Investigation into Allegations of Child Abuse and Neglect at Western New York Children's Psychiatric Center: Final Report

NYS Commission on
QUALITY
OF CARE
for the Mentally Disabled

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April 1990

INVESTIGATION INTO ALLEGATIONS OF CHILD ABUSE AND NEGLECT AT WESTERN NEW YORK CHILDREN'S PSYCHIATRIC CENTER: FINAL REPORT

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Preface

In January 1989, the Commission issued an interim report, ***Investigation into Allegations of Child Abuse and Neglect at Western New York Children's Psychiatric Center,*** which presented preliminary findings of the agency's investigation of 32 separate child abuse and neglect reports at the facility filed with the State Central Register for Child Abuse and Maltreatment over the seven-month period, March 14, 1988 - October 17, 1988.

The purpose of the interim report was to provide an overview of the Commissin's preliminary findings and its recommendations for specific reforms and changes. The Commission recognized the likely long-term duration of its investigation and believed that the seriousness of the reported cases and its preliminary investigation findings warranted an interim report to facilitate the remediation of facility and systemic problems that had been identified.

This follow-up report has a dual purpose. First, the report adds the closing chapter to the Commission's investigations of the original 32 allegations of child abuse and neglect at Western New York Children's Psychiatric Center, and to the more general findings and conclusions contained in the interim report. Second, the report examines the follow-up corrective actions planned and/or taken by the Office of Mental Health subsequent to the Commission's interim report, both at Western New York Children's Psychiatric Center and statewide with respect to the delivery of children's inpatient mental health services.

In the year since the interim report was issued, officials at the Office of Mental Health and Western New York Children's Psychiatric Center report significant improvements in the facility's provision of appropriate care, supervision and treatment for children. Thus, major changes in admission practices and discharge planning procedures, as well as the enhancement of outpatient services, have produced a 50 percent census reduction. Several changes in the facility physical layout both assure children more appropriate bedroom privacy and ensure that only children of like ages are grouped together on living units. Finally, there has been a nearly complete change of senior management and clinical personnel: an expert clinical consultant on abused and sexually active children is now available on-site; and operational procedures now ensure greater accountability for supervision of children, appropriate treatment assessments and programs as well as more appropriate handling of untoward incidents. At the same time, the Office also reports that during this time, it has undertaken a comprehensive review and is now engaged in an overhaul of services and treatment for this population in all of its children's facilities and living units.

The Commission recognizes that engineering change of this magnitude is a formidable task, and it supports the Office's determination to make radical systemic revisions in the delivery of inpatient care to children. According to OMH, critical to this endeavor are the deliberations of several in-house work groups and the outside consultation services to be provided by Boy's Town. These efforts will provide direction for revisions in discharge planning policies, for guidelines for the treatment of abused and sexually active children, and for the establishment of minimum qualifications for key administrative and clinical staff.

The Office of Mental Health has already spent considerable senior staff time and has dedicated present and future financial resources to this plan for revamping children's inpatient services. The results and effectiveness of this strategy will not be clearly evident for many years. What is evident, however, is that, as reported in the Office of

Mental Health response to this draft report and in subsequent conversations, such issues as revisions in discharge planning policies, final guidelines for the treatment of abused and sexually active children, and the establishment of minimum qualifications for key administrators and clinicians will not be addressed for several years until the work groups and consultants have completed their work. This delay greatly concerns the Commission.

In light of this concern, the Commission has recommended that in its next round of peer reviews or quality assurance reviews, the Office of Mental Health identify and ensure the viability of those elements of treatment, supervision and incident review which must be in place to safeguard the youths. We have requested that the report of these reviews be shared with the Legislature and the Commission by January 1991.

Appended to this report is the response of the Office of Mental Health, as well as further comments of the Commission. This report represents the unanimous view of the members of the Commission.

Clarence J. Sundram
Chairman

Irene L. Platt
Commissioner

James A. Cashen
Commissioner

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Introduction

In January 1989, the Commission issued an interim report of its investigation of allegations of abuse and neglect at Western New York Children's Psychiatric Center ***(Investigation into Allegations of Child Abuse and Neglect at Western New York Children's Psychiatric Center***, January 1989). This interim report presented preliminary findings of the agency's investigation of 32 reports of child abuse and neglect filed with the State Central Register involving children at the facility over the seven-month period March 14, 1988 - October 17, 1988. The report also discussed the agency's initial assessment of the underlying issues and circumstances which appeared to have contributed to the high rate of serious incidents at the facility. These preliminary findings included:

- Over a long period of time, many young children at Western New York Children's Psychiatric Center had engaged in sexual activity with other children. Many of these incidents appear to have occurred and/or persisted because of inadequate supervision of the children by staff at the facility.
- Line staff had been aware of this sexual activity, and had generally reported it appropriately to senior supervisory, administrative and clinical staff.
- Although senior administrative and clinical staff at the facility had knowledge of this sexual activity, they took little, and often inappropriate, action to intervene to prevent the activity from recurring.
- Senior management did not recognize the seriousness of the sexual conduct being reported; they did not take sufficient action to protect the children or to assure an appropriate level of supervision; and, they did not ensure that the children's behavior was addressed in the course of their treatment.
- Senior management also frequently failed to report the incidents promptly to the State Central Register for Child Abuse and Maltreatment, Office of Mental Health officials, and law enforcement authorities, when warranted.
- Most critically, many of the children involved in these incidents of sexual activity had been admitted to Western New York Children's Psychiatric Center with a prior history of either inappropriate sexual behavior or significant physical or sexual abuse. The facility virtually ignored these histories in developing treatment plans for many of the children and in assuring these children received special protections.

In this interim report, the Commission also made a number of recommendations for corrective actions to the New York State Office of Mental Health, some specifically directed to the Western New York facility and others related more generally to the State's mental health services system for children.

The purpose of this follow-up report is twofold. First, the report adds the closing chapter to the Commission's investigations of the original 32 allegations of child abuse and neglect at Western New York Children's Psychiatric Center, and to the findings and conclusions contained in the interim report. Second, the report examines the follow-up corrective actions planned and/or taken by the Office of Mental Health subsequent to the Commission's interim report, both statewide in respect to the delivery of children's mental health services and at Western New York Children's Psychiatric Center.

Status of the Reports to the State Register

In accordance with the Child Abuse and Prevention Act of 1985, the Commission notified the Department of Social Services and the facility director of its recommended determination, at the close of the investigation of each of the 32 reports of possible abuse and neglect referenced in its interim report on Western New York Children's Psychiatric Center.* Additionally, the Commission's letters to the acting facility director (copies of which were also forwarded to OMH Western Regional and Central Offices) also made recommendations for corrective and disciplinary actions. Notably, such recommendations were offered in both indicated and unfounded cases, as appropriate.

Of the 32 original allegations, 23 involved some kind of sexual activity; 8 involved an allegation of physical abuse; and 1 involved an allegation of verbal abuse. Of the 23 cases involving some form of sexual activity, 15 involved allegations of child-to-child sexual behavior and 8 related an allegation of sexual contact between a child and a staff member.

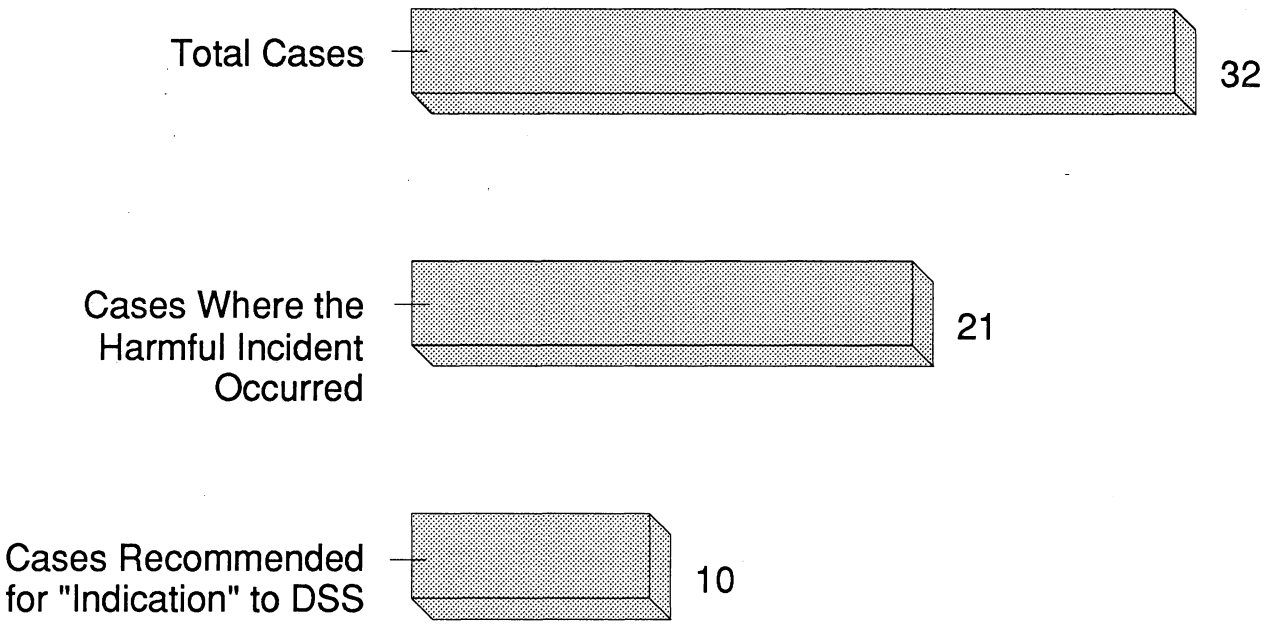
Completed investigations revealed that there was credible evidence that the incident(s) related in 21 of the original 32 allegations had occurred, substantially as reported. More specifically, the Commission found that in all of the 15 allegations involving some form of child-to-child sexual activity, the alleged sexual incidents had actually occurred, and that in four of the eight allegations relating sexual contact between a staff person and a client, the contact had occurred. Relatedly, in two of the eight allegations of physical abuse, there was evidence that the incident had occurred substantially as reported. (The six other physical abuse cases involved allegations of the inappropriate restraint of a child; notably, in all of these cases, the Commission did determine that the restraint had occurred, and in two, a minor injury to the child had resulted, but there was no evidence to substantiate inappropriate staff action.) In the one incident of verbal abuse, the evidence suggested that the incident had not occurred as reported. (Figure 1)

The Commission made a recommendation to the Department of Social Services to "indicate" 10 of the 32 original cases, including 5 of the 15 cases involving child-to-child sexual contact, 4 of the 8 cases involving staff sexual contact with a child,** and 1 of the 8 cases involving staff physical abuse. In 11 of the 22 cases where the Commission made an "unfounded" recommendation, including all 10 of the unfounded cases involving sexual contact between children, the investigation did find, however, that the alleged incident had occurred. In these cases, the recommendation of "unfounded" was put forth, either because the Commission could not trace the incident to neglect by a specific employee, or because the nature of the misconduct did not fall within the parameters of the statutory definition of child abuse and neglect in CAPA of 1985. In five of these "unfounded" cases, although staff actions or inactions could not be directly linked to contributing to the incident, other staff misconduct associated with the incident was identified.

*The Child Abuse and Prevention Act of 1985 provides that at the close of its independent investigations, the Commission shall "recommend" to the Department of Social Services its finding of "indicated" or "unfounded." According to statute, the Department reviews this recommendation and makes the final determination in the case.

**In one of the indicated cases of staff sexual abuse, criminal prosecution of a staff member was initiated.

Figure 1: WNYCPC Cases by Confirmation that the Incident Occurred and Indication Recommendation to DSS [March 14 - October 17, 1988]



For example, in one case which involved two boys engaging in sexual activity, the Commission's investigation found the primary therapists for the boys had failed to provide and document appropriate clinical interventions with regard to the boys' sexual activity. The investigation also cited the clinical supervisor for failing to ensure appropriate administrative clinical supervision of the treatment teams for both boys. Finally, an administrator was cited for his failure to report the incident to the State Central Register.

In another case which involved an allegation that a child was regularly "stripped searched" contrary to facility policy, the Commission investigation confirmed that inappropriately conducted searches had occurred over some period of time. While the Commission did not recommend "indicating" the case, as it was not possible to identify individual staff responsible for the specific incidents reported, the Commission did cite several administrative staff for their failure to promulgate and monitor the proper implementation of facility policy guidelines related to searches of children. In this case, the Commission also noted that a clinical staff person had intentionally misrepresented the facts of the situation to the child's parents.

In relating its investigative determination of "indicated" or "unfounded," in most cases the Commission also offered recommendations for corrective and/or disciplinary action. In 19 of the 32 cases (3 indicated cases and 16 unfounded cases), the Commission's recommendations were limited to those contained in its interim report.* In six other cases, the Commission offered more specific recommendations for corrective action, targeted to the needs of specific children or staff or an aspect of facility policy or practice relevant to the case.** The Commission also made recommendations to the facility to consider disciplinary action for staff involved in 11 of the cases.*** In several instances, disciplinary recommendations related to the same staff person involved in two or more of the cases. In total, such recommendations were made relative to 11 different staff persons.

Correspondence from the acting director, dated May 15, 1989, indicates that the center has substantially implemented all of these case-specific recommendations.****

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*See Report pp. 17-20 for a list of the recommendations in the CQC Interim Report and OMH's planned and implemented corrective actions.

**See Appendix A for a listing of CQC's recommended corrective actions pertinent to individual cases.

***See Appendix B. for a complete list of CQC's recommended disciplinary actions and Western New York Children's Psychiatric Center's response.

****The Commission has not verified these reports through record checks, interviews with families/other caregivers, or direct contact with the children.

Reported Corrective Actions at WNYCPC

In addition to the case-specific corrective and disciplinary actions reported above, Office of Mental Health and Western New York Children's Psychiatric Center officials report many systemic corrective actions at the Western New York facility.

Census Reduction

Perhaps the singularly most visible change has been the administration's efforts to reduce admissions and the census of the facility. As of February 15, 1990, the census of the facility was 35 children, reflecting nearly a 50 percent decrease in the center's census since January l989, when the Commission issued its interim report.

According to facility officials, this census reduction has been achieved through aggressive efforts to divert admissions through increased family support services, increased efforts to ensure intensive outpatient services, and the creation of a Mobile Assessment Team which travels to agencies (Division for Youth, Erie County Medical Center, the Department of Probation, and the Department of Social Services) providing assessment and consultation services. Facility officials also report intensive efforts to ensure prompt discharge of children back to their families or less restrictive program settings. These efforts have reportedly been facilitated by the facility's greater emphasis and deployment of resources to family support services and other outpatient services.*

Management and Clinical Staff Changes

The facility has also undergone nearly a complete change in senior management and clinical staff. The Facility Director, at the time when most of the incidents occurred, has retired; the previous Deputy Director for Quality Assurance resigned (then retired); and, the Chief Medical Officer was removed from his duties, and later resigned. Additionally, the Chief of Service was demoted, and three treatment team leaders were reassigned. A new Acting Director was appointed in December 1988, and a new Deputy Director for Quality Assurance was appointed in June 1989. In addition, in the past year, a new Chief of Service for Outpatient Services, as well as two new treatment team leaders, have been appointed.

A board-eligible child psychiatrist was also hired in July 1989, and a psychiatrist from the University of Rochester has been hired as a consultant to help develop and implement a quality assurance program for medical staff. The Office of Mental Health also reports that it is continuing to recruit for a Deputy Director for Clinical Services and two additional child psychiatrists for the center. OMH officials also informed the Commission that the selection process for a permanent director has been underway and that a final selection is still pending.**

*The Commission has not verified these reports through record checks, interviews with families/other caregivers, or direct contact with the children.

**As of February 19, 1990, this final selection of a permanent director was still pending.

Reforms in Clinical Practices

The acting director also reports that substantial changes have been made in clinical practices at the center, particularly as they affect the initial comprehensive assessments and discharge planning services for children with histories of sexual or physical abuse or precocious sexual activity. Among other efforts, the center has ensured the on-going services of a specially trained consultant in the clinical treatment of children with sexual abuse histories, who reportedly is present at the center weekly, assisting with the treatment and discharge planning for individual children and with staff training.

The acting director also reports that the recently hired Deputy Director for Quality Assurance is developing a system to check the quality of comprehensive assessments for children who are admitted to the center, and that the discipline coordinators in psychology and social work are sharing the responsibility of monitoring the quality of discharge planning activities.

Additionally, the Medical Records Department of the center now regularly monitors all records to ensure that assessments and discharge planning summaries are appropriate. The center also reports that since the inception of this monitoring, record-keeping deficiencies have decreased significantly.

New procedures have also been developed at the center to ensure that children alleged to have been involved in sexual incidents receive a competent medical examination by specially trained medical personnel. Specifically, the facility has now established contracts with the Erie County Medical Center and the Children's Hospital of Buffalo to perform these specialized exams. According to the acting facility director, it is now standard operating procedure to provide a medical exam at one of these two facilities for any child who is alleged to have had genital sexual contact with another child or custodian. Facility physicians are accountable for making the decision to ensure an outside exam, and these decisions are reportedly reviewed by the Incident Review and Peer Review Committees. The acting facility director reports that facility physicians have not, however, received any additional training in interacting with or examining children who may have been sexually abused or involved in sexual incidents with other children.

Environmental and Procedural Changes

The center has also undertaken a number of environmental and procedural changes designed to enhance the protection and supervision of children. For example, the children's unit has been subdivided into two units, one serving children 10 and under and one serving children 11 to 14 years of age. Many double and triple bedrooms have been converted to single bedrooms;* the main entrances of the facility are now locked to provide additional security; and night staff are now physically stationed in hallways where the children's bedrooms are located. Additionally, the center reports that administrative unannounced rounds of the facility are conducted weekly during the evening or night shift or on weekends, and that center policies have been revised for special precautions and supervision of "at risk" children and children with off-grounds privileges.

*Specifically, all bedrooms on the youngest children's unit, the intensive treatment unit, and the latency-age unit are now single bedrooms.

Reforms in Incident Reporting and Review

Management staff also state that numerous changes in center procedures have strengthened incident reporting and review practices. Over a six-week period, Central Office staff provided weekly technical assistance to center staff in developing a trend analysis format for incidents. The incident review process at the center has also been revised to ensure that all members of the Incident Review Committee review each incident and that the Committee's meeting minutes are distributed to all units for review. In addition, three staff, one per shift, have been charged with ensuring that incidents are properly reported, and the administrative assistant to the acting director has been designated to attend Incident Review Committee meetings and to complete quarterly trend analysis reports of incidents.

External Monitoring

The Office of Mental Health has also assured periodic external monitoring of the center and its treatment practices through the appointment of a three-person team of clinical experts, who reported directly to the Office's Acting Chief Medical Officer. This team has made two group visits to the center since February 22, l989, and individual members have each made two additional visits. This expert team has also completed a report of their findings and recommendations (June 16, 1989) which has been sent to the Commissioner and is now under review. This report confirms and supplements the Commission's preliminary findings that deficiencies in clinical treatment at the center were serious and that they require prompt attention and correction.

The report identified poor psychiatric assessments, inadequate treatment planning, the lack of written treatment rationales, and the failure to develop and inculcate a hospital mission statement as problems at the center. The expert consultants recommended the hiring of qualified psychiatrists to address treatment deficiencies; increased staff training; increased use of group therapies to deal with such topics as sex education, anger control, social skills, drug and alcohol abuse, and sexual abuse; more parental involvement in treatment; and the need to help staff deal more openly with the sexual histories of the children served.

Based on the expert team's verbal summary to the facility on April 14, 1989, actions have reportedly already been implemented to provide more intensive treatment to patients and to establish more clearly defined staff responsibilities for case coordination. Specifically, the facility has ensured that a physician or a psychologist serves as each child's primary therapist and that this therapist will be responsible for coordinating the child's treatment by the entire treatment team. Additionally, as noted above, additional staff psychiatrists have been hired, and the facility has ensured the weekly presence of a psychiatric consultant.

Statewide Corrective Actions

In addition to specific corrective actions at Western New York Children's Psychiatric Center, the Commission's interim report also made a number of recommendations to the Office of Mental Health pertinent to all state-operated children's psychiatric centers and children and youth units of adult psychiatric centers. The Office of Mental Health agreed to implement all of these corrective actions, and as noted below, in some instances steps have been taken to initiate implementation of these statewide corrections. In part, reflective of the substantial effort involved in fully implementing these changes statewide, and also because decisions on several key policy issues have been deferred until the major work of the consultants from Boy's Town has been completed, progress has been slower in achieving these desired corrective actions. (See Figure 2, Report pp. 17-20.)

Management Review

In view of the absence of key administrative and clinical staff with substantial education, training, and experience in working with children at Western New York Children's Psychiatric Center, the Commission recommended that the Office of Mental Health review its policies and practices regarding the qualifications for directors and senior staff at state-operated children's psychiatric facilities to ensure that these personnel have adequate and appropriate expertise in working with children with mental disabilities. The Office concurred with this recommendation and stated that a review would be initiated and that based on this review, it would develop appropriate qualifications and performance indicators for these personnel.

In the past nine months, the Office reported that in the context of "peer reviews" of each children's center and unit, the qualifications of staff in leadership positions were evaluated. (See Report p. 12.) The Associate Commissioner for Children and Families has also provided both verbal and written directives to regional and facility directors to ensure that candidates for clinical and supervisory positions have education, training, and experience in children's mental health services. OMH senior staff also stated that in ***July 1990***, OMH will issue a report identifying the systemic training needs and describing an appropriate in-service training program for individuals in senior management and clinical positions.

During interviews with Commission staff (October 1989), senior OMH officials indicated that no final decisions have been made regarding the qualifications for directors and senior staff of children's centers or units, as OMH is still considering the most appropriate management model for these facilities and programs. OMH officials reported that the process of making these decisions has been complicated by the existing variation in the management structures and personnel qualifications among children's centers and units, as well as OMH's current effort in evaluating the appropriate future role of state-operated children's centers and units. In particular, OMH has indicated its desire to gradually limit the role of these facilities and programs to intermediate care (while vesting acute care in hospital-based facilities) and to restrict its services to children over 12 years of age.

Enhancing Basic Values and Clinical Treatment Practices

A related Commission recommendation focused on the need for the Office of Mental Health to convene the directors and senior management and clinical staff of children's psychiatric centers and units to review the issues raised by the investigation of Western

New York Children's Psychiatric Center, with a view toward clarifying the basic values and principles that should guide the care, treatment and nurturance of children in their custody. In particular, the Commission recommended enhanced guidance to staff in responding appropriately to sexual behavior among children.

The Office of Mental Health concurred with this recommendation and reported that an initial meeting with directors and senior management and clinical staff to achieve the stated goals had already been held in October 1988, before the release of the interim report. Subsequently, two additional meetings were held in February l989 and March 1989. The Office also reported a number of additional initiatives designed to meet the intent of the Commission's recommendation:

(1) The development of a uniform, structured peer review process whereby all children's centers and units would be assessed to identify the strengths and weaknesses in a program's ability to manage and treat children safely;

(2) Formation of a task force to identify education and training needs related to the treatment and management of sexually abused children and to ensure the provision of this training "as soon as it can be negotiated;"

(3) Formation of a task force to identify guidelines for staff working with sexually abused children, covering such topics as, basic value statements regarding children's sexual behavior, the relationship between inpatient programs and families, community norms and values, supervision and clinical management of children, staffing, and incident reporting, investigation, and review.

Over the past nine months, the Office of Mental Health has ensured peer reviews for all state-operated children's centers and units. These reviews, which involved many staff at the facility, regional office, and central office levels, assessed each state children's center and unit for vulnerability to the problems identified in the course of the Western New York investigation. Final reports of these reviews, which covered a variety of issues, including the appropriate supervision of children and staff, physical plant layout, staff attitudes, patient assessment and treatment and discharge planning issues, and the handling of untoward incidents, were issued to each center/unit, and plans of correction were required and reviewed by the Office of Mental Health. At four facilities where the most serious concerns were noted during the peer reviews, the Office has also conducted follow-up reviews and noted substantial corrective actions. The Office plans to conduct two additional follow-up reviews at Western New York Children's Psychiatric Center and the Children and Youth Unit of Kingsboro Psychiatric Center. All of the remaining centers/units were required to conduct follow-up self-assessments.

In a recent meeting with OMH senior officials, the Commission was also informed that beginning in ***the spring of 1990***, its Bureau of Children and Families will ensure semi-annual focused clinical reviews at each children's psychiatric center and unit. Additionally, the Office has begun a similar review process relying on Central and Regional Office staff at state-licensed residential treatment facilities (RTFs) for children . The Commission is strongly supportive of both of these OMH initiatives.

The Office of Mental Health has also convened the two task forces to examine staff training needs/solutions and to develop guidelines for working with children who have been sexually abused. Over the past nine months, members of the former task force have reviewed a number of different training programs and shared them with the senior staff of the children's centers and units. Recently, the Office has chosen one curriculum, and it initiated this training in ***January 1990*** with "train the trainer" training sessions. OMH reports that this training will focus on three priority areas: (1) an overview of sexual abuse issues; (2) treatment interventions; and (3) effective treatment planning. The 1990 training is the first of a

curriculum that spans five years and covers such topics as social skills, drugs and alcohol, learning disabilities, and abandonment and neglect.

The Office of Mental Health has also recognized the value of using outside experts to provide some of the needed training, and it has recently distributed a request for proposals for outside contractors to provide additional training. As response to this request for proposals was unacceptable, OMH has recently referred the issue of external training back to a work group for further consideration.

The task force developing the guidelines for working with children who have been sexually abused issued draft guidelines in March 1989. These draft guidelines were circulated to the management staff of the children's centers and units. The Commission was also afforded an opportunity to review the draft guidelines. Based on the comments received on the guidelines, Office of Mental Health senior officials originally reported that the guidelines were being redrafted and that they anticipated issuing final guidelines to the centers and units in ***January 1990***. More recently, however, OMH has indicated that it will defer drafting final guidelines until the Boy's Town consultants have completed much of their work.

The Commission is also concerned that over the past year, in part because of the attention centered on child abuse and neglect, staff in some children's programs have expressed increasing concern that their appropriate affectionate responses to children may leave them vulnerable to a report of child abuse or neglect. Notably, this fear has been expressed, although none of the cases accepted by the State Register reflect such staff behavior. These fears are the unfortunate and unwarranted consequence of the investigations of allegations of abuse and neglect and serve as a powerful reminder that staff training on the expectations for staff performance and behavior requires on-going attention by senior staff in children's programs. Staff need to be reassured that an essential aspect of providing care and treatment to children is to encourage the development of normal relationships between adults and children in which non-sexual physical contact is natural.

Assuring More Appropriate Clinical Assessments

In recognizing that for many children at Western New York Children's Psychiatric Center, their vulnerability to sexual abuse and/or sexual involvements with other children was overlooked because thorough clinical assessments of their prior histories of sexual and/or physical abuse were either not done or not appropriately incorporated in their treatment, the Commission recommended that the Office of Mental Health take immediate steps, including the use of consultants, if necessary, to ensure that clinical staff at all children's centers and units have the capability to conduct appropriate assessments and to incorporate assessment findings in treatment planning decisions. The Commission also recommended that staff from the Office's Quality Assurance Division periodically monitor clinical records to assure that high standards for assessments and treatment are maintained.

The Office of Mental Health agreed with this recommendation, stating that the "peer reviews" would focus on the quality of assessments and that the task force developing guidelines for working with children who had been sexually abused would use expert consultants to develop an intake instrument and process for conducting clinical assessments. The Office also indicated that training would be provided to staff in the use of these tools and in the relationship between assessments and treatment planning. Additionally, the Office stated that the Division of Quality Assurance would develop a system for the periodic review of clinical records.

The Commission's review of closing reports of the initial peer reviews of the children's centers and units indicated that clinical assessment issues were addressed in these reviews, and that all centers/units are working toward strengthening these procedures. To date, however, the Office has not developed a statewide assessment instrument or process to address these issues. According to senior OMH officials, such an assessment form is in use at Western New York Children's Psychiatric Center, but a final decision has not been made to use this tool statewide.

Statewide training on clinical assessment issues has also not yet begun, although the Office of Mental Health reports that many centers/units have ensured their own in-service training and supervision on this topic. OMH also reports that although to date the Quality Assurance Division has not begun its on-site monitoring efforts, in ***the spring of 1990***, its semi-annual clinical reviews of all children's centers and units will begin and that spot-checks of the appropriateness of clinical assessments will be included in these assessments.

Medical Interventions/Exams

Noting that the vast majority of the children involved in sexual incidents at Western New York Children's Psychiatric Center had not been examined by an appropriately trained physician, the Commission recommended that the Office of Mental Health promptly develop and implement a policy and procedure to ensure that this serious oversight in attending to children's needs not be repeated at this facility or any state-operated inpatient program. The Commission recommended that this policy and procedure should provide that: (1) any child who is the subject of sexual activity should be immediately examined by qualified and specially-trained medical personnel, who have ready access to evidence kits to preserve physical evidence of sexual activity; and (2) all such children receive appropriate follow-up treatment and counseling, as needed. The Commission also recommended that the Office of Mental Health, in developing its policy and procedure, consider the applicability of adopting the preexisting guidelines which have been issued by the Department of Health for these purposes. The Office of Mental Health agreed to implement this recommendation and to review the applicability of the Department of Health guidelines.

To date, senior officials of the Office of Mental Health report that they researched applicable guidelines for the development of a policy and procedure, but have disseminated the Department of Health guidelines to all the facilities. OMH officials noted that the Department of Health guidelines are presently being revised and that when issued, they hope to successfully negotiate Health Department training of the OMH physicians.

The Office has indicated that it is encouraging centers and units to establish formal affiliations with a specialized hospital or rape crisis center to provide appropriate exams of children by ***October 1990***.

Improving Incident Reporting and Review Procedures

The Commission recommended that in view of the many problems at Western New York Children's Psychiatric Center surrounding the prompt reporting of incidents to the State Central Register and in ensuring appropriate interventions and investigations, that the Office of Mental Health should offer refresher training to all senior administrative and clinical personnel at the facility in these areas. The Office responded that it concurred with this recommendation and that it had "identified the need to provide refresher training systemwide in the reporting, review, investigation, and monitoring of incidents involving sexual activity." (Letter from Commissioner Richard Surles, January 10, 1989)

In its response, the Office also indicated that it would provide enhanced monitoring of all incidents involving sexual activity over a

six-month period, by requiring all children's centers and units to file all such incident reports with Central Office. In filing these reports, the Office indicated that center/unit staff would be required to complete a brief checklist indicating that they had assured needed interventions (i.e., medical examinations for the children involved, needed revisions to treatment plans, family notifications, needed changes in the child's environment and supervision). Additionally, the Office reported that it had already instituted a requirement that each children's center and unit appoint a designated staff person on each shift to be responsible for reviewing all reported incidents and making appropriate external notifications.

Since the issuance of the Commission's interim report, the Office indicated that issues surrounding the proper handling of all unusual incidents, and especially incidents involving sexual activity, have been addressed with each center and unit in the context of the Office's "peer reviews" of each program. Additionally, all centers/units have submitted plans of correction addressing outstanding issues in these areas which surfaced in the course of the peer reviews. The Regional Office for the Central Region also has taken the additional step of providing a two-day retreat for the unit chiefs of its four children and youth units to review problems surrounding the incidents at Western New York Children's Psychiatric Center and to address appropriate procedures and practices to avoid these problems at their programs.

In subsequent correspondence (Letters from Commissioner Richard Surles, June 8, l989 and August 22, 1989), the Office has reported that it continued to believe that systemwide refresher in-service training is needed in these areas, and that the Office's Bureau of Employee Relations is developing an overview of current problems and a request for proposals for the needed training at all centers/units. While OMH officials could not provide target dates for the provision of this training, they noted that it remained a high priority.

The Office has also reported that it followed through on its commitment to ensure Central Office receipt of all sexual incident reports from children's centers and units over a six-month period. According to senior OMH officials, these reports were reviewed individually as they were received, and any needed corrective or follow-up actions were taken in regard to individual incidents. The Office of Mental Health has also recently stated, in response to a draft of this report, that no statewide problems were apparent in these incident reports. Due to resource constraints, however, these officials stated that no aggregate review or analysis of the reported sexual incidents has been completed.

Attention to Discharge Planning

In conjunction with its review of a number of incidents at Western New York Children's Psychiatric Center, the Commission noted repeated problems in discharge planning for children involved in these incidents and especially in properly informing and training families or other surrogate caregivers in addressing the children's histories of sexual abuse and sexual behavior upon their discharge. In its interim report, the Commission recommended that these issues be addressed at Western New York Children's Psychiatric Center. In its response to this recommendation, the Office of Mental Health stated that it "is reviewing its discharge planning policy in order to develop a discharge planning process and protocol for state-operated and licensed inpatient programs which [will] include treatment needs and recommendations regarding a child's sexual history, development, and behavior." (Letter from Commissioner Richard Surles, January 10, 1989)

Subsequent update reports from the Office of Mental Health indicated that discharge planning issues were addressed during the "peer reviews" of each children's center and unit and that all programs have submitted plans of correction addressing identified problems in these areas. An OMH Task Force has also been meeting to address the systemwide issues in discharge planning for children's programs; OMH initially reported that its final conclusions and recommendations for policy and procedural change would be available in ***January 1990.*** More recently, in response to a draft of this report, OMH indicated, however, that policy and procedural change related to discharge planning will be deferred until the near completion of the Boy's Town consultants' work. The Office also reports that its upcoming clinical audits of children's centers and units will ensure spotchecks of discharge planning practices.

Environmental and Physical Plant Improvements

In response to the Commission's identification of several environmental and unit organizational issues which contributed to the incidents at Western New York Children's Psychiatric Center, the Office of Mental Health made a commitment to review similar issues at each of its children's centers and units. These reviews were provided in the context of the "peer reviews" at each center and unit, and reportedly many specific environmental and unit organizational changes have been undertaken at many programs. OMH officials report that they are in the process of preparing a complete list of these changes for the Commission's review.

FIGURE 2: RECOMMENDATIONS IN THE CQC INTERIM REPORT AND OMH'S COMMITMENTS AND PLANNED AND IMPLEMENTED CORRECTIVE ACTIONS

CQC Recommendations (January 1989)	*OMH Commitments*	*OMH Planned and Implemented Corrective Actions (As of February 1990)*
1. The Office of Mental Health should review the suitability of the current management and clinical staff at Western New York Children's Psychiatric Center. If necessary, it should consider augmenting the senior management of the facility with strong and capable clinical leadership.	The Office of Mental Health concurred with this recommendation and also agreed to conduct a review of the qualifications and experience of key administrative and clinical staff at its other state-operated children's psychiatric centers and children and youth units. Based on this review, the Office also stated that it would develop appropriate qualifications and performance indicators for these personnel.	The Office of Mental Health reports that in the context of the peer reviews of each children's center and unit, the qualifications of staff in leadership positions were evaluated. Written directives have also been issued to regional and facility directors to ensure that candidates for clinical and supervisory positions have education, training, and experience in children's mental health services. The Office also plans to issue a report identifying the training needs of individuals in senior management and clinical positions. The Office has not, however, made any final decisions about the needed qualifications for directors and other senior staff of its children's centers and units. Senior OMH officials report that final decisions about the appropriate management structure for these programs are pending its overall evaluation of the future role of these programs in serving children with mental health needs. **Status: Partially Implemented**
2. The Office of Mental Health should convene senior management and clinical staff at Western New York Children's Psychiatric Center to review the issues raised by this investigation, to clarify the basic values which should guide the care, treatment and nurturance of children in their custody, and to develop appropriate policies, procedures, and training programs for staff. In particular, there is a need to provide guidance to staff in responding to sexual behavior among children.	The Office of Mental Health concurred with this recommendation and noted that meetings were already underway to ensure its implementation. The Office also noted three other initiatives to address the objectives of the recommendation: (1) development of a peer review process to assess the ability of all children's centers and units to safely manage and treat children; (2) formation of a task force to identify the education and training needs of staff in treating and caring for children with histories of sexual abuse; and (3) formation of a task force to identify guidelines for staff working with sexually abused children.	The Office of Mental Health has held three meetings with senior staff of its children's centers and units to clarify the values and expectations for the supervision, care, and treatment of children in their custody. The Office has also developed and implemented a peer review process at all of its state-operated children's centers and units, and assured follow-up on noted deficiencies and problems. Additionally, the Office has announced plans to continue these reviews semi-annually and has begun a similar review process at its licensed residential treatment facilities. The Office has also convened the two promised task forces for identifying training programs and developing staff guidelines for caring and treating children with histories of sexual abuse. The "training" task force has identified a proposed training curriculum, and has begun the implementation of the first year of the five-year training project.

(Continued)

CQC Recommendations	*OMH Commitments*	**OMH Planned and Implemented Corrective Actions**
		The task force developing guidelines for staff working with sexually abused children issued draft guidelines to the field in March, 1989. Comments from the Commission, as well as facility, regional office, and central office staff on the draft guidelines indicated that a number of revisions were needed. OMH initially agreed to promptly revise these guidelines, and in December of 1989 indicated that final guidelines would be forthcoming in January 1990. More recently in response to the draft of this report, the Office of Mental Health indicated that the issuance of final guidelines would be delayed until the final stages of the Boy's Town contract. **Status: Partially Implemented**
3. Western New York Children's Psychiatric Center should designate a specific official on each shift to be responsible for reviewing all incidents and for making all external notifications pursuant to law or Office of Mental Health regulations.	The Office of Mental Health concurred with this recommendation and agreed to make similar designations at all of its children's centers and units.	The Office of Mental Health has reported that this recommendation has been implemented at each of its children's centers and units. **Status: Implemented**
4. The Office of Mental Health should ensure that Western New York Children's Psychiatric Center has the capability to obtain adequate histories of the children admitted, including histories of prior physical and sexual abuse and neglect, to enable appropriate diagnosis and treatment. If necessary, consultants should be used to ensure this capability. Additionally, Quality Assurance staff should periodically monitor the facility to ensure that these clinical practices are in place.	The Office of Mental Health agreed with this recommendation, stating that the peer reviews would focus on the quality of assessments and that the task force developing guidelines for working with children who have been sexually abused would use expert consultants to develop an intake instrument and process for conducting clinical assessments. The Office also agreed to offer training to staff in the use of these new tools and the relationship between assessments and treatment planning, and to assure periodic review of clinical records related to these issues under the direction of the Office's Division of Quality Assurance.	The Office of Mental Health has assured attention to these issues in its peer reviews of children's centers and units; but to date, it has not developed an intake assessment form or process for use in state-operated children's centers and units. Statewide training on these issues has also not yet begun, although the Office reports that many centers and units have ensured their own in-service programs on these topics. Recently, OMH officials have indicated that due to a poor response to its request for proposals for this training, these concerns have been referred back to a work group. Additionally, while no periodic reviews of clinical records at children's centers and units have yet begun, OMH officials indicate that this process will begin in May 1990, under the joint direction of the Office's Division of Quality Assurance and the Bureau of Family and Children's Services. **Status: Partially Implemented**

(Continued)

CQC Recommendations	*OMH Commitments*	**OMH Planned and Implemented Corrective Actions**
5. Western New York Children's Psychiatric Center should ensure the development and implementation of policies and procedures to ensure that any child who is the subject of a report of sexual activity is examined by qualified and specially trained medical personnel. This policy should also ensure that all such children receive appropriate follow-up treatment and counseling.	The Office of Mental Health concurred with this recommendation and agreed to ensure similar procedures and protections for all of its state-operated children's centers and units.	The Office of Mental Health has ensured that such arrangements and procedures are in place at Western New York Children's Psychiatric Center. To date, however, the Office has not developed statewide standards or guidelines for ensuring appropriate medical intervention and attention in its facilities for children who may have been involved in sexual activity, nor has it provided any statewide training for medical personnel in its children's centers and units on these issues. Rather, it has forwarded to the facilities copies of the guidelines issued by the Department of Health. The Office reports that it is researching applicable standards and guidelines. The Office also indicates that it is encouraging centers and units to establish formal affiliations with a specialized hospital or rape crisis center to provide appropriate exams of children by **October 1990.** **Status: Partially Implemented**
6. The Office of Mental Health should offer refresher training for senior administrative and clinical personnel at the facility in the reporting, review, investigation, and follow-up of all untoward incidents, particularly such incidents which involve sexual contact or sexual activity among children or allegations of staff sexual abuse.	The Office of Mental Health concurred with this recommendation and stated that it had "identified the need to provide refresher training systemwide in the reporting, review, investigation, and monitoring of incidents involving sexual activity." The Office also indicated that it would conduct a six-month statewide review of all incidents involving sexual activity among children.	The Office of Mental Health did assure that all incident reports relating to sexual activity among children were submitted to Central Office for review. This practice continues to date. Reportedly, initially these incident reports were reviewed individually as they were received, and OMH determined that no statewide problems or concerns were detected. Due to resource constraints, however, OMH officials reported that no systemic review or analysis of the received reports was conducted. The Office has also not yet developed the refresher training program which it noted was needed for staff in incident reporting procedures and investigation. Reportedly, this training has been delayed pending the response to a request for proposals for outside consultants to conduct the training. The Office does report, however, that these issues were addressed during the peer review process and that its Central Regional Office has provided specialized training in this area for unit chiefs of its four children and youth psychiatric units. **Status: Partially Implemented**

(Continued)

CQC Recommendations	*OMH Commitments*	**OMH Planned and Implemented Corrective Actions**
7. Western New York Children's Psychiatric Center should ensure that all children discharged from the facility are afforded comprehensive discharge plans which address their treatment needs and concerns, including their histories of sexual abuse and/or unusual sexual activity with other children or siblings.	The Office of Mental Health concurred with this recommendation and indicated that it is reviewing its current discharge policy to develop a discharge process and protocol for all its state-operated children's centers and units.	The Office of Mental Health has addressed discharge planning issues in its peer reviews of children's centers and units, and a task force has been meeting to discuss statewide issues in discharge planning. To date, however, no new procedure or protocol has been issued and most recently, in response to a draft of this report, OMH indicated that it was deferring statewide action on discharge planning issues referenced in the Commission's report, until the latter stages of the Boy's Town contract. **Status: Not Implemented**
8. The Office of Mental Health should review environmental and physical plant conditions at Western New York Children's Psychiatric Center that impair the adequate supervision and monitoring of children and develop a plan to correct such conditions. In particular, the Office should examine the facility's practice of congregating very young children (ages 5-8) with older children (ages 9-12).	The Office of Mental Health concurred with this recommendation and made a commitment to conduct similar reviews at its other state-operated children's centers and units.	The Office of Mental Health assured the conduct of these reviews at Western New York Psychiatric Center, as well as its other state-operated children's centers and units in the context of its peer reviews of these facilities. Reportedly, many specific environmental and unit organizational changes have been undertaken at many of these facilities. OMH reports that it is in the process of preparing a complete list of these changes for the Commission's review. **Status: Implemented**
9. Given the seriousness of the events which have transpired, the Office of Mental Health should seriously consider assigning an independent clinical monitor in Western New York Children's Psychiatric Center for the coming year to review and critique professional judgments, to evaluate assessments, treatments plans, and discharge plans for children, and to oversee the facility's practices for reporting, handling, investigating, and monitoring untoward events occurring at the facility.	The Office of Mental Health concurred with this recommendation.	The Office of Mental Health assured external review of Western New York Children's Psychiatric Center over the past year through the appointment of a three-person team of clinical experts, who reported directly to the Office's Acting Chief Medical Officer. This team has made two group visits to the center since February 22, 1989, and individual members have each made two additional visits. The team also prepared a report of its findings (June 1989) which identified a number of clinical treatment deficiencies at the center. Concurring with the findings of the Commission's Interim Report, the expert team's report identified poor psychiatric assessments, inadequate treatment planning, the lack of written treatment rationales, and the failure to develop and inculcate a hospital mission statement as significant problems at the center. **Status: Implemented**

Conclusions

In conclusion, in the 14 months since the Commission's release of its interim report, many improvements and positive outcomes have been achieved at Western New York Children's Psychiatric Center. Perhaps more importantly, the Office of Mental Health has undertaken efforts to provide enhanced safeguards for the protection and more appropriate treatment of children in state-operated children's psychiatric centers and children and youth units systemwide. It is also noteworthy that the Office has initiated efforts to ensure comparable review practices in its licensed residential treatment facilities for children.

As reflected in this report, these efforts by the Office of Mental Health reflect a commitment to a comprehensive examination and evaluation of children's mental health services in the state, and many will require the sustained commitment of resources over the coming year to achieve their intended outcomes. In particular, the Office's goals for the delivery of its ambitious five-year training schedule, the implementation of the first year of which has already begun, will require assurances that the Bureau of Children and Families within the Office is adequately staffed with appropriately trained and qualified personnel.

Similarly, enhancement of clinical treatment services in state-operated centers and units must be predicated on qualified and competent clinical leadership and staffing in each of these programs. The Commission is supportive of OMH's commitment to continue its evaluation of the existing administrative and clinical resources available to each state-operated program, although it recognizes that the findings of these efforts may likely result in recommendations to reconfigure and/or augment the senior clinical staff capability in some programs.

Providing an enhanced medical staff capability to respond to the needs of children with histories of physical and sexual abuse and neglect and children who are alleged to be abused or sexually involved with other children is equally important. The Commission strongly endorses OMH's goal of ensuring an affiliation with a medical facility with competence in this area for each children's center and unit and urges that the planned timeframe for achieving this goal be accelerated. While the Commission recognizes that OMH is awaiting issuance of the revised Department of Health guidelines for the conduct of medical examinations of persons alleged to have been sexually abused and hopes to negotiate physician training with DOH, the Commission strongly urges that the adoption of pertinent guidelines and training not be postponed indefinitely.

Concerns regarding the reporting, investigation, and review of incidents of possible abuse and neglect have also rightfully received substantial attention from the Office of Mental Health, children's mental health facilities, and the Commission over the past year. This attention has yielded many positive benefits in heightening administrative, clinical, and line staff awareness of the mandates of the Child Abuse and Prevention Act of 1985, as well as in reducing the likelihood that reportable allegations will not be filed with the State Register.

The Commission recognizes that many changes in policies and practices it recommended have taxed the resources of the Office of Mental Health, particularly at a time when a number of fundamental questions are being raised by OMH about the future role and direction of state-operated children's psychiatric centers and children and youth units. While progress has been made in implementing a number of recommenda-

tions, particularly those specific to Western New York Children's Psychiatric Center, for most of the system-wide recommendations, the past year has been spent essentially in assessing implementation strategies and planning. Inherent in the OMH decision to await the completion of the efforts of internal work groups and external consultants before attempting to implement the system-wide recommendations is the acceptance of significant delays in addressing issues such as:

- the establishment of minimum qualifications for key clinical and administrative staff;
- the issuance of guidelines for the treatment of sexually abused and sexually active children; and,
- the revision of discharge planning procedures.

While these delays are a matter of concern to the Commission, the effectiveness of this strategy will be tested with time.

APPENDIX A

CQC Recommended Corrective Actions Pertaining to Individual Cases at Western New York Children's Psychiatric Center

- The staff at Western New York Children's Psychiatric Center should ensure that any child making a request to contact the Commission is provided access and assistance to do so.
- Western New York Children's Psychiatric Center should ensure that staff interviewing a child in association with an investigation of possible abuse and neglect are fluent in the child's primary language.
- Western New York Children's Psychiatric Center should use staff assignment and sign-out sheets on all units to ensure greater accountability for staff presence/absence.
- Western New York Children's Psychiatric Center should ensure that staff rounds of the residential units are staggered to preclude the ability of the children to easily predict the times staff will be checking their whereabouts.
- Western New York Children's Psychiatric Center should closely review the histories and current behaviors of children in planning their participation in facility field trips.
- Western New York Children's Psychiatric Center should develop clearer guidelines for staff supervising children on van trips, especially in relationship to their seating arrangements on the van.

APPENDIX B

CQC Recommended Disciplinary Actions Related to Western New York Children's Psychiatric Center and the Facility's Response

- The facility concurred with the CQC recommendation to discipline the Nursing Service Coordinator for failing to monitor the implementation of the facility's policy related to searches of children, and a letter of counseling was issued to this individual.
- The facility concurred with the CQC recommendation to discipline a social worker for failing to share information about an incident pertinent to the safety of the children involved with their primary therapists.
- The facility concurred with the CQC recommendation to discipline a primary therapist for her failure to document a child's allegations of abuse in her progress notes or to file an incident report.
- As recommended by the CQC, the facility took disciplinary action against a unit chief for failure to report allegations of child abuse and neglect promptly to the State Central Register. The unit chief was demoted from a Grade 35 to a Grade 23, and he received a letter of reprimand and an unsatisfactory performance evaluation.
- As recommended by the CQC, a treatment team leader was disciplined for failure to modify children's treatment plans to address significant protection issues related to reported incidents. The facility reassigned the treatment team leader from administrative and direct care responsibilities and is pursuing other appropriate disciplinary actions.
- The facility concurred with the CQC recommendations to pursue discipline of two primary therapists of children at Western New York Children's Psychiatric Center for failing to address their histories of inappropriate sexual activity prior to admission and involvement in inappropriate sexual activity subsequent to their admission in the children's treatment plans.
- The facility Director for Quality Assurance resigned as of March 31, 1989, in the face of charges that he had not assured the appropriate review and investigation of incidents.
- The facility agreed to pursue disciplinary action against a facility physician and psychologist for failing in their capacity as children's primary therapists to provide and document appropriate clinical interventions for the children who had been involved in sexual activity.
- The facility agreed to pursue disciplinary action against a social worker for failing to document an incident appropriately and for failing to follow up with the child's primary therapist regarding a reported incident. The facility noted that it could not pursue discipline against this employee for allegedly interfering with the CQC investigation without more specific facts from the CQC.

- The facility agreed to pursue discipline against a social worker for misrepresenting the facts of an incident to a child's parents, but it maintained that it could not take action against the social worker's other alleged acts of "unprofessional conduct," without more specific information from the CQC.
- The facility noted that it lacks sufficient evidence to bring charges, as recommended by the CQC, against two staff in an alleged sexual abuse incident, but it indicated that it is seeking termination against one of the employees on a time and attendance issue. The facility also noted that this employee is currently on suspension without pay for allegedly stealing $20.00 from a patient .
- The facility disagreed with the CQC recommendation to discipline a social worker for holding a group discussion of an incident which could have interfered with its investigation. The facility noted that the group discussion was really a regularly scheduled group therapy session, and that the special investigator was present. (For the same reason, the facility did not concur with the CQC recommendation to discipline the team leader for failing to appropriately supervise this social worker.)
- The facility disagreed with CQC's recommendation to discipline the Deputy Director for Institutional Administration for failing to ensure the proper promulgation of the facility's policy related to searches of children, noting that this individual had no responsibility related to policies pertaining to nursing services.

APPENDIX C

NEW YORK STATE
OFFICE OF MENTAL HEALTH
44 Holland Avenue, Albany, New York 12229

RICHARD C. SURLES, Ph.D., Commissioner

January 16, 1990

Clarence Sundram, Chairman
Commission on Quality of Care
for the Mentally Disabled
99 Washington Avenue - Suite 2001
Albany, New York 12224

Dear Mr. Sundram:

Enclosed is the Office of Mental Health's response to the Commission on Quality of Care's December 1989 Final Report on the Investigation into Allegations of Child Abuse and Neglect at Western New York Children's Psychiatric Center. Included in the response are several corrections and updates with regard to WNYCPC and statewide improvement initiatives.

In general, the Commission's report is viewed by the OMH as a fair and accurate assessment of this agency's efforts to enhance the quality of care and treatment of sexually abused children in the inpatient programs which we operate. Moreover, the report has been instrumental in pointing to the need for OMH to develop a comprehensive system-wide approach to dealing with this issue.

As the attached response indicates, however, OMH has serious overall concerns about how this investigation has been reported. These concerns relate to the Commission's presentation of its data - in both content and tenor - throughout this investigation. In fact, only 10 of the 32 reported cases detailed in the CQC report were found to be indicated.

Also troubling is the Commission's omission in the final report that numerous initiatives were well underway prior to the events at WNYCPC. Many of the initiatives which the Commission recommended have been part of a system improvement plan for

children's mental health services in New York State and were clearly referenced in the 1988 OMH State Mental Health Plan. Others were OMH recommendations following our own reviews at WNYCPC which, in most areas, paralleled those identified by the Commission in its interim report.

The OMH appreciates the opportunity to review the Commission's report prior to its publication. We look forward to continuing to work collaboratively with the Commission for improvement of the services and care we provide to seriously emotionally disturbed children and their families in New York State.

Sincerely,

Richard C. Surles, Ph.D.
Commissioner

OFFICE OF MENTAL HEALTH

RESPONSE TO THE

COMMISSION ON QUALITY OF CARE'S

FINAL REPORT

(December, 1989):

INVESTIGATION INTO

ALLEGATIONS OF CHILD ABUSE

AND NEGLECT AT

WESTERN NEW YORK

CHILDREN'S PSYCHIATRIC CENTER

January 1990

The Office of Mental Health (OMH) has reviewed the Commission's final report on the investigation into allegations of child abuse and neglect at Western New York Children's Psychiatric Center (WNYCPC). For the most part, OMH finds the report to be an accurate and fair assessment of the steps we have taken to improve the quality of care and treatment for sexually abused children in state-operated inpatient programs.

OMH was gratified to find that the Commission's report reflected a sensitivity to the difficulties involved in implementing statewide initiatives which sometimes involve delayed timelines and strategy changes.

We have identified a few areas in the report that are in need of correction or update relative to statewide and Western New York Children's Psychiatric Center specific improvement initiatives. These are referenced in Appendix A.

OMH does have concerns with two issues which have permeated the initial investigation at WNYCPC, subsequent actions by the Commission, and this final report. Our position on the two issues is spelled out to correct what we perceive as serious misreporting of events that occurred at WNYCPC and of the overall children's system improvement initiatives. Areas to be addressed are: Data Presentation and Credit for System Improvement Initiatives.

I. Data Presentation

Of the 32 reported cases of child abuse and neglect filed with the State Central Register involving children at WNYCPC over the seven-month period, March 14, 1988 - October 17, 1989, only 10 cases were actually indicated.

The data presentation of the Commission's interim report and final report sensationalizes the incidents - giving the reader the impression that all 32 incidents were of the same severity and had equal conclusiveness as to their occurrence and negligence on the part of staff. It is OMH's position that this type of data presentation contributes to an inaccurate portrayal of the severity of the issues.

To state that 10 incidents occurred at WNYCPC over the course of seven months, for which there was evidence of abuse or neglect on the part of a staff member, and to outline the serious system weaknesses uncovered throughout the facility would present the material far more accurately and fairly. The sensationalism that is created by the misrepresentation of the data has devastating consequences for the entire child-serving system.

OMH does not intend to minimize the wrongdoing to the children at WNYCPC or the pain experienced by the families of the children. OMH does believe that the deficiencies noted and the improvements to WNYCPC and the entire children's mental health system could have come about without as much damage to those staff that were innocent at WNYCPC and to the mental health staff throughout the State who were doing their jobs well.

OMH was, in fact, surprised by the type of data presentation the Commission used in the WNYCPC situation. All previous reports by the Commission had focused on numbers of "indicated" cases. This report appeared to mask the actual number of indicated cases behind numerous data presentations of cases that, for the most part, were not indicated.

OMH has demonstrated through its comprehensive follow-up to the events at WNYCPC, that interface with and responsiveness to oversight bodies is taken seriously. OMH strongly recommends that oversight bodies, specifically the Commission, present their data and their reports in a sound and reasonable manner - understanding that presenting the facts in a confusing manner can ultimately delay the ability of any state agency to help rally its staff to initiate needed corrective action.

II. Credit for System Improvement Initiatives

The Commission's recommendations on the interim WNYCPC report were sound and ones with which OMH concurred. The recommendations which specifically addressed needed improvements in treating sexually abused children were well targeted, and OMH appreciates the insight and directions the Commission gave to OMH in this very critical area. It must be noted, however, that many of the other initial recommendations were initiatives already underway by OMH. The Commission's concurrence with these initiatives provided OMH with additional incentive to move forward. OMH wishes to highlight the fact that the impetus for these major initiatives was underway prior to August, 1988.

To elucidate this point, OMH formed a children and families task force to draft a background paper in response to Federal Law 99-660 which mandated the formation of the Mental Health Planning and Advisory Council. This activity was already underway prior to the exposure of the events at WNYCPC. This background paper sets forth a model for children's mental health services in New York State which is both family-centered and community-based.

Additionally, the Bureau of Children and Families had reorganized prior to the events at WNYCPC. The reorganization was to designed to ensure: a) responsible planning for seriously emotionally disturbed children and families on a local level; b) the development of state-of-the-art programs for seriously emotionally disturbed children; and c) the focus of program improvement initiatives in currently operating programs.

The Commissioner's search to bring Senior-level staff into Central Office with technical expertise in their respective areas and special backgrounds in working with seriously emotionally disturbed children also began prior to the events at WNYCPC.

Furthermore, the active role played by the national Child and Adolescent Service System Program (CASSP) in the Office of Mental Health's Bureau of

Children and Families must be recognized. Since 1985, CASSP has been instrumental in setting a framework to effectively address the issues involved in building a responsive system of care.

Most importantly, the 1988 OMH State Plan clearly established that OMH is moving toward a community-based system of care for children and youth, outlining many of the initiatives that the Commission recommends in their current report. In fact, one of the first tasks of the OMH Commissioner in 1987 was to reconfigure the plans for the Brooklyn Children's Psychiatric Center. The new "Brooklyn model" called for the development of a system of care in Brooklyn, including emergency services, small community residences, Home-Based Crisis Intervention, Family Support Services, and Family-Based Treatment Programs. The hospital itself is designed to serve as a small, very focused, part of the child mental health delivery system in Brooklyn.

So, although OMH does not wish to undervalue the contribution of the Commission in bringing sexual abuse to the forefront as an issue needing immediate corrective action, OMH also needs to clearly point out that this issue was one improvement of a system overhaul that was well underway before the events at WNYCPC.

It is also interesting to note that the OMH reviews of the events at WNYCPC, conducted by designated OMH employees soon after the incidents became known, included recommendations for improvements at WNYCPC and a call for a system review in the majority of the same areas eventually included in the Commission's interim report. The OMH review and recommendations were presented in a manner that enabled the facility, the regions and the Central Office to evaluate themselves and move forward with making needed changes. The presentation style of the Commission's reports which included presenting data with detailed scenarios of alleged events tended to immobilize personnel from moving forward immediately as they reacted to the accusations and subsequent critical press attention. The Commission's emphasis on a cause/effect relationship between their problem identification and OMH improvements significantly overlooks OMH's goals and objectives established prior to the WNYCPC events.

In conclusion, OMH appreciates the opportunity to respond to the Commission's document before it is made public. Although OMH feels there was some unnecessary and destructive sensationalism surrounding the Commission's reports, positive benefits for the children and families needing care through OMH state-operated inpatient programs have and are occurring. OMH looks forward to working with the Commission in the future to jointly and carefully work towards continuing to improve services for our seriously emotionally disturbed children and their families.

Appendix A

CORRECTIONS/UPDATES TO EVENTS OUTLINED IN THE COMMISSION ON QUALITY OF CARE'S FINAL REPORT:

INVESTIGATION INTO ALLEGATIONS OF CHILD ABUSE AND NEGLECT AT WESTERN NEW YORK CHILDREN'S PSYCHIATRIC CENTER

January 1990

I. Corrections:

A. p. 12 regarding Peer Review at WNYCPC. WNYCPC does not have a Peer Review Committee. They have put into place a Peer Review System.

B. p. 23 and 24 regarding WNYCPC's Assessment "Tool". WNYCPC does not have an assessment "tool" in use. They have developed a form to help clinicians incorporate histories of sexual abuse on assessments, and have put a process of review in place to ensure the inclusion on all assessments.

C. p. 29 regarding Aggregated Data from Incident Reports. The Division of Quality Assurance regularly completes quarterly reports that include aggregated data and analysis on sexual incidents in all of the children's facilities. These reports, in fact, aggregate data on a number of other significant areas also. The intent of the six-month reporting to regional and central office of all sexual incidents was to assess the specifics of the ongoing reporting and follow-up process at each children's state-operated inpatient program and to include this information as part of each program's individual plan of corrective action. The review actually did not point out any systemic or regional deficiencies.

C. p. 16 regarding A report identifying systemic training needs for senior management and clinical positions. The target data for completion is July, 1990, not January, 1990 (see September bi-monthly response to the Commission, p.4.).

D. p. 20 regarding Reviews at the Residential Treatment Facilities. The reviews at the Residential Treatment Facilities (RTFs) actually started in November, 1989.

II. Updates:

A. p. vi., p. 21, 22, 23 and 24 regarding The "train-the-trainer" program that was distributed as an RFP AND a system for the monitoring of clinical records. Because the response to the RFP was inadequate, a new plan is being considered for the areas that were to be included in the RFP. The training was to have included focus on developing clinical criteria for both conducting clinical assessments in the area of sexual abuse, and for how to translate the clinical findings into treatment plans.

A new workgroup has been named to evaluate the areas of the overall plan of correction that have not been accomplished. The main focus of the workgroup will be to make recommendations for a monitoring tool to be used by facilities, regional and central offices to monitor clinical records. This group convenes on Tuesday, January 16th. The agenda will include reviewing all outstanding areas of the plan of correction, including competency training for clinical staff, and to make recommendation for next steps.

B. p. 21 regarding The final guidelines being issued in January, 1990. The decision to re-draft the guidelines for working with children who have been sexually abused and to issue final guidelines on the safeguarding and treatment of all children in state-operated inpatient programs is on hold. The expected contract with Boys Town or another consultant to develop a program model at WNYCPC and to provide statewide exposure training to all top administrative staff of our children's state-operated inpatient programs will help OMH, with both evaluation data and input from our top administrators (after exposure to the same system expectations) to better finalize guidelines. To push final guidelines before establishing a base of treatment and evaluative priorities and interventions will result in a document that is not comprehensive or tested. In the interim, the guidelines distributed in March of 1989,

combined with the individual plans of correction from the peer reviews, continue to give direction to the field on safeguarding all of our children and treating our sexually abused children.

C. p. 21 regarding Training Curriculum Content. The "train-the-trainer" planned for January will focus on: 1) an overview of sexual abuse issues; 2) general treatment interventions for all staff; and 3) effective treatment planning.

The issue of effective documentation will only be covered briefly in this training initiative because of time constraints.

D. p. 29 and 30 regarding Discharge Planning. The work at improving each individual facility's discharge planning process continues through the plans of corrective action and continued peer reviews.

A final document recommending policy and procedural changes will be delayed until the contract with Boys Town or another consultant has begun and interim recommendations can be evaluated.

CQC Response to OMH Comments

The OMH response states, in part, that "OMH has serious overall concerns about how this investigation has been reported... throughout this investigation" and that OMH perceives "serious misreporting of events that occurred at WNYCPC." These current assertions are at odds with the view expressed in the Office's letter of January 10, 1989, which characterized the Commission's Interim Report as "an excellent summary of a very difficult situation."

Since neither the response letter nor the attachments identifies *any* specific factual misrepresentation, it appears that this comment reflects the OMH view that the final report should only reference the ten "indicated" cases at WNYCPC. The Commission does not concur with this OMH position, as it would misrepresent the actual gravity of the investigation findings.

Eleven cases were not recommended for "indication," although there was evidence that the harmful activity referenced in these cases did occur. We recommended that these cases be "unfounded" because the serious problems in clinical and administrative staff supervision at the facility, or the untimely reporting of the incidents, made it impossible to identify the specific staff person accountable for the supervision or treatment of the children at the time. A significant limitation of the current statute (CAPA 1985) is that a case may be recommended for indication only if an individual perpetrator can be found responsible for the abusive or neglectful incident. The Commission's view of the gravity of several of these unfounded cases is supported by the fact that the Commission recommended and the facility took disciplinary action against employees even though their conduct fell outside the scope of CAPA.