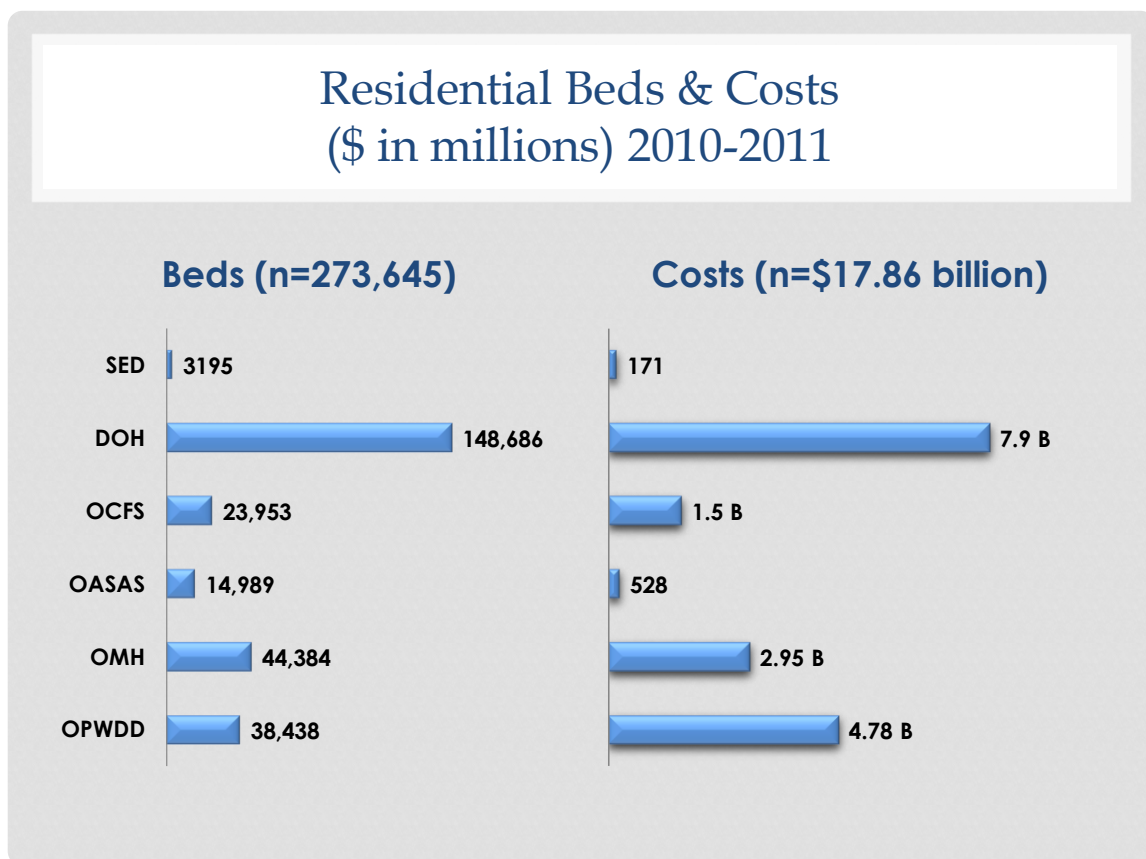
## **II. Residential Programs**

As of December 31, 2010, there were approximately 273,600 children and adults with disabilities or other life circumstances that make them vulnerable who were in residential facilities operated, licensed, certified or funded directly or indirectly by the state through agencies including the Office of Mental Health (OMH), the Office for People With Developmental Disabilities (OPWDD), the Department of Health (DOH), the Office of Children and Family Services (OCFS), the Office of Alcoholism and Substance Abuse Services (OASAS) and the State Education Department (SED). The number of people served is substantially larger as some of the residential beds, especially in the OMH and OASAS systems provide short-term treatment and turn over frequently. In total, these programs cost approximately \$17.9 billion and encompass approximately 11,700 provider sites. State operated institutions include psychiatric and developmental centers, addiction treatment centers, rehabilitation hospitals, juvenile detention facilities and state-operated schools. Private agencies are authorized to operate a variety of other facilities by one or

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<sup>1</sup> As used in this report, the term “abuse” or “abuse and neglect” includes all forms of maltreatment and exploitation of the vulnerable individual.

more of the above listed state agencies. These facilities include private psychiatric hospitals, psychiatric wards of general hospitals, residential treatment centers (OCFS), residential treatment facilities (OMH), group homes, residential schools in state and out of state, various OASAS residential programs, foster care and family care placements, agency boarding homes, Intermediate Care Facilities/Developmental Disabilities (ICF/DDs), Individual Residential Alternatives (IRAs), supported living facilities, adult care facilities (which includes adult homes), and residential health care facilities including nursing homes.




**Fig. 1 Residential Beds & Costs<sup>2</sup>**

#### ***A. Human Services and the Risk of Human Failure***

In all of these facilities that are a part of the human services system, there is a constant risk of human failure. At the frontlines of the service systems where most of the interactions occur between residents and staff, the latter may not be adequately trained for the jobs

<sup>2</sup> A more detailed agency-by-agency breakdown of programs and costs can be found in Appendix B.



they hold; there may not be enough of them to perform all of the tasks that are essential for the safety and welfare of the residents with whose care they are entrusted; or they may simply fail to do what they have been trained to do – whether due to fatigue, frustration, impatience, inattention, honest mistakes or carelessness. For a variety of reasons, shortages of staff are not uncommon and usually impose additional burdens on the staff that are present. Such shortages require staff that is present to work additional shifts to compensate for workers who are unavailable, increasing their fatigue and levels of stress while depleting their ability to cope. Failures of these types are not infrequent and they contribute to the type of abuse that a fatigued or over-stressed parent might engage in (e.g., slapping, pushing, shoving, verbal abuse) and to errors of commission (e.g., medication errors) or omission (not performing tasks that are required to be done). In rarer cases, the human failure is deliberate. A small minority of staff may make conscious decisions to physically or sexually abuse the residents entrusted to their care, or to engage in acts of financial exploitation or psychological cruelty. The harm they inflict upon vulnerable residents is severe, sometimes resulting in serious injuries, psychological damage and even death. Much of this latter behavior also violates the criminal laws.<sup>3</sup>


The occurrence of harm to vulnerable people, especially egregious acts of abuse or neglect, rightly draws attention to the failings of systems of care. The public attention that is given to such failures is felt acutely by all direct support workers, who perceive such attention as tarnishing the reputations of all who work in similar capacities. However, such incidents are newsworthy precisely because they are unusual – deviations from the norm of tens of thousands of caring people who do their jobs quietly and unspectacularly every day.

### ***B. Direct support staff at the point of service delivery***

These jobs at the point of service delivery in the human services systems are difficult and demanding. Workers provide hands-on services to children and adults with mental and physical disabilities who need varying levels of assistance with activities of daily living

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<sup>3</sup> The relative infrequency of abuse cases with serious injuries is illustrated by data taken from inpatient and residential abuse reports provided by the Office of Mental Health. Of the 1165 such reports in 2010, 1040 (89%) contained information on the level of injury sustained. Of these, 23 cases (2.21%) of substantiated abuse involved injuries where treatment beyond first aid was required.



including eating, bathing, dressing and toileting; they physically transfer immobile residents who need assistance in getting out of bed or using a bathroom; they serve as surrogate parents to children who have been removed from their families due to abuse or neglect at home; they provide supervision for people who would be endangered if left alone; they attend to the myriad tasks that keep a residence functioning including planning and preparing meals, doing the laundry, conducting fire drills and keeping the residence clean; they are called upon to help with implementing treatment and behavior programs and are the first to identify and respond to illnesses or other needs for medical or professional attention; they enforce house rules that are a part of communal living, break up fights between residents and try to maintain peaceful co-existence; and they are required to document most of the preceding activities. These direct support jobs require knowledge, skills, patience, caring, tolerance and understanding in dealing with maladaptive behaviors and sometimes with deliberate provocations.

With few exceptions, entrance level direct support positions require at a minimum a high school diploma or equivalent. Exceptions include nursing homes where Certified Nurse's Aides must successfully complete the CNA exam. Residential programs licensed or certified by state agencies are generally required to develop a staffing plan that demonstrates staff sufficient in number and kind to meet the program's responsibilities. This staffing plan is submitted to the state agency for approval. Despite the difficulty of these jobs and the essential part they play in the fabric of the social safety net, as described above, formal qualifications for such positions are minimal and training programs to equip workers with the skills they require are highly variable among the different systems of services.

Perhaps reflective of this, such jobs are compensated poorly, with many workers living at or near the poverty level or forced to work multiple jobs to make ends meet. One might summarize the job description of the direct support worker as requiring the wisdom of Solomon, the patience of Job and the caring of Florence Nightingale. While much is said about the value of these direct support jobs, the traditional hallmarks of value are often missing – qualifying credentials, adequate pay, career ladders, attention to working conditions, adequate training, managerial and supervisory support and so on. Worse, when



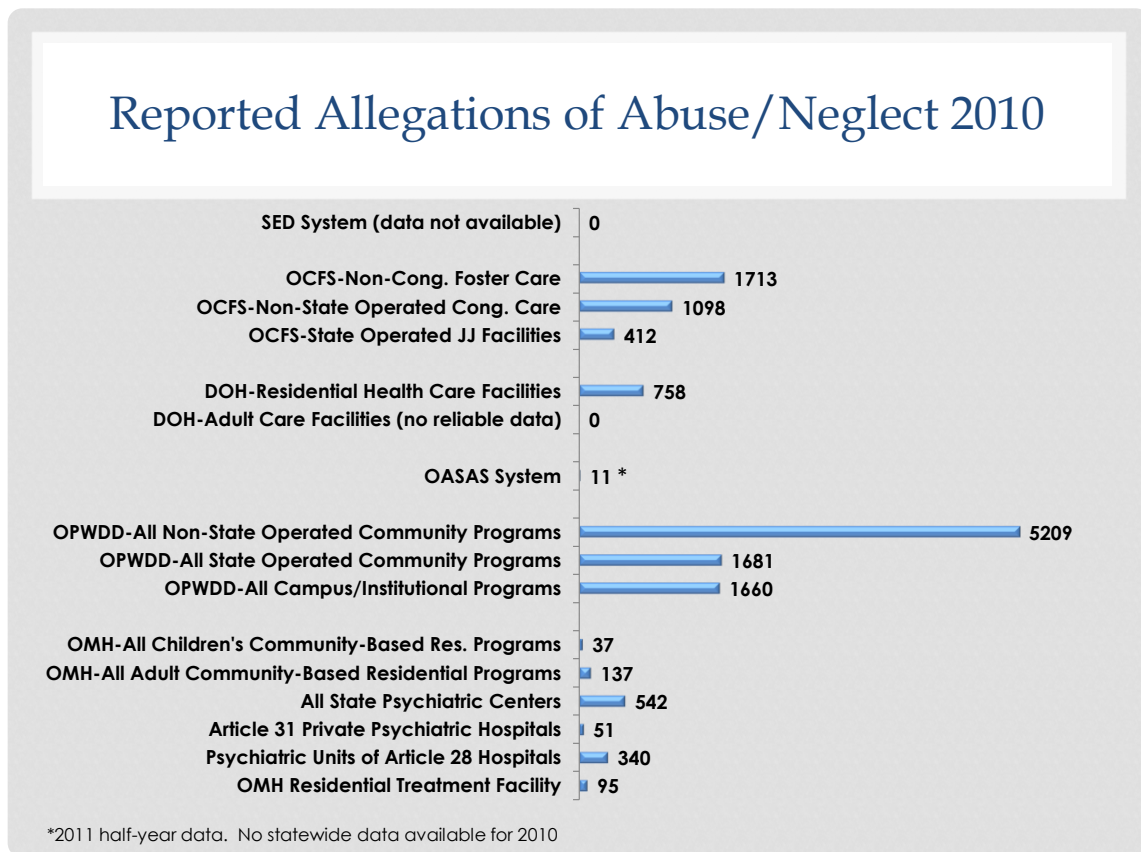
something goes wrong, the direct support worker is expendable, most often targeted for dismissal, justly or unjustly, especially in the private sector which generally lacks robust due process protections for employees.

### **III. Incident Reporting and Investigations**

Incident reporting systems are an essential part of a functioning quality assurance and quality improvement system. They exist for reporting deviations from expected performance, with the purpose of ensuring swift and thorough investigations into incidents, identification of errors and their causes, and the prompt implementation of appropriate corrective or disciplinary action, and preventive measures to avoid recurrence. The existence of these systems is an essential safeguard for vulnerable residents and is also intended to reassure family members that there is constant vigilance for the safety and welfare of their loved ones who have been entrusted to the care of the state or its agents. The occurrence of an incident opens up a window of opportunity for scrutiny of how a program is operating, of how the incident occurred and the factors causing or contributing to its occurrence and for implementation of improvements to reduce the likelihood of future incidents. As will be discussed later in this report, there is considerable variability among state agencies in how incident reporting and investigation systems are implemented, and how widely the window is opened to examine the root causes and contributing factors leading to incidents.


For incident reporting and investigation systems to work, they require the trust and confidence of the two groups of people who are the most knowledgeable about what happens on the frontlines of the service systems, at the point of service delivery. These are the residents themselves and the direct support workers. If these groups do not have trust and confidence that the systems will work as intended, and are not trained, encouraged and supported to report incidents and protected against reprisals when they do, the systems will fail at the very first step, by a failure to report incidents. The variable and generally low rate of reporting in some human service systems and facilities suggest that there is a significant problem of non-reporting and under-reporting of incidents. In section V below,

this report will describe in greater detail the barriers and disincentives to reporting incidents by both groups.



**Figure 2—Reported Allegations of Abuse/Neglect in various classes of facilities**

It is notable that some state agencies do not keep track of and could not provide information regarding the volume or rates of reported incidents of abuse and neglect. OCFS Family Type Homes for Adults have traditionally been overseen by local social services districts and statewide data about reports of abuse and neglect at these facilities were not available. Concerning adult care facility data, DOH does not maintain a centralized system for recording reports of abuse. Data on abuse allegations are kept by DOH's Regional Offices. However, the Regional Offices vary with regard to the types of abuse data recorded. Some may include abuse of staff by residents, or resident to resident abuse, while others may not. As such, comparable data for establishing rates were not readily available. The residential components of SED certified schools in New York State are under the jurisdiction of other state agencies, and abuse numbers and rates for these were included in the calculations for those agencies. There were no allegations of abuse



from the two schools SED directly operates according to the State Central Register and SED has no data on allegations of abuse arising in out-of-state schools.

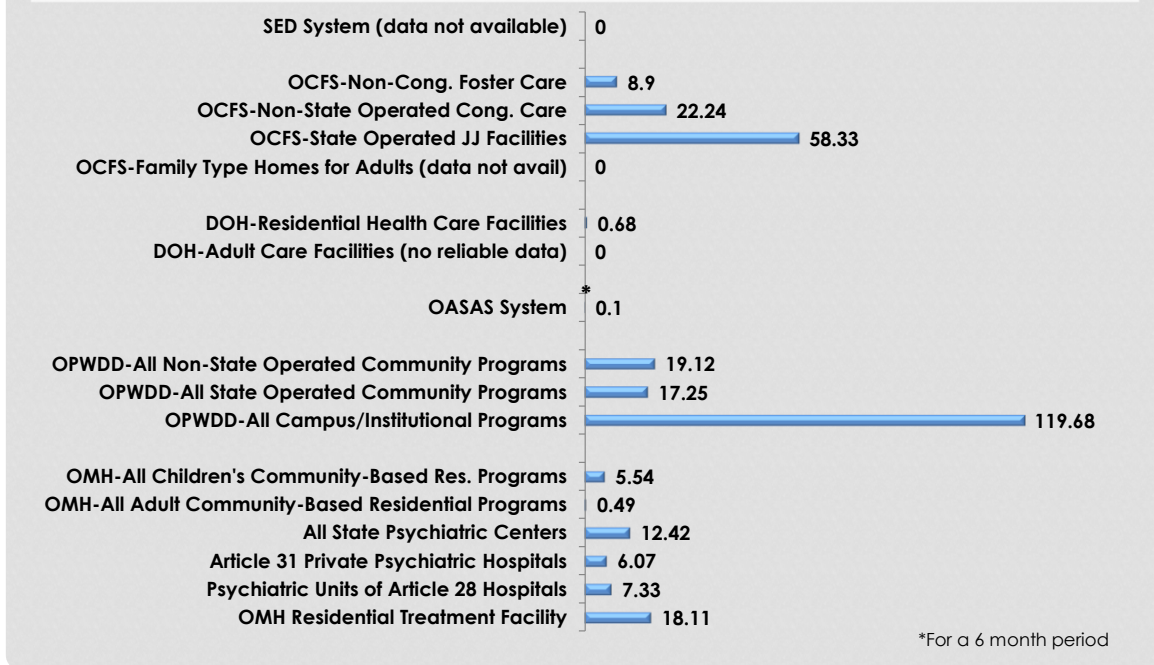
For other systems serving large numbers of individuals in residential care (see Figure 2 above), the overall level of reporting is very low, raising concerns about under-reporting and non-reporting of incidents of abuse and neglect. OASAS issued incident reporting regulations for all chemical dependency programs in late 2010. Although occupancy rate data for 2010 were available, no statewide abuse data were available for that period given the recently promulgated regulations. Statewide abuse data were provided for the period December 1, 2010 through May 31, 2011. To calculate rates, the 2010 occupancy rate data was used.

Aside from the variable rates of reporting between different types of facilities as depicted in Figure 3 below, there is also great variation among similar facilities within each type of program.<sup>4</sup> Reporting rates are also likely to be affected by decisions made at the facility level and sometimes at the state agency level about how to classify an incident that is reported. For example, a relative's report of finding a resident lying in a soiled diaper may be classified as an allegation of neglect; or it could be classified as a complaint about quality of care; or it may be treated as a violation of a required standard of conduct. Each classification opens up a different pathway for addressing the underlying incident. There are many other factors which influence reporting patterns, which are discussed later in this report, but the leadership and management of each facility and the type of culture and values that exist in the workplace strongly influence reporting behavior.

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<sup>4</sup> Abuse allegation rates per 100 occupied beds should be viewed as rough comparisons as data which were completely comparable across all state systems were not available. They were calculated using 2010 abuse allegation data provided by state agencies and either certified capacity and occupancy rate data for 2010 provided by some agencies, or actual census data provided by other agencies for points in time, usually quarters, for 2010. These rates do not reflect the reality that residents' length-of-stay (LOS) vary across facility types and that 100 beds occupied in one type of facility may serve many more people over time than 100 beds occupied in a different type of facility. For example, the average LOS in a psychiatric unit of a general hospital is 14.1 days; in certain community residential facilities the average LOS may be a year or more; and in other facilities, such as developmental centers or residential health care facilities, lengths-of-stay may be many years, if not a life-time for some residents. Essentially, no two facilities with 100 occupied beds are the same in terms of their residents' exposure to abuse. In short-term stay facilities, more residents may be exposed to abuse given the ebb and flow of residents; in longer-term stay facilities, where resident turnover is less, residents may be exposed to more frequent acts of abuse.

## Abuse Allegations Per 100 Occupied Beds - 2010



**Fig. 3 Rates of Reported Allegations<sup>5</sup>**

### IV. What's Wrong with the Existing System?

The variability of reporting rates from different types of facilities is also influenced by the different policy guidance provided by state agencies. Current reporting and investigation practices are guided by two separate conceptual frameworks for dealing with allegations of abuse/neglect of vulnerable persons in out-of-home placements, one dealing with all residents generally and the other specifically with children. Within each framework, definitions of abuse/neglect and systems for investigating, remediating situations and protecting individuals from future harm differ based on the regulatory requirements of the six state agencies responsible for the care and protection of vulnerable New Yorkers. For agencies serving both vulnerable adults and children – who equally require protection from harm - difficulties in implementing prescribed standards become significantly more complex.

<sup>5</sup> A more detailed breakdown of agency reporting rates, based on available data, is included in Appendix C.



### ***A. General Framework***

Reports of resident abuse and neglect must be put into the larger context of all untoward events or incidents which cause or have the potential to cause residents harm. Some state agencies - OASAS, OMH and OPWDD - have promulgated incident management standards for all programs they operate or certify. These standards require the identification, reporting, investigation and review of harmful events (not only abuse or neglect) in order to identify causes and take corrective action to prevent their recurrence. DOH has prescribed similar requirements for Residential Health Care Facilities. However, in the case of Adult Care Facilities, DOH does not have similar requirements nor do OCFS and SED require comprehensive incident management systems at the program level.

In the absence of comprehensive incident management systems, programs miss opportunities to identify and address abuse and other significant events which may endanger residents. An example illustrates the gap. A resident falls down a flight of stairs and is injured. Was he pushed? And if so, by whom? An employee? A fellow resident? Did he trip as a result of an environmental hazard in need of repair? Had he recently developed ambulation problems that clinicians were unaware of? In some programs, these questions and others would be explored as a result of incident reporting and investigation requirements. In other programs, however, the event would only require reporting and investigation if the resident or someone else alleged he had been abused or pushed by an employee. As depicted in Appendix D, the laws and regulations of the state agencies which serve vulnerable persons differ significantly in many important respects regarding the reporting and investigation of abuse and neglect. Some of these include:


- ***Whose conduct is covered by abuse reporting and investigation systems?***  
Some systems focus on employees only, while others cast a wider net to include all persons coming in contact with the service recipient. OMH, for example, defines abuse as certain acts of an employee, defined as an “administrator, employee, consultant, volunteer or student affiliated with a program” (14 NYCRR

524.4 (a) and (g)). OPWDD indicates that certain acts or inactions by “anyone,” including employees, consultants, visitors, contractors, fellow service recipients and others (family members, neighbors, etc.) constitute abuse (14 NYCRR 624.4 (c)). DOH, like OMH, covers employees only and does not require that abusive acts by residents of residential health care facilities upon other residents be reported as abuse (10 NYCRR 81.3).

- ***For what conduct?*** The breadth of the conduct that falls within the definition of “abuse” and “neglect” also varies widely among agencies. OPWDD has the broadest definitions while other agencies have definitions that are narrower but varying in scope. OPWDD’s definition of physical abuse, for example, indicates that in addition to hitting, slapping, kicking, strangling, etc., “physical contact which is not necessary for the safety of a person and/or causes discomfort” may be considered abuse. OPWDD defines neglect, in part, as a condition of deprivation in which persons “receive insufficient, inconsistent or inappropriate services to meet their needs” (14 NYCRR 624.4(c) (1), (10)). OMH defines physical abuse as non-accidental contact that “causes or has the potential to cause pain or harm” (14 NYCRR 524.4(a) (2)). Neglect, according to OMH regulations, is any act or inaction which “impairs or creates a substantial risk of impairing a client’s physical, mental or emotional condition” (14 NYCRR 524.4(o)). Regulations for DOH and OCFS certified Adult Care Facilities (18 NYCRR Parts 487, 488, 489, and 490) do not describe what conduct constitutes abuse or neglect, nor do mandated incident reporting forms identify neglect as a reportable incident. Surveyors from DOH indicated that operators as well as DOH surveyors interpret abuse differently: to some it may include resident-to-resident assaults and resident assaults on staff, and to others it may mean solely staff’s physical abuse of residents, and not emotional abuse. This, plus the fact that neglect is not a reportable incident, makes determining rates of abuse and neglect in these facilities a nearly impossible task.
- ***Who investigates the reported abuse/neglect?*** In some systems, investigations are done by the provider agency with reports to the certifying agency; in others

investigations are done by the certifying agency as well. Still others are silent on the responsibility for investigations. In their regulations requiring programs to establish comprehensive incident management programs for the reporting, investigation, review and remediation of incidents, OASAS, OMH and OPWDD require that facilities investigate all allegations of abuse. OASAS, OMH and OPWDD are permitted to directly investigate any allegation, but are not required to do so (14 NYCRR Parts 836, 524 and 624). In the DOH regulated nursing home and health related facility system, while individual facilities are required to develop incident management policies and procedures and to report and investigate allegations of abuse, DOH is required to directly investigate each allegation as well (PHL § 2803-d (6); 10 NYCRR 415.4 (b)). By contrast, there are no requirements that programs supervised or certified by SED or OCFS develop incident management systems and conduct internal investigations of incidents and allegations of abuse. Rather, allegations of child abuse and neglect in these programs reported to and accepted by the Statewide Central Register of Child Abuse and Maltreatment are investigated by OCFS.

- ***What requirements are there for investigations?*** Some state agencies require/encourage training for investigators, others do not. Standards for investigation reports vary. Some address potential conflicts of interest of investigators, others do not. Some agencies have scarcely any requirements for investigations. OMH's Manual for Special Investigations provides step-by-step guidance for investigators in state operated facilities. OMH encourages staff from agencies it licenses to attend training in investigations it offers periodically across the state. Recently, OMH has added training on conducting Root Cause Analysis of Sentinel Events to its training roster. Both DOH, for residential and health care facilities, and OPWDD, for all its facilities, require thorough investigations of reports of abuse and identify elements of such investigations. DOH addresses issues such as identifying witnesses, securing witness statements, reviewing statements of policies and other documentary evidence, and analysis of the evidence gathered to reach conclusions as to what occurred (DOH Dear Administrator Letter-DAL/DQS 05-10). OPWDD addresses reviewing adequacy



of staffing patterns and training, supervision and resident behavioral needs and establishing specific facts as to what occurred and why. Both state agencies require or strongly encourage that investigators be trained in investigative techniques. OPWDD also requires an arms-length distance between the investigator and the event being investigated (OPWDD Part 624 Handbook for standards 624.5(b) (6) and 624.5(c)). On the other hand, standards for DOH certified Adult Care Facilities and OCFS Adult Care Family Type Homes do not directly address an operators responsibility to investigate incidents or allegations of abuse; they merely require that the resident's version of events be included on the standard incident report - DSS-3123 (18 NYCRR 487.7 (d)(13) and 18 NYCRR 489.10(b)(13)). The DSS-3123 form itself, however, indicates that statements of other participants or witnesses are to be attached, suggesting, but not requiring, some level of inquiry into the event be conducted.

**Key Standards Concerning Incident Reporting and Abuse/Neglect (A/N)  
Across Human Service Agencies Providing Residential Services**

Issue	DOH- HRFs	DOH- Adult Care Facility	OCFS Youth / Secure	OCFS Youth / Other	OCFS Adult Family Homes	OPWDD	OMH	OASAS	SED In-State	SED Out of State
Incident Management Program Required										
Definitions of A/N										
Program Investigates A/N										
Timeframe for Program Completion of Investigation										
Requires Trained Investigators										
Program Reports A/N to NY Licensing Agency										
NYS Licensing Agency Conducts Investigation										

**Fig. 4 Key Standards**

- Required by law or regulation for all programs
- Encouraged or permitted by State licensing agency, but not required of all programs
- Not addressed by law or regulation

- ***What is the standard of proof used in investigations?*** The standard of proof for substantiation of an allegation is generally preponderance of the evidence, although some systems are silent on this issue and child abuse investigations use “some credible evidence” as the standard of proof. However, if the subject of a report challenges the determination of the investigating agency to “indicate” a report, the standard of proof in the subsequent review process is a preponderance of the evidence.

## APPLICATION OF EVIDENTIARY STANDARDS ACROSS SYSTEMS FOR ABUSE/NEGLECT ALLEGATIONS (A/N)

Applicable to:

Standard / Use	DOH	OCFS	OASAS	OMH	OPWDD	SED
<u>Sufficient credible evidence</u> : used to confirm A/N allegations for Article 28 Nursing Homes/Health Related Facilities	✕					
<u>Some credible evidence</u> : used by Institutional Child Abuse Investigating Authorities to confirm / indicate child A/N allegations		✕	✕	✕	✕	✕
<u>Fair preponderance of evidence</u> : used in fair hearings to <u>sustain</u> determinations made by Institutional Child Abuse Investigating authorities		✕	✕	✕	✕	✕
<u>Preponderance of evidence</u> : used by programs operated or certified by NYS to confirm A/N of any service recipient, child or adult			✕	✕	✕	
<u>Preponderance of evidence</u> : used by programs operated by NYS in disciplinary actions involving employees covered by collective bargaining agreements	✕	✕	✕	✕	✕	✕
No standards specified in regulations governing abuse in Adult Care Facilities certified by DOH and OCFS	✕	✕				

**Fig. 5 Evidentiary Standards**



- ***What is the standard for reporting possible crime to law enforcement agencies?***

The requirements for reporting allegations of abuse to law enforcement authorities also vary both as to the conduct to be reported and the sufficiency of information that triggers the duty to report. The Department of Mental Hygiene (DMH) agencies are required to report to law enforcement if there is reason to believe that a ***crime*** has been committed. (MHL §§ 7.21 (b); 13.21(b); 16.13 (b); 31.11 (2)).<sup>6</sup> But the Social Services Law governing adult homes sets the reporting threshold at ***felonies*** (SSL §461-m). SED regulations require reporting incidents “of a criminal nature.” (8 NYCRR 200.15(e) (1) (ii)). For other types of facilities, reports are required only if the District Attorney of the locality has indicated a prior interest in receiving them. For residential health care facilities, DOH reports all cases to the Medicaid Fraud Control Unit (MFCU) in the Office of the Attorney General which has the capacity to conduct its own investigations and to prosecute criminal behavior. In 2010, the MFCU conducted 50 prosecutions for abuse or neglect or misuse of residents’ funds in such facilities and obtained 36 convictions (MFCU 2010 Annual Report).

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<sup>6</sup> Pursuant to Chapter 558 of the Laws of 2011, these laws were amended to expedite the reporting process for allegations involving sexual abuse of “an incompetent or physically disabled person.”











Standards for Reporting Abuse Allegations to Law Enforcement Authorities	
Standard for Reporting	Agencies Governed by Reporting Standard
If it appears a crime may have been committed	<ul style="list-style-type: none"> <li>• OASAS, OMH, OPWDD operated or certified programs</li> <li>• Commission on Quality of Care (CQC)</li> </ul>
If there is reasonable suspicion of a crime	<ul style="list-style-type: none"> <li>• DOH Residential Health Care Facilities</li> </ul>
If it is of criminal nature	<ul style="list-style-type: none"> <li>• SED residential programs</li> </ul>
If it is believed a felony crime may have been committed	<ul style="list-style-type: none"> <li>• DOH certified adult care facilities</li> </ul>
If it is determined that it appears likely a crime may have been committed	<ul style="list-style-type: none"> <li>• OCFS in its capacity as a child abuse investigating authority</li> </ul>
Any crime (i.e. any act believed to be a misdemeanor or felony as defined by NYS Law)	<ul style="list-style-type: none"> <li>• OCFS policy for its state-operated facilities</li> </ul>
Upon prior written request by the District Attorney	<ul style="list-style-type: none"> <li>• Child abuse investigating authorities (i.e. CQC &amp; OCFS) relative to child care residential settings</li> <li>• DOH relative to Residential Health Care Facilities</li> </ul>
No standard articulated in regulations governing incidents	<ul style="list-style-type: none"> <li>• OCFS certified adult care facilities (i.e. Family Type Homes)</li> <li>• OCFS certified child care facilities (some events in these facilities may be reported by child abuse investigating authorities if they have received a prior written request from a District Attorney)</li> </ul>

**Fig. 6 –Standards for Reporting Crimes**

- *What requirement is there for maintenance of a registry?* DOH is the only agency required to maintain a registry indicating whether direct support staff -- nurse aides -- have been determined competent and also whether they have had a criminal conviction related to resident abuse or have been found responsible for abuse, mistreatment, neglect or misappropriation of residents' property by DOH (PHL § 2803-j and 10 NYCRR 415.31). Other types of convictions in state, and convictions in other jurisdictions, are not required to be reported.

Residential Health Care Facilities cannot employ individuals on the registry who have been found responsible for abuse or who have certain criminal convictions. Other human service residential agencies, however, do not have similar restrictions.

OCFS maintains the Statewide Central Register of Child Abuse and Maltreatment (SCR) that contains information on institutional child abuse cases. The information in the SCR is used by prospective employees in the child care field to check on prospective employees.






Issue	DOH-HRFs	DOH-Adult Care Facility	OCFS Youth / Secure	OCFS Youth / Other	OCFS Adult Family Homes	OPWDD	OMH	OASAS	SED In-State	SED Out of State
Requires Incident A/N Trends Analysis										

**Fig. 7 Trend Analysis**

- ***What requirement is there to perform trend analyses?*** An important part of a quality assurance and quality improvement process is looking for patterns and trends in reported incidents and examining reasons for outliers. In their incident reporting regulations, OASAS, OMH and OPWDD require facilities to have internal review committees. In addition to critiquing the thoroughness of individual investigations and the appropriateness of recommendations arising from such, these committees are charged with looking at patterns or trends in incidents and abuse allegations and to recommend appropriate actions to safeguard against their recurrence (14 NYCRR 836.8, 14 NYCRR 524.8 and 14 NYCRR 624.7). DOH likewise requires nursing homes to have quality assessment and assurance (QA) programs to develop and implement quality improvement initiatives by identifying clinical and administrative problems in need of attention. Among other things, members of the QA committees must regularly review resident complaints, reported incidents and other documents pertinent to problem identification (10 NYCRR 415.27). OMH and OPWDD are subject to a requirement to perform such analyses and report to the Commission on Quality of Care and Advocacy for Persons with Disabilities (CQC).<sup>7</sup> DOH is

<sup>7</sup> MHL § 29.29 requires uniform procedures for “reporting, compilation, and analysis of incident reports” of accidents and injuries affecting patient health and welfare at facilities. CQC has a requirement to prepare an annual report on the protection of children in residential care from abuse and neglect for the DMH agencies (MHL § 45.07(c) (9)) and OCFS is required to provide an annual report on abuse and neglect allegations involving children in residential care (SSL § 426). See also, MHL § 16.19 (d) (3).

required to submit an annual report on incidents of abuse, mistreatment and neglect in nursing homes statewide to the Governor and Legislature (PHL § 2803-d (9)). There are no comparable requirements for other state agencies or the programs they certify.


Issue	DOH-HRFs	DOH-Adult Care Facility	OCFS Youth / Secure	OCFS Youth / Other	OCFS Adult Family Homes	OPWDD	OMH	OASAS	SED In-State	SED Out of State
Program Reports A/N to Independent Oversight Agency with Power to Investigate Reports and Other Matters	OAG / MFCU		SCOC			CQC	CQC	CQC		

**Fig. 8 Independent Oversight**

- *What requirement is there to report to external parties with the oversight/investigatory powers?* The DMH agencies are subject to oversight by CQC (MHL § 45.07) and CQC has some oversight responsibilities for adult homes licensed by DOH (MHL § 45.10). Secure juvenile facilities are subject to the oversight of the state Commission of Corrections (SCOC) (Correction Law Article 3, 9 NYCRR 7406). The Office of Attorney General receives reports of abuse and neglect in nursing homes and other health-related facilities and has the authority to investigate and prosecute such cases (42 USCA § 1396(b)(q)(4) and 42 CFR § 1007.11). But other state agencies (OCFS, SED, and DOH-Adult Care Facilities) and their residential programs are not subject to independent oversight.<sup>8</sup>

These differences affect the scope and effectiveness of the protection provided to the residents, and probably the interpretation of the state collective bargaining agreements which do not independently define patient abuse for the purposes of employee discipline. Moreover, even systems covered by the *same* set of laws vary significantly in the manner in which these laws are implemented, which also affects the scope and effectiveness of

<sup>8</sup> A fuller description of the requirements of each state agency for reporting, investigating and responding to allegations of abuse and neglect is contained in Appendix E.



their response. Actual reporting practices of providers vary widely within and between the different human service systems, making reliance on the volume of reported incidents an inaccurate indicator of the actual level of harm that may be occurring (*See*, Figures 2 and 3 above). Finally, the different systems are subject to differing levels of oversight of the manner in which they carry out their obligations. While the CQC has oversight jurisdiction of the mental hygiene agencies and their providers, and the state Commission of Corrections maintains oversight over some aspects of secure juvenile detention facilities, much of the rest of the system has no effective independent oversight.

The inconsistency of definitions and varying reporting responsibilities is confusing to providers, a significant subset of which operate programs licensed or certified by more than one state agency, sometimes on the same campus. This co-location phenomenon is particularly prevalent with programs providing residential services for children and adolescents. There are at least 112 agencies issued operating certificates to provide residential/inpatient care by multiple state agencies, each with different incident and abuse reporting and management standards. A number of these agencies serve only adults; others serve children and adults; and still others serve children exclusively. At least 14 agencies serving children have multiply certified programs located on the same campus, often just yards apart from each other, thus exacerbating problems for staff who must adhere to varying standards as residents mingle during campus activities and programs, or who are assigned to work on units operated under different reporting standards.


## Number of Providers with Multiple Licenses (n=112)

Provider Numbers	State Certifying Agencies			
43	OASAS	OMH		
2	OASAS	OPWDD		
28	OMH	OPWDD		
13	OMH	OCFS		
9	OPWDD	OCFS		
3	OASAS	OMH	OPWDD	
11	OMH	OCFS	OPWDD	
1	OASAS	OCFS	OPWDD	
2	OASAS	OMH	OPWDD	OCFS

**Fig. 9 Providers with Multiple Licenses**

The inconsistency complicates the challenge of communicating simply to direct support employees the obligation to report abuse and neglect. It creates unnecessary requirements for differential training which involve more time and expense, and likely diminished effectiveness.





















In summary, what emerges from this review is that there is one service system –nursing homes and health related facilities supervised by DOH – which has a robust statutory framework and established policies and procedures for the reporting and investigation of allegations of abuse and neglect, with internal review of investigations by the Division of Legal Affairs and external reporting to the Office of Attorney General’s Medicaid Fraud Control Unit, and a registry for nurse’s aides to be used in screening prospective employees. This system, which was established in the wake of the nursing home scandals of the 1970s and based on the recommendations of a Moreland Act Commission established by the late Governor Hugh L. Carey, supplemented by more recent



requirements of the federal Centers for Medicare and Medicaid Services, has in place all of the key standards examined (as depicted in Figure 4). Applying the maxim, “if it ain’t broke, don’t fix it,” I recommend leaving this discrete system intact and not disrupting its operations while attempting to remedy the more obvious deficiencies in other parts of the human services systems. This is not to say that all of these statutory and regulatory mechanisms are working consistently as intended, but this system does not appear to present the same types of concerns as the others described in this report. The DOH should report in its next annual report to the Governor and Legislature on the operational issues that may exist in this system, especially in the area of possible under-reporting of incidents of abuse and neglect, and their capacity to timely and thoroughly investigate all reports. The observations of the Attorney General’s Medicaid Fraud Control Unit and the Long-Term Care Coordinating Council on these issues would also be helpful and instructive.

### ***B. Children’s Framework***

While the response to adult abuse is characterized by variability and inconsistency between state agencies responsible for the operation or supervision of different human service systems, the Child Abuse Prevention Act (CAPA) provides a common construct for dealing with institutional child abuse that cuts across most institutional facilities. However, this statutory commonality is undercut by the variability with which state agency regulations define abuse and neglect. This variability affects the manner in which the child abuse statute is interpreted to apply to conduct within their programs. So, if the failure to perform an act is defined as neglect in one agency’s regulations (e.g., sending a child to bed before the recreational program prescribed in the individual service plan) this conduct will fall within the statutory definition of neglect for its operated and certified programs, while the same conduct at a program governed by another agency’s more narrowly written regulations would not.

Issue	OCFS Youth / Secure	OCFS Youth / Other	OPWDD	OMH	OASAS	SED In-State	SED Out of State
Program Reports Child A/N to Child A/N Investigators							
Time Frames for Child A/N Investigation Complete							
Child A/N Investigators Trained							

**Fig. 10 Key Standards for Child Abuse Investigations**

In New York, the responsibility for institutional child abuse investigations is assigned by law to either OCFS (for juvenile, foster care, in-state residential educational facilities and co-located facilities) or the CQC for children in DMH facilities. Children sent by New York State to out of state residential facilities are not covered by this law and their protection against abuse depends largely on the child abuse system in place in the receiving state, with no consistent oversight by any New York State agency.<sup>9</sup> So, what's wrong with the institutional child abuse structure?

New York's institutional child abuse law is built on an inappropriate foundation of familial child abuse standards and incorporates much of the law and process that may be appropriate in familial situations but which are completely ill-suited to the environment of residential care facilities.

1. The familial child abuse laws have a very low threshold of proof ("some credible evidence") and were designed to enable child care workers to enter a family home, assess the risk of danger to the child's life or health, and intervene swiftly to either remove the child or to offer support services to a family in need.

<sup>9</sup> As of June 30, 2011, there were approximately 650 students in such facilities in 12 states at an annual cost of approximately \$143 million. For adults who remain in out of state facilities, the protection is even more uncertain as some states have no effective adult protective service to deal with institutions.

2. This low standard of proof serves no function in a residential care facility where the child has already been removed from his or her family, there are no public policy considerations of intrusion into family life, the state and the residential care provider already have a large arsenal of tools to provide protection and additional services that may be needed.

3. The low standard of proof also makes the investigations done pursuant to the child abuse laws useless in employee disciplinary cases which have different definitions of abuse and neglect and a different and higher standard of proof. As a result, an employee can be "indicated" for child abuse (even multiple times) and yet not subject to any significant discipline, as the standard of proof of a violation of the disciplinary code of conduct may not be met. It is likely that at present there are many employees working directly with children who have been "indicated" for child abuse and neglect. Agencies are hampered in publicly explaining their inability to discipline such employees and their continued employment by the secrecy that attends most aspects of this law. On the other hand, some private agencies have policies requiring the termination of any employee indicated as a result of a child abuse investigation.

The child abuse laws also do not distinguish between different types or gradations of abuse or neglect.<sup>10</sup> While the term "child abuse" conjures up in the public mind the types of horrific abuse that are reported in the press of sexual abuse of children or life-threatening violence or neglect, in the residential care context most of what is reported is generally of a much lower level of severity, most often a lapse in supervision. But once a report is accepted by the SCR as meeting the definition, the investigative process is triggered.

4. There are tight statutory time-frames governing investigative actions in child abuse cases, which do not exist for cases involving vulnerable adults. As a

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<sup>10</sup> In 2011, New York enacted legislation (Chapter 45) to enable counties to opt to institute a differential response to certain lesser serious allegations of child abuse, in place of the traditional child protective services response. This alternative response is rooted in the concept of rehabilitation with appropriate supports. The program – known as the Family Assessment Response, or FAR - started as a pilot in certain counties.

result, investigative agencies are forced to give lower priority to responding to a much more serious report of an abuse of a vulnerable adult.

5. The investigations result in a binary determination of either "indicated" or "unfounded." All indicated cases are treated alike regardless of the severity of the underlying conduct. The consequence of being indicated is being placed on the child abuse register for 10 years past the child's 18<sup>th</sup> birthday. This is an extraordinarily long period of time, particularly if the child is young. The rationale for this period makes sense in a familial environment where the relationship is life-long, but is of a questionable rational relationship in the case of a workplace characterized by frequent turnover of staff, especially in the voluntary sector.

6. The child abuse register is now used to screen prospective foster parents, adoptive parents, and employees in a wide variety of service professions. Thus, the employment consequences of an indication can last for a substantial portion of an individual's professional life.<sup>11</sup>

7. A substantial subset of the cases reported deal not with physical or sexual abuse of a child but with neglect, or the failure to perform a prescribed duty which results in harm or risk of harm. Many of these failures occur due to circumstances beyond the control of the employee on duty – e.g., short staffing or multiple and conflicting duties. Putting the names of such employees into the child abuse register, with all the attendant consequences, serves no useful purpose. An earlier attempt to recognize these types of cases as "institutional neglect" and focus the investigation on remedying the underlying conditions has been substantially undone by how the law has been interpreted and implemented. This concept was eliminated entirely by Chapter 323 of the Laws of 2008.

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<sup>11</sup> See, *In the Matter of Anne FF v. NYS Office of Children and Family Services*, 85 A.D. 3d 1289, [3d Dep't. June 2, 2011], annulling a determination to indicate a part time day care worker for a momentary lapse in supervision that resulted in no harm to a three-year old child. The worker, an honors college student, was motivated to challenge the indication as it would have ended her plan for a teaching career. (*Court restores dream of teaching*, Albany Times Union, June 13, 2011)


8. The investigative process itself exacts a considerable toll upon employees, providers and investigative agencies alike. The lack of discretion in responding to a report from the SCR also lends itself to the manipulative use of reports against employees by disgruntled children. Despite a very low standard of proof, less than 20% of the reported cases of institutional child abuse and neglect are “indicated,” (See, Fig. 10 below), and of these approximately half are overturned on appeal.

9. Finally, the institutional child abuse law is not as comprehensive as it needs to be. It does not address facilities' obligations to report and investigate harmful incidents which do not meet the statutory abuse/neglect definition (e.g., a child falling down a flight of stairs and suffering injuries), nor does it address their obligation to conduct trend analyses, institute corrective actions in all instances, train investigators, etc. Some residential programs of OMH/OPWDD (family care) are not covered under this law but are included under the familial definitions of child abuse.

## **V. Reporting Practices and Disciplinary Actions**

### ***A. Barriers and disincentives to reporting incidents***

As noted above, most of the abuse that occurs in residential facilities results from acts of frustration and exasperation rather than from sadistic or exploitive behavior by employees. Most of the neglect occurs due to fatigue, stress, lack of training and supervision, or inconsistent implementation of agency policies and practices, rather than deliberate inattention to the needs of residents. This “minor abuse and neglect” occurs most frequently during periods of greatest staff-to-resident interaction such as during mealtimes, bathing and dressing of residents who need assistance, transportation routines to get them to day programs or other appointments, when the cumulative effects of understaffing, varying job demands and the level of assistance needed are most acutely felt. The characterization of this type of abuse and neglect as “minor” is not intended to minimize its effect upon the residents but to distinguish it from more severe and more culpable forms of abuse or neglect.



Adverse working conditions are experienced by all direct support staff and most of them therefore understand what motivates such minor abusive conduct. Direct support staff see themselves as victims of a larger system that would be quick to punish them for minor abuses but that is slow to recognize and improve adverse working conditions that create the stress that contributes to this abusive behavior. Consequently, when they witness such abuse, they are more likely to merely caution the co-worker not to repeat the behavior. Minor offenses are rarely reported to superiors, except by visitors, trainees, or the residents themselves, by a fellow employee who feels personal animosity towards the abuser; or by other staff who become convinced that the abusive behavior is excessive in its frequency or degree, and beyond the informal, unarticulated norms that exist among the peer group.


Since minor abuse is often unreported,<sup>12</sup> and when reported difficult to prove due to the absence of physical evidence, few staff are ever punished for it or corrected by their supervisors. Given that and the conditions under which staff work, there is little general or specific deterrence to this type of minor abuse. A workplace culture which accepts and tolerates such minor abuse inflicts continuing damage upon the vulnerable residents. It poisons their daily lives and reinforces the stigma they already experience due to their disability or vulnerability. The acceptance of non-reporting of such abuse not only devalues the residents in the eyes of the staff but also creates a continuing risk that the line may shift over time to conceal increasingly severe abuse and neglect.

The so-called code of silence that exists for minor abuse of residents does not generally extend to major abusive behaviors such as sadistic behavior, sexual exploitation or the infliction of serious injuries upon patients. Direct support staff generally has little sympathy for such behaviors. Because such major abusive behavior lies outside the

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<sup>12</sup> In a recent survey of OPWDD staff to assess the culture surrounding the reporting of health and safety concerns, although staff reported a high level of knowledge about how to report abuse and neglect, between 4% and 19% of the employees admitted there were circumstances where they would not report alleged abuse and neglect, and between 39% to 79% of the employees believed their coworkers would not report in all instances. The primary reason given was a fear of retaliation.

Similarly, although there is a broad definition of neglect in the OMH regulations (14 NYCRR 524.4 (o)), there are many troubled facilities that have had no reports at all of neglect. There is also an overall low level of reporting from residential health care facilities and no reliable data on abuse rates in adult care facilities; together these modalities serve almost 150,000 residents (*See*, Figures 2 and 3 above).




informal staff norms and is less accepted by staff, it is less likely to occur in front of witnesses. Sexual behavior in particular tends to occur outside the presence of witnesses and is less likely to be discovered except in the case of a sexually transmitted disease or pregnancy.

But even when such behaviors are witnessed, there are powerful factors at work that hinder the prompt reporting of severe resident abuse by employees as well as by residents. These factors include management's attitude towards employees charged with allegations of abuse; perception of staff about the lack of evenhandedness of the disciplinary system as applied to clinical, managerial and supervisory staff on the one hand, and direct support staff on the other; and the ineffectiveness of the disciplinary machinery in punishing the alleged abusers, in state operated facilities.

### **1. Management's attitude towards alleged abusers**

Managers and supervisors often express the view that no abuse is tolerable and it is their intent to seek dismissal of any employee who is believed to have committed an abusive act. Such an attitude puts them on the side of the angels when it comes to dealing with consumers, advocates, families and the public. A "one-size-fits-all" zero tolerance policy which seeks termination as a response to every act of abuse is not only unfair to the employee but ultimately is an ineffective policy.

The concept of "zero tolerance" originally referred to a standard of conduct, rather than to a penalty. Thus, zero tolerance on drugs meant that the standard of conduct would be no drug use. But, over the years, zero tolerance has taken on a different meaning to embrace the application of an automatic penalty for a designated behavior. So, zero tolerance on drugs and weapons has led school administrators to suspend or expel students for bringing an aspirin pill or a nail file to school. Such an application of the concept of zero tolerance has been criticized for suspending good judgment and common sense. Making intelligent distinctions based upon the severity of conduct is entirely consistent with sound public policy and common sense. The concept of proportionality of a consequence to the severity of the act is deeply ingrained in our societal sense of justice. The penal law, for example,




makes distinctions in classifying transgressions as violations, misdemeanors and felonies and provides for differing consequences for such transgressions ranging from probation to a life sentence without parole, considering a variety of factors including the severity of the offense and the history of the offender.

In the context of abuse and neglect in residential settings, zero tolerance should be understood in its original meaning as a standard of conduct that clearly states that no abuse or neglect is acceptable and no such incident will be ignored or lack a consequence. Employees should be required to report all such incidents without exception. However, it does not follow that every such incident should be treated alike with an automatic penalty of termination.

For state employees, the disciplinary process is established through collective bargaining. It ultimately reposes disciplinary power not in the management but in an arbitrator jointly selected by the state and the union from a mutually approved list. Management may propose, but the arbitrator disposes. Management's decision to seek dismissal – the capital punishment of the workplace – for every act of abuse or neglect, regardless of severity, the employee's prior record or extenuating circumstances, generally will have three effects, all of them counterproductive. First, management will be unlikely to prevail in its recommendation in all but the most egregious cases of proven abuse or repeated misconduct. Second, the recommended penalty of termination will soon cease to carry any weight with the arbitrator who will perceive that the management is simply passing along a political hot potato rather than making an honest attempt to find a punishment proportionate to the offense. Third, the willingness of employees to report instances of abuse will be adversely affected since they recognize that such a report can be tantamount to a "death sentence" for a co-worker.

To the extent that management is perceived as seeking discipline tailored to the gravity of the offense, it is more likely to impress the arbitrator, prevail in its position, and eliminate an unnecessary but powerful barrier to reporting of abusive incidents.




In the private sector where there is generally no comparable formal disciplinary process, the problem is of a different nature. Employers are likely to dismiss a worker who is accused of abuse, sometimes even before an investigation into the allegation can be completed. Such a practice may be intended to send a message of being tough and intolerant of abuse, but the message is likely to be received by employees as both an unjust and sometimes disproportionately harsh response to the underlying conduct and circumstances. This policy is also ultimately counterproductive as it simply reinforces the code of silence that prevents reporting incidents in the first place. It also allows managers to avoid a more searching inquiry which might require confronting their own responsibility for conditions leading to the incidents such as for scheduling adequate staff, providing training, supervision, correction and learning by their employees. Such unfair disciplinary practices powerfully communicate to employees management's lack of regard for their worth.

## **2. Fairness and proportionality of disciplinary action**

Closely related to management's attitude towards direct support staff that are charged with abuse are the perceptions of such staff about the fairness and evenhandedness of the disciplinary system in dealing with professional staff and supervisors who may bear a share of responsibility for conditions contributing to the incident under investigation. Policies and regulations dealing with abuse and neglect are often silent on the responsibility, beyond that of the person immediately involved in the incident, and investigations often do not focus on supervisory responsibility or management failures which contribute to the incident. Consequently, the disciplinary process usually does not address supervisory responsibility for failing to address a known danger with foreseeable harm, for long-standing tolerance of workplace practices that are inconsistent with agency policies and procedures or for a lack of training and supervision that may have contributed to the abusive incident.

Job descriptions for direct support staff are usually far more specific and detailed than those for professional staff and supervisors, which provide considerable latitude for acceptable behavior and make it more difficult to pin down failures of supervision or



training to specific duties. In a legally oriented disciplinary process, direct support staff is therefore more susceptible to discipline for breach of a defined duty than professional staff. Furthermore, when the implementation of a disciplinary sanction appears imminent, most professional staff have considerably greater employment options than direct support staff and are assisted in some cases by assurances of a clean letter of reference. If the disciplinary machinery is perceived to grind down the powerless while leaving the more powerful unscathed, direct support staff have no incentive to provide colleagues as fodder for this machine.

### **3. Effectiveness of the disciplinary process**

Even more important perhaps than the previous two factors in the state system is the employees' perception of the effectiveness of the disciplinary system once its operation is triggered in the case of a serious abuse. The employee who is an innocent witness to an incident of abuse is faced with a Hobson's choice: he can do nothing about it and become a silent accomplice, subject to disciplinary sanctions himself for failure to report the incident, or he can report the abuse, risk the wrath of and perhaps reprisals from the abuser and his allies, and face ostracism from fellow employees who do not approve of his action. The likelihood of discovery in the former instance is uncertain, but the negative effects of the latter course of action are likely to be real and immediate. Will the disciplinary system be effective in dealing with the abuser or will it fail, leaving the employee who reported the abuse in the uncomfortable and even untenable position of working alongside the abuser and his allies?


In the state system, the employee witness confronts a difficult choice between doing the right thing and the wrong but perhaps prudent thing. The available evidence indicates that only a small percentage of cases of reported abuse ever reached the arbitration stage and even then, the chances of proving guilt are uncertain. Moreover, even if the employee is found guilty of an act of serious abuse there is a substantial probability that he will probably not be terminated from employment but will eventually resume his resident care duties.

#### **4. Victims and residents as witnesses**

Like employee witnesses, victims and resident witnesses are placed in the difficult position of having to choose between silence and accusing an employee who is likely to remain in his job and in a position to retaliate. Residents depend daily on employees for their most basic needs. They and their families are at the receiving end of the power relationship and they are deeply fearful of the consequences, real or imagined, of complaining about employees.

In the state system, if a competent resident does choose to accuse an employee, the ensuing disciplinary proceeding is a mismatch. The employee and his union-supplied attorney, usually a skilled labor lawyer, may confront and cross examine the accusers, but the case for the facility typically is presented by a personnel officer, and the victim and other resident witnesses are entirely without representation. The personnel officer may fail to appreciate the relevance and probative value of key pieces of documentary, testimonial or circumstantial evidence. Personnel officers are likely to lack the training and experience to prepare their witnesses adequately for the experience of testifying or for the types and lines of questions they are likely to encounter. For resident witnesses, the cross-examination process itself may be a substantial ordeal particularly since, as with most of due process proceedings, lengthy delays are often inevitable. Their confidential clinical records may have to be disclosed to facilitate cross-examination. Finally, their very status as a person in a residential facility and their diagnostic history cast a shadow on the competence and credibility of their testimony. Few investigations and disciplinary cases supported solely by the testimony of a person in a residential facility are successful. Given these factors it is not surprising that victims and residents have demonstrated little enthusiasm for reporting abusive behavior.

In meetings held with groups of former residents, there has been striking consistency in their widespread reports of having been victims of physical, psychological or sexual abuse while in various types of residential facilities. Yet, most said they did not report the abuse for a variety of reasons. For some, it was a fear of reprisals ranging from overt threats and intimidation by staff, to the withholding of privileges like cigarettes, access to property or



phone calls to family, or a change in their level of privileges that would deny them access to the grounds or to community outings. Residents of facilities often have so little that taking away seemingly small things is experienced as taking away everything. Others said it was the practical problem of getting access to a telephone and privacy to make a call to a family member or friend to report the abuse and get help. Still others were discouraged by prior experiences of their own or fellow residents where their report of abuse was either not taken seriously or the investigation failed to substantiate it.

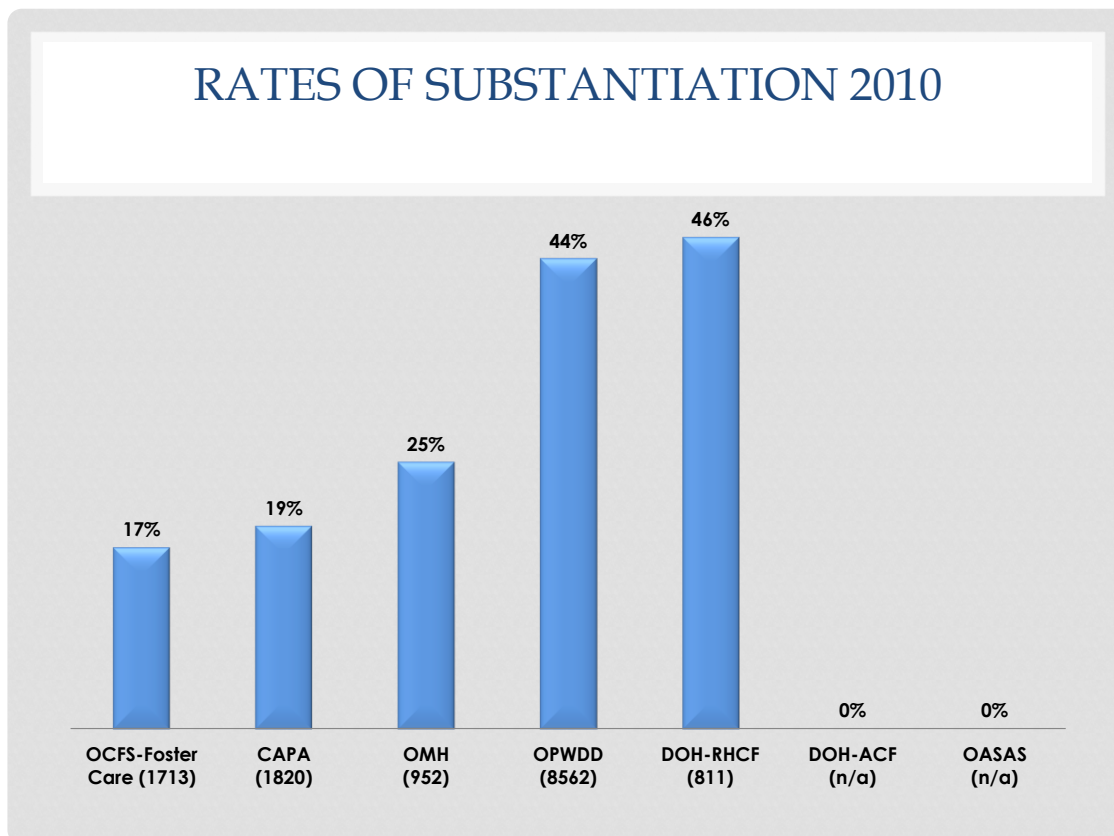
The elevated standard of proof that is sometimes applied in disciplinary proceedings seeking termination<sup>13</sup> and the strains on investigators and residents combine to produce investigations that often terminate inconclusively. This happens sometimes due to the inherent difficulty of investigations in the service environment but also due to skill deficits in the people assigned to perform investigations who, in some agencies, are not required to have any particular training or demonstrated level of skill, nor to be free of conflicts of interest that may impair their ability to conduct a searching inquiry.

### ***B. Inconclusive Investigations***

There is reason to suspect, however, that in addition to these very real problems, and perhaps because of them, managers have a fairly powerful and probably subconscious inclination to follow the path of least resistance. Barring any outcry by families or patient advocates, many will conclude an investigation with the decision of allegation unsubstantiated, which avoids the inevitable confrontation with labor unions and attendant adverse consequence for the facility and the resident (54% of the cases investigated in DOH facilities in 2010 were unsustainable and investigations ended inconclusively in 17% of the OMH cases and 26% of the OPWDD cases).

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<sup>13</sup> Friedman, CH: *Arbitration of discipline for abuse of mental patients*. ARBITRATION JOURNAL 33:16-22, 1978.



**Fig. 11 Rates of Substantiation**

The inconclusive results of investigations into reports of abuse and the failure of discipline when investigations conclude that serious abuse occurred simply reinforce the message to victims and witnesses of abuse that discretion in reporting may indeed be the better part of valor. The end result is that at present there is little externally imposed deterrence to abusive behavior, be it minor or severe.

Beyond the barriers discussed above, interviews with direct support staff reveal another more troubling practice, the prevalence of which is difficult to measure. In some agencies and at some sites, they report being actively discouraged by their supervisors from reporting incidents due to the supervisor's concern about the inevitable outside scrutiny that such reports might trigger. Some direct support staff in the private sector report that management's fear of liability for harm to residents results in initial reports being edited to recast the incident in a more benign light and to reduce the level of scrutiny they receive.




Despite the staff's disagreement with such actions, their fear of retaliatory dismissal prevents their speaking out about such practices when they occur.

The reporting and investigation systems are also not generally diligent in keeping the reporter informed of the outcome of the investigation or the implementation of corrective and preventive actions that may have been prompted by his or her action in calling attention to a problem by reporting the incident. Mandated reporters of child abuse and maltreatment have the right to request the findings of the investigation of a report they make (*See*, Social Services Law, § 413 (1) (c)). From an employee's perspective, scarcely anything positive comes from reporting an allegation of abuse or neglect. There are no plaudits for doing so but many negative consequences as described above. Some reporters complain that they are treated as "trouble makers" when they report such allegations and often become targets of discipline themselves, sometimes for lesser infractions such as time and attendance violations or vaguer charges of insubordination.

There are statutory protections on the books that were enacted to protect "whistle blowers" from reprisals for taking action to report various types of abuses (*See*, e.g. Labor Law, § 740; Social Services Law, § 413 (1) (c); and § 1150B of the federal Social Security Act applicable to certain Long Term Care facilities which receive federal funds). Despite these laws, the fears of retaliation persist at least in part because of the difficulty in proving that the employer's motive for an adverse personnel action was due to the protected activity, rather than "predicated on other grounds" (Labor Law, § 740 (4) (c)).

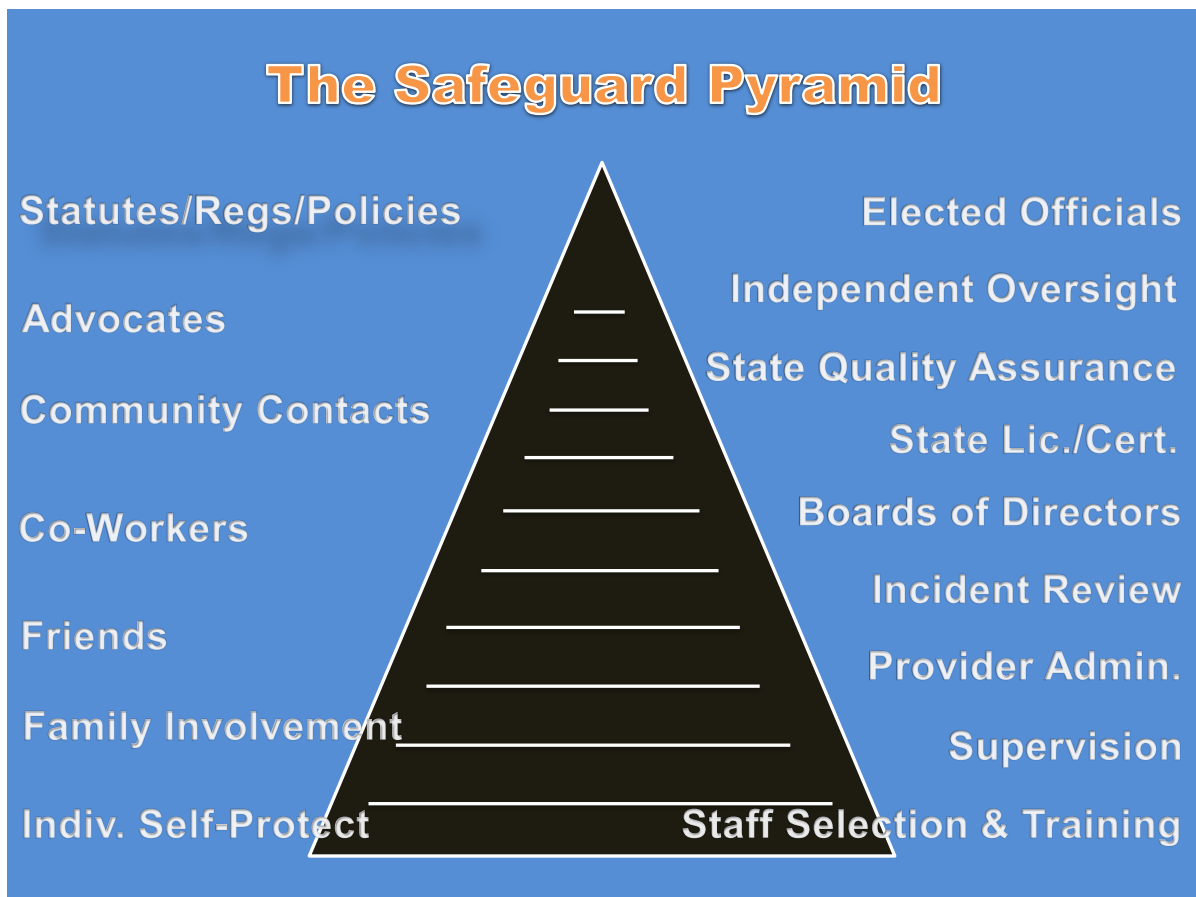
## **VI. Comprehensive Reforms**

All of these factors point to a need for a comprehensive approach to implementing a system of safeguards that addresses these critical problems with incident reporting and investigation in each service system, and restores the trust and confidence of the residents, staff, families and the public. Doing that requires a coordinated and consistent effort to:

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- Remove the barriers that currently prevent reporting incidents in the first place as described above;
  - Create an effective system for thorough investigations of incidents once reported;
  - Implement differential responses to reported incidents based on the nature and severity of the conduct at issue that provides for:
    - Termination of the small numbers of employees whose conduct clearly demonstrates their unsuitability for this line of work and prohibition of their reemployment in similar positions;
    - Prosecution of those who commit serious crimes against vulnerable residents;
    - Fair and proportional disciplinary action, including mechanisms for rehabilitation of employees committing lesser offenses; and
    - Identification and implementation of durable corrective and preventive actions that address the conditions which cause or contribute to the occurrence of incidents.
  - Ensure independent oversight and accountability of the system to the Governor, Legislature and the public.

While much of this effort is focused on the reporting and investigation of incidents of abuse and neglect, the larger context in which this work occurs must be kept in mind. As depicted in Fig. 11 below, the safety and well-being of vulnerable persons in residential facilities depends largely on the quality of their interactions with direct support staff with whom they interact on a daily basis. Their safety depends in the first instance upon their own capacity for self-protection and on how well provider agencies do their job of selecting direct support staff, inculcating a sense of mission in

the important role they are undertaking and training them to perform their important roles. When persons in residential facilities have a diminished capacity for self-protection and are also bereft of the regular support of family and friends and others in the community (the left side of the pyramid), their vulnerability increases as does their dependence upon formal safeguards (the right side of the pyramid). As one moves up each level of the pyramid, the protection offered by the specific safeguard is attenuated. It is therefore essential that leaders of the health, human service and education agencies and the leadership of provider agencies focus their efforts on strengthening the base of the pyramid.




**Fig. 12 Safeguards**

## A. *Four Pillars to Support the Safety Net*

1. *A strong, well trained and committed direct support staff.* The foundation for this comprehensive approach is a dependable, competent and caring core of direct support staff. Understanding the stresses of the workplace on the direct support staff, agency leaders and managers need to create a workplace culture that focuses upon and reinforces the value and ***purpose*** of the front-line worker. This requires more than simply teaching the skills required to perform job tasks; it requires inculcating an appreciation of their role in safeguarding and caring for vulnerable residents and helping agencies carry out their core mission. Efforts to achieve minimum standards through prescription of duties may be successful in achieving compliance, but such efforts by themselves do not fully capture the talents and value of staff which is best expressed when they are internally driven rather than externally mandated. There is a difference in training staff to check a fire extinguisher to make sure it is charged in order to pass an inspection, and teaching them that the lives and safety of the residents in an emergency depend on how well they carry out their safety responsibilities. The goal here is to create a community of caring, built upon personal and professional relationships between residents and staff that preclude the development of a culture of tolerance among the front-line staff of ***any*** level of abusive conduct in the workplace.

Supervisors and managers must see their role as coaches in creating such environments. Many front-line workers come to their jobs with very little knowledge about the nature of disability and may bring with them harsh and punitive attitudes towards common behaviors that are manifestations of the disabilities of those they are to serve. Some may come from societies in which people with disabilities are devalued and stigmatized. Managers must appreciate that their responsibility requires more than simply reacting to occasional reports of abuse and neglect. Managers need to play a direct and personal role in motivating and inculcating values among the staff they have recruited and coaching them in understanding the vital nature of their role, learning to perform their functions and reinforcing them when they do what they have been taught to do. An important



part of the duty is recognizing risks and ensuring that there is reasonable vigilance in guarding against them. Vigilance requires being attentive to the lack of reports and knowing when it is "too quiet out there." It also requires supporting and protecting workers when they report incidents that create discomfort because they do not reflect well on agency performance, rather than allowing or tolerating negative reactions to such reports.

2. Clear and intelligible standards of expected conduct. In place of the confusing maze of complex, differing and conflicting definitions of abuse and neglect, and the absence of any definitions at all in some human service systems,<sup>14</sup> there must be consistency, precision and clarity to communicate to those whose behavior is to be affected and what it is they should or should not do. As discussed in greater detail below, there is a need to define standards of conduct which staff can realistically meet in the workplace or else they will fail to win the respect of those whose conduct they govern, and will increase the risk of non-compliance. Simpler and consistent definitions of abuse and neglect across agencies will also facilitate the development and use of a common training curriculum on abuse and neglect prevention and reporting for all employees.


3. Simple and reliable incident reporting systems

a. *A single point of reporting with capacity to receive anonymous reports.*

The state has been successful in clearly communicating that reports of child abuse and neglect, wherever they occur, are to be called into a central toll-free hotline which is available around the clock and capable of screening and routing reports promptly to the appropriate investigating agency and to a law enforcement agency if there is reasonable suspicion that a crime has occurred. There is a need for the same type of simplicity and clarity when it comes to reporting allegations of abuse and neglect not only of vulnerable children but also of vulnerable adults in residential facilities. The capacity to receive anonymous reports is essential to respond to the experience of staff that there is discouragement from reporting incidents in some

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<sup>14</sup> See Appendix D for a chart comparing agency definitions of abuse and neglect.



programs, making waves or exposing programs to liability, and the fears of reprisals expressed by former residents and family members. The system must have the capacity to receive reports in a variety of ways currently in use in each of the human service agencies, including electronic transmission, telephone reports and fax transmission to avoid duplication or the creation of additional reporting burdens.

- b. *Prompt, thorough and effective investigations into incidents, their causes and contributing factors.*
- c. *Incident review processes that examine the thoroughness and adequacy of the investigation and its recommendations for appropriate preventive, corrective or disciplinary actions that appear warranted (and involve independent stakeholders).*

4. Effective implementation of preventive, corrective and disciplinary actions. This is necessary for direct support workers and individuals in their care and their families to put their faith in the system and to address the problems with the current system of discipline and arbitration. In doing so, there is a need to:

- a. *Distinguish between serious transgressions or repeated misconduct warranting termination and lesser offenses for which progressive discipline is appropriate.*
- b. *Implement proportional and progressive discipline.* For employees who will either remain in their jobs or return to employment following a period of suspension, there should be a system for developing individualized rehabilitation plans for disciplined workers to plan their re-entry to the workplace. Such plans should take into consideration repentance, reparations, rehabilitation and restoration, and address any particular training or supervisory needs and workplace conditions that would

facilitate successful re-entry with the support of co-workers and residents.

- c. *Examine and correct working conditions which cause or contribute to the incidents to give direct support workers a stake in the system and a reason to invoke it.* For employees to understand and appreciate the salutary effects of the reports they make, agencies must develop mechanisms to keep everyone in the workplace regularly informed of the preventive and corrective actions that are the outcome of investigations of reported incidents.


### ***B. Transparency***

For this system to work effectively and maintain accountability, it will require transparency to the residents, their families, advocates, the Legislature and the Governor. Some of the steps to assure transparency include:

- Providing reports on the outcomes of individual case investigations, with appropriate redactions of information that is required to be kept confidential under law, to residents and their families;
- Including representatives of family, consumer and advocacy groups in the membership of Incident Review Committees which review the adequacy of investigations and their outcomes, with appropriate safeguards against conflicts of interest and for preservation of confidential information and protection against the use of deliberations in lawsuits;<sup>15</sup>

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<sup>15</sup> This balance between transparency and confidentiality is consistent with Education Law section 6527(3) which expressly establishes that QA proceedings are privileged and case law has consistently upheld this privilege. Notably, *Katherine F.* found that the “thrust of 6527(3) is to promote the quality of care through self-review without fear of legal reprisal.” Furthermore, this case found that the language of the statute (Education Law section 6527(3)) is unequivocal, exempting three categories of documents from disclosure including records relating to medical review and quality assurance functions. [\*Katherine F. ex rel. Perez v. State\*, 1999, 94 N.Y.2d 200, 702 N.Y.S.2d 231, 723 N.E.2d 1016](#). See also, *Smith v. State*, 181 AD2d 227 (3<sup>rd</sup> Dept. 1992) and *Brathwaite v. State*, 208 AD2d 231 (1<sup>st</sup> Dept. 1995).

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- Independent oversight by the Justice Center of the whole system of reporting and investigation of reports of abuse and neglect, and an annual public report on system performance by the Center, as described below.
  - Extending the Freedom of Information Law to have state agencies require their private contractors be subject to the same disclosure requirements as state providers regarding the reports and investigations of allegations of abuse and neglect.

## **VII. The Proposed Alternative**

Implementing these comprehensive reforms will require statutory and regulatory changes.


The patchwork of existing laws, regulations, policies and practices often fail to distinguish:

- Abusive and even criminal conduct that requires termination of employment and swift and effective prosecutorial responses;<sup>16</sup> from
- Lesser transgressions that should be subject to progressive discipline, corrective action and opportunities for employee rehabilitation and return to employment; and from
- Harmful situations which arise from systemic problems, rather than specific employee misconduct, which cause or significantly contribute to reported incidents, and likely affect other residents and staff beyond those involved in the reported incident.

As discussed earlier, this failure to make intelligent and common sense distinctions contributes to the creation of a code of silence that results in the under-reporting or non-reporting of both minor and serious abuse and missed opportunities to meaningfully

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<sup>16</sup> In conjunction with the new collective bargaining agreement that calls for the development of a table of penalties for “increasingly severe acts of misconduct,” an interagency workgroup with OMH, OPWDD, OASAS, OCFS and GOER has developed a proposed list of serious offenses for which termination of employment is the only appropriate sanction.



address underlying factors that expose individuals to harm.<sup>17</sup> There is a need to recognize and respond to reports of institutional abuse and neglect differently than we deal with familial child abuse and neglect. The commonality here is not with children being cared for by their families but with all vulnerable persons in residential care, adults and children alike. I recommend a new law that replaces existing statutes governing the response of child abuse and neglect in residential settings and provides a uniform definition of abuse and neglect in residential care that would apply across the board to all vulnerable persons in such facilities,<sup>18</sup> and that are consistent with employee disciplinary standards of proof so that a single investigation could serve multiple purposes rather than the present system where multiple investigations produce inconsistent results and findings.

**Key elements of an alternative approach:**

**A. *Uniform definitions of abuse and neglect in residential facilities serving vulnerable populations.***

1. Definitions must broadly define abuse and neglect to meet the core obligation to protect vulnerable populations.
2. Classify abuse and neglect for differential handling and response based on severity.
  - i. Category one - serious physical and sexual abuse by employees which warrants criminal prosecution, and other serious offenses warranting termination of employment and placement on a permanent registry to ban employment in human services.<sup>19</sup> The law should contain a clear

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<sup>17</sup> CJ Sundram, *Obstacles to Reducing Patient Abuse in Public Institutions*, HOSPITAL & COMMUNITY PSYCHIATRY, Vol. 35, No. 3, pp. 238-243 (March 1984)

<sup>18</sup> This should cover all residential programs operated, licensed, certified or funded by OMH, OPWDD, OASAS, OCFS, DOH Adult Care Facilities and SED.


<sup>19</sup> Examples of such conduct include:

- 1) Non-accidental conduct that causes physical injury which creates a risk of death, or which causes death or serious disfigurement, impairment of health or loss or impairment of the function of any bodily organ or part or creates a foreseeable risk of such physical injury. Examples of such physical

proscription of continued employment upon a determination that an employee has committed a category one offense and bar the hiring of persons with a record of similar offenses. Clearly focusing on the most serious conduct for this response should help develop a consensus of support, including from labor unions.


- ii. Category two - lesser misconduct including abuse and neglect by employees, consultants and others who have regular and substantial contact with the residents of a facility. These would be subject to progressive discipline and, in the state system, addressed by the Table of Penalties developed pursuant to the collective bargaining agreement. The Table of Penalties would also serve as a guide to the application of

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- injuries include a broken bone, tooth, or any injury that requires treatment in a hospital or emergency room.
- 2) Failure to perform an essential duty that causes physical injury which creates a risk of death, or which causes death or serious disfigurement, impairment of health or loss or impairment of the function of any bodily organ or part, or serious emotional harm, or creates a foreseeable risk of either.
  - 3) Conduct including, but not limited to, threats, taunts, derogatory comments, ridicule which causes serious emotional harm or creates a foreseeable risk of serious emotional harm.
  - 4) Engaging in, or encouraging others to engage in, cruel or degrading treatment of a service recipient.
  - 5) Engaging in sexual conduct of any kind with a service recipient including sexual intercourse, deviate sexual intercourse, aggravated sexual contact, or sexual contact (including kissing or sexual touching).
  - 6) Encouraging, facilitating or permitting another to engage in sexual conduct with a service recipient who is non-consenting or incapable of consent.
  - 7) Promoting or encouraging or permitting another to promote a sexual performance of a service recipient.
  - 8) Use or distribution of any unlawful controlled substance as defined by article 33 of the public health law at the work place or while on duty.
  - 9) Unlawful administration of any controlled substance as defined by article 33 of the public health law to a service recipient.
  - 10) Falsification of records related to the safety, treatment or supervision of a service recipient including medical records, fire safety inspections and drills, and supervision checks.
  - 11) Failure to report any of the conduct in 1-10 when discovered.
  - 12) Failure by a supervisor to act upon a report of conduct in 1-10 as directed by agency policy.
  - 13) Making a false statement or withholding information during an investigation into a report of conduct in 1-10 or otherwise obstructing such an investigation.
  - 14) Discouraging a report of conduct in 1-10 or retaliating against any employee making such a report in good faith or against a service recipient who makes a report or on whose behalf a report is made.



fair and proportional consequences for employee misconduct in these settings operated by non-state providers, consistent with any existing collective bargaining agreements. Repeated misconduct in this category would elevate severity to category one for placement on the abuse registry and a ban on future employment.


- iii. Category three - conduct between service recipients that results in harm. These cases should be investigated as they may be indicators of staff neglect or systemic problems (see paragraph iv below). If it is determined by investigation to be neither, but the allegation is substantiated, service recipients would not be eligible for inclusion in the register but the incident may require plans of prevention and correction to avoid recurrence.
  - iv. Category four - a category of “systemic problems” to deal with cases of harm to individuals where any staff culpability is substantially mitigated by program deficiencies such as inadequate staff, training, supervision etc. For such cases, the supervising state agency would have responsibility to ensure prompt remediation of the deficient condition. Providers should be held responsible for repeated systemic problems at their sites and subject to aggressive enforcement of standards, including termination of operating certificates for prolonged or repeated failures to correct identified problems. In some cases, systemic problems may also support a finding of neglect of duty by supervisors and managers.
3. Introduce the concept of restorative justice as a response to category two violations where there is reason to believe in the potential for rehabilitation of the employee. Employers have a lot invested in the recruitment and training of each employee, and the process of replacing them, while incurring substantial economic and human costs, provides no greater assurance that a new employee, drawn from the same labor pool, will not commit a similar transgression. For such cases, the disciplinary



process should include an individual rehabilitation plan for the offending employee who recognizes the transgression, imposes a fair and proportional consequence, and plans for the eventual reintegration of the employee into the workplace under conditions that make possible a fresh start with co-workers and service recipients.

4. As part of this reform, the penal law should be amended to strengthen the crime of abuse of a vulnerable person in residential care.
5. The law should contain a clear ban on sexual relations between staff and a person in residential care as is currently done for inmates of correctional facilities.
6. The law should include clear protections against retaliation against employees who make good faith reports of abuse and neglect.
7. With respect to the issue of reporting abuse and neglect to law enforcement agencies, in lieu of the current conflicting statutory standards and the varied reporting practices among the different human service systems and individual service provider sites, this important obligation could be simplified and made more consistent. Rather than placing this responsibility at the approximately 11,700 provider sites, with the risk of both over-reporting and under-reporting which is the current condition, the responsibility for screening and referral for criminal investigation should be placed at the hotline, to be carried out with the assistance of the state police or experienced law enforcement officers as described below. The existing child abuse hotline already has in place a system for screening and referrals to law enforcement which can serve as a guide.

**B.** *A new and separate centralized 24-hour hotline for reporting allegations of abuse or neglect* from all covered programs serving children and adults. The OCFS which currently operates the SCR for child abuse and neglect has the experience and infrastructure to assist in implementing this similar system. This




reporting system should include all programs operated, licensed or certified by OMH, OPWDD, OASAS, OCFS, DOH-Adult Care Facilities and SED in-state and out-of-state. Preference would be to make this an electronic reporting system for providers to the extent this is feasible to facilitate timely reporting, routing and response, and to minimize paperwork and data entry errors. A web-based reporting system with drop-down menus and up-to-date listings of all provider sites would facilitate electronic reporting and routing of cases to the appropriate state agency and investigator. The system should also have the capacity to receive electronic feeds from other state agency electronic reporting systems to minimize duplication of effort.<sup>20</sup> However, the system would also have the capacity to receive telephone and fax reports including anonymous reports.

1. The hotline would have a trained staff to screen, classify and route the report to the appropriate state agency for investigation in accordance with its policies and procedures, much as the current child abuse hotline currently does.
2. If the report contains any allegation of conduct which, if true, would constitute a crime, the screening staff would have access to experienced law enforcement personnel who would review all allegations of criminal conduct to determine if a criminal investigation is warranted and, if so, contact appropriate local law enforcement officials to make referrals for investigation and possible prosecution, provide or facilitate state police investigative assistance upon request, and track the resolution of the referral.
3. The hotline would have responsibility for assigning a unique identifier to each case, (routing it to the appropriate state agency for investigation and response in accordance with the agency's policies and procedures),

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<sup>20</sup> OPWDD and OMH have been working with CQC to provide CQC with an electronic feed for incidents of patient abuse and neglect, in an effort to replace the current labor intensive process of paper reporting and duplicative data entry. Similar efforts are underway with DOH and OASAS.



tracking closure of each case within 60 days, and maintaining a searchable database.

4. The hotline would maintain a permanent statewide central registry of category one cases which have been substantiated following an investigation based upon a preponderance of the credible evidence. For such a registry to be effective, it must cover all human services agencies. Failing that, employees may simply move from one system to another which is not covered by the registry. In the case of an employee who resigns during the course of an investigation, the law should provide either that the investigation continues in any event, or that the case is entered into the register, with a notation "resigned while under investigation". It would also administer a due process system for individuals who wish to challenge their inclusion in the registry, similar to the process in place for child abuse cases.
5. It would provide information to potential employers who are required to use the registry to screen applicants for employment. By limiting what is maintained in the registry to cases of serious or repeated misconduct, unlike the current child abuse registry, potential employers would be assured that only persons whose conduct indicates unsuitability for working with vulnerable populations are flagged.


**C. Investigations.** For the Category 1 cases, the responsibility for investigations would be given to the Justice Center for protection of vulnerable persons whose creation and functions are more fully described in the Recommendations. This Center would be independent of all service providing agencies. For all other investigations, responsibility would be delegated to trained and certified investigators for each agency who would be required to conduct investigations pursuant to standards established by the Center. This division of labor recognizes the importance of ensuring timely, competent and credible investigations into reports of abuse or neglect and focuses the highest level of resources as the most serious cases. At the same time, it recognizes the size of the human services



system described earlier, and the approximately 11,700 residential programs spread across the state. Investigators would need to be able to get to the site quickly, ensure resident safety and commence the investigation promptly. Moreover, investigators would have to have a degree of familiarity with the nature of the diverse programs operated under the auspices of each of the state agencies to be able to identify program deficiencies that may have played a role in the occurrence of the incident.


For the less serious reports of abuse or neglect the report recommends strengthening the existing responsibility of each state agency to ensure the performance of investigations, building in safeguards such as a requirement for trained investigators; consistent investigation standards; incident review committees with membership that includes representatives of consumer, family and advocacy organizations to review the thoroughness and adequacy of investigations; requirements that investigation reports be sent to the state licensing/certifying agency which has the capacity to conduct further investigations, if needed; and expanded independent oversight of the whole system by the newly established Justice Center, which would also have the authority to selectively perform investigations as needed and be required to make a public annual report to the governor and legislature. The report also recommends that the state licensing/certifying agency examine a provider's performance of these duties in the process of renewal of the license or operating certificate.

This approach reinforces the primary responsibility of the provider agency, which has been entrusted with and paid for the care and safety of the persons in their facility, to have a capacity to immediately respond to incidents which jeopardize such safety. It also improves provider accountability for the investigative response with additional safeguards as described above. Provider agencies are most knowledgeable about the nature of the programs they operate and well positioned to conduct immediate investigations, attend to the safety of the residents and examine the root causes – beyond employee behavior – that may have caused or



contributed to the incident under investigation, and to implement preventive, corrective and disciplinary actions as warranted by the investigation findings.

1. The law should specify the responsibility of each of the state licensing/certification agencies to hold its providers responsible for compliance with the reporting and investigation requirements which are established pursuant to this law, whether through conditions in the operating certificates or provisions in the contracts through which services are purchased. Common definitions and investigation standards should facilitate cooperative agreements where multiple state agencies certify or fund a single program.
2. Common requirements/expectations for each state agency system:
  - i. immediate response to each report to assure safety/medical attention of vulnerable persons implicated by the report;
  - ii. determining the appropriate investigative response based upon the preliminary review (trained investigator, program review, delegation to provider agency [standards to ensure no conflicts of interest], etc.);
  - iii. common standards for the conduct of an investigation, format of the report, review of investigation by an Incident Review Committee to ensure adequacy of investigation methods and that all appropriate preventive, corrective or disciplinary measures have been considered;
  - iv. Incident Review Committees should include independent participants (representatives of consumer, family and advocacy groups with appropriate safeguards against conflicts of interest and to protect confidentiality of information and privilege for the deliberative process);
  - v. common standard of proof by a preponderance of the evidence;



vi. final report to be sent to the register within 60 days with a determination of:

- a. substantiated (incident occurred, identified perpetrator responsible);
- b. inconclusive (cannot prove that the incident happened or that the identified perpetrator is responsible);
- c. disconfirmed (incident did not happen or identified perpetrator is clearly not responsible); and
- d. systemic problems (incident happened, identified perpetrator not responsible or not solely responsible, program deficiencies substantially caused or contributed to the occurrence of the incident). Systemic problems may be found in addition to a determination under paragraphs a, b, and c.


vii. The register records the outcome of each case in a database which can be used to track repeat victims and repeat abusers whose cases are subject to elevation from category two to category one. Only substantiated cases in category one and category one cases where the subject resigned from the position while under investigation are subject to disclosure to prospective employers during background checks. Cases in categories B and C would be sealed and later expunged from the register, as is currently done with unfounded child abuse reports.

viii. Each state agency is responsible for ensuring follow-up of the implementation of any recommendations made as a result of the investigation, including referrals to professional licensing bodies. Systemic problems would be referred to licensing/certification for voluntary providers.



*D. Quality assurance and independent oversight*

1. The existing monitoring and oversight functions of the CQC under state law would be transferred and assumed by the Justice Center which is proposed to be created. These functions would be expanded to all programs serving vulnerable persons including DOH-Adult Care Facilities, SED residential schools and OCFS facilities (except Residential Health Care Facilities subject to DOH and OAG oversight) and provide access to the hotline database.
2. Simultaneously, the existing CQC role of primary responsibility for conducting child abuse investigations in OMH, OASAS and OPWDD facilities, and the OCFS role for conducting similar investigations in co-located facilities of OMH, OPWDD and OASAS, would be replaced by a requirement to treat such cases in the same manner as other cases of abuse/neglect of a vulnerable person which are investigated either by the Division of Investigations and Prosecution within the Justice Center for serious cases, or by certified investigators in all other cases.
3. Providers would be required to include review of allegations of abuse and neglect as part of their quality assurance programs, and incorporate annual plans of improvement based on such reviews.
4. State operating/certification agencies would be required to review patterns and trends in the reporting and response to allegations of abuse and neglect in their systems; and ensure that providers conduct root cause analyses for sentinel events defined as an unexpected occurrence involving death or serious physical or psychological injury, or risk thereof. Serious injury specifically includes loss of limb or function. Sentinel events signal the need for immediate investigation and response.
5. The Justice Center would be required to provide an annual report to the Governor and the Legislature with descriptive data from the hotline



database regarding the reporting, investigation and resolution of allegations of abuse and neglect including outcomes of the investigative process at an individual and systemic level (e.g., numbers of individuals placed in the registry, numbers of repeat offenders elevated from category two to category one; number of systemic problems, etc.); analysis of patterns and trends; identification of common deficiencies, and recommendations for systemic improvements. The report should examine performance measures in each state agency and for each type of facility, spotlighting the outliers on such measures as:

- \*rate of reporting of incidents;

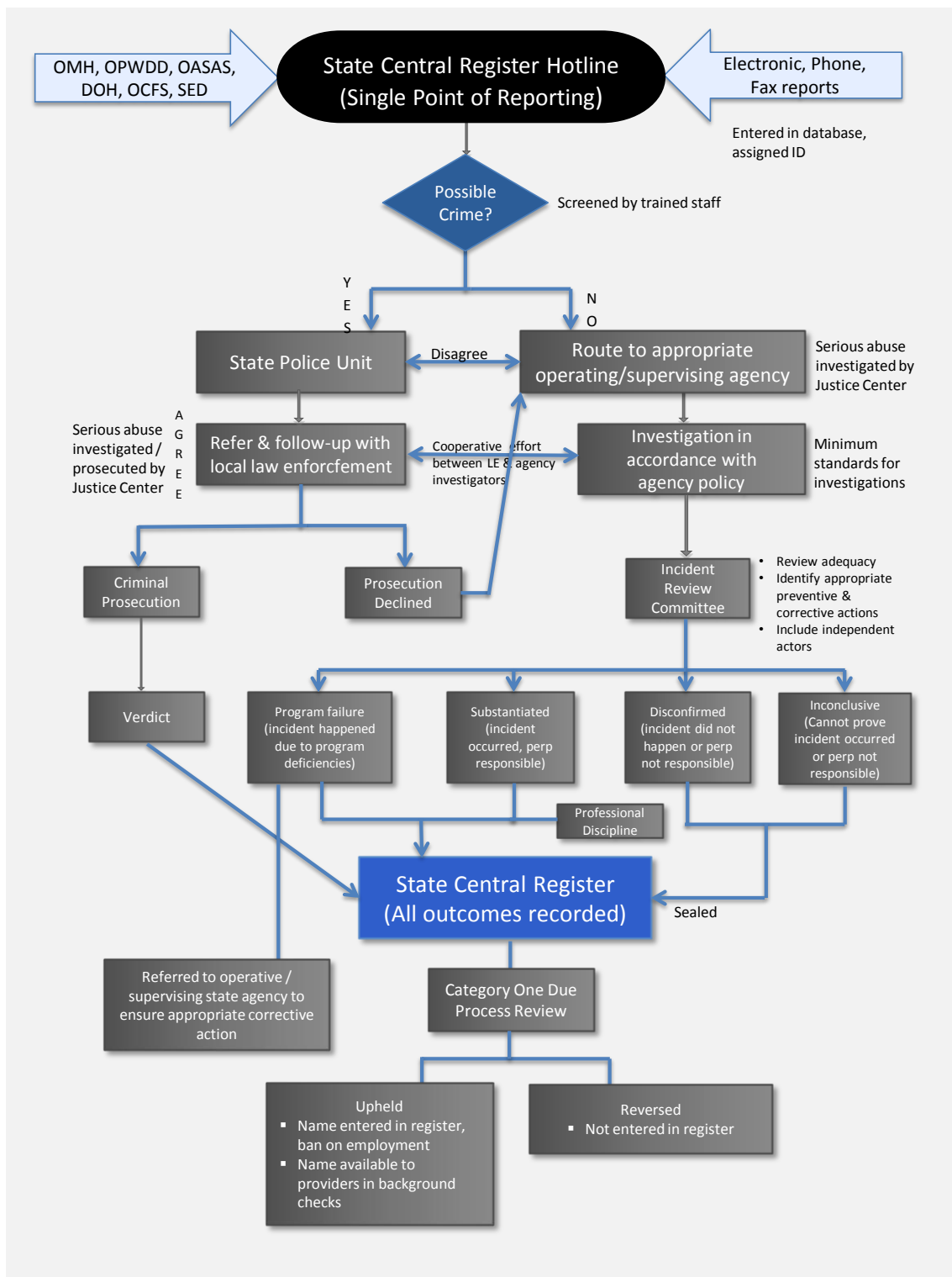
- \*rate of serious incidents;

- \*timely resolution of investigations;

- \*rates of substantiation;

- \*effectiveness of implementing recommendations for disciplinary, corrective and preventive actions taken as a result of investigations.

The Justice Center should construct an annual survey to solicit information from consumers, families, direct support staff, advocates and others about their opinions regarding the state of resident safety in the different types of facilities, and report on the results in this report to the Governor and the Legislature.



**Fig. 13 –Flow chart of Central Reporting/Hotline process**

## VIII. Recommendations:

### A. *Legislative action*


1. Enact legislation creating a common definition of abuse and neglect regarding children and adults in the covered programs;
2. Create a Justice Center for protection of vulnerable persons in the Executive Department that would serve as the focal point of the state's efforts to implement major reforms across all of its human service systems, as described in this report. The Justice Center would:

#### A. Establish a Hotline and Statewide Central Register for vulnerable persons across human service systems to:

- i. to receive reports of abuse and neglect involving vulnerable persons, including anonymous reports, 24 hours a day;
- ii. screen and classify reports of abuse and neglect, with the assistance of experienced law enforcement officers, and ensure their prompt investigation and remediation, as well as referral of criminal conduct to appropriate law enforcement agencies as warranted;
- iii. maintain a registry of all persons who have been found substantiated for serious or repeated acts of abuse or neglect of vulnerable persons, as described in this report, and who would be barred from continued employment in positions requiring direct contact with vulnerable persons.

#### B. Establish a Division of Investigation & Prosecution to:

- i. Directly investigate all serious cases of abuse and neglect, as well as any other cases it deems warranted;
- ii. Delegate other cases to trained and certified investigators in accordance with policies and procedures it develops for doing so, and receive and review the reports and outcomes of such investigations, as well as investigations into other serious incidents, and take any further action it deems warranted (using sampling, spot-checks, reviews of outliers and other techniques);

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- iii. Have concurrent jurisdiction with the district attorney to prosecute crimes involving abuse or neglect against vulnerable persons, as it deems warranted;
    - iv. Represent the state in disciplinary cases seeking termination of state employees for abuse or neglect of vulnerable persons.
  - C. Establish a Division of Fair Hearing to conduct all fair hearings relating to reports of abuse or neglect.
  - D. Establish a Training Academy which would
    - i. develop investigation standards and a training curriculum for investigators;
    - ii. certify trained investigators who may be assigned to investigate reports of abuse or neglect and other serious incidents;
    - iii. work with human service agencies and constituency groups to develop a common core curriculum for direct support workers and a system for credentialing such workers; and
    - iv. Promulgate a code of conduct applicable to all employees in human service agencies consistent with principles to be established by law.
  - E. Establish a clearinghouse for background checks of all direct support workers across human service agencies, as described in this report, in order to promote consistency and reduce duplicative background checks.
  - F. Establish a Division of Monitoring and Oversight to assume the existing monitoring and oversight responsibilities of the Commission on Quality of Care and Advocacy for Persons with Disabilities under state law, which will be expanded to cover other human service systems currently lacking independent oversight.
  - G. Submit an annual report to the governor and legislature, and such other reports as it deems warranted, reviewing and analyzing patterns and trends in the reporting of and response to incidents of abuse and neglect, and other serious incidents, and recommending appropriate preventive and corrective actions to remedy individual or systemic problems.

3. Enact a quality assurance statute to provide confidentiality for deliberative discussions regarding incident investigations and formulation of recommendations for implementation of preventive, corrective and disciplinary action to protect against the use of such information in lawsuits.<sup>21</sup>
4. Enact legislation making sexual activity between staff and residents of a facility a crime.
5. Enact legislation banning a person with convictions for specified violent and sex crimes and substantiated category one abuse from future employment in human service agencies in any capacity where the person would have regular and substantial contact with persons receiving services.
6. Strengthen the laws making abuse of a vulnerable person in residential care a crime.

## ***B. Prevention***

1. Reinforce the policy of community integrated services wherever possible, and use congregate residential care as a last resort. The opportunity for people in residential facilities to be seen regularly and to interact with persons outside their residence is a powerful safeguard. It creates opportunities to form personal relationships with people not affiliated with their residence in whom they can confide or who may notice signs and symptoms of abuse or neglect and who are not deterred from reporting it.
2. There is a need to reduce the use of restraints and hands-on interventions to control or manage the behavior of children and adults in residential facilities. Such interventions expose them as well as the staff to a risk of harm and

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<sup>21</sup> This balance between transparency and confidentiality is consistent with Education Law section 6527(3) which expressly establishes that QA proceedings are privileged and case law has consistently upheld this privilege. Notably, *Katherine F.* found that the “thrust of 6527(3) is to promote the quality of care through self-review without fear of legal reprisal.” Furthermore, this case found that the language of the statute (Education Law section 6527(3)) is unequivocal, exempting three categories of documents from disclosure including records relating to medical review and quality assurance functions. [\*Katherine F. ex rel. Perez v. State\*, 1999, 94 N.Y.2d 200, 702 N.Y.S.2d 231, 723 N.E.2d 1016](#). See also, *Smith v. State*, 181 AD2d 227 (3<sup>rd</sup> Dept. 1992) and *Brathwaite v. State*, 208 AD2d 231 (1<sup>st</sup> Dept. 1995).

adverse consequences.<sup>22</sup> Although a Committee on Restraint and Crisis Intervention Techniques within CCF has met and studied these issues pursuant to Chapter 624 of the laws of 2006 and Chapter 670 of the laws of 2008 in settings serving children, there is not yet a clear pathway to achieving the goal of reduced use of restraints. A starting point for this effort is to gather comparable data across systems to examine how frequently restraints are being used, under what circumstances, with what safeguards and with what consequences. In the meantime:

- a. Facility staff should address in the individual service plan specific risk factors for each individual, the best ways of responding when an individual is having a behavioral episode or otherwise losing control.
  - b. In all cases where there is a hands-on intervention, there must be a physical examination by a physician or nurse following every intervention.
  - c. Every such intervention should require a quality assurance review with a view to learning what might have been done to avoid it, including interviewing the individual subject to the intervention.
3. There should be a clinical consultation capacity in each region to help with the development and implementation of behavior management strategies to assist providers and staff in safe responses to maladaptive behavior of individuals. This may be a role in which the resources of state psychiatric and developmental centers would assist providers.
  4. Schedule clinical staff to work flexible schedules including evening and weekend hours.
  5. State agencies should require that managers and supervisors work flexible schedules including evening and weekend hours and make unannounced visits and unscheduled tours on all shifts of state operated and state certified residential programs.


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<sup>22</sup> Equip for Equality: National Review of Restraint Related Deaths of Children and Adults with Disabilities: The Lethal Consequences of Restraint (2011).

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6. Institute a practice of exit interviews with staff, residents and families as part of the quality assurance process to examine issues regarding safety and protection from harm of the residents.
  7. Residential service providers should be required to create Resident Councils or other forums for resident involvement, with necessary support, to meet periodically to review issues affecting safety and quality of life and to make recommendations for improvement to facility managers.
  8. Residential service providers should be encouraged to create a monthly forum to provide all staff, including direct support workers, an opportunity to be heard in the running of the facility and in making recommendations for improved practices to address safety and quality of life of the residents, and working conditions for the staff.


### ***C. Recruitment***

1. Through the Training Academy that is part of the Justice Center, establish consistent minimum qualifications for direct support workers across human service systems. There is work to be done to re-examine the minimum level of qualifications for direct support jobs at the frontline of the services systems and the manner in which background checks are performed. OPWDD has already begun that effort regarding state employees and other agencies need to engage in a similar review of their requirements for all front-line workers and others with a regular and substantial contact with service recipients. With the increased role that Medicaid is playing in the financing of services, and the concomitant requirements for documentation of service delivery for billing purposes, the literacy of the direct support worker is essential.
2. Establish consistent procedures for background checks for all direct support workers and a clearinghouse within the Justice Center to reduce duplicate checks. At present, there are differing statutory requirements for fingerprinting prospective employees, for paying for background checks, in the scope of the checks, in the crimes which are disqualifying and in the locus of decision-making about disqualification. Fingerprinting and background checks done for one state agency

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- or program may not be available or usable for another state agency. A provider agency which operates multiple programs may need to have multiple and differing checks done on the same employee who works in more than a single program.
3. Perform character and competence reviews of provider agencies initially and upon renewal of licenses and operating certificates. At the time of renewal, look at performance records regarding incident management, the role of the Board of Directors in maintaining oversight over agency performance in this area, and the management of incidents affecting resident safety, including cases of systemic problems. This review should also include management of public funds provided for resident care.
  4. Also review agency commitment to training and development of employees, and implementation of preventive and corrective actions that were identified as a result of investigations, including implementation of consistent, fair and proportional consequences for employee misconduct.

#### ***D. Staff training***

1. Through the Training Academy develop a core curriculum of training for all direct support workers that covers common obligations to support residents.
  - a. The training should include value based training on the purpose and importance of the jobs, and should include involvement of consumers and families in training.
  - b. Adoption of a Code of Ethics for direct support workers. Whatever might be done with future hiring practices and changing qualifications for direct support professionals, the reality is that there are currently hundreds of thousands of persons in direct support jobs in each of the human service systems. For these workers, and for the future hires, each state agency should adopt a Direct Support Professional (DSP) credentialing program that certifies competency and professional ethical conduct. One such program is that of the National Alliance for Direct Support Professionals ([www.NADSP.org](http://www.NADSP.org)) that is based on a Code of Ethics and the nationally validated Community Support Skills



Standards (CSSS). The credentialing program should be reinforced through compensation incentives and career pathways based on achievement. Recognizing that this effort cannot be accomplished immediately and will likely have cost implications, each state agency should develop a plan to accomplish this objective over the next two years working with the voluntary agency sector as well as the state labor unions and the Department of Civil Service.

- c. Training using a common core curriculum addressing abuse and neglect prevention and incident reporting, as well as on the process for making anonymous reports to the hotline.
2. Provide training for mid-level supervisors on the management of frontline workers, supervisory duties and the need for vigilance. This training should also address the effective use of probationary periods to carefully assess the performance of new employees and their suitability for working with vulnerable residents.
3. All training should stress the importance of linguistic and cultural competence and sensitivity and means of accessing resources to assist in meeting such needs of residents.
4. Train residents and families on the process for reporting incidents and on their rights to information regarding incidents, their investigation and access to closing documents.
5. Consistent with the work of the Spending and Government Efficiency Commission, state agencies should consider the value of collaborating in training all direct support professionals in the core curriculum, using various forms of instruction including web-based teaching and training. Similar training efforts may be undertaken for the benefit of state survey staff and state investigators.




### ***E. Career ladders***

1. Develop certification programs for direct support workers in each agency with defined steps, required training and competencies linked to graduated pay increases.
2. Provide access to relevant educational programs to enhance knowledge and skills, using community colleges and the resources of the State University and City University of New York.
3. To the extent that there is a career path for the direct support worker at present, it is to leave direct support and move into an administrative position. However, there are many direct support workers who are passionately committed to the work they do, who excels at it and who does not want to move up and out from the personal contact with the residents they support. These employees are valuable role models for other workers and for new hires. Provider agencies must develop means to retain such workers in this capacity, while rewarding the contribution they make to the provider's mission, through enhanced compensation, and recognition as a Master Direct Support worker much in the same way as progressive schools have established the position of Master Teacher to keep skilled and passionate teachers in the classroom.

### ***F. Incident reporting and investigation***

1. Require every state agency to assure that their providers have an incident reporting and investigation policy and procedure consistent with the proposed law, and adequate investigative capacity, either on their own, or through collaboration with other provider agencies, to carry out these functions within the timeframe established for the completion of investigations.
2. State agencies should establish a monitoring role to ensure compliance by their providers.
3. The law policy and procedures should identify mandated reporters, and the treatment of failures to make required reports as misconduct subject to discipline.

4. The reporting obligation is to report all abuse and neglect based on reasonable suspicion to the hotline as soon as possible but within 24 hours of discovery.
5. The law policies and procedures should provide for notification to families of all incidents involving their relative along with a notice of their rights to information at the conclusion of the investigation.
6. For serious incidents (category one as described in the report), investigation should be conducted by trained and certified investigators who are free of conflicts of interest.
7. Serious incident investigations must meet specified standards.
8. Investigation reports should be done in a standard format.
9. Incident investigation reports must be reviewed by an Incident Review Committee which includes representation from family, consumer and advocacy groups (e.g., member of the board of visitors, protection and advocacy, Mental Hygiene Legal Service), with appropriate safeguards to protect confidential information from other uses, including litigation.
10. Investigation reports must result in a finding of Substantiated, Inconclusive, Disconfirmed, or Systemic Problems. The standard of proof to substantiate a case is by a preponderance of the evidence.
11. The conclusion of the investigation report must be submitted to the new Statewide Central Register as well as to the state licensing/certification agency, and for Medicaid funded agencies, to the Office of Medicaid Inspector General.
12. The provider agency is responsible for implementation of any recommendations for preventive, corrective or disciplinary action and reporting the same to the state supervising agency. For substantiated cases of abuse, referrals should be made to the appropriate professional licensing body in the case of licensed professionals.
13. Cases of Systemic Problems must be followed up by the state supervising agency through its licensing/certification process to ensure prompt remediation of the conditions.
14. Disconfirmed and inconclusive cases will be sealed in the State Central Register.

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15. Substantiated cases of category one abuse will be maintained in the State Central Register for residential facilities, with a due process procedure to enable the subject to challenge the determination. Employees with such substantiated category one cases will be barred from future employment with human service agencies and the determination will be disclosed to prospective employers during background checks.
  16. State agencies should develop and implement programs to publicly recognize and value the contributions of reporters whose actions prompt corrections and improvement in the service system.

### ***G. Employee discipline***

1. State System. In Coordination with the Governor's Office of Employee Relations:
  - a. Implement the Table of Penalties for consistent, fair and proportional consequences for employee misconduct.
  - b. Develop a program of training for the select panel of arbitrators to address the special conditions affecting vulnerable people in state facilities.
  - c. Provide for the expeditious scheduling and completion of the hearing process of cases that go to arbitration, to reduce lengthy suspensions of employees and stress on residents and co-workers.
  - d. For cases where the penalty sought is termination, state agencies should use attorneys skilled in trial practice from the Justice Center Division of Investigation and Prosecution to present the state's case before the arbitrator.
  - e. Include in the presentation of the state's case a victim impact statement presented by an advocate (e.g. a family member, protection and advocacy staff, or Mental Hygiene Legal Service attorney).
  - f. For all cases where termination is not the outcome to be sought, use positive disciplinary approaches which target the behaviors to be corrected, the skills to be enhanced, and the conditions that would

minimize the likelihood of repetition of the misconduct. Develop Individual Rehabilitation Plans involving the subject, in planning re-entry to the workplace.

- g. The separate process of fair hearings for credentialed staff accused of misconduct including abuse was also found to take long periods of time to conclude final decision making. These multi agency (SED, OASAS) proceedings should be the subject of a separate review to determine if efficiencies and stricter timelines for task completion are needed.

## 2. Non-State providers

The Table of Penalties provides guidance to non-state providers effectuating consistent, fair and proportional consequences for employee misconduct, consistent with any applicable collective bargaining agreements.

### ***H. Provider discipline/correction***


1. State agencies should ensure that systemic problems are promptly corrected.
2. Repeated failures of this type and the failure to implement prompt corrective action should be dealt with through provider sanctions including monetary fines and, where appropriate, revocation or limitation of operating certificates.
3. In the license/certification review process, data of each provider's performance regarding the handling of cases of abuse/neglect should be reviewed.
4. Transparency of certification reports/results. Agency reports leading to certification decisions should be posted on the website and made publicly available, with such redactions as may be necessary to preserve legally confidential material.

## *I. Oversight of human service agencies*

1. The responsibilities of the CQC under state law for monitoring and oversight should be transferred and assumed by the Justice Center that is recommended to be created and its jurisdiction should be expanded to include all programs operated or licensed by OMH, OPWDD, OASAS, OCFS, DOH adult care facilities and SED, with the exception of residential health care facilities regulated by DOH.
2. The CQC's responsibility for primary investigations of allegations of child abuse and neglect in DMH facilities should be removed and replaced with a broader mandate of the Justice Center for oversight of the abuse and neglect reporting and investigation system recommended in this report, with proportional additional resources to carry out this function. This change in responsibilities and expansion of oversight jurisdiction should be phased in over a two year period, to enable the development of an implementation plan and the identification of resources needed to perform the additional duties required.
3. The Justice Center should be required to submit an annual report to the Governor and Legislature regarding the reporting, investigation and resolution of allegations of abuse and neglect that are reported to the Statewide Central Register. As discussed in the body of the report, the annual report should analyze patterns and trends in reporting and substantiation practices, types of deficiencies identified, systemic implications of such findings, with recommendations for appropriate legislative or executive action. In performing this function, the commission should be authorized to review a sample of cases to monitor fidelity to the process of reporting and investigation recommended herein. To perform this function, the commission will require a capacity for policy analysis as has been previously recommended.
4. Legislation was recently enacted and signed into law by Governor Cuomo transferring to the CQC the Ombudsman program currently operated by OPWDD.<sup>23</sup> The Justice Center should explore the enactment of legislation

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<sup>23</sup> Chapter 542 of the Laws of 2011.




creating a similarly staffed ombudsman program for OMH, OASAS, OCFS and DOH residential facilities.

5. The law should be extended to require that the Mental Hygiene Legal Service be notified of allegations of abuse and neglect in private hospitals and residential community mental health facilities as is currently required for community-based OPWDD programs to enable MHLS to receive, review and respond to these reports.

#### ***J. Miscellaneous recommendations***

1. The state currently has no reliable information about the quality of out-of-state residential programs or the safety of New York State children residing there. There are no regular monitoring visits by any state agency, unclear obligations for reporting incidents of harm to SED, and the lack of any regular on-site response by any state agency to serious incidents of harm. Children are sent to these out-of-state facilities due to a perceived lack of capacity to meet their needs in in-state programs. The state currently spends in excess of \$140 million per year on such residential facilities for approximately 650 students.
2. There are provider agencies within New York who have the capacity and willingness to develop programs to meet the needs of these students. The barriers to developing these programs have been in the failure to provide comparable rates of reimbursement for in-state providers as are made available to out-of-state programs; the financial disincentives for families whose children are placed in Medicaid funded programs in-state; and in the obstacles to information sharing between educational and other human service agencies to facilitate advance planning for youths aging out of educational placements. There needs to be a renewed effort to overcome these barriers and to develop an accountable in-state capacity to meet the needs of children and young adults who are in out-of-state facilities and who would be at risk of placement in such facilities in the future.




## ***K. Next phases***

1. There are residential programs that exist in the shadows that are not currently licensed or certified by any state agency, are not clearly subject to any abuse reporting laws, and about which relatively little is known. Examples include residential camps for children and youth (summer camps are regulated by DOH and subject to the child abuse reporting laws), unlicensed boarding homes, so-called "sober homes" and other similar facilities.
2. Vulnerable children and adults are also served in non-residential programs and the safeguards that exist for such programs require examination.
3. With the increasing emphasis on providing services and supports in the most integrated and normative settings, more and more individuals with intellectual and cognitive disabilities and other vulnerabilities are exposed to harm not due to the actions of others but due to limitations in their ability to protect themselves and their own interests. The effectiveness of safeguards for this group should be examined to determine if there is an appropriate balance between respect for autonomy and protection from harm.

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While this report focuses specifically on my assignment to examine the problem of abuse and neglect in human service systems in the state, its findings regarding the numerous inexplicable gaps and inconsistencies in the legislative and regulatory framework are sobering and have broader implications. Many of the underlying laws have been added piecemeal over the years by the work of separate legislative committees of jurisdiction over a particular system in response to specific concerns. The patchwork quilt of laws is compounded by the proliferation of inconsistent regulations adopted by agencies, sometimes pursuant to the same laws. The findings in this report should prompt a broader re-examination of how the state manages the vast resources that it devotes to the support of these multiple systems of human services, and the consistency of its policies and practices in doing so.




Over the past 35 years, the role of the state as a direct provider of services has diminished dramatically as state institutions have been closed or drastically downsized and services transferred to the community. These community-based services are predominantly delivered by private organizations licensed, certified, regulated and funded by the state. Although the state is primarily a purchaser and funder of services delivered by such organizations, in this area as well there are major and inexplicable inconsistencies in how common functions are carried out, sometimes resulting in multiple processes by different state agencies to accomplish the same objective with the same provider.

At the same time, several state agencies continue the direct delivery of services similar to those provided by private agencies with which they contract. Yet, there is no common set of performance expectations or a Code of Conduct to hold accountable the employees engaged in this work on behalf of the state or the private providers. Unless grounded in a compelling rationale for a difference, inconsistent policies and processes among state agencies to accomplish the same goals are inefficient and wasteful of scarce state resources, and also create unnecessary difficulties for provider organizations – especially those that interact with multiple state agencies in delivering services to different groups of people.

The recommendations included in this report will, when implemented, help insure the safety and well-being of those vulnerable persons entrusted to the care of the state and its authorized agents. However, true system reform must be broader than the agenda set forth by this report. The expansion of home and community based services that has occurred over the better part of the last four decades has not yet achieved the original vision of enabling people with disabilities to live in fully integrated settings; families of people in need continue to have to negotiate a complex and frustrating maze of services; and there has yet to evolve a truly accountable provider network whose success is measured by the success of the people it serves.

The recommendations in this report complement other major reform initiatives announced by Governor Cuomo. These include the recommendations of his Medicaid Redesign Team, including the development of health homes, care management for all Medicaid



enrollees, and the repatriation of individuals with disabilities who are being served out-of-state. The development of behavioral health organizations for those with behavioral health needs and implementation of the People First Waiver models of care envisioned for people with developmental disabilities, are intended to promote person care planning and assure greater provider accountability.



## APPENDICES

- A. List of Attendees/Participants
- B. Agency Programs and Costs
- C. Abuse and Neglect Reporting Rates by Agency
- D. Chart Comparing Legal Frameworks
- E. Key Standards

## APPENDIX A

### LIST OF ATTENDEES/PARTICIPANTS

- Antone Aboud, Consultant, Antone Aboud Assoc.
- Ramon Aldecoa, Self Advocate, OPWDD Advisory Council
- Mary Ann Allen, Chief Executive Officer, Wildwood Programs
- Richard Altman, Chief Executive Officer, Jewish Child Care Assoc.
- Shameka Andrews, Self Advocate, OPWDD Advisory Council
- Fred Apers, Executive Director, Cardianl Hayes Home for Children
- Diana Babcock, Self Advocate, Mental Health Empowerment Project
- Tina Beauparlant, Prog. Asst./Educ. Spec., Parent to Parent Cap. Dist.
- Linn Becker, Executive Director, Hospitality House
- Ellen Benson, Executive Director, Harmony Heights
- Allan Bergman, Consultant, Allan I. Bergman
- Marvin Bernstein, Director, Mental Hygiene Legal Service
- Sue Bissonette, Executive Director, Cazenovia Recovery Systems, Inc.
- Marc Brandt, Executive Director, NYSARC
- Marianne Briggs, Self Advocate, Mental Health Empowerment Project
- Kathy Broderick, Assoc. Exec. Director of Operations, AHRC NYC
- Bridgit Burke, Supervising Attorney, Albany Law School
- Gary Burkle, Self Advocate, OPWDD Advisory Council
- Nick Cappoletti, Chairman, OPWDD Advisory Council
- Michael Carey, Advocate
- Sheila Carey, Executive Director, DDPC
- Kathie Cascio, Self Advocate, Mental Health Empowerment Project
- Christopher Cittadino, DSP, Schenectady ARC
- Ronnie Cohn, Independent Evaluator for Willowbrook Class
- Michelle Cole, Regional Coordinator, Parent to Parent Oneonta
- Amy Colesante, Exec. Director, Mental Health Empowerment Project
- Jeanette Collins, Advocate
- Bill Combes, Program Director, PADD / PA TBI
- Kevin Connally, Executive Director, Hope House
- Peaches Conquest, DSP, Orange County AHRC
- Susan Constantino, President & CEO, CPA of NYS
- Les Cook, Self Advocate, Mental Health Empowerment Project
- Sonji Cooper Searight, Self Advocate, Mental Health Empow. Project
- John Coppola, Exec. Director, Assoc. of Substance Abuse Providers
- Robert Costello, Exec VP & Chief Operating Officer, Abbott House
- Emmett Creahan, Director, Mental Hygiene Legal Service
- Kevin Cremin, Director of Litigation, MFY Legal Services
- Heather Daignault, DSP, Rensselaer County ARC
- Norwig Debye-Saxinger, VP Gov. Relat. & Pub. Policy, Phoenix House
- Eva Dech, Self Advocate, Mental Health Empowerment Project
- Gina DeCrescenzo, Staff Attorney, Legal Services for Hudson Valley
- Lesley DeLia, Director, Mental Hygiene Legal Service
- Bill Devita, Executive Director, Rehabilitation Support Services, Inc.
- Tammy Elowsky, Parent, OPWDD Advisory Council

- Fred Erlich, Executive Director, Living Resources
- Mary Beth Fadelici, MSC Parent Educator, Parent to Parent NYC
- Dennis Feld, Deputy Director, Mental Hygiene Legal Service
- Lisa Fish, Self Advocate, Mental Health Empowerment Project
- Jan Fitzgerald, Director, Parent to Parent
- Stuart Flaum, Advocate
- Jack Flavin, Executive Director, Lincoln Hall
- Kathy Flood, Assistant Executive Director, AABR
- Bill Flynn, Supervising Attorney, Legal Services for Hudson Valley
- Chris Fortune, Executive Director, Orange County AHRC
- Patricia Fratangelo, Executive Director, Onondaga Community Living
- Rhonda Frederick, Chief Operating Officer, PeopleInc.
- Beth Fye, Advocate/Parent
- Alexis Gadsdon, Vice President, Outreach Development Inc.
- Bill Gamble, Self Advocate, Mental Health Empowerment Project
- Mark Gazin, non-gov Provider, OPWDD Advisory Council
- Joseph Geglia, Executive Director, Elmcrest Children's Center
- Dr. Melvin Gertner, President, AHRC NYC
- Tim Giacchetta, President & CEO, Berkshire Farm Center
- Shirley Goddard, non-gov Provider, OPWDD Advisory Council
- Gary Goldstein, DDS, non-gov Provider, OPWDD Advisory Council
- Darrell Griffin, DSP, Orange County AHRC
- Helen Halewski, Chief Human Res. & Org. Devel. Officer, Hillside Family of Agencies
- Kelly Hansen, Executive Director, CLMHD
- Ann Hardiman, Executive Director, NYSACRA
- Beth Harhoules, Sr. Staff Attorney, NYCLU
- Stephen Harkavy, Deputy Director, Mental Hygiene Legal Service
- Carole Hayes Collier, Self Advocate, Mental Health Empow. Project
- Ernest Haywood, VP of Res. Svcs & Devel., Lifetime Assistance Inc.
- Daniel Hazen, Self Advocate, Mental Health Empowerment Project
- Mary Jo Hebert, Reg. Coord. & MSC Prog. Asst., Parent to Parent
- Michael Helman, non-gov Provider, OPWDD Advisory Council
- Dr. Lorrie Henderson, Executive Director, AHRC NYC
- John Henley, CEO, Northeast Parent & Child
- Brad Herman, Executive Director, William George Agency
- Robin Hickey, Program Planner, DDPC
- Lysa Hitchens, DSP, Aspire of Western NY
- Steve Holmes, Administrative Director, SANYS
- Chip Houser, President & CEO, Children's Home of Wyoming Conf.
- Tom Hughes, Executive Director, Westchester ARC
- James Jeffreys, Ph.D., Clinical Director, Hospitality House
- Rick Johnson, LCSW-R/ACSW, Parson's Child & Family

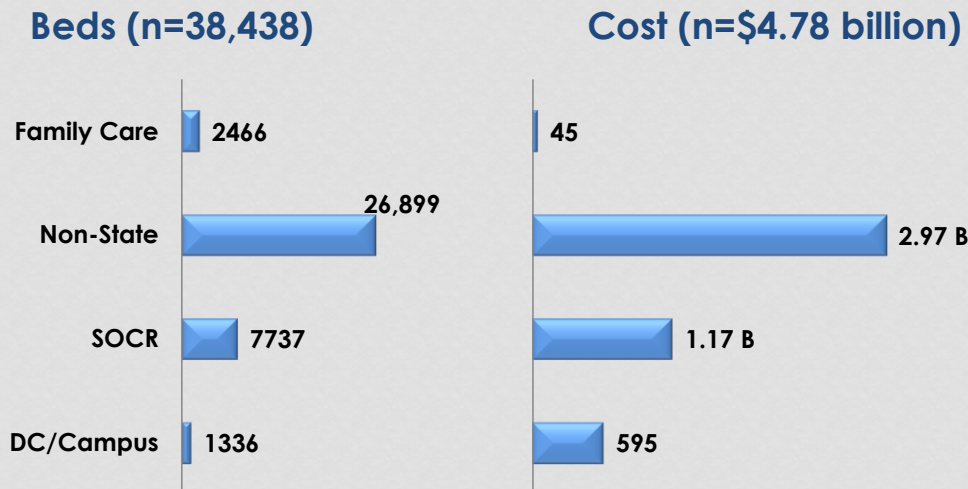
- Sally Johnston, Self Advocate, OPWDD Advisory Council
- Michele Juda, Project Director, Family to Family Health Info Center
- Harriet Kang, MD, non-gov, OPWDD Advisory Council
- Alden Kaplan, Chief Financial Officer, AHRC NYC
- Laurie Kelley, non-gov Provider, OPWDD Advisory Council
- Maura Kelley, Director MH Peer Connection, WNY Indep. Living Center
- Laura J. Kennedy, Board of Directors, AHRC NYC
- Jeremy Klemanski, President & CEO, Syracuse Behavioral Health Care
- Jeremy Kohamban, President & CEO, The Children's Village
- Alan Krafchin, President & CEO, Center for Disability Services
- Douglas Lasdon, Executive Director, Urban Justice Center, NYC
- Toni Lasicki, Executive Director, The Assoc. for Community Living
- Theresa Laws, DSP, Rensselaer County ARC
- Arnett Leftenant, Executive Director, Lake Grove School
- Kathy Less, Parent/Advocate
- David LeVine, Deputy Director, Mental Hygiene Legal Service
- Geoff Lieberman, Executive Director, CIADNY
- Glenn Liebman, CEO, MHANYS
- David Liscomb, Self Advocate, OPWDD Advisory Council
- Michael Lottman, Attorney, NYCLU
- Lee Lounsbury, Assoc. Exec Director, Upstate, COFCCA
- Dr. Robert Lustig, Quality/Compliance Officer, St. Joseph's Villa Roch.
- Joe Macbeth, Executive Director, National Alliance for DSP's
- Dr. Robert Maher, Executive Director, St. Christopher Inc.
- Monica Hickey Martin, Dep. Atty Gen., Medicaid Fraud Control Unit
- Gerard McCaffery, President/CEO, Mercy First
- Regis McDonald, VP Quality Improvement, The Children's Village
- James McGuirk, Executive Director/CEO, Astor Services
- Ellen McHugh, Lead Coordinator, Parent to Parent NYC
- Hanns Meissner, Chief Executive Officer, Rensselaer ARC
- Mike Miriello, Self Advocate, Mental Health Empowerment Project
- Richard Mollot, Executive Director, Long Term Care Comm. Coalition
- Jennifer Monthie, Staff Attorney, Disability Advocates, Inc.
- Michele Montroy, RN/Administrator, United Helpers
- Peg Moran, Senior VP Residential & Housing Services, FEGS
- Susan Moran, Assistant Executive Director, SCO Family of Services
- Roberta Mueller, Attorney, NYCLU
- Ismael Munoz, Self Advocate, Mental Health Empowerment Project
- Michael Neville, Deputy Director, Mental Hygiene Legal Service
- Gail Noyowith, Executive Director, SCO Family of Services
- Dru Nordmark, Coordinator, Parent to Parent North Central Region
- Regis Obijiski, Executive Director, New Horizons
- Douglas O'Dell, Chief Program Officer, SCO Family of Services

- Wil Parker, DSP, Otsego County ARC
- Mary Patricia, Comm. Service Board Rep., OPWDD Advisory Council
- Betty Pieper, Parent, OPWDD Advisory Council
- Darby Penney, Self Advocate, Mental Health Empowerment Project
- Paige Pierce, Executive Director, Families Together in NYS
- Peter Pierri, Executive Director, Interagency Council
- Margaret Puddington, Parent, OPWDD Advisory Council
- James Purcell, Chief Executive Officer, COFCCA
- Leonardo Rodriguez, Deputy Executive VP, JBFCs
- Ramon Rodriguez, non-gov Provider, OPWDD Advisory Council
- Fredda Rosen, Executive Director, JobPath
- Joel Rosenshein, Ph.D., non-gov Provider, OPWDD Advisory Council
- Harvey Rosenthal, Executive Director, NYAPRS
- Neil Rowe, Deputy Director, Mental Hygiene Legal Service
- Cynthia Rudder, Ph.D., Dir. Of Spec. Proj, LT Care Community Coalition
- Dally Sanchez, Self Advocate, Mental Health Empowerment Project
- Jeffrey Savoy, VP/Director Clinical Support, Odyssey House
- Ray Schimmer, Chief Executive Officer, Parsons Center
- Raymond Schwartz, Executive Director, Venture House
- James Scordo, Executive Director, Credo Community Services
- Sheila Shea, Director, Mental Hygiene Legal Service
- Amy Sheak, DSP, Columbia County ARC
- Ken Stall, Executive Director, Columbia County ARC
- Seth Stein, Exec Director/Gen. Counsel, Alliance of LI Agencies
- Robin Stiebel, Supervising Attorney, Legal Services for Hudson Valley
- Mildred Suarez-Milligan, Regional Coordinator, Parent to Parent NYC
- George Suess, CEO, Delaware ARC
- Elizabeth Sunshine, Board Member/Co-founder, NYSID
- James Swart, Regional Coordinator, Parent to Parent Capital District
- Laurent Tenney, Self Advocate, Mental Health Empowerment Project
- Maria Torgalski, QA Director, Aspire of WNY
- Michael Tuggey, DSP, Adirondack ARC
- Beth Wallbridge, Advocate, Legal Services of Central NY
- Barbara Wale, CEO, ARC of Monroe
- Nicole Wan, DSP, Heartshare Human Services
- Shelly Weizman, Attorney, MFY Legal Services
- Chris Weldon, former Executive Director, AABR
- Joseph Whalen, Executive Director, Green Chimney's
- Karl Wiggins, Executive Director, Gustavus Adolphus Family Services
- John Wilson, Program Director for Adolescents, Credo Comm. Services
- Jeff Wise, President & CEO, NYSRA
- Bill Wolff, Executive Director, LaSalle School
- David Woodlock, CEO, Four Winds
- James Yonai, CLMHD Designee, OPWDD Advisory Council
- Cliff Zucker, Executive Director, Disability Advocates Inc.

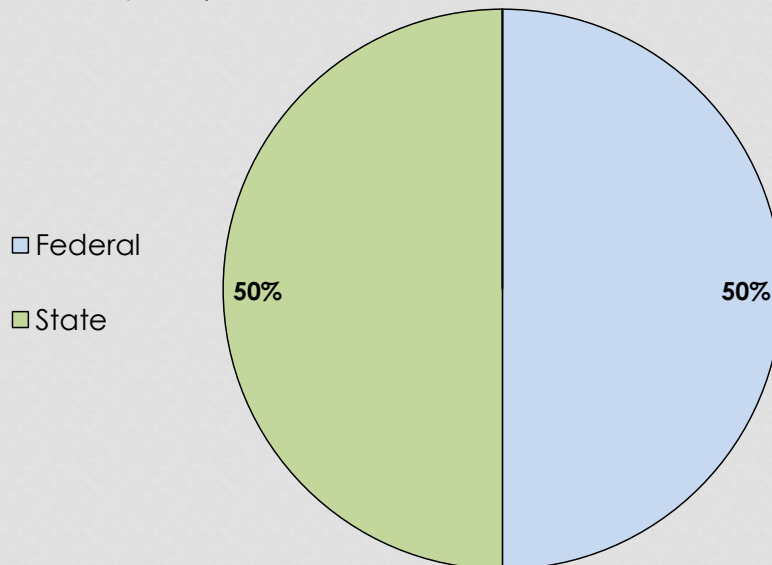
## APPENDIX B

### AGENCY PROGRAMS AND COSTS

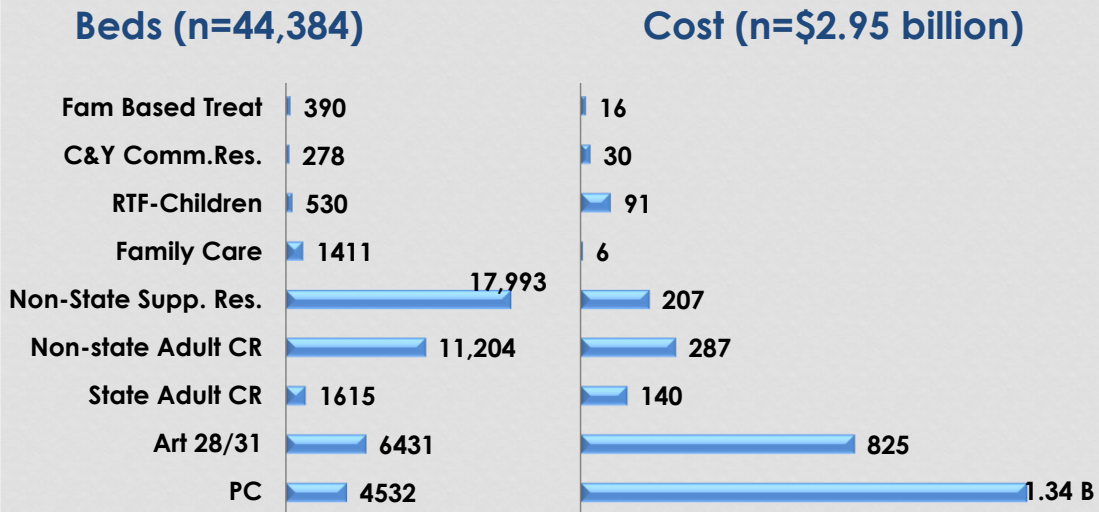
#### OPWDD Residential Beds & Costs (\$ in millions) 2010-2011



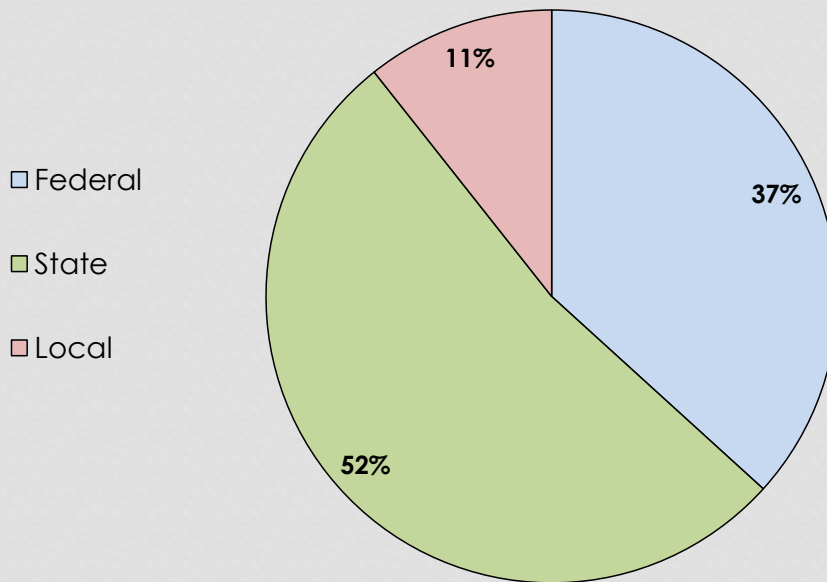
Average per bed costs range from 19K/yr in family care to \$445K/yr in DC and campus programs. Costs are shared equally with the federal government. State operated community programs on average cost \$150K/yr compared to voluntary agencies at \$110K/yr.



# OMH Residential Beds & Costs (\$ in millions) 2010-2011



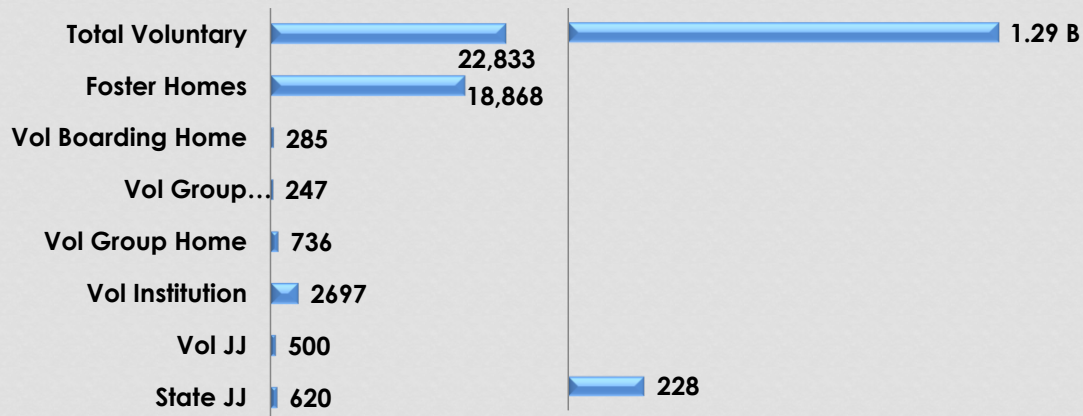
Per bed costs range from \$274K/yr in state PCs to Non state operated Adult CRs @ \$26K and supported residences @12K/yr, which are the largest two programs.



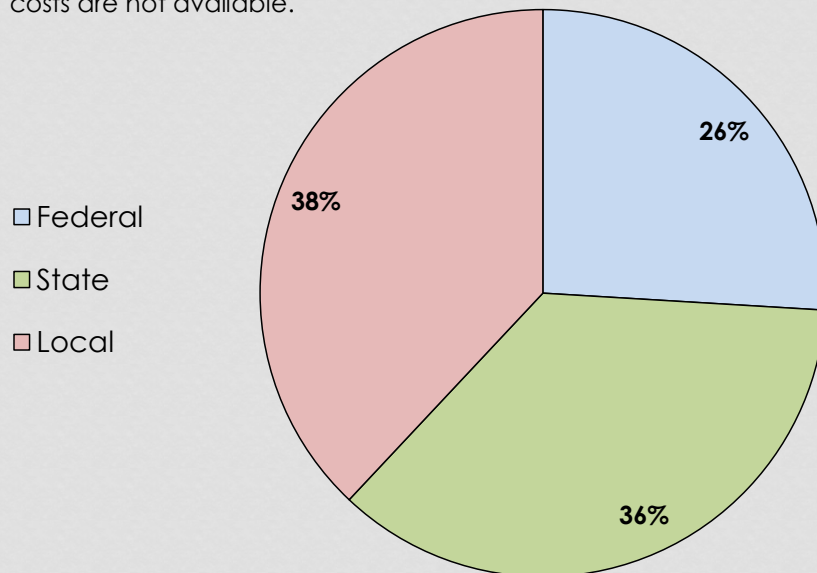
## OCFS Residential Beds & Costs (\$ in millions) 2010-2011

**Beds (n=23,953)**

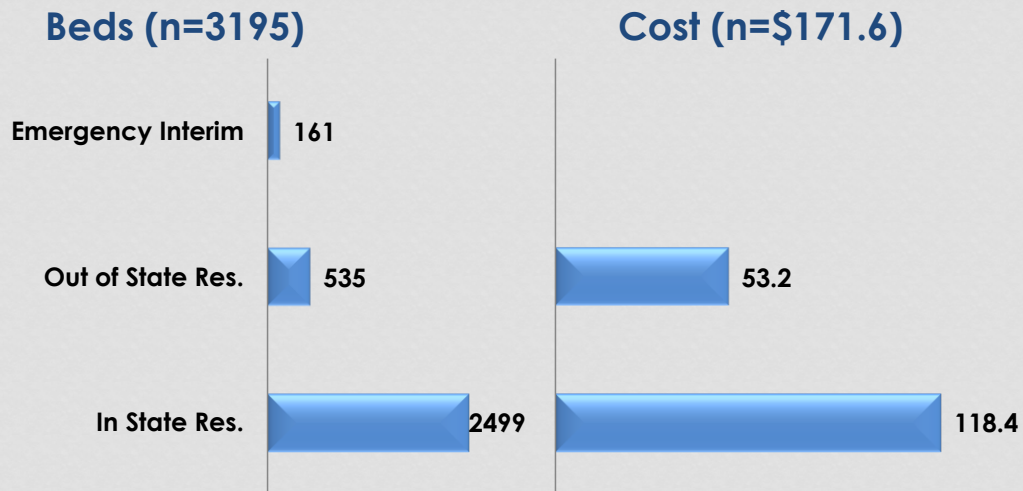
**Cost (n=\$1.52 billion)**



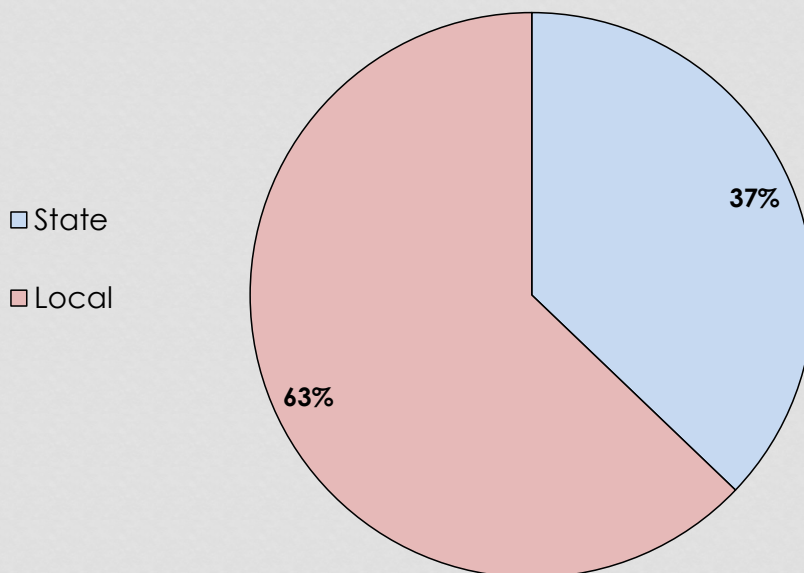
These facilities include state operated juvenile justice detention facilities which cost \$257K/ per bed per year, as well as an unknown number of vol. operated juvenile justice detention facilities for which cost data is not available. The costs of all these programs as well as foster care are bundled in a single appropriation and per bed costs are not available.



## SED Residential Beds & Costs (\$ in millions) 2010-2011



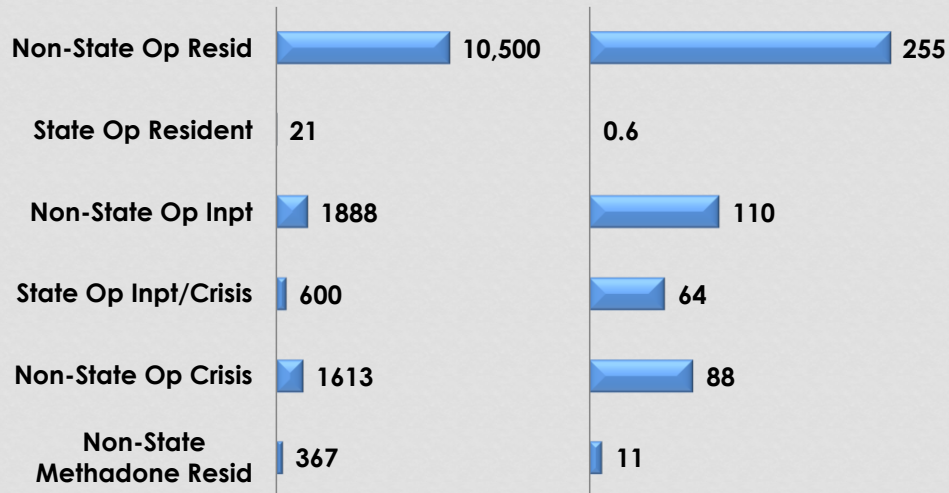
Costs of Emergency Interim included in Out of State costs. The costs reported are for educational services only. The room and board costs are included in OCFS. The overall average costs for out of state placements is \$219K per year. The children in these programs are a small fraction of the 450,000 students with disabilities.



## OASAS Beds & Costs

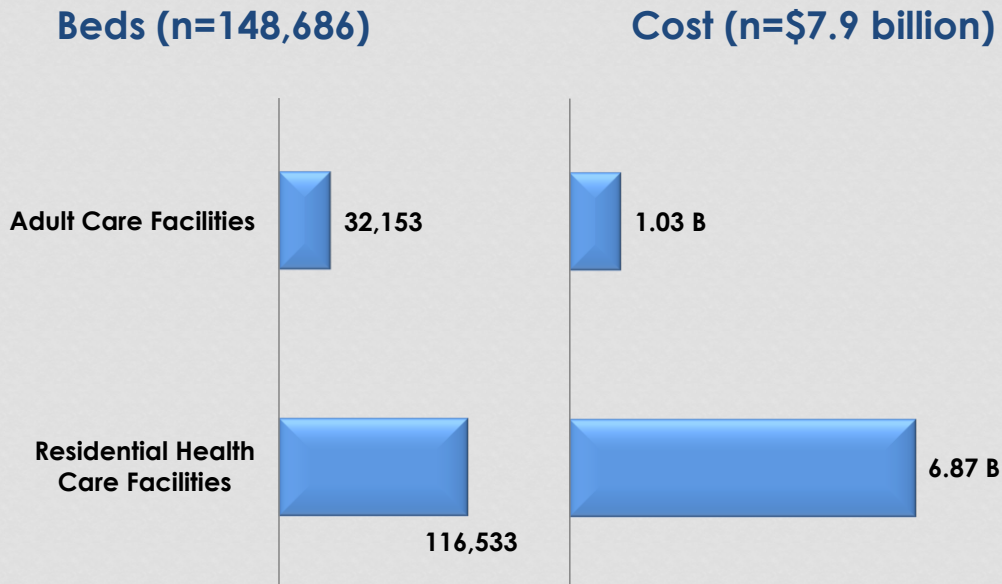
**Beds (n=14,989)**

**Cost (n=\$528 million)**



Data on Federal, State and Local shares of cost were not immediately available. Annual per bed costs range from 24k and 29k for residential programs to 107k for state inpatient programs.

## DOH Residential Beds & Costs (\$ in millions) 2010-2011



DOH has programs at both extremes. The 635 Art 28 nursing homes, health related facilities and specialty beds for AIDS and other conditions (TBI) are the single largest residential program and the most expensive one in total and at an average cost of \$82K/yr. The costs are an estimate of Medicaid spending based on available data. The per bed costs is based on 2007 cost reports and excludes the costs of the specialty beds.

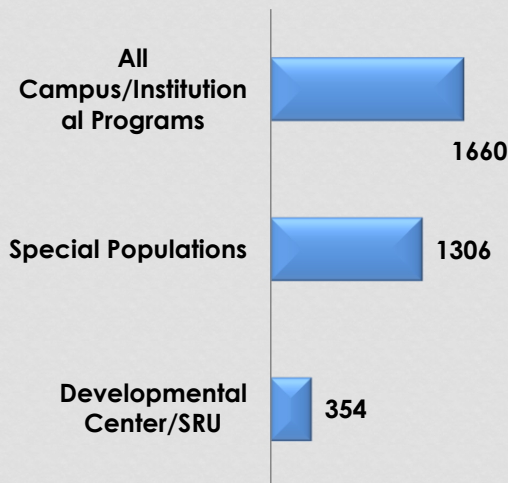
DOH is also responsible for certification of 482 adult homes, assisted living and enriched housing programs which are a lower level of care at \$32K/yr. Of the residents of adult homes, 32% or 9,901 are mentally disabled. 150 of the 482 (41%) homes are impacted.

## APPENDIX C

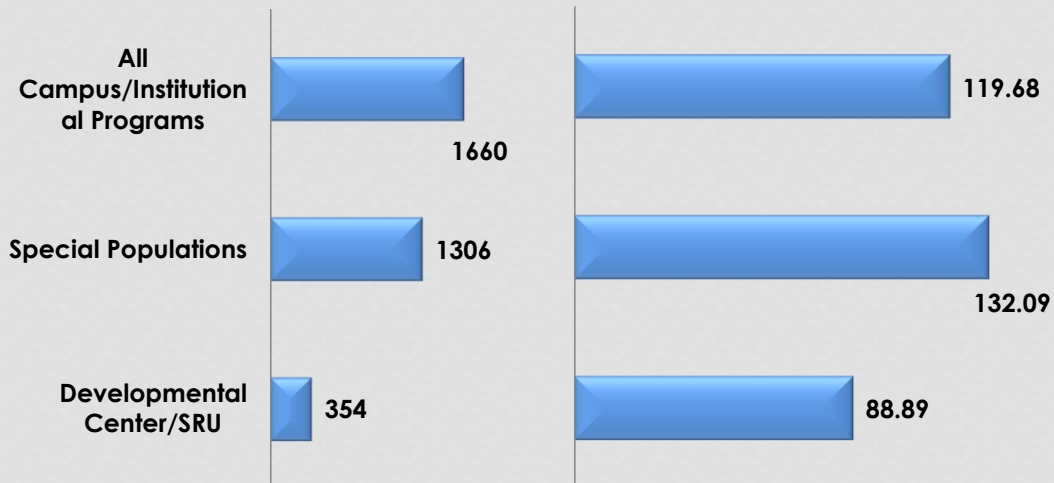
### ABUSE AND NEGLECT REPORTING RATES BY AGENCY PER 100 OCCUPIED BEDS - 2010

#### OPWDD - STATE INSTITUTIONAL

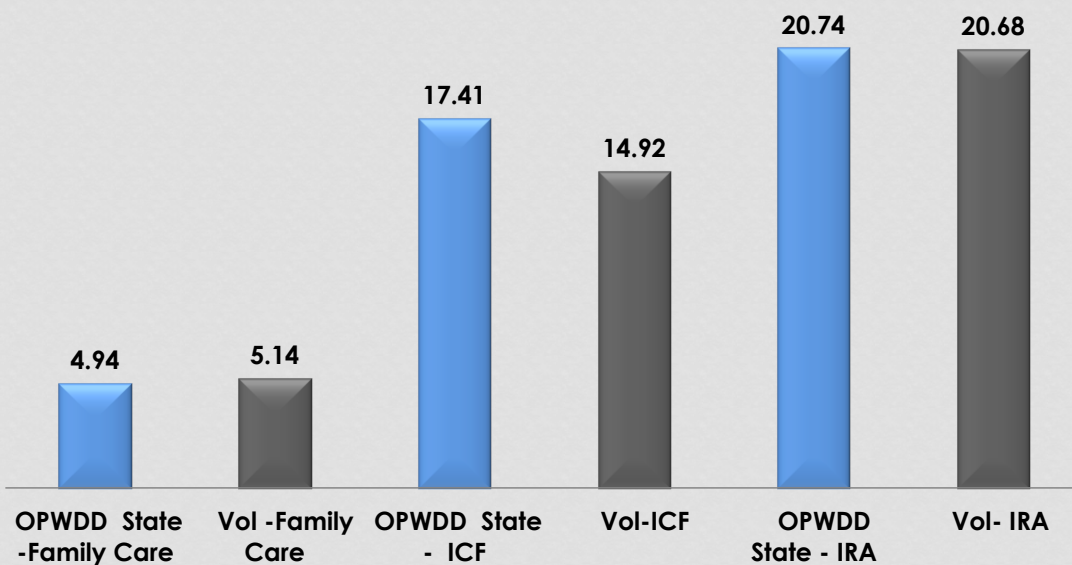
##### Allegations (n=1660)



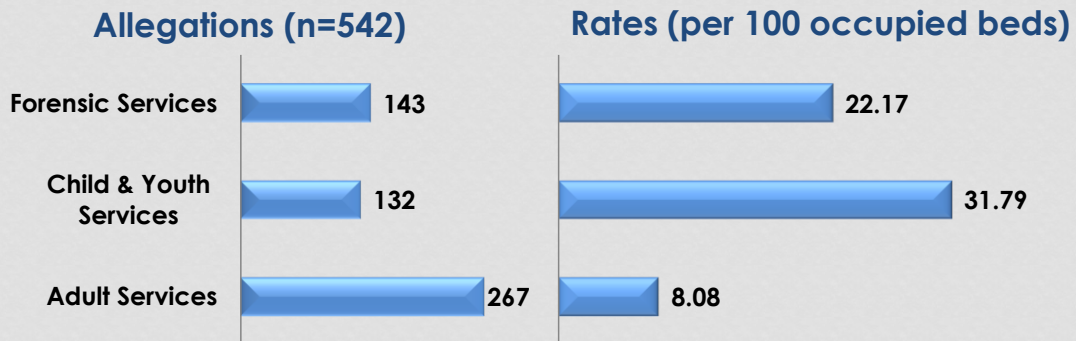
##### Rates



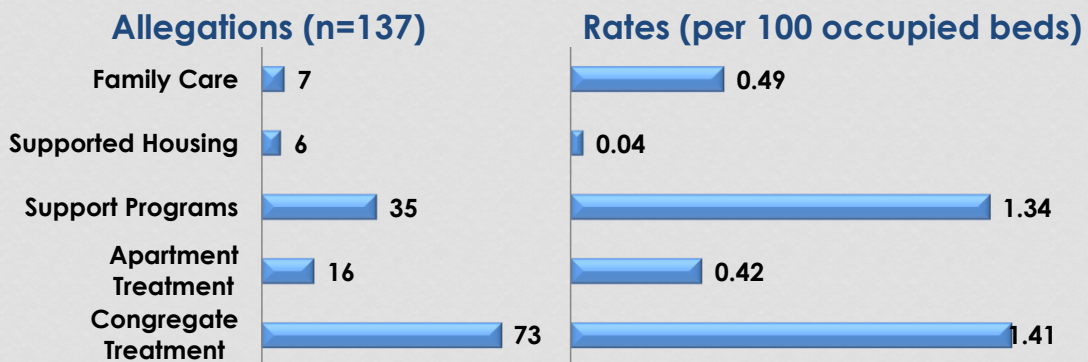
#### Comparison of Reporting Rates in State vs. Voluntary Agency Community Programs



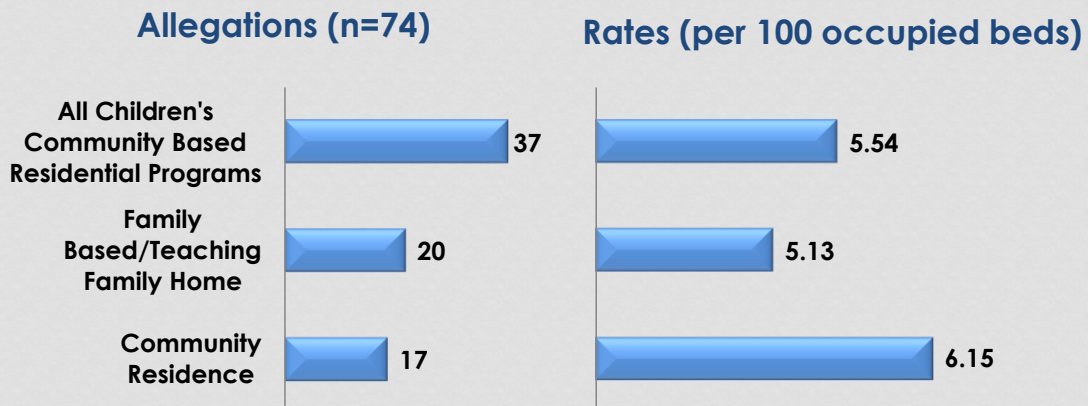
## State Psychiatric Centers



## OMH-Adult Community Based Residential



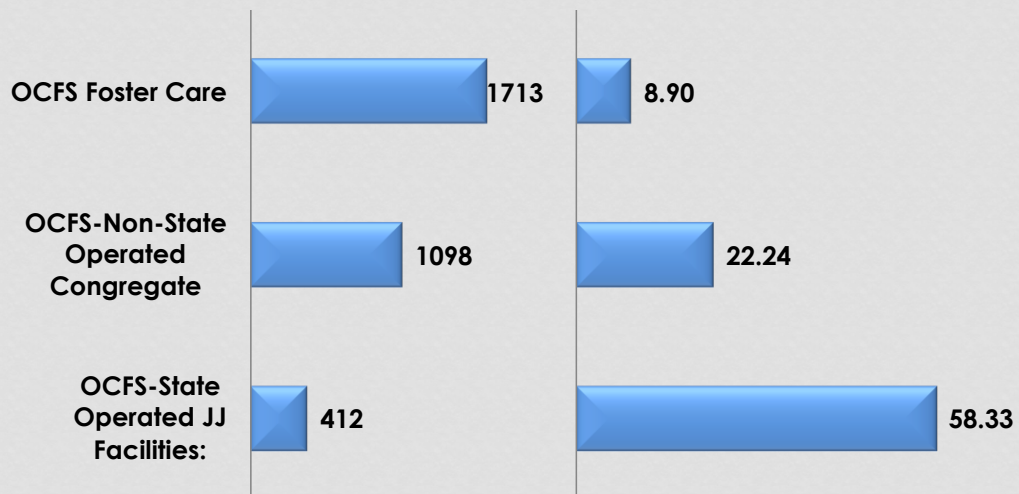
## OMH-Children's Community Based Residential



## OCFS Facilities

**Allegations (n=3223)**

**Rates (per 100 occupied beds)**



## APPENDIX D

### CHART COMPARING LEGAL FRAMEWORKS

	Department of Health Residential Health Care Facility	Office of Alcohol and Substance Abuse Services	Office of Mental Health	Office for People With Developmental Disabilities	Department of Health, Office of Children & Family Services Adult Care Facilities
Source	10 NYCRR 81.1	14 NYCRR 836.4	14 NYCRR 524.4	14 NYCRR 624.4	18 NYCRR 487, 488 and 489
<b>Definition of Abuse (General)</b>	The term abuse shall mean inappropriate physical contact with a patient or resident of a residential health care facility, while such patient or resident is under the supervision of the facility, which harms or is likely to harm the patient or resident. Inappropriate physical contact includes, but is not limited to, striking, pinching, kicking, shoving, bumping and sexual molestation.	Abuse is maltreatment of a person that would endanger the physical or emotional well-being of such person through the action or inaction on the part of anyone.	Abuse means any of the following acts of an employee: • Improper medication administration • Physical abuse • Psychological abuse • Sexual abuse	The maltreatment or mishandling of a person receiving services which would endanger the physical or emotional well-being of the person through the action or inaction on the part of anyone, including an employee, intern, volunteer, consultant, contractor, visitor, or others, whether or not the person is or appears to be injured or harmed. The failure to exercise one's duty to intercede on behalf of a person receiving services also constitutes abuse. While a person receiving services may have allegedly abused another person receiving services, it is necessary to take into consideration the aggressor's judgement and cognitive capabilities to determine whether the act is to be reviewed as an abuse allegation or as a behavioral problem. Abuse is categorized as follows: • mistreatment, • neglect, physical abuse • psychological abuse, • seclusion • sexual abuse • unauthorized/inappropriate use of restraint • unauthorized/inappropriate use of aversive conditioning • unauthorized/inappropriate use of time-out • violation of civil rights	Regulations state: A resident shall have the right to receive courteous, fair and respectful care and treatment at all times, and shall not be physically, mentally or emotionally abused or neglected in any manner. These terms, however, are not defined.
<b>Mistreatment</b>	The term mistreatment shall mean inappropriate use of medications, inappropriate isolation or inappropriate use of physical or chemical restraints on or of a patient or resident of a residential health care facility, while such patient or resident is under the supervision of the facility.		OMH does not define mistreatment. However, it defines improper medication administration as a form of abuse. Improper medication administration means any intentional administration of a prescription drug or over-the-counter medication to a client which is not in substantial compliance with a physician's, dentist's, physician's assistant's or nurse practitioner's prescription.	The deliberate and willful determination on the part of an agency's administration or staff to follow treatment practices which are contraindicated by a person's plan of services which violate a person's human rights, or do not follow accepted treatment practices and standards in the field of developmental disabilities.	

<b>Neglect</b>	The term neglect shall mean failure to provide timely, consistent, safe, adequate and appropriate services, treatment, and/or care to a patient or resident of a residential health care facility while such patient or resident is under the supervision of the facility, including but not limited to: nutrition, medication, therapies, sanitary clothing and surroundings, and activities of daily living.		Neglect means any action or failure to act by an employee which impairs, or creates a substantial risk of impairing, the physical, mental or emotional condition of a client.	A condition of deprivation in which persons receiving services receive insufficient, inconsistent or inappropriate services, treatment, or care to meet their needs; or failure to provide an appropriate and/or safe environment for persons receiving services. Failure to provide appropriate services, treatment, or care by gross error in judgment, inattention, or ignoring may also be considered a form of neglect.	
<b>Physical Abuse</b>	Inappropriate physical contact which harms or is likely to harm the patient. Includes but is not limited to striking, pinching, kicking, shoving, bumping and sexual molestation.	Any non-accidental contact involving staff, clients or others to whom this regulation is applicable, any conduct or inaction on the part of such persons that causes or has the potential to cause physical pain or harm.	Physical abuse means any non-accidental contact with a client which causes or has the potential to cause physical pain or harm, including but not limited to hitting, kicking, slapping, shoving, punching or choking.	Physical contact which may include, but is not limited to such obvious physical actions as hitting, slapping, pinching, kicking, hurling, strangling, shoving, unauthorized or unnecessary use of personal intervention, or otherwise mishandling a person receiving services. Physical contact which is not necessary for the safety of the person and/or causes discomfort to the person may also be considered to be physical abuse, as may the handling of a person with more force than is reasonably necessary.	
<b>Psychological Abuse</b>		Any verbal or non-verbal action or exchange involving staff, clients or others that would cause a reasonable person emotional distress.	Psychological abuse means any verbal or nonverbal action by an employee which is intended to cause a client emotional distress including, but not limited to, teasing, taunting, name calling or threats.	The use of verbal or non-verbal expression, or other actions, in the presence of one or more persons receiving services that subjects the person(s) to ridicule, humiliation, scorn, contempt or dehumanization, or is otherwise denigrating or socially stigmatizing. In addition to language and/or gestures, the tone of voice, such as that used in screaming or shouting at or in the presence of persons receiving services, may, in certain circumstances, constitute psychological abuse.	
<b>Seclusion as Abuse</b>	Addressed under mistreatment.			The placement of a person in a secured room or area from which he or she cannot leave at will. This does not include placement in a time-out room as part of a behavior management plan that meets all applicable requirements. Seclusion is considered to be a form of abuse and is, therefore, prohibited.	

<b>Sexual Abuse</b>	"Sexual molestation" is identified as a type of inappropriate physical contact (see above definitions) but is not elaborated on.	Any sexual contact involving staff, clients or others to whom this regulation is applicable involving a non-consenting person that is allowed or encouraged by staff or others. For purposes of this Part, lack of consent is inferred if an alleged perpetrator has responsibility to care for the victim, or holds a situational advantage over a victim's status in treatment, or over a victim's mental, emotional, or physical incapacity or impairment of which the alleged perpetrator should be aware. A person less than 17 years of age is deemed incapable of consent. For the purpose of this Part, sexual contact means any touching of the sexual or other intimate parts of a person for the purpose of gratifying sexual desire of either party.	Sexual abuse means any sexual contact involving a client and an employee; or any sexual contact involving a non-consenting client which is allowed or encouraged by an employee. A person less than 17 years of age is deemed incapable of consent. For the purposes of this Part, sexual contact means any touching of the sexual or other intimate parts of a person for the purpose of gratifying sexual desire of either party.	Any sexual contact between a person receiving services and an employee, intern, consultant, contractor or volunteer of an agency is always considered to be sexual abuse and is prohibited. Any sexual contact between persons receiving services and others, or among persons receiving services, is considered to be sexual abuse unless the involved person(s) is a consenting adult. This shall not include those situations in which a person with a developmental disability who was a service recipient becomes an employee of a service provider organization and already has a relationship with another service recipient of the same or another service provider organization; in such a situation, this shall be noted in the person's service plan and the relationship shall not be considered as "sexual abuse" unless there is reason to believe that there is harassment, coercion, exploitation, etc. involved. Sexual contact is defined as the touching or fondling of the sexual or other intimate parts of a person, not married to the actor, for the purpose of gratifying the sexual desire of either party, whether directly or through clothing. Sexual contact also includes causing a person to touch	
<b>Unauthorized or inappropriate use of restraint</b>	Addressed under mistreatment.			The use of a mechanical restraining device to control a person without the written, prior authorization of a physician or the senior staff member if the physician cannot be present within 30 minutes; or the use of a mechanical restraining device without it being specified in a plan of services; or used for medical purposes without a physician's order. The intentional use of a medication to control a person's behavior that has not been prescribed by a physician for that purpose is considered to be unauthorized use of restraint. Inappropriate use of a restraint shall include, but not be limited to, the use of a device(s) or medication for convenience, as a substitute for programming, or for disciplinary (punishment) purposes.	
<b>Unauthorized or inappropriate use of aversive conditioning</b>				The use of aversive conditioning without appropriate permissions is the unauthorized use of aversive conditioning. Inappropriate use of aversive conditioning shall include, but not be limited to, the use of the technique for convenience, as a substitute for programming, or for disciplinary (punishment) purposes.	
<b>Unauthorized or inappropriate use of time-out</b>				The use of time-out without appropriate permissions is the unauthorized use of time-out. Inappropriate use of time-out shall include, but not be limited to, the use of the technique for convenience, as a substitute for programming, or for disciplinary (punishment) purposes.	
<b>Violation of Civil Rights</b>				Any action or inaction which deprives a person of the ability to exercise his or her legal rights, as articulated in State or Federal Law.	

Definitions of Abuse/Maltreatment/Neglect of Children in Family Care and Foster Homes Operated or Certified by OMH, OPWDD and OCFS	
Source	<b>§412 Social Services Law and §1012 Family Court Act</b>
Abuse	An "abused child" means a child under eighteen years of age who is defined as an abused child by the family court act which defines an abused child as one whose parent or other person legally responsible for his care (i) inflicts or allows to be inflicted upon such child physical injury by other than accidental means which causes or creates a substantial risk of death, or serious or protracted disfigurement, or protracted impairment of physical or emotional health or protracted loss or impairment of the function of any bodily organ, or (ii) creates or allows to be created a substantial risk of physical injury to such child by other than accidental means which would be likely to cause death or serious or protracted disfigurement, or protracted impairment of physical or emotional health or protracted loss or impairment of the function of any bodily organ, or (iii) commits, or allows to be committed an offense against such child defined in article one hundred thirty of the penal law; allows, permits or encourages such child to engage in any act described in sections 230.25, 230.30 and 230.32 of the penal law; commits any of the acts described in sections 255.25, 255.26 and 255.27 of the penal law; or allows such child to engage in acts or conduct described in article two hundred sixty-three of the penal law provided, however, that (a) the corroboration requirements contained in the penal law and (b) the age requirement for the application of article two hundred sixty-three of such law shall not apply to proceedings under this article.
Maltreatment / Neglect	A "maltreated child" includes a child under eighteen years of age who has had serious physical injury inflicted upon him or her by other than accidental means or is defined as a neglected child under the Family Court Act which defines a neglected child as one whose (i) whose physical, mental or emotional condition has been impaired or is in imminent danger of becoming impaired as a result of the failure of his parent or other person legally responsible for his care to exercise a minimum degree of care (A) in supplying the child with adequate food, clothing, shelter or education in accordance with the provisions of part one of article sixty-five of the education law, or medical, dental, optometrical or surgical care, though financially able to do so or offered financial or other reasonable means to do so; or (B) in providing the child with proper supervision or guardianship, by unreasonably inflicting or allowing to be inflicted harm, or a substantial risk thereof, including the infliction of excessive corporal punishment; or by misusing a drug or drugs; or by misusing alcoholic beverages to the extent that he loses self-control of his actions; or by any other acts of a similarly serious nature requiring the aid of the court; provided, however, that where the respondent is voluntarily and regularly participating in a rehabilitative program, evidence that the respondent has repeatedly misused a drug or drugs or alcoholic beverages to the extent that he loses self-control of his actions shall not establish that the child is a neglected child in the absence of evidence establishing that the child's physical, mental or emotional condition has been impaired or is in imminent danger of becoming impaired as set forth in paragraph (i) of this subdivision; or (ii) who has been abandoned, in accordance with the definition and other criteria set forth in subdivision five of section three hundred eighty-four-b of the social services law, by his parents or other person legally responsible for his care.
Definitions of Abuse/Neglect of Children in Congregate Residential Programs Operated or Certified by OASAS, OMH, OPWDD, SED and OCFS.	
Source	<b>§412-a Social Services Law</b>
Abuse	"Abused child in residential care" means a "child" in "residential care" who: (a) is subjected to any of the following acts, regardless of whether such act results in injury, when such act is committed by a custodian of the child, is not accidental and does not constitute emergency physical intervention necessary to protect the safety of any person: (I) being thrown, shoved, kicked, burned, stricken, choked, smothered, pinched, punched, shaken, cut or bitten; (II) the display of a weapon, or other object that could reasonably be perceived by the child as a means for the infliction of pain or injury, in a manner that constitutes a threat of physical pain or injury; (III) the use of corporal punishment; (IV) the withholding of nutrition or hydration as punishment; or (V) the unlawful administration of any controlled substance as defined by article thirty-three of the public health law, or any alcoholic beverage, as defined by section three of the alcoholic beverage control law, to the child; or (b) is inflicted, by other than accidental means, with a reasonably foreseeable injury that causes death or creates a substantial risk of death, serious or protracted disfigurement, serious or protracted impairment of his or her physical, mental or emotional condition, or serious or protracted loss of impairment of the function of any organ; or (c) is subjected to a reasonably foreseeable and substantial risk of injury, by other than accidental means, which would be likely to cause death, serious or protracted disfigurement, serious or protracted impairment of his or her physical, mental or emotional condition, or serious or protracted loss of impairment of the function of any organ; or (d) is the victim of any offense described in the article one hundred thirty of the penal law or section 255.25, 255.26 or 255.27 of the penal law; or is allowed, permitted or encouraged to engage in any act described in article two hundred thirty of the penal law; or is allowed or used to engage in acts or conduct described in article two hundred sixty-three of the penal law; provided, however, that (I) the corroboration requirements in the penal law and (II) the age requirements for the application of articles one hundred thirty, two hundred thirty and two hundred sixty-three of the penal law and any age based element of any crime described therein shall not apply to the provisions of this title.
Neglect	"Neglected child in residential care" means a "child" in "residential care" who: (a) experiences an impairment of his or her physical, mental or emotional condition or is subjected to a substantial risk of such impairment because he or she has not received: (I) adequate food, clothing, shelter, medical, dental, optometric or surgical care, consistent with the rules or regulations promulgated by the state agency operating, certifying or supervising the residential facility or program, provided that the facility has reasonable access to the provision of such services and that necessary consents to any such medical, dental, optometric or surgical treatment have been sought and obtained from the appropriate individuals; (II) access to educational instruction in accordance with the provisions of part one of article sixty-five of the education law; or (III) proper supervision or guardianship, consistent with the rules or regulations promulgated by the state agency operating, certifying or supervising the residential facility or program; or (b) is inflicted with a physical, mental or emotional injury, excluding a minor injury, by other than accidental means, or is subjected to the risk of a physical, mental or emotional injury, excluding minor injury, by other than accidental means, where such injury or risk of injury was reasonably foreseeable; or (c) is inflicted with a physical, mental or emotional injury, excluding minor injury, by other than accidental means, or is subjected to the substantial risk of a physical, mental or emotional injury, excluding minor injury, by other than accidental means, as a result of failure to implement an agreed upon plan of prevention and remediation pursuant to this chapter, the mental hygiene law, the executive law or the education law; or (d) is subjected to the intentional administration of any prescription or non-prescription drug other than in substantial compliance with a prescription or order issued for the child by a licensed, qualified health care practitioner.

## APPENDIX E

### KEY STANDARDS

#### Key Incident Management and Abuse/Neglect (A/N) Standards Across NYS Human Service Systems Providing Residential/Inpatient Services

**Department of Health (DOH) System – Residential Health Care Facilities (Serving over 116,000 residents/patients in more than 600 programs)**

- Requires agencies to have incident management (reporting, investigation, and remediation) policies.
- Defines incidents including abuse/neglect (A/N).
- Requires all agencies' staff to report A/N; failure to do so constitutes misconduct.
- Requires agencies to report A/N allegations to DOH.
- Requires agencies to conduct investigations of A/N.
- Requires agencies' investigations be completed within 5 working days.
- Requires agencies' investigators be trained in investigation techniques.
- Requires agencies' investigations be thorough; suggests elements that constitute a thorough investigation.
- Requires agencies to conduct trend analyses of quality assurance issues, including incidents.
- Requires, by statute/regulation, that DOH commence investigations within 48 hours into all A/N allegations, in addition to the agency investigation.
- Requires all DOH investigative staff to be trained in investigative techniques.
- Requires agencies to report possible crimes to local law enforcement officials.
- Requires DOH to report A/N allegations to District Attorneys who have requested such notification.
- DOH also routinely reports A/N allegations to the Attorney General's Office for review and appropriate action.
- Does not require the reporting of A/N of children to independent child abuse investigative authorities, although a number of Residential Health Care Facilities serve children.
- Does not require the reporting of A/N to other external parties than those mentioned above with the authority to investigate for their review and appropriate action.

**Department of Health (DOH) System –  
Adult Care Facilities  
(Serving over 32,000 residents/patients  
in more than 480 programs)**

- Does not require agencies to have incident management (reporting, investigation, and remediation) policies.
- Does not define A/N.
- Does not require all agency staff to report A/N.
- Requires agencies to report A/N (not defined) along with other events (such as deaths, missing persons, attempted suicides, etc.) to DOH using a standardized Incident Report.
- In terms of investigations by the agency, requires only that the agency include the resident's version of the event on the Incident Report. The Incident Report provides space for a description of the incident and indicates that statements by participants/witnesses may be attached.
- Does not specify timeframes for agency investigations or elements that would constitute a thorough investigation.
- Does not require agency investigators to be trained in investigation techniques.
- Does not require agencies to conduct trend analyses of incidents to determine systemic issues/underlying causes.
- Requires, by internal policy, that DOH respond to A/N reports received from agencies.
- Does not require that DOH staff responding to A/N allegations reported by agencies have training in investigation techniques. A Training Academy for DOH Adult Care Facility surveyors which taught investigative techniques was eliminated in recent budgets.
- Requires agencies to notify law enforcement officials if it's believed a felony crime has been committed.
- Does not require the reporting of A/N to other external parties with the authority to investigate for their review and appropriate action, except in cases where the resident has received mental hygiene service. In such cases, the Commission on Quality of Care must be notified.

**Office for Children and Family Services (OCFS) –  
Children, Youth & Juvenile Justice Congregate Care  
(Serving over 5000 residents in more than 300 programs)**

- Does not require agencies to have incident management (reporting, investigation, and remediation) policies.
- Does not require agencies to conduct investigations into incidents or allegations of A/N.
- Does not require agencies to have trained investigators, or specify timeframes for investigations or components of a thorough agency investigation.
- Does not require agencies to conduct trend analyses of incidents to determine systemic issues/underlying causes.
- Requires agencies to report allegations of Child A/N, as defined in Social Services Law, to the State Central Registry (SCR) for investigation by Child Abuse Investigation authorities.
- Requires agencies' staff, as mandated reporters, to cause a report of suspicion/allegation of Child A/N to the SCR.
- Requires that all allegations of Child A/N defined in SSL and reported to the SCR be investigated by OCFS.
- Requires OCFS Child A/N investigative staff to be trained in investigative techniques.
- Requires the completion of OCFS investigations into Child A/N reports within 60 days.
- Requires that District Attorneys be informed of Child A/N reports for which they've requested notification.
- Requires, pursuant to NYS Commission of Corrections (COC) standards, that Secure Juvenile Justice facilities, of which there are four serving 238 individuals, report certain incidents to COC, including assaults, employee misconduct, hostage situations, etc.
- COC does not require reporting of, nor define A/N. OCFS is required to investigate COC reportable incidents.
- Does not require the reporting of allegations of A/N to other external parties with the authority to investigate.

**Office for Children and Family Services (OCFS) –  
Adult Care Facilities; Family-Type Homes  
(Serving over 800 residents in more than 450 programs)**

- Does not require operators to have incident management (reporting, investigation, and remediation) policies.
- Does not define A/N.
- Requires the operator to report A/N (not defined) along with other events (such as deaths, missing persons, attempted suicides, etc.) to local Social Service Districts using a standardized Incident Report.
- In terms of investigations, requires the operator to include the resident's version of the event on the Incident Report. The Incident Report provides space for a description of the incident and indicates that statements by participants/witnesses may be attached.
- Does not require operators to have investigation training, or specify timeframes for investigations or components of a thorough agency investigation.
- Does not require operators to conduct trend analyses of incidents to determine systemic issues/underlying causes.
- Does not address the reporting of possible crimes to law enforcement authorities.
- Does not address local Social Service Districts role in investigating allegations of A/N.
- Does not require the reporting of allegations of A/N to other external parties with the authority to investigate.

**Office for People With Developmental Disabilities  
(OPWDD) System**

**(Serving over 38,000 residents in  
more than 7500 programs)**

- Requires agencies to have incident management (reporting, investigation, and remediation) policies.
- Defines incidents including A/N.
- Requires all agencies staff to report A/N; failures to do so constitute A/N.
- Requires agencies to report A/N allegations to OPWDD.
- Requires agencies to conduct investigations of A/N.
- Encourages that agencies' investigators be trained in investigation techniques.
- Requires agencies' investigations be thorough; suggests elements that constitute a thorough investigation.
- Does not specify timeframes for agencies' completion of investigations. Requires monthly updates on status of investigations.
- Requires internal committees at agencies to review thoroughness of investigations, appropriateness of recommendations and their implementation.
- Requires agencies to conduct trend analyses of incidents to determine systemic issues/underlying causes.
- Requires direct and independent investigations by the Commission on Quality of Care (CQC) in addition to the agencies' investigations, into allegations of Child A/N, as defined in Social Services Law.
- Permits, but does not require, OPWDD to conduct investigations into any incident or A/N allegation at agencies it certifies/funds. (OPWDD is the primary investigator of allegations in programs it operates.)
- Requires agencies to notify law enforcement officials of events/incidents if it appears that a crime may have been committed.
- Requires the reporting of allegations of A/N to other external parties (CQC, Mental Hygiene Legal Services) with the authority to investigate for their review and appropriate action.

**Office of Alcoholism and Substance Abuse Services  
(OASAS) System**  
**(Serving over 14,500 residents/patients in more than 350 programs)**

- Requires agencies to have incident management (reporting, investigation, and remediation) policies.
- Defines incidents including A/N.
- Requires all agencies staff to report A/N.
- Requires agencies to report A/N allegations to OASAS.
- Requires agencies to conduct investigations of A/N.
- Encourages that agencies' investigators be trained in investigation techniques.
- Does not suggest elements that constitute a thorough investigation.
- Requires that preliminary incident reports (prepared within 24 hours) be completed within 10 days. Upon substantial completion of investigation, the incident report containing the results of such is to be sent to the Incident Review Committee. (See below.)
- Requires Incident Review Committees at agencies to review thoroughness of investigations, appropriateness of recommendations and their implementation.
- Requires agencies to conduct trend analyses of incidents, identify patterns and take preventive corrective action.
- Requires direct and independent investigations by the Commission on Quality of Care (CQC) in addition to the agencies' investigations, into allegations of Child A/N, as defined in Social Services Law.
- Permits, but does not require, OASAS to conduct investigations into any incident or A/N allegation at agencies it certifies/funds. (OASAS is the primary investigator of allegations in programs it operates.)
- Requires agencies to notify law enforcement officials of events/incidents if it appears that a crime may have been committed.
- Requires the reporting of allegations of A/N externally to CQC which has the authority to investigate for its review and appropriate action.

**Office of Mental Health (OMH) System**  
**(Serving over 44,000 residents/patients in more than 1400 programs)**

- Requires agencies to have incident management (reporting, investigation, and remediation) policies.
- Defines incidents including A/N.
- Requires all agencies staff to report A/N.
- Requires agencies to report A/N allegations to OMH.
- Requires agencies to conduct investigations of A/N.
- Encourages that agencies' investigators be trained in investigation techniques.
- Does not suggest elements that constitute a thorough investigation.
- Does not specify timeframes for agencies' completion of investigations. Encourages timely investigations.
- Requires internal reviews by agencies to determine the appropriateness of preventive/corrective action stemming from investigation.
- Requires agencies to conduct trend analyses of incidents to identify appropriate preventive/corrective actions.
- Requires direct and independent investigations by the Commission on Quality of Care (CQC) in addition to agencies' investigations, into allegations of Child A/N, as defined in Social Services Law.
- Permits, but does not require, OMH to conduct investigations into any incident or A/N allegation at agencies it certifies/funds. (OMH is the primary investigator of allegations in programs it operates.)
- Requires agencies to notify law enforcement officials of events/incidents if it appears that a crime may have been committed.
- Requires the reporting of allegations of A/N to other external parties (e.g., CQC) with the authority to investigate for their review and appropriate action.

### State Education Department

(Approves or certifies the educational components of residential schools serving approx. 2500 children & youth in NYS. The residential components of these schools are certified by other state agencies, e.g. OMH, OPWDD, OCFS, etc. Also directly operates two residential schools with a bed capacity of approx. 200. SED also approves out of state residential schools for approx. 650 students requiring such placement.)

- Does not require residential schools to have incident management (reporting, investigation, and remediation) policies.
- Does not require residential schools to conduct investigations into incidents or allegations of A/N.
- Does not require residential schools to have trained investigators, or specify timeframes for investigations or components of a thorough agency investigation.
- Does not require residential schools to conduct trend analyses of incidents to determine systemic issues/underlying causes.
- Requires NYS-based residential schools to report allegations of Child A/N, as defined in Social Services Law, to the State Central Registry (SCR) for investigation by Child Abuse Investigation authorities.
- Requires residential schools' staff, as mandated reporters, to cause a report of suspicion/allegation of Child A/N to the SCR.
- Requires that all allegations of Child A/N defined in SSL and reported to the SCR be investigated by OCFS or CQC.
- OCFS and CQC Child A/N investigative staff are required to be trained in investigative techniques and must complete investigations into Child A/N reports within 60 days.
- Requires incidents to be reported to law enforcement authorities if the event is of a criminal nature.
- Does not require the reporting of allegations of A/N to other external parties with the authority to investigate.

## **GLOSSARY OF TERMS**

### **Department of Health (DOH)**

#### **Nursing Homes/Residential Health Care Facilities**

Nursing Homes/Residential Health Care Facilities are governed by Article 28 of the Public Health Law and provide residential skilled nursing care and services and residential health-related care and services to a myriad of individuals with disabilities or health related problems. Residents range from infants with multiple impairments to young adults suffering from the sequelae of traumatic brain injury to the frail elderly with chronic disabilities.

#### **Adult Care Facilities**

Adult Care Facilities (ACF) certified by the DOH provide long-term residential care and services to adults who, though not requiring continual medical or nursing care as provided by facilities licensed or operated pursuant to Article 28 of the Public Health Law or various articles of the Mental Hygiene Law, are, by reason of physical or other limitations associated with age, physical or mental disabilities or other factors, unable or substantially unable to live independently. There are two types of ACFs certified by DOH: Adult Homes which provide long-term residential care, room, board, housekeeping, personal care and supervision to five or more adults; and Enriched Housing which provides long-term residential care to five or more adults, primarily persons 65 years of age or older, in community-integrated settings resembling independent housing units. Adult Homes and Enriched Housing Programs, or portions thereof, may seek additional certification from DOH to operate as Assisted Living Residences or to provide assisted living services.

### **Office of Alcoholism and Substance Abuse Services (OASAS)**

#### **Withdrawal and Stabilization Services**

Chemical Dependence Withdrawal and Stabilization Services are designed to provide a range of service options, that are the most effective and appropriate level of care, to persons who are intoxicated or incapacitated by their use of alcohol and/or substance. The primary purpose of any chemical dependence withdrawal and stabilization service is the management and treatment of alcohol and/or substance withdrawal, as well as disorders associated with alcohol and/or substance use, resulting in a referral to continued care.

#### **Inpatient Rehabilitation Services**

Inpatient Rehabilitations Services have as their goals: (1) the promotion and maintenance of abstinence from alcohol and other mood-altering drugs or substances except those prescribed by a physician, physician's assistant, or nurse practitioner; (2) the improvement of functioning and development of coping skills necessary to enable the patient to be safely, adequately and responsibly treated in the least intensive environment; and (3) the development of individualized plans to support the maintenance of recovery, attain self-sufficiency, and improve the patient's quality of life.



## **Residential Services**

A Chemical Dependence Residential Service provides an array of services for persons suffering from chemical dependence. Such services may be provided directly or through cooperative relationships with other community service providers. There are three levels of service that can be offered in a residential setting: intensive residential rehabilitation services, community residential services, and supportive living services. Each is distinguished by the complement of services available on site as well as the degree of dysfunction of the individual served in each setting.

## **Office of Mental Health (OMH)**

### **Inpatient Services**

#### **State Psychiatric Center**

Operated by the OMH and provides 24-hour psychiatric inpatient treatment care. Some psychiatric centers serve children and adolescents exclusively; other psychiatric centers serve child, adolescents and adults. There are also psychiatric centers for forensic patients.

#### **Inpatient Psychiatric Unit of a General Hospital**

A 24-hour inpatient psychiatric treatment program that is jointly licensed by OMH and DOH and operated in a medical hospital licensed under Article 28 of Public Health Law.

#### **Private Psychiatric Hospital / Hospital for Mentally Ill**

A 24-hour inpatient psychiatric treatment program that is licensed by OMH under Article 31 of Mental Hygiene Law and operates in private hospitals that provide behavioral health services exclusively.

#### **Residential Treatment Facility**

Residential Treatment Facilities provide fully-integrated mental health treatment services to seriously emotionally disturbed children and youth between the ages of five and 21 years of age. These services are provided in 14-61 bed facilities which are certified by both the OMH and the Joint Commission on the Accreditation of Health Care Organizations or Council on Accreditation.

### **Community Residential Services**

#### **Support Program**

Licensed residential support programs are offered in congregate, apartment and single room residences where limited on-site assistance is provided, consistent with the resident's desire, tolerance and capacity to participate in services.

#### **Treatment Program**

Licensed residential treatment programs are offered in congregate, apartment and single room residences where on-site interventions are goal-oriented, intensive, and usually of limited duration.



### **Family Care**

A licensed program in which a private residence and a family are certified by OMH to provide 24-hour residential services in a small family setting.

**Family Based Treatment Program:** The Family Based Treatment Program treats children and adolescents who are seriously emotionally disturbed within a home environment that is caring, nurturing and therapeutic. The program employs professional parents who are extensively trained and supervised.

### **Teaching Family Home**

Teaching Family Homes are designed to provide individualized care to children and youth with serious emotional disturbances in a family-like, community-based environment. Specially trained parents live and work with four children and youth with serious emotional disturbances in a home-like setting.

### **Unlicensed Housing**

There are unlicensed, but OMH funded, programs which provide long term or permanent housing in a setting where residents can access the support services they require to live successfully in the community.

## **Office for People With Developmental Disabilities (OPWDD)**

### **Community-Based Programs**

#### **Family Care**

Family Care is a residential program that provides a structured and stable home environment within a family unit to a person with a developmental disability, offering support, guidance, and companionship. Family Care providers are home owners who receive a monthly stipend to care for individuals with developmental disabilities in their own homes.

#### **Individualized Residential Alternatives**

Individualized Residential Alternatives (IRAs) are certified homes that provide room, board and individualized service options. There are two different kinds of IRAs. A Supervised Individualized Residential Alternative is a home that has staff nearby at all times that individuals are at the residence. A Supportive Individualized Residential Alternative is a home in which living is more independent and supervision is based on the person's needs for supervision; staff typically are not onsite at all times when residents are home.

#### **Intermediate Care Facilities**

Intermediate Care Facilities (ICFs) are residential treatment options in the community for individuals with specific medical and/or behavioral needs. ICFs provide 24-hour on-site assistance and training, intensive clinical and direct-care services, supervised activities and a variety of therapies. ICFs are designed for individuals whose disabilities severely limit their ability to live independently.



## **Community Residences**

A Community Residence provides housing, supplies for daily living like food and toiletries, and services on a daily basis for individuals who have developmental disabilities. Community Residences foster supportive interpersonal relationships, offer supervision to ensure health and safety, and assistance in learning activities that are a part of daily living. Community residences are designed to provide a home environment, and also to provide a setting where individuals with developmental disabilities can acquire the skills necessary to live as independently as possible. There are two types of community residences: supervised community residences, in which staff are nearby at all times that individuals are at the residence and supportive community residences in which living is more independent. In supportive residences, staff are onsite and available less than the entire time individuals are home, based on the specific support needs of an individual.

## **Campus Housing**

### **Developmental Center and Specialty Units**

A Developmental Center is a large, state operated ICF authorized to provide housing, services, and supports for people with developmental disabilities. In addition to large ICFs, there are smaller state operated ICFs on the grounds of current or former Developmental Centers. They are designed to provide services for individuals with specific needs, such as autism, dual diagnoses, behavioral challenges and forensic issues. There is also a state operated program known as a Small Residential Unit (SRU) which is an ICF with limited capacity designed for the purpose of providing small residential group settings on the grounds of a developmental center.

## **Office of Children and Family Services (OCFS)**

### **Children's Services: Juvenile Justice Facilities**

#### **Secure Residential Center**

Secure Residential Centers are the most controlled and restrictive of the residential programs operated by OCFS and provide intensive programming for youth requiring this type of environment. Virtually all program services are provided on-grounds and access to and from facilities are strictly controlled. The facility is surrounded by security fencing and individual resident rooms are locked at night. The majority of youth admitted to secure facilities are sentenced as juvenile offenders or juvenile offender/youthful offenders by the adult courts.

#### **Limited Secure Residential Center**

Limited Secure Residential Centers provide the most restrictive service setting for the juvenile delinquent population. First admissions to these facilities are comprised of adjudicated juvenile delinquents. Limited secure facilities are also used for youth previously placed in secure facilities as a first step in their transition back to the community. Virtually all services are provided on-grounds. Services provided include education, employment training, recreation, counseling, medical and mental health services.



### **Non-Secure Residential Centers**

Non-Secure Residential Centers provide a non-secure level of placement that consists of a variety of urban and rural residential centers. Admissions to these facilities consist of adjudicated juvenile delinquents. Youth in residential centers require removal from the community but do not require the more restrictive setting of a limited secure facility.

### **Children's Services: Non-Juvenile Justice Congregate Care Facilities**

#### **Institution**

Institution is any facility for the care and maintenance of 13 or more children operated by a child-care agency.

#### **Group Residence**

A Group Residence is an institution for the care and maintenance of not more than 25 children operated by an authorized agency.

#### **Group Home**

A Group Home is a family-type home for the care and maintenance of not less than seven, nor more than 12, children who are at least five years of age, operated by an authorized agency, in quarters or premises owned, leased or otherwise under the control of such agency.

**Agency Boarding Home** means a family-type home for the care and maintenance of not more than six children operated by an authorized agency, in quarters or premises owned, leased or otherwise under the control of such agency.

### **Adult Services**

#### **Family-Type Home for Adults**

Family-type home for adults is an adult care facility governed by Social Services Law. It is established and operated for the purpose of providing long-term residential care, room, board, housekeeping, supervision and/or personal care to four or fewer adults unrelated to the operator.

### **State Education Department**

#### **Residential Schools-In State**

SED certifies the educational component of residential schools serving approximately 2,500 children and youth in New York State. The residential components of these schools are certified and under the jurisdiction of other State agencies, such as OMH, OPWDD and OCFS. SED also directly operates two schools, one for youth that are blind and one for youth who are deaf.

#### **Out-of-State Residential Schools**

SED approves out-of-state schools for children and youth who, in the opinion of local school or social services districts, require such placement in the absence. Approximately 650 students are in such out-of-state placements.