CLOSE TO HOME

QUALITY ASSURANCE STANDARDS

DECEMBER 2022

Table of Contents

I.01.00 Direct and Close Supervision of Youth 6
I.01.01 Youth-to-Staff Ratio in the Facility 7
I.01.02 Youth Count 8
I.01.03 Census and Roster Reporting 9
I.01.04 Bed Checks 10
I.01.05 Youth Safety While Away from the Facility 11
I.01.06 Supervision During Vehicle Transport of Youth 13
I.02.00 Safety and Security Protocols at the Facility 15
I.02.01 Addressing Gang-related Activity at the Facility 16
I.02.02 Safety of the Physical Environment 17
I.02.03 Control and Use of Keys 19
I.03.00 Preventing AWOCs Under Provider Supervision 20
I.03.01 Responding to AWOC Incidents Under Direct Provider Supervision 21
I.04.00 Central Control Room (LSP only) 23
I.04.01 CCTV Monitoring 24
I.05.00 Use of Physical Interventions 26
I.05.01 Mechanical Restraints (LSP Only) 28
I.05.02 Room Isolation (LSP Only) 30
I.05.03 Law Enforcement Contacts 32
I.06.00 Searches and Screening for Contraband 33
I.06.01 Disposal of Contraband 35
I.07.00 Regular Inspections of Facilities 36
I.08.00 Weapons in the Facility 37
I.09.00 Access to Emergency Phone Numbers 38
I.09.01 Emergency Operations Plan 39
I.09.02 Emergency Notification Protocol 40
I.09.03 Fire Drills 41
I.09.04 Other Emergency Drills 42
I.10.00 Abuse and Neglect 43
I.10.01 Abuse and Neglect Prevention and Reporting 44
I.10.02 Response to Witnessed or Suspected Abuse of Youth 45
I.11.00 Facility Requirements 47
I.12.00 Control of Hazardous Materials 48

I.12.01 Storage of Medication and Medical Equipment 49
I.12.02 Tool Management System 50
I.12.03 Kitchen Utensils and Sharp Objects Management System 51
I.13.00 Vehicle Maintenance 52
II.01.00 Full Orientation for Youth 53
II.02.00 Youth and Parent/Discharge Resource Handbook 55
II.03.00 Basic Needs 56
II.04.00 Youth Right to Privacy 58
II.05.00 Youth Personal Property 59
II.06.00 Youth Access to Counsel 61
II.07.00 Youth Phone Calls and Facility Visits 62
II.08.00 Youth Rights: Sibling Visitations 64
II.09.00 Youth Rights: Mail 65
II.10.00 Grievance Process for Youth and Families 66
II.11.00 Soliciting Input from Youth 67
II.12.00 Photography or Video of Youth 68
II.13.00 Preparing Youth for Adulthood (PYA) 69
II.14.00 Credit Checks 70
II.15.00 Sexual and Reproductive Health of Youth 71
II.16.00 Pregnant Youth, Expectant Fathers, and Parenting Youth 73
II.17.00 LGBTQ/Transgender and Gender Non-Binary Youth (TGNB) 75
II.18.00 Immigration Services for Youth in Placement 78
III.01.00 Living Environment 79
III.02.00 Accommodating Stated Capacity with Sufficient Space 80
III.03.00 Therapeutic Culture 81
IV.01.00 Admission 82
IV.02.00 Admission Screenings 83
IV.02.01 Response to Screening Results 84
IV.03.00 Review and Incorporation of Admission Information 85
IV.04.00 Care Coordination 87
IV.05.00 Medical Services 88
IV.06.00 Family Team Conference Model (FTC) 91
IV.07.00 Juvenile Justice (JJ) Service Planning 93
IV.08.00 Engagement of Family and Youth's Support Network in Service Planning 95
IV.09.00 Concurrent Planning 97

IV.10.00 Casework Contacts ... **98**
IV.11.00 Behavior Management System (BMS) ... **99**
IV.11.01 Behavior Support Plan (BSP) ... **100**
IV.11.02 Addressing Challenging or Disruptive Behavior ... **101**
IV.12.00 Treatment Team Meetings ... **102**
IV.13.00 Suicide Prevention and Intervention ... **103**
IV.14.00 Behavioral Health Services ... **105**
IV.14.01 Psychiatric Referrals ... **109**
IV.14.02 Engagement with Mental Health Services ... **110**
IV.14.03 Substance Use Services ... **111**
IV.14.04 Responding to Acute Mental Health Crises ... **113**
IV.15.00 Medication ... **114**
IV.16.00 Incorporation of Gender Responsive Programming ... **116**
IV.17.00 Gang-involved Youth ... **117**
IV.18.00 Crossover Youth ... **118**
IV.19.00 Educational Services ... **119**
IV.19.01 Educational Records and Assessments ... **121**
IV.19.02 Educational Planning ... **122**
IV.19.03 Educational Programming and Services ... **124**
IV.19.04 Education Support Staffing ... **125**
IV.19.05 Youth Transitions to Community School and Education Programs ... **127**
IV.19.06 Accredited, Developmentally Appropriate Vocational Program ... **129**
IV.20.00 Program Model Adherence ... **130**
IV.21.00 Programming and Activities ... **131**
IV.21.01 Daily Schedule ... **133**
IV.21.02 Incorporation of Youth Needs, Interests, and Characteristics ... **134**
IV.21.03 Restorative Justice Component ... **135**
IV.21.04 Skills Development ... **136**
IV.21.05 Religion/Spirituality ... **137**
IV.21.06 Exercise and Nutrition ... **138**
IV.22.00 Financial Literacy ... **139**
IV.22.01 Regular Monetary Allowances ... **140**
V.01.00 Staffing Requirements ... **141**
V.02.00 Required Staff Qualifications ... **142**
V.03.00 Staff Workload and Coverage ... **144**

V.04.00 Screening of Potential Employees ... 146
V.05.00 Required Staff Trainings ... 148
V.05.01 Staff Supervision and Coaching ... 150
V.06.00 Supervisory Case Reviews of CNNX ... 152
V.07.00 Performance Evaluations ... 153
V.08.00 Professional Boundaries ... 154
VI.01.00 Family Participation ... 155
VI.02.00 Family Visits ... 156
VI.03.00 Home passes for NSP ... 158
VI.04.00 Support Services for Parents, Family, Extended Family ... 161
VI.05.00 Family Assessment and Service Plan (FASP) ... 162
VII.01.00 Community Advisory Boards ... 163
VII.02.00 Record Keeping ... 165
VII.03.00 CNNX Case Record Required Documentation ... 167
VII.04.00 Health and Mental Health Documentation in CNNX ... 168
VII.05.00 Confidentiality and Sharing Information ... 171
VII.06.00 Youth and Family Satisfaction Surveys ... 173
VII.07.00 Program Manuals ... 174
VII.08.00 Workplace Violence Prevention ... 178
VII.09.00 ACS's Policies and Procedures ... 179
VII.10.00 Youth Transfers and Modifications ... 180
VII.11.00 Quality Assurance/Improvement System ... 182
VII.11.01 Collaborative Quality Improvement (CoQI) ... 184
VII.12.00 Safety Plans, Heightened Monitoring (HMS), Corrective Action (CAS), and Probationary Corrective Action Status (PCAS) ... 185
VII.13.00 ACS Site Inspections ... 189
VII.14.00 Finance and Budget ... 190
VII.15.00 Incident Reporting, Documentation, and Review ... 191
VII.16.00 Video Reviews ... 192
VII.17.00 Overnight Unannounced Management Inspections ... 193
VIII.01.00 Planning for Transition and Release to Aftercare ... 194
VIII.02.00 Transition to Aftercare Timeline ... 198
IX.02.00 Case Planner/Caseworker Functions ... 200
IX.03.00 Casework Contacts with NSP Youth ... 201
IX.04.00 Family Assessment and Service Plan (FASP) in Aftercare ... 203

IX.05.00 Conditions of Release and Aftercare Compliance 205
IX.06.00 Youth Level of Service (YLS) 206
IX.07.00 Education Support for Youth on Aftercare 208
IX.08.00 Vocational Training for Youth on Aftercare 211
IX.09.00 Incentives for Youth on Aftercare 212
IX.10.00 Elevated Risk Conference (ERC) 213
IX.11.00 Crisis Response and Follow-Up 214
IX.12.00 Incidents in Aftercare 215
IX.12.01 AWOC Youth While in Aftercare 217
IX.12.02 Reporting and Record Keeping in Aftercare 219
IX.12.03 Monthly Data Collection and Tracking in Aftercare 220
IX.13.00 QI/QA Internal Monitoring 221
IX.14.00 Revocations While on Aftercare 222

I.01.00 Direct and Close Supervision of Youth

Staff must always practice direct and close supervision of youth (i.e. staff must remain engaged, aware, awake, alert, and undistracted). Staff must maintain visual supervision of youth and be able to hear all conversations among youth throughout the shift.

- All youth must always be closely supervised. Under no circumstances may youth be left unattended in the facility or during supervised off-premises activities.
- While on-duty, all direct care staff must be aware of the level of tension/activity within the group and are responsible for positioning themselves to de-escalate youth behavior and/or intervene in critical incidents when necessary.
- Providers must staff each shift with sufficient coverage to maintain ratio and meet programmatic needs.
- Staff must remain posted in full camera view, as feasible for facility layout.
- Staff may not use personal electronic devices while on duty, unless approved by a supervisor.
- Staff must ensure all movements and activities are documented in the Communications Log.

<u>Supervision during daytime hours:</u>

- Staff must remain in direct eyesight, or when necessary for privacy of youth, in direct earshot, of youth while youth are awake (e.g., when showering, at school, during transport, etc.).
- If any direct care staff member must leave his or her position on the floor for any reason, all staff on duty (including supervisory staff) must:
  - Ensure that the appropriate staff-to-youth ratio is maintained;
  - Maintain awareness of individual staff member's location while off the floor;
  - Be knowledgeable of the duration of time that the staff member will be away from his/her post; and
  - Ensure any special supervision assignments that must be covered.

<u>During overnight hours:</u>

- Staff must be positioned so that they can maintain effective supervision while youth are sleeping, as appropriate and feasible for the layout of the facility (e.g., positioned at the front and end of the hallway, positioned in front of egress door).
- One (1) staff member may complete chores within the facility, but off the main floor, while a minimum of one (1) staff member remains with sleeping youth, if facility is calm and all youth are in beds/bedrooms.
  - Providers should have a protocol in place, available to ACS upon request, to address how/when staff can be deployed for these activities.
  - The moving staff member must keep stationary staff aware of location through ongoing communication (e.g. cell phone, walkie-talkie, etc.) and physically check-in on main floor every 30 minutes.

I.01.01 Youth-to-Staff Ratio in the Facility

At least two staff must actively supervise youth at all times. Staff must conduct safety/risk assessments of youth to determine if more than two (2) staff are needed. The required youth-to-staff ratio must be maintained on all shifts.

- Providers must ensure appropriate youth-to-staff ratio is maintained and must plan accordingly to meet this requirement (e.g. if the contract specifies that there is more than one (1) program within the same facility, youth bedrooms are located on two (2) different floors or operating on different sides of the building).
  - Youth-to-staff ratio should also consider planned activities.
  - A minimum of two (2) staff must actively supervise youth at all times (24 hours a day, 7 days pers week).

Additional staff must meet the following ratios, as applicable:

- For all specialized NSP programs:
  - If there are more than twelve (12) youth in the facility, a minimum ratio of six (6) youth to one (1) direct care or supervisory staff must be maintained for each shift (i.e., 13-18 youth require three staff; 19-24 youth require four staff; etc.).
- For all regular NSP residential programs:
  - During all waking hours: If there are more than sixteen (16) youth in the facility, a minimum ratio of eight (8) youth to one (1) direct care/supervisory staff must be maintained for each shift (i.e., 17-24 youth require three (3) staff; etc.).
  - During all sleeping hours: If there are more than 24 youth, a minimum ratio of twelve (12) youth to one (1) direct care/supervisory staff must be maintained each shift (i.e., 25-36 sleeping youth require three (3) staff; etc.).
- For all specialized LSP residential programs:
  - If there are more than six (6) youth in the facility, a minimum ratio of three (3) youth to one (1) direct care/supervisory staff must be maintain for each shift (i.e., 7-9 youth require three (3) staff; 10-12 youth require four (4) staff; etc.).
- Facilities must have a supervisor or designee accessible or on-call and accountable for each shift.
  - In the absence of supervisor, lead staff or designee will be identified in the communication log by noting the staff's name.

Maintaining ratio during AWOC incident:

- If a facility AWOC occurs during a shift in which ratio is being maintained by two staff, staff must assess the safety and feasibility for one staff to pursue the youth, while remaining staff maintains supervision and safety other youth present.

I.01.02 Youth Count

Staff must always account for the whereabouts of youth under their supervision. Staff must physically count youth at various times throughout the day.

- Youth counts must be conducted and documented in the Communications Log, at a minimum:
  - At the beginning and end of every shift, by both incoming and outgoing staff prior to shift change;
  - Prior to, during and after outdoor activities; and
  - During any emergency (e.g., disturbances or incidents that interrupt regularly scheduled activities such as when an Absence Without Consent (AWOC) has occurred).
- If staff cannot account for the whereabouts of any youth during a youth count, the staff must immediately attempt to ascertain the whereabouts of absent or missing youth.
  - The incident must be reported to MCCU when safety is established but no more than one (1) hour later.
  - Any delay in reporting must be documented in the Communication Log.

I.01.03 Census and Roster Reporting

Providers must maintain an accurate, daily, real-time census of all youth in their programs. Providers must report census and roster information to MCCU at times and frequency determined by ACS.

- The census is intended to count "occupied beds."
- The roster is intended to identify where youth are (e.g., a youth may be considered AWOC but still have a bed assigned to them, home pass, medical appointment, court hearing, in facility, etc.).
- Providers must submit a verbal census and roster on a daily basis to DPPM and must call MCCU each time a newly admitted youth arrives to the facility.
  - Provider must document each reported youth count in the Communication Log and include the name of staff reporting and the name of MCCU staff receiving count.
  - Counts reported during the school day by provider staff at schools must be documented in the Communication Log as a part of the shift summary.

I.01.04 Bed Checks

Staff must conduct, and report, bed checks as required by ACS during sleeping hours or anytime a youth is in his or her bedroom, accounting for any youth temporarily away from the facility. If staff cannot account for the whereabouts of any youth, the staff must take immediate action (e.g., conduct a search of every room as well as the outer perimeter of the facility) to determine the whereabouts of absent or missing youth and to report this information as required by ACS.

- Bed checks must be conducted when youth are sleeping /retire to their bedroom by adhering to the following procedure:
  - Staff must conduct a physical check of youth, observing evidence youth is safely in bed, observing that there are no hazardous conditions, and documenting contemporaneously in the Communications Log the outcome of the bed check for each individual youth as required by the Log Book policy.
  - Bed checks must be conducted, at a minimum, every 30 minutes.
  - Where feasible by facility layout, staff must position themselves in camera view and in a way that maximizes staff view of all youth and considers privacy, safety and security risks
  - Staff must observe evidence of the youth in bed through visual observation of youth body part, skin, breathing observed through bedding, etc. Staff must use a light source that enables them to visually conduct the bed checks, absent auditory evidence.
  - Where indicated, the staff must open the door and conduct the bed check.
  - The staff must make every effort to not impact the youth’s quality of sleep.
  - Staff must not physically touch a sleeping youth.
  - In a facility with single bedrooms, dim hallway lighting must always be on.

I.01.05 Youth Safety While Away from the Facility

Providers are responsible for the safety, support, and supervision of all youth at all times, including while off premises and in the process of transitioning.

- All exceptions to this standard must be granted on an individual case-by-case basis and require PPS Directors and CTH Assistant Commissioner's approval.
- All LSP outings require ACS approval.

Supervised outings:

- Approved supervised community outings may include, but are not limited to: community activities, treatment/appointments, community programs, community school, and any emergencies that require facility evacuation.
- Providers must regularly provide sufficient support and supervision of youth and assess each outing to determine safety, eligibility, and appropriateness of approved outings.
- Staff on outings must arrange for periodic check-ins with supervisors.
- Providers must have access to necessary contact for the local police precinct, contact information of the closest hospital, mapping of the exits/points of egress, and full details regarding location(s) youth are going to, including an emergency plan.
- At minimum, the youth-to-staff supervision ratio requirement (referenced in I.01.00) must be maintained at all times throughout the duration of the outing.
  - Providers must assess the need to increase the staffing plan based on the type of outing, the number of participating youth and current safety and security concerns.
- The schedule of activities and projected duration of the trip should be determined in advance of the trip/outing.
- A lead staff should be identified during each outing to reach out to the supervisor, call in census, direct movement, etc.
- Additional guidelines apply to out-of-state and overnight outings:
  - ***Out-of-state and overnight outings:*** All out-of-state or overnight individual or group outings require ACS approval at least one week in advance. Requests submitted less than one week before outing will be considered on a case-by-case basis. For these outings, providers must submit:
    - a security plan;
    - signed parental consent;
    - supervision plan; and
    - staffing numbers to ACS.

Unsupervised outings:

- All unsupervised outings must be approved by ACS. Unsupervised outings include all instances in which a youth is approved to travel alone without provider supervision (e.g., traveling to community school, traveling to SYEP or other employment, etc.).
  - Providers must have a process in place to check on youth while they are on unsupervised outings to prevent AWOC and other incidents. This process should be discussed with PPS and may include but is not limited to: having an emergency plan and emergency

information readily available, planning for staff's incident/emergency handling and reporting, reviewing the itinerary and expectations with the youth, having periodic check-ins with the youth throughout the outing, etc.

I.01.06 Supervision During Vehicle Transport of Youth

Providers must provide transportation for youth as needed (e.g., to hospitals, health appointments, home visits, community schools, court appointments, etc.). Youth must be closely supervised, and appropriate staff-to-youth ratios must always be maintained during transport.

Ratio and Staffing:

- Two (2) staff excluding driver must be utilized for transportation of youth during outings (medical appointments, school, recreation outings, etc.) and for supervision of youth while in community.
  - Exceptions may be made for youth who are preparing for transition to aftercare or where developmentally appropriate for the youth. Exceptions must be discussed and approved by ACS CTH Associate Commissioner or Designee.
  - While on outings, all providers should ensure the group remains together for each activity and provide sufficient staffing to ensure staff can supervise bathroom requests and activities simultaneously.
  - Providers must assess the safety of the group to determine if additional staff are needed to safely transport youth to and from off-site destinations.
- Any staff supervising youth as part of the ratio during transportation must be appropriately trained (and in compliance) in the approved ACS physical intervention technique, first aid, and CPR.
  - Additional supporting or accompanying staff need only be certified in areas related to their role (i.e. nurse).
- Staff assigned to transport youth must have an agency cellular phone or radio to use in the event of a vehicle problem or emergency.

Safety and Seating:

- Youth are prohibited from sitting in the front passenger seat of any agency vehicle. Providers must assess the risk for any youth to sit directly behind the driver. Vehicle seating arrangements should be assigned and must be communicated to all staff prior to transport.
- All staff and youth must always wear seatbelts.
- Staff are required to count the number of youths prior to exiting the facility, once all youth and staff arrive and enter the designated location, and again once all youth have returned to the vehicle.
- When exiting the vehicle at least two (2) staff must supervise and accompany the youth.
- Prior to exiting the facility an inspection of the vehicle should be conducted by the driver to ensure vehicle is in good working condition, is free of contraband, and that all doors are secured/locked. Vehicle key must never be left in the ignition. Vehicle must always be secured by staff and not left unattended and idling.

Accidents

- If the vehicle is involved in an accident while transporting youth:
  - The accident must be reported to the proper authorities;

- Parents/guardians must be notified of all vehicular accidents within 24 hours;
- The accident must be reported to MCCU; and
- All youth must be seen by a medical professional regardless of the gravity of the incident. Medical refusals must be documented in the Communication Log.

I.02.00 Safety and Security Protocols at the Facility

Providers must have protocols in place to maintain the safety and security of youth in the facility and to prevent unauthorized individuals from entering the facility.

Testing of Facility Systems:

- Providers must submit a protocol for ACS approval that specifies how the provider will regularly test the safety alarms, windows, doors, locks, etc. including:
  - Assignment and oversight of testing responsibilities;
  - Frequency and documentation of checks; and
  - Actions that must be taken in case of a safety or security breach.
- Any malfunctions must immediately be reported to MCCU.
- Screening of Facility Visitors;
  - Providers must have a facility security plan in writing, and available to ACS upon request, that includes at a minimum:
    - The process for receiving and screening individuals seeking entry;
    - Plans for prohibiting entry from unauthorized persons;
    - Precautions for and response to individuals who may be dangerous;
    - Response to critical incidents; and
    - Protocol for requesting police support.

I.02.01 Addressing Gang-related Activity at the Facility

Providers must have processes in place for addressing and managing the influence of gangs in the facility.

- Facilities must create and maintain safe environments free of gang activity.
- The gang management protocol must include, but is not limited to:
  - Prohibitions on wearing or exhibiting gang colors, clothing, beads, jewelry, signs, graffiti, literature, and all other identifiers.
  - This protocol must be included in the program manual and must address how the facility's model and behavioral management systems will address gang-related activity at the facility.
- New staff must be trained to identify and manage the influence of gangs and all staff must receive a refresher at least annually.

I.02.02 Safety of the Physical Environment

The facility's physical environment must be safe for all persons on the premises. Facilities must comply with all applicable laws, ordinances, rules, regulations, and codes related to buildings, fire protection, health, and safety, including applicable regulations issued by OCFS and ACS policies and procedures.

- All exit doors in NSP facilities must have delayed egress, unless approved by ACS/OCFS.
  - The egress delay must never exceed the time delay allowed by the fire code applicable to the area in which the facility is located.
  - Under no circumstances can the delay exceed 30 seconds.
  - Doors must be alarmed.
  - Exceptions require ACS/OCFS approval.
  - Facilities must receive written approval by the authority having jurisdictions over fire codes and/or fire inspections.
- Windows must be functional, alarmed, or have window guards, unless approved by ACS/OCFS.
- Maintenance supplies and equipment must be properly secured.
- Furniture must be functional and safe.
- All facilities must be in good working order and free of environmental and fire hazards, including but not limited to:
  - Loose metal, broken glass, wires, or woodwork that could be used as a weapon or instrument of self-harm.
- Paints and all flammable and combustible chemicals must be properly stored and secured.
- Exits must be lit and clearly marked. Exit pathways must be kept unobstructed.
- Fire extinguishers must function properly and be properly charged.
- Evacuation plans must be conspicuously posted on every floor of the facility.
- Portable heaters are prohibited.
- Radiators must be covered.
- Doors used as smoke stop separations must be equipped with self-closing devices and magnetic hold-open devices.

Annual Inspections:

- Providers must ensure the boiler is inspected on an annual basis and must obtain documentation indicating the details of the inspection, including the result. Documentation must be available to ACS upon request.
- Providers must request in writing an annual safety inspection of the buildings and all fire protection equipment by local fire authorities (FDNY) and/or facility's fire and casualty insurance carrier.
  - Providers must maintain a copy of the written request, report, and actions taken, available to ACS upon request.
  - Providers are responsible for correcting any hazards noted as a result of such inspection. A copy of the report with a dated written record of any corrective action taken must be

submitted to OCFS. Providers must also maintain a copy of the written request, report, and actions taken, available to ACS upon request.

- A current Certificate of Occupancy must be conspicuously posted at the facility.
- Any exceptions to these guidelines require ACS approval.

I.02.03 Control and Use of Keys

Providers must have a system in place to monitor the use and control of keys. Providers must keep keys secure and ensure youth do not obtain access.

- Facility keys must be accounted for at all times.
- Providers must develop a process and protocol for monitoring the use of keys at all times. This process must be supervised during each shift.
  - Provider monitoring system must include, at a minimum, a protocol for: securing, assigning and distributing, inventorying and tracking, and reporting and replacing lost, missing, or damaged keys.
- All handcuff and foot cuff keys must be stored in a locked and secure key cabinet in the LSP facility control room. Authorized staff members are required to sign out handcuffs and sign them in when they are no longer in use and by the end of the shift. Hand cuffs, foot cuffs, and keys must be physically accounted for at the end of each shift.
- During the shift change, both shifts are responsible for jointly conducting a key count.
- All keys handed off between shifts must be counted and documented in the Communication Log.
- All keys maintained permanently by staff should be documented as part of provider protocol.
- For LSP sites, keys must be kept in the control room when not in use.
- Handcuff keys must be affixed to a soldered ring with facility keys.
- Staff are prohibited from taking facility keys home. Keys accidentally taken home must be returned to the facility immediately. Designated managers may be permitted to take keys off-site with the facility director's approval.
- Personal house and car keys must be secured in staff lockers or offices and must not be accessible to the youth.

Lost Keys:

- Information on lost keys must be documented in the Communication Log, communicated to the incoming shift at turnover, and reported to the Facility Director and MCCU.
- A facility search must be conducted immediately when keys are missing.

I.03.00 Preventing AWOCs Under Provider Supervision

Provider must maintain custody of youth admitted to a facility at all times and prevent unauthorized absences from the facility.

- Provider staff must make all efforts to prevent a youth from leaving the facility without permission through:
  - Supervision and prevention strategies to keep youth safe at the facility and off-site (e.g., staff positioning and oversight when supervising youth and during bed checks, proactively engaging with youth at all times, validating the youth's feelings, assessing potential risk associated with outings, debriefing with youth immediately after any incident, assessing the tone of the facility at the beginning of the shift, etc.).
  - Utilizing verbal de-escalation strategies when a behavior of concern occurs.
  - Utilizing physical safety interventions or any other ACS approved physical intervention only upon exhaustion of all available preventive strategies and de-escalation techniques, and when provider staff have determined that being AWOC clearly indicates the intent of the youth to inflict physical injury upon oneself or others or to otherwise jeopardize the safety of any person.
  - Continuing to de-escalate potential crisis situations during and after a physical intervention.
  - Communicating/documenting between shifts to identify and develop strategies to mitigate any AWOC concerns and risks in a timely manner.
  - Conducting inspections of the facility, at the beginning of the shift in order to identify any non-functional safety equipment (e.g., alarms, windows, doors, etc.). For further reporting see I.07.00.
  - Conducting AWOC drills at least quarterly, and more if indicated as a result of APA assessment, to train and assess how to effectively and successfully implement the AWOC incident response protocol. AWOC drills must be conducted at different shifts to ensure all staff have participated in AWOC drills.
    - Providers must implement and document a process for tracking AWOC drills and have documentation available for ACS review.

I.03.01 Responding to AWOC Incidents Under Direct Provider Supervision

Staff must follow ACS policies and procedures, including all documentation and notification requirements, for youth who are absent without consent.

- If an AWOC incident occurs from the facility or under staff supervision, providers must immediately secure all other youth.
- For all AWOC incidents, providers must:
  - Notify MCCU within one (1) hour of occurrence.
  - Obtain the warrant generated by MCCU.
    - ACS Warrants must be issued with all currently available information and, must be updated as needed to include: the name of the staff member/caller, the facility name, the 24-Hour Facility Contact Number, ACS Placement and Permanency Specialist’s name, youth’s name, any aliases, date and time of AWOC, description of how youth went AWOC, date of birth, placement date, gender, ethnicity, height and weight, eye color, hair color, scars/distinguishing marks, youth’s home address, placing court, photograph.
  - Immediately notify local law enforcement for entry into the National Crime Information Center.
  - Notify the National Center for Missing and Exploited Children as soon as practicable but no later than 24 hours after receiving notice of such absence.
  - Notify the parents or guardian as soon as possible, but no later than two (2) hours after learning of the AWOC; except when, pursuant to Title 18 NYCRR 431.8(b)(4), parental rights have been terminated, surrendered, or where the parent cannot be located.
  - Notify the youth’s former foster parent and/or foster care provider case planner as soon as possible, but no later than two (2) hours after learning of the AWOC if the youth is currently known to ACS as the subject in a child protective case, has been designated as a destitute child, a Person in Need of Supervision (PINS), or has been placed via a voluntary child welfare placement agreement.
  - Make every effort to recover AWOC youth. Diligent efforts to find the youth’s whereabouts may include, but are not limited to:
    - Contacting members of the youth’s former foster family household and/or the agency where the youth was placed prior to admission, members of the youth's family and extended family, youth's school principal, teacher(s) or other appropriate staff at the school last attended, close friends and boyfriends or girlfriends of the youth, where known, adults known to be working with the youth in recreational or educational activities, and/or professional persons involved with the youth's development, including, but not limited to, doctors, nurses, psychologists, psychiatrists, or clinical social workers, etc.
    - Checking youth’s social media accounts (Facebook, Instagram, etc.)
    - Requesting assistance of police where indicated, in attempting to apprehend AWOC youth.

- These diligent efforts must be documented in CNNX weekly (or other specified/required database), indicating the type of contact made (e.g., personal, phone or mail correspondence, the name of the person contacted and their response regarding the youth's whereabouts).
- While on AWOC status, if the youth contacts the facility and provides a location or provider becomes aware of youth's location, and it is safe to do so, provider should immediately arrange to pick up the youth and notify ACS accordingly. ACS notification at minimum should include but is not limited to the PPS Team and MCCU.
- While on AWOC status, if a youth's whereabouts become known to the provider and the provider is unable to, or deems it unsafe to arrange pickup, the provider shall immediately contact local police to execute a warrant.
- Once the youth is returned and secured at the facility/detention, providers must contact the assigned PPS, PPS Director and MCCU to vacate the warrant.
- Based on provider assessment of youth and Behavioral Support Plan (BSP) and needs, but no later than five (5) days after his or her return to care, the caseworker or case manager must conduct a screening to determine if the child was a victim of sex trafficking (and follow all CSEC guidelines) and document the results in CNNX.
- Documentation:
    - AWOC incidents must be updated through MCCU.
    - This incident must be documented in CNNX and updated in the Communication and Incident Report Logs.
- Follow up:
    - AWOC incidents must be debriefed with leadership and applicable staff at the facility within 24 hours to conduct assessment of root cause, actions that could have been taken to prevent AWOC and maintain safety in the facility
    - Providers are required to debrief with the youth within 48 hours upon the youth's return and document in CNNX including understanding of push/pull factors, where youth went and why and use debriefing to prevent future AWOCs.
    - Providers must document specific actions taken including, but not limited to, determining the reasons for the youth's absence and identifying the steps to be taken to address those issues in the current placement and any future placements.
- All youth returning from AWOC must be examined by a licensed by a health care practitioner for evidence of physical injury or trauma, unsafe behaviors such as drug use.

I.04.00 Central Control Room (LSP only)

All LSP facilities must have a central control room to coordinate security functions. At least one (1) trained staff member must be in the control room at all times except for brief durations for staff relief.

- Only staff trained and assigned to work the Control Room must be permitted access to the Control Room.
- Control Room staff must:
  - Coordinate and monitor movement throughout the facility;
  - Monitor facility internal/external security including all video, phone, fire, power, entry and exit safety and detection systems;
  - Control, monitor, maintain, collect, and distribute (when necessary) all security and emergency equipment such as keys, radios, and mechanical restraints;
  - Monitor and record communication necessary to maintain safety in the program and community such as in-program movements, persons entering/exiting the program, emergency or crisis situations or incidents, etc.;
  - Respond and when available assist in de-escalating and/or managing crisis situations as per emergency response training and ACS policies and procedures; and
  - Maintain control room log book.
- Provider must have a process in place for control room to respond to emergencies.
  - In such an instance, control room staff must contact all appropriate facility leadership to alert them of the issue.
- Control room must be staffed at all times except for brief durations for staff relief (breaks, rest room use).
  - Any gaps in control room coverage must be communicated to facility staff and protocols for communicating movement throughout the facility must be maintained.

I.04.01 CCTV Monitoring

Providers must have properly functioning closed-circuit television (CCTV) to monitor all interior common spaces and the building's exterior.

- Camera coverage at the facility within common areas must be complete without blind spots, except for where prohibited by law and/or ACS regulations.
  - CCTV coverage is not required in staff offices, however youth access to staff office should be limited to approved, documented programming or support.
  - CCTV is prohibited in: youth bedroom, bathrooms, and areas used for medical exams.
  - CCTV coverage is permitted in areas used for confidential contact between youth and counsel, and/or with representatives from the OCFS Office of the Ombudsman (OOTO), as long as sound is not recorded. Any exceptions must be approved by ACS.
- Providers must create protocols to ensure CCTV system is fully functional on all shifts.
- Cameras should record continuous footage at all times.
- If a facility's CCTV system stops functioning or malfunctions, in whole or in part, the facility must notify MCCU of this incident as soon as possible and must, per their service contract, make all efforts to have the system fixed within 24 hours.
- CCTV coverage must be available in:
  - All common areas in living units;
  - Program and activity areas, such as cafeterias, indoor and outdoor recreation areas, classrooms, visiting room, and libraries;
  - All points of entry to and exit from the facility and complete exterior perimeter;
  - All hallways and staircases inside the facility;
  - All means of entry to areas inside the facility to which youth do not normally have access
- Providers must have sufficient lighting around the perimeter as applicable.

LSP sites:

- Motion activated perimeter lighting, CCTVs with night vision, or other nighttime security measures that alert LSP staff of any movement on or near the premises or perimeter of the facility at night must be maintained and utilized during periods of darkness.
- CCTV must monitor the perimeter, including but not limited to the sally port, and the facility's entry and exit points.
- When blind spots are identified, providers must take immediate action to remedy this issue.
- The control room.

Access to Recordings:

- Video records showing youth in care at the facility must be confidential and must be treated as records concerning youth in care for confidentiality purposes. The facility must have a policy governing access to, security of, and permissible uses of video records involving youth.
- Providers must have the capacity to record and download to other electronic media all footage from the CCTV and recordings must be readily accessible to ACS/OCFS upon request.

  - Requested video footage must be submitted to ACS within two (2) business days of the original request.
- Requests for video:
  - All requests for video records, other than from ACS, OCFS, or the Justice Center must be referred to ACS and will only be provided pursuant to a grand jury or court ordered subpoena or other court order directing the release of such records.
  - Requests from law enforcement to view video on-site is allowable per the provider's discretion.
- Recordings must be maintained for a minimum of 90 days and be readily accessible to ACS on request. In instances where video footage is beyond 90 days, but an incident is under review and/or investigation, the provider must maintain the footage until, at the earliest, the completion of the investigation.
- Video footage of any restraint or an incident that involves injury to youth must be retained for a minimum of three (3) years beyond the restrained or injured youth's 18 birthday. Video of any incident which must be reported to Justice Center must be stored indefinitely until authorized for disposal by OCFS or Justice Center.
- Providers must create protocols to guide the labeling and storage of CCTV footage in accordance with ACS policies and procedures.
- Cameras should record continuous footage 24 hours a day and 7 days per week. Backup storage should be retrievable for at least 90 days.

I.05.00 Use of Physical Interventions

After all appropriate pro-active, non-physical, and less restrictive behavior management techniques have been tried and failed, staff shall use only the minimum amount of physical intervention necessary to stabilize the youth or situation in which youth presents an imminent risk of harm to him/herself or to another person.

Behavioral Support Plan:

- To de-escalate youth, staff must begin with using the Behavioral Support Plan (BSP) and non-physical interventions (e.g. counseling and validating the youth's feelings).
- Every youth in placement must have a BSP highlighting the youth's known triggers and identifying effective interventions for that can support staff in working with and de-escalating youth to prevent use of physical interventions.
- All staff assigned to supervise or work with youth must be familiar with the BSP for each youth.
- The BSP must be updated as needed and accessible to all staff. The plan itself and any changes must be documented in CNNX.

Use of physical interventions:

- Staff must always attempt to verbally de-escalate youth before, during, and after the use of physical intervention.
- Staff must use multiple interventions to prevent the need for physical intervention, including the de-escalation of problematic behavior, relationship and trust building, and the use of verbal alternatives.
- Physical intervention is a last resort. Staff must evaluate risk of harm in individual situations.
- Physical interventions must never be utilized by providers when youth is refusing to participate in programming (e.g. school, medical appointments, internal programming, etc.).
  - Physical interventions must only be used to address youth refusal to participate in programming or scheduled appointments when such refusal escalates to create imminent risk of harm to self or others and must only be used after all other de-escalation strategies have been attempted and have failed. Physical interventions must never be used as retaliation for youth's refusal to participate in programming or appointments.

Reporting and Follow-up:

- Any use of physical intervention is considered a reportable incident and must be reported to MCCU.
- Any use of physical intervention must be documented in the Communication Log, Incident Report Form, and CNNX.
  - In addition, staff must complete a Physical Restraint Form and attach it to the Incident Report Form.
- All youth who have been placed in a physical restraint must receive a post-restraint health review within 72-hours by a medical staff member or other licensed health care professional.

- If youth refuses to be seen by health services, a Refusal Form must be completed. The Refusal Form must be signed by a supervisor and staff person or, if supervisor is not on site, by a minimum of two (2) staff.
- After a youth has been released from the physical intervention, and when it is safe to do so, a debriefing must take place with the youth.
  - A supervisor, the facility director, or designee must conduct the debriefing and include any staff involved in the incident.
- Debriefing must include a discussion with the youth and other staff, or peers involved, if applicable, about the sequence of events that led to the physical intervention.

I.05.01 Mechanical Restraints (LSP Only)

Mechanical restraints must only be used as an intervention when other forms of intervention are either inappropriate or have been ineffective. In such circumstances, the least restrictive/intrusive intervention necessary must be used.

- Mechanical restraints are permissible in LSP facilities only in pre-determined circumstances as dictated by the policy and informed by the individual assessment of the youth.
- Providers are required to complete ACS's Restraint Assessment Form that captures individualized assessment of each youth.
  - The mechanical restraint assessment form must be completed and approved by the facility director or designee for every transport and must include specific information on why the youth poses an immediate safety issue.
  - The form must be fully completed and particular to the individualized risk/assessment of each youth.
- Mechanical Restraints may only be used on youth displaying acute physical behavior that presents a serious and evident danger to him/herself or others, and for off-site vehicular transport if the youth presents a clear danger to public safety and him or herself and should only be used as an intervention when other forms of intervention are either inappropriate or have been ineffective.
- Unless there are exigent circumstances, prior approval from the facility director or designee for the use of mechanical restraints is required
  - If exigent circumstances make prior approval impossible to obtain, staff must report use of mechanical restraints to the facility director as soon as practicable, but no later than one (1) hour after the mechanical restraints were applied.
- Staff must use safe transitions from any physical interventions to mechanical restraints. Providers must release youth from all forms of mechanical restraints as soon as it is safe to do so.
- Use of mechanical restraints must also be in line with the youth's BSP or medical conditions, which may limit or prohibit their use.
- Only staff who have successfully completed and are up-to-date with their training on the use of mechanical restraints, SCM/TCI, first aid, and CPR are authorized to use mechanical restraints.
- Foot cuffs must only be used during transport.

Use of mechanical restraints for short term-intervention:

- Outside of transport, mechanical restraints must not be used in excess of 15 minutes, and if more time is required, another 15-minute period must be authorized by the facility director. Use of mechanical restraints beyond 30 minutes must be authorized by ACS's Field Operation's unit.

Health Assessment after non-transport Mechanical Restraint:

- All youth who have been placed in mechanical restraints must receive a post-restraint health review by a medical staff member or other licensed health care professional.
  - Photographs of those parts of the youth's body where mechanical restraints were applied must be taken as part of the health assessment, and photographs of any areas of complaint or injuries reported by youth or staff during the period of mechanical restraint must also be taken.
- The youth must also be assessed by a mental health clinician. When mental health staff members are not on site and the youth wants to see a clinician, a mental health referral must be generated, and the youth must be evaluated within 24 hours of the mechanical restraint incident.
- If youth refuses to be seen by health services, a refusal form must be completed. The refusal form must be signed by a supervisor and staff person or if supervisor is not on site, at minimum by two (2) staff.

Debriefing after Mechanical Restraints Used in Crisis

- After a youth has been released from mechanical restraints, and when it is safe to do so, a debriefing must take place with the youth. A supervisor or the facility director must conduct the debriefing and include staff who were involved in the use of the mechanical restraints. Debriefing must include a discussion with the youth and other staff, or peers involved, if applicable, about the sequence of events that led to the mechanical restraint.
  - Debriefings must be documented in CNNX and in the Incident Report Form.

Notifications, Documentation, and Reporting

- Staff must notify a youth's parent, guardian, or other discharge resource after use of mechanical restraints, other than for transport, as soon as possible but no later than eight (8) hours after their use.
- Staff must document all attempts to notify the parent, guardian, or other discharge resource on the use of mechanical restraints.
- Notification must also occur if an injury was identified, the staff witnessed a potential injury, or the youth complained of any pain.
- All instances of mechanical restraints must be documented in the Communication Log, Mechanical Restraint Log, Incident Report Form, and CNNX.
  - Staff must also document the incident or circumstances that precipitated the intervention attempts to obtain director/designee approval, staff observations of youth status/behavior, efforts to engage youth in release strategy, contacts made with clinical staff for advice on how to calm the youth, etc.

I.05.02 Room Isolation (LSP Only)

The purpose of room isolation is to protect a youth from harming himself, herself, or others. Room isolation is permissible only in LSP facilities and only after all approved less restrictive interventions have been attempted and found to be ineffective and/or inappropriate.

- Room isolation must only to be used as a last resort to calm and contain the acute physical behavior of youth.
- Staff must advise youth on how to avoid room isolation and/or be released from room isolation as soon as practicable.
- Room isolation may only be used with approval of the facility director or his or her designee. If staff determine that the youth requires immediate isolation for safety reasons and there is no time or opportunity to obtain prior authorization, then staff must notify the director/designee as soon as possible after the event but under no circumstances more than 15 minutes after room isolation began.
- Room isolation must be used for the least amount of time necessary for the youth to regain self-control. Room isolation may not exceed two (2) hour increments and may not exceed a period of six (6) hours without authorization for an extension from ACS's Field Operations unit.
- Staff must not use room isolation for youth who are on special supervision for suicide, have a medical condition (e.g., seizure disorder) that makes room isolation unsafe, have significant intellectual or developmental disabilities, are severely depressed or when therapeutic restrictions have been established prohibiting its use (i.e., in BSP).
- The isolation room must be clean, fit for habitation, and in compliance with the room isolation policy requirements. Prior to using a room for room isolation, staff must thoroughly inspect the room to make sure that it is free of any objects that are potentially hazardous to the youth or which the youth could use in a disruptive, dangerous, or self-injurious manner.
- Staff must conduct a pat-frisk search, when practicable, before placing a youth in room isolation, in order to prevent the youth from bringing contraband into the room.
- Staff must permit the youth to use the bathroom, upon request, at least once (1) per hour. Staff must provide the youth with the same meals and drinks in the room as scheduled in the program. Staff must provide the youth with their regularly scheduled medication. Staff must provide the youth with reading material or other items, approved by the facility director, which may help calm the youth.

<u>Supervision/Evaluation During Room Isolation</u>

- A facility director, assistant facility director, unit supervisor, or designee must visit the youth at least once every two (2) hours.
- A psychiatrist, psychologist, social worker, or mental health counselor must visit the youth within the first hour of room isolation or within one (1) hour of clinical staff becoming available.
- A nurse, physician assistant, or physician must examine the youth in room isolation at least once in any room isolation event lasting more than two (2) hours. This examination must

occur within the first hour of room isolation or within one (1) hour of health services staff becoming available.

- One (1) staff must be positioned in a manner that allows a visual of the youth at least once every four (4) minutes during the first hour of room isolation and at a minimum every ten (10) minutes after the first hour of isolation. A staff member must be in auditory range of the youth throughout the youth's period of room isolation.

Health Assessment after Room Isolation

- All youth who have been in room isolation must receive a post-room isolation health review by a medical staff member or other licensed health care professional.
- Upon release of a youth from room isolation, staff must provide an opportunity for the youth to see a mental health clinician if he or she chooses.
- If youth refuses to be seen by health services, a refusal form must be completed. The refusal form must be signed by a supervisor and staff person or if supervisor is not on site, at minimum by two (2) staff with knowledge of the incident.

Debriefing after Room Isolation

- After an incident of room isolation, staff must debrief and document the incident in accordance to CTH incident and Log Book policies.
- After a youth has been released from room isolation, and when it is safe to do so, a debriefing should take place with the youth. An LSP provider supervisor or the facility director must conduct the debriefing and include staff who were involved in the use of the mechanical restraints.
- Debriefing must occur and include a discussion with the youth and other staff, or peers involved, if applicable, about the sequence of events that led to the room isolation. This debriefing must be documented in CNNX.

Notifications, Documentation, and Reporting

- Family must be notified about room isolation by phone as soon as possible, but no more than four (4) hours after the period of room isolation begins. Staff must attempt to notify the parent or guardian until a successful contact is made.
    - Youth must be notified of and participate in call. Discussion should include what other interventions were employed, duration, youth's response, and any insight family have into diffusing situation to end isolation if ongoing, etc.
- All instances of room isolation must be documented in the Communication Log, Incident Report Form, and CNNX.
- All instances of room isolation must also be documented in the Room Isolation Log. Staff must individually report circumstances that precipitated room isolation.
- Providers must submit a monthly report to OCFS and ACS on the number of youths held in room isolation during the previous month.

I.05.03 Law Enforcement Contacts

Staff must immediately notify a youth's parent/guardian and attorney, as well as PPS, PPS Director and MCCU in any case where a youth is arrested and/or taken out of the facility by law enforcement. This contact must occur immediately but, in all cases, must occur no longer than one (1) hour after law enforcement exits the facility.

- Providers must have a protocol in writing, and available to review, to address law enforcement contacts including, but not limited to:
  - The circumstances under which the police are to be called;
  - Process of supervisory review;
  - Protocol for responding to unannounced police visits; and
  - Maintaining good relationships with the local police and the precinct community relations officer.
- Law enforcement cannot remove a youth from ACS's custody without a signed judicial order. An I-card (investigation card) is not legally sufficient to remove a youth from a facility.
- Law enforcement contacts must be documented in CNNX and the Communication Log.
- If law enforcement is contacted due to a youth's behavior, the incident that led to the law enforcement contact must be reported to MCCU.
- If youth is escorted in handcuffs out of the facility by law enforcement, this information must be reported to MCCU, and the youth must be cleared by medical staff, upon return to the facility.
- If a youth has disciplinary contact with law enforcement (i.e., not part of programming) that de-escalates (e.g., does not result in the youth being taken out of the facility, arrested, or taken to the hospital), providers must still notify the parents/guardians within 24 hours of the contact and the youth's attorney on the next business day. If the youth's attorney is not known, provider must ensure youth is aware of their right to contact their attorney.
- Staff must have the local precinct's phone number readily available for emergency use.

Responding to arrests

- Within three (3) days of the arrest or issuance of the appearance ticket, as applicable, providers must provide MCCU and other ACS-identified staff a written report completed by the applicable Case Planner detailing the following information:
  - Comprehensive and sufficiently detailed information about the arrest or appearance ticket, as applicable, and any resulting criminal charges including, but not limited to, information about the parties involved in the circumstances that led to the arrest or issuance of the appearance ticket, a narrative of such circumstances, and the time when and the location where such circumstances occurred; and
  - The youth's current location (e.g., the facility, detention center, etc.).
- Providers must immediately inform MCCU and other ACS-identified staff when providers learn of a youth's upcoming court dates related to the original criminal charges and/or subsequent arrest or appearance ticket, as applicable, and resulting charges, if any.

I.06.00 Searches and Screening for Contraband

Providers must prevent the introduction of contraband into facilities and minimize access to contraband within facilities. Providers must follow ACS's prescribed policies and procedures for all searches, including but not limited to, personal youth searches, facility searches, and visitor search policies. All discovered contraband must be appropriately secured, vouchered, documented, and reported per ACS's contraband policy requirements.

Searches of Facility Spaces

- Room Searches: A thorough and orderly search of a youth's room and its contents. Searches must be conducted every other week at a minimum.
- Area Search: A search of a specified area of the facility or facility grounds (but not youths' bedrooms). This may include areas such as day rooms, living rooms, kitchens, recreation rooms, bathrooms, vehicles, classrooms, and linen, clothing, and supply closets. Every non-bedroom area must be routinely searched a minimum of once (1) per week.

Personal Youth Searches

- Pat-frisk searches: A visual and manual inspection of a youth's body that consists of physically patting down his/her clothing. The youth may be required to remove his/her outer clothing, and these searches may also include the use of a hand-held metal detector.
- Security searches: Inspections to check for contraband, conducted to maintain the safety and security of staff and youth which require the youth to wear a medical gown or robe (that protects youth's privacy/is not sheer). If youth is not in a private space (e.g. bathroom stall, behind curtain, etc.), gown/robe should be worn after removing his/her upper garments and before removing all of his/her undergarments. Security searches must also include the use of a hand-held metal detector.
- Strip searches: (LSP only) Inspections to check for contraband believed capable of inflicting harm on the youth, staff, or others, conducted to maintain the safety and security of youth and staff. This type of search requires a youth to remove all clothing. The removed clothing is carefully inspected, and the body is visually inspected only, without probing any body cavities. Visual inspection of the mouth to check for medication/contraband is allowed.
- Prohibited personal searches: Body cavity searches (e.g., visual, manual, and/or instrument inspection of a youth's anal or vaginal cavity) are PROHIBITED in both NSP and LSP.
- Youth may be searched when they enter and leave the facility and off-site school premises where applicable, after receiving a visit at the facility, and at the discretion of staff when suspected of possessing contraband.
  - Providers must post a list of contraband items conspicuously throughout the facility including the main entrance, waiting area, and visiting room.
- Providers must examine (e.g., shake, hold against the light, ask youth to open in front of staff) all letters and packages coming into the facility for youth for contraband while maintaining confidentiality.
- Staff and visitors should not bring their personal items (e.g., purses, backpacks) into the facility unless pre-approved by the facility director. All personal items must be in a secure area inaccessible to youth such as lockers or a locked staff office or lounge.

- All lockers must always be kept locked when not in use. If providers use pad-locks to secure items/belongings, pad-locks must never be left unlocked.
- All visitors shall be subject to search prior to a visit. Any visitor refusing to consent to a search must be directed to exit the facility and cannot be allowed to visit the youth on that day.
- All youth searches for contraband must be documented in the Searches for Contraband Log and the Communication Log. All contraband items that are discovered must be recorded.

I.06.01 Disposal of Contraband

Providers must immediately confiscate and voucher all contraband found in the possession of youth. Illegal items must be turned over to local law enforcement authorities.

- Staff must immediately confiscate all contraband found in the possession of youth.
- Provider agencies must voucher all contraband found. Each voucher must contain the following information, and staff should provide a copy of the voucher to the youth unless doing so would compromise an investigation:
  - Youth's name, address, date of birth and date of admission;
  - Detailed description of each item and where and how the contraband was found;
  - Provider staff member's name and signature who first discovered the contraband;
  - Date the voucher was completed and signed.
- After seizing contraband that can be safely moved, the staff member must place it in a contraband envelope or other container that can be locked or sealed, along with a copy of an Incident Report that includes a description of the time, manner, and location of the seizure. The staff member must then seal and sign the envelope or other container and move it to the designated secure location.
- Providers must attempt to turn all illegal items over to local law enforcement authorities.
- Any items not collected by law enforcement after a request must be disposed of.
  - Providers must have a clear and documented process for disposal of contraband.
- Staff must document the disposal of contraband in the Searches for Contraband Log and the Communication Log.
- If applicable, unauthorized items must be properly inventoried, recorded, and signed for by the youth and must be returned to the youth upon release from the program or facility, or on home pass, if applicable, or to the parents (e.g., non-perishable items).
- When appropriate, contraband being held as evidence in an investigation may not be returned to the individual from whom it was confiscated until the investigation has concluded.

I.07.00 Regular Inspections of Facilities

Providers must regularly inspect facilities, document these inspections, and report and/or correct any deficiencies identified in accordance to ACS's policies and the provider's contract requirements.

- Inspections are defined as a routine close visual examination to check that standards of cleanliness, orderliness, safety and security are maintained.
- Programs must conduct inspections to detect and report any safety and security concerns.
    - At a minimum, the facility director or designee must inspect every area in the facility at least twice (2) per week.
    - Supervisory staff must inspect each area under their supervision daily.
    - Direct care staff must inspect the areas for which they are responsible at the beginning and end of each shift.
    - When requested, programs must complete a Facility Site Self-Assessment Tool, which will be signed and submitted to Agency Program Assistance for review.
- All concerns identified by staff must be reported immediately to the supervisor on duty and followed by a written report, immediately or as soon as feasible. The report must be routed through the appropriate channels to the facility director/designee.
    - The facility director must oversee the initiation of corrective action when necessary.
- All deficiencies identified must be documented in the Communication Log.

I.08.00 Weapons in the Facility

Weapons are prohibited inside all facilities

- “Weapons” are defined as: objects or items designed or used for inflicting bodily harm or physical damage (e.g., firearms, sharps, explosives, etc.).
- All incidents involving a weapon must be reported to the facility director/designee and MCCU and be documented in the Communications Log.
- All weapons must be handled in accordance with the contraband policy.
- This requirement does not apply to Law Enforcement Officials

I.09.00 Access to Emergency Phone Numbers

Emergency phone numbers must be readily available.

- Providers must have the following numbers readily available:
  - Local police and fire department precincts;
  - Poison control;
  - VPCR;
  - SCR;
  - The OCFS Office of the Ombudsman;
  - MCCU;
  - Facility leadership and designated staff required should an emergency occur;
  - Safety and security vendors including 24/7 technical assistance and troubleshooting where applicable;
  - Plumber;
  - Exterminator; and
  - Con Ed/electric company.
- Providers must have all emergency family contact information for each youth. Family information must be posted in secure areas inaccessible to youth.

I.09.01 Emergency Operations Plan

Providers must maintain a written Emergency Operations Plan that details the procedures for caring for youth and continuing operations during an emergency or disaster.

- Providers must be prepared in case of an emergency.
- Evacuation floor plans must be conspicuously posted on every floor throughout the facility.
- Disasters/emergencies include: fires, severe weather (e.g., snow emergencies, hurricanes, floods, earthquakes, tornadoes, etc.), energy failures, chemical spills, man-made disturbances or disasters, active shooters, national security, terrorism, and medical emergencies, per regional vulnerability assessment.
- Each facility must have the ability to utilize a generator, petty cash, a "go bag", one (1) emergency kit per floor, enough emergency food for 72 hours for all staff and youth, emergency liquid for 72 hours.
- Emergency Operations Plan must include a process to ensure medication is available in an emergency.
- Providers must maintain a checklist for all vehicles.
  - All facility vehicles used to transport youth must be maintained with no less than half a tank at all times.
- Emergency plans must be reviewed annually and updated as needed.
- Providers must share a written Emergency Operation Plan every September with ACS for review and approval. Any revisions to the plan must be shared with ACS and be available upon request.
- Providers must advise all employees of the Emergency Operations Plan and their responsibility under the plan. Providers must provide training on the plan for new employees and annual training for all staff.
- Providers must keep an Emergency Operations log book in the "go bag" to be used in the event of an actual emergency evacuation.

I.09.02 Emergency Notification Protocol

Providers must implement a protocol for emergency notification.

- The emergency notification protocol must be posted in the facility and reviewed with all staff quarterly.
- In the event of an emergency/disaster (as stated in standard I.09.01), staff must follow their internal protocol to notify provider agency leadership, ACS leadership, MCCU, and OCFS in a timely manner.
  - Contact information for the emergency response list (recall list) must be current, readily accessible and updated whenever there is a change, or as otherwise necessary.
  - During or following an emergency/disaster, as soon as it is safe to do so, providers must notify the parent/guardian of youth’s location and status.
- Providers must have a protocol in place for maintaining contact with youth/families on Home passes or on aftercare during/after an emergency.

I.09.03 Fire Drills

Providers must conduct fire drills regularly. Providers must adhere to all applicable fire safety codes and requirements and must conspicuously post plans and procedures for building evacuation and fire emergencies in all hallways, common areas, and reception areas.

- Fire drills must be held as often as is needed, but at least once every 30 days, to familiarize and instruct youth and staff with the routine.
  - Fire drills must be conducted during varying shifts and on different days and times (i.e., AM, PM, overnight) to ensure all youth and staff know which means of egress should be used to evacuate during various activities.
- All staff, youth, and visitors physically present in the building during a fire drill must participate.
- Evacuation time must be two (2) minutes or less.
- An annual FDNY inspection report, or annual insurance carrier inspection submitted and approved by OCFS, must be available for review upon request.
- Fire drills must be documented in the Communication and Fire Drill Logs and must include the following information:
  - The date and time of each fire drill;
  - The amount of time it took to evacuate;
  - Which staff were present, which youth were present, and the location of any youth who did not participate in the drill;
  - The results of the fire drill (e.g., the fire drill was conducted as planned, the fire alarm malfunctioned, the fire exit light malfunctioned, there were issues with egress doors, evacuation time lasted longer than two (2) minutes, etc.); and
  - The page number in the Communication Log where the fire drill was documented.

I.09.04 Other Emergency Drills

Providers must conduct emergency drills regularly. Providers must adhere to all applicable safety codes and requirements and must conspicuously post plans and procedures for building evacuation and emergencies procedures in all hallways, common areas, and reception areas.

- Providers must conduct disaster/emergency drills regularly and at minimum at the intervals listed below.
  - Shelter in place drills must be conducted on a quarterly basis;
  - Disaster evacuation drills must be conducted on a bi-annual basis for NSP; and
  - Simulated evacuations must be conducted on a bi-annual basis for LSP.
- All staff, youth and visitors physically present in the building during a drill must participate.
- Youth's discharge resource must be provided with a description of the evacuation plan.
- Drills must be documented in the Communication Log and must include the following information:
  - The date and time of the drill;
  - The duration of the drill and amount of time required to evacuate;
  - Names of youth and staff who participated;
  - The location and reason for non-participation of any youth or staff member who did not participate in the drill; and
  - The page number in the Communication Log where the drill was documented.

I.10.00 Abuse and Neglect

The facility environment must be free of abuse, neglect, and intimidating behavior.

- Providers must adhere to all protocols to prevent abuse and neglect in the facility and must respond appropriately to all alleged incidents.
- New York state law defines abuse and neglect of vulnerable persons in broad terms, including both actual harm and the risk of harm.
- Prohibited conduct/reportable incident includes, but is not limited to,
  - **Physical Abuse**: Intentional contact (e.g., hitting, kicking, shoving, etc.); corporal punishment; injury which cannot be explained and is suspicious due to extent, location, or the number of injuries at one (1) time; or the frequency over time.
  - **Psychological Abuse:** Taunting; name calling; using threatening words or gestures.
  - **Sexual Abuse**: Sexual touching; attempting, threatening, or requesting sexual touching; indecent exposure; sexual assault; taking or distributing sexually explicit pictures; voyeurism; incest; other sexual exploitation; or any other sex offense as defined by Article 130 of the Penal Law. All sexual contact between a staff and a service recipient is sexual abuse.
  - **Neglect**: Failure to provide supervision, or adequate food, clothing, shelter, health care, or access to an educational entitlement.
  - **Deliberate misuse of restraint or seclusion:** Use of physical interventions with excessive force, as a punishment or for the convenience of staff.
  - **Controlled Substances:** Using, administering, or providing any controlled substance contrary to law.
  - **Aversive conditioning:** Unpleasant physical stimulus used to modify behavior without person-specific legal authorization.
  - **Obstruction:** Interfering with the discovery, reporting, or investigation of abuse/neglect; falsifying records; or intentionally making false statement.

I.10.01 Abuse and Neglect Prevention and Reporting

Providers must adhere to all policies and internal protocols with regards to mandated reporting of suspected or alleged abuse, neglect, and significant incidents to the State Central Register (SCR) or the Vulnerable Persons' Central Register (VPCR) in accordance with New York State law. Providers must protect youth and staff from fear and victimization by establishing and maintaining a trauma-informed environment that supports social and cognitive skill-building for all youth in their care.

- Providers must adhere to all policies related to abuse and neglect prevention and reporting and must develop an internal protocol for approval by ACS.
- Providers must take the following steps to prevent and address instances of alleged abuse and neglect:
  - Each staff person must be trained on the child abuse prevention policy and understand his or her duty as a mandated reporter.
  - Additionally, at minimum, staff must be trained on keeping appropriate professional boundaries, working with youth with histories of trauma, and the appropriate use of physical force.
  - Upon admission, intake staff must provide age-appropriate information to youth explaining the facility's zero tolerance policy regarding abuse and neglect (including sexual abuse and sexual harassment), a youth's right to be free from any form of abuse and neglect, and how to report incidents or suspicions of abuse and neglect or situations where a youth does not feel safe.
  - The Justice Center's VPCR number and OCFS Office of the Ombudsman's contact number must be conspicuously posted in areas accessible to the youth.
  - For LSP sites, providers must also refer to and comply with the LSP PREA policy.
  - Providers must have a grievance process in place as a method for reporting abuse.
  - Youth must be provided unhindered access to methods for reporting abuse.
  - If there is a finding of indicated abuse, maltreatment, or neglect by providers' employee, providers must immediately act in accordance with the initial safety plan approved by OCFS.
  - Staff must be able to report abuse and neglect suspicions anonymously.
  - Any mandated reporter (i.e., all staff) is required to report a case of suspected abuse or neglect to the VPCR. Mandated reporters who knowingly and willfully fail to do so may be guilty of a Class A misdemeanor.

I.10.02 Response to Witnessed or Suspected Abuse of Youth

Providers must report any allegations of abuse and neglect immediately to the VPCR, SCR, ACS, and OCFS accordingly. This notification must occur within 24 hours of becoming aware of the incident.

- Allegations of abuse and neglect and significant incidents are reportable incidents that must be reported to MCCU within one (1) hour of occurrence.
- Each mandated reporter (i.e., all staff) who has reasonable cause to suspect that a vulnerable person has been subjected to a reportable incident is required to make a report to the VPCR unless the mandated reporter has actual knowledge that the reportable incident has already been reported to the VPCR and that he/she has been named as a person with knowledge of the incident in such report.
- Discovery occurs when the mandated reporter witnesses a suspected reportable incident or when another person who was involved in or witnessed the incident, including the vulnerable person, comes before the mandated reporter in the mandated reporter's professional or official capacity and provides the mandated reporter with reasonable cause to suspect that the vulnerable person has been subjected to a reportable incident.
- If the provider has reasonable cause to suspect that staff has abused, maltreated, neglected, assaulted, or endangered the welfare of any child/youth, the provider must immediately report such belief to the VPCR, develop a safety plan with OCFS, and take appropriate measures to ensure the safety of the alleged victim and the rest of the youth.
- If providers (including staff and volunteers and contractors) have reasonable cause to suspect that a youth coming before them in their professional or official capacity is an abused or maltreated child, providers must contact the SCR.
- After contacting the VPCR or SCR, staff must immediately notify the facility director of the allegation.
  - If the allegations are reported to the VPCR, providers must notify the alleged victim and their personal representatives within 24 hours.
  - Within 48 hours of receiving notification that a youth will be interviewed regarding a VPCR investigation by the Justice Center, providers are required to notify service recipients who are potential witnesses to an alleged abuse or neglect incident, and their personal representatives, that the service recipient may be interviewed as part of the investigation of the report (unless such notification interferes with the investigation). Providers must document all notifications.
  - Information (documentation) must not be shared with staff suspects or witnesses.
- When maltreatment is alleged, the program must take immediate action to protect the safety of the alleged victim in accordance to the safety plan developed in collaboration with OCFS.
- When staff-on-youth mistreatment is alleged, the program must develop and share a safety plan as agreed upon with the Justice Center and OCFS, until the allegation is proven unsubstantiated or the investigation concludes.
  - When mistreatment is alleged, the program must take immediate action to notify the youth's parents or guardians.

- Non-mandated reporters who want to report suspected cases of child abuse or maltreatment should be directed to the VPCR. If abuse or maltreatment is suspected at the youth's home, then the non-mandated reporter should be directed to the SCR.

I.11.00 Facility Requirements

Providers are responsible for ensuring the facility is compliant with required laws and regulations with regards to safety and security, service provision, facility maintenance, required equipment, etc.

- Outdoor and/or indoor space must be available to provide appropriate physical recreation space for the number of youths housed in the facility.
- Providers must maintain closed circuit television ("CCTV") monitoring and recording of all interior common spaces and all exterior space of the facility and must ensure that such CCTV recording includes video recording, is saved for the minimum period set forth in ACS Policies, is easily transferable to ACS upon request, and provides continuous footage 24 hours per day, 7 days per week (See I.04.01).
- Providers must apply for, obtain, and maintain an OCFS operating certificate for the facility and other regulatory approvals, permits and licenses required by ACS policies and the law. Providers must ensure that the facility complies with all applicable law including, but not limited to, building, safety, health and fire rules, codes and regulations.
- The facility must have a current Certificate of Occupancy, or temporary Certificate of Occupancy with the approval of ACS and OCFS.
- Providers must ensure that the building containing the facility is clearly named and/or numbered, displays prominent signs directing visitors to the facility, and contains an obvious reception area to receive and process visitors.
- Providers must ensure that all areas utilized by youth, including but not limited to common areas and sleeping quarters, is appropriately furnished and all such furnishings are in accordance with ACS policies and the law.
- To the extent reasonably practicable, providers must organize sleeping quarters so that youth are with others in their age group and/or developmental stage, and gender identity where appropriate.

Maintenance

- Providers must be responsible for all ongoing operating, interior and exterior maintenance, fire safety and security expenses associated with the facility. Providers' obligation pursuant to this section includes maintaining and repairing building systems, equipment and fixtures, including administration of all contracts for such services, such as on-call building maintenance contracts, at the provider's sole expense.

I.12.00 Control of Hazardous Materials

Providers must maintain strict control of all poisonous, flammable/combustible, and toxic items and materials and must store them in a secure place inaccessible to youth. A complete inventory of hazardous items must be maintained and regularly updated. Youth must not be permitted to use, handle, or clean-up hazardous chemicals unless under supervision and as part of a facility activity.

- Poisonous, flammable/combustible, and toxic items and materials include items such as cleaning supplies, paint, and paint thinner. These items and materials must be stored in secure, appropriate locations (e.g., non-combustible cabinet for combustible materials) that are inaccessible to youth.
- Providers must make Material Safety Data Sheets (MSDS) available for all poisonous, flammable/combustible, and toxic items and materials.
- If applicable, cleaning tasks in which youth participate (including but not limited to those tasks which involve the use of hazardous or dangerous chemicals) must always be under staff supervision while chemicals are being used. Once the activity concludes, staff must collect, inventory, and secure the hazardous supplies in their proper place.
- As part of the facility inspections, staff must ensure all hazardous materials are secured and inaccessible to youth.
- Providers must establish and document guidelines for working with outside contractors who might require or use hazardous items.

I.12.01 Storage of Medication and Medical Equipment

All medication and medical equipment must be properly inventoried and stored in compliance with applicable ACS policies and procedures.

- All prescription medication must be stored in well-lit, secure areas that are inaccessible to youth.
- Prescription medications must be readily accessible to medical staff for the administration of medications or to trained direct care staff who supervise the self-administration of medication by youth.
- All medication, including controlled substances, must be stored in double-locked containers or cabinets.
- Medication requiring refrigeration must be kept inside a locked box in a refrigerator and must only be used for storing medications.
- Providers must have trained staff to conduct and document a daily inventory of all medications prescribed to youth in CTH facilities.
- Providers must maintain an inventory of all medical equipment.
- For Over the Counter (OTC) products, the provider must confirm that adequate supplies of the OTC medications and products are present and that none of the medications have passed their expiration date. This confirmation must occur once (1) a month.
- Each facility must have a documented process for the disposal of medication that is approved by a prescriber. Disposal of medications must be recorded on the DYFJ Medication Disposal Form.
- Discrepancies in the pill count must be immediately reported to MCCU.
- Staff medication must not be stored with the youth's medication. Staff medication must be secured in the staff's locker or office space and must be taken as needed away from the youth.
- When requested, providers must complete a Medication Management Self-Assessment Tool, which will be signed and submitted to Agency Program Assistance for review.

I.12.02 Tool Management System

Providers must have a tool management system that minimizes the risk of youth obtaining unauthorized access to tools or equipment. Providers must have procedures in place to make certain that youth use tools safely and under appropriate supervision in order to prevent injuries to other youth, staff, or themselves. Providers must establish guidelines required for outside contractors, including information about tool control and restrictions.

- Providers must establish guidelines required for outside contractors, including information about tool control and restrictions.
- Tools include those used for building or property maintenance (e.g., hammers, drill, bolt cutters, etc.).
- Providers must maintain an inventory of all permanent tools stored within the facility. All tools must be stored securely in areas inaccessible to youth unless supervised for vocational or programming purposes. Tools must be signed out upon issuance and in upon return.
- Providers must attempt to limit risk of youth coming into contact with tools used by designated contractors or onsite vendors.
- If applicable, providers must have a process in place to conduct tool inventory checks. Discrepancies in the count must be reported as required to MCCU.
- Supervisors must conduct weekly tool inventory checks.
- All tools must be labeled and described for easy identification in case of misplacement.
- Staff and youth must be trained on intended and safe use of any tools that they use.
- Staff must assess youth for risk to self/others before being granted access to use tools during facility activities. Youth must be closely supervised during activities involving the use of tools.
    - Providers must understand and follow the facility's rules around tool management/control (e.g., must restrict youth access to any work area, immediately report any missing tool), and providers must follow procedures around tool control. Providers must conduct a perimeter and facility search after outside contractors leave the premises and document findings in the Communication Log.

I.12.03 Kitchen Utensils and Sharp Objects Management System

Providers must store kitchen utensils and sharp objects in a double-locked space inaccessible to youth at all times.

- Kitchen utensils and sharp objects include but are not limited to the following: metal knives, forks, spoons, or sporks; ceramic or glass plates and cups; and compasses, scissors, or other sharp items.
- Sharps must be kept in a secure, locked area at all times.
- If applicable, youth must only use sharps under staff supervision (e.g., youth using silverware to eat).
- Providers must maintain an accurate inventory of all kitchen utensils and sharp objects
  - Discrepancies in the sharp inventory count must be investigated, reconciled, and reported immediately to MCCU and documented in the Communication Log.
  - Defective sharps must be discarded safely and documented. The inventory sheet must be updated accordingly.

I.13.00 Vehicle Maintenance

Providers must check agency vehicle before and after any use to ensure vehicle is safe and in proper working order. Providers are responsible for ensuring all agency vehicles are compliant with required inspections and regulations.

- Providers must have vehicle accountability process in place to document use of vehicle and any relevant maintenance concerns. This must include:
  - Destination(s) of community outings, including date, time, and staff who drove vehicle;
  - A basic maintenance check to ensure all safety features are working properly (e.g. locks, doors, head/tail lights, signals, check engine lights, etc.);
  - Confirmation that all emergency equipment (e.g., fire extinguisher, approved first aid kit, log of picture and identifying information for youth (gender, DOB, ethnicity, height, weight, scars/distinguishing marks, etc.), issued warrants as applicable, etc.) is present.
- The vehicle accountability process must be completed prior to and after the use of the agency vehicle.
- Vehicle specifications (adequate seating capacity, child safety lock features etc.) must meet the needs of youth and staff of program and vehicle(s) must be safe and appropriate for all weather conditions.
  - If child safety locks are unavailable, there must be a supervision strategy in place to mitigate the risk of youth exiting vehicle without authorization.
- All vehicles must get a safety inspection at a DMV licensed inspection station every 12 months and maintained as necessary. A valid inspection sticker must be displayed on the vehicle.

II.01.00 Full Orientation for Youth

Upon admission to the facility, youth must receive a full orientation. Orientation information must be provided to youth verbally and in writing. All information discussed with youth must be included in the youth handbook.

- Receive a mental health screening within (1) one hour of arrival at the facility using the DYFJ's Screening Form.
- Youth must be allowed to contact their legal guardian(s)/family resources on the day of their arrival to the facility. The initial attempted call or refusal must be documented in CNNX.
- If youth refuse to speak to their legal guardian(s)/family resources, providers must attempt to contact the legal guardian(s) on the youth's behalf to confirm that the youth arrived safely at the facility, discuss next steps, and clarify any questions or concerns. Efforts conducted to speak to the legal guardian(s) must be documented.
- When providing orientation information verbally and in writing to youth, providers must consider the language and literacy needs of the youth and use language that youth can understand.
- Youth must read, date, and sign confirming they received and understood the materials covered during orientation (e.g., fire and evacuation procedures). If the youth refuses to sign, the supervisor must indicate the youth's refusal to sign.
- The signature receipt for the handbook must be kept in the youth record.
- Youth must receive a copy of signed documents (e.g., youth handbook, etc.).
- Information covered at orientation must be documented in CNNX and included in the youth handbook.
- Staff must document in the Communication Log that orientation was conducted.
- Staff must review and reinforce information covered at orientation to ensure youth understands all content (e.g., if youth have any follow-up questions, etc.).
- Upon admission, within 24 hours, youth must:
  - Receive a copy of the facility rules and discuss the facility rules with a staff member;
  - Receive a copy of their legal rights and discuss their legal rights with a staff member;
  - Review emergency procedures, especially fire and evacuation;
  - Receive a brief overview of Close to Home;
  - Receive a tour of the facility (for example, room, bathroom location);
  - Be made aware of opportunities for personal hygiene (personal hygiene products must be provided immediately); and
  - Be offered the opportunity to ask any clarifying questions about any of the orientation materials provided.
- Within two (2) weeks of admission, youth must receive and review:
  - Information on how to report abuse and neglect;
  - Information on the use of force, restraints, and isolation;
  - Facility rules and expectations of youth;
  - Rules about the personal property of youth;
  - Information about key staff and roles (e.g., youth's case manager/planner, medical staff);

- Information about visitation, correspondence, and telephone use (schedule, limits, and youth rights);
- An overview of the behavior management system and behavior expectations including incentives for positive behavior and consequences that may result from violation of the rules of the facility and the individual youth's Behavior Support Plan (BSP);
- Contraband and youth search policies;
- Information about access to emergency and routine health and mental health care;
- Information about access to education, religious services, programs, and recreational materials;
- Youth's right to non-discrimination;
- Information about opportunities and/or accommodations for youth religious preferences and needs;
- Information related to the management of youth allergies, special diet, medical concerns, etc.;
- Rights for transgender, intersex, or transgender non-binary youth, including the opportunity to request that staff of their identified gender conduct any pat-frisk, security search, or necessary strip search of the youth;
- Age-appropriate information to youth explaining the facility's zero tolerance policy regarding sexual abuse and sexual harassment;
- A youth's right to be free from any form of sexual abuse and sexual harassment, and how to report incidents or suspicions of sexual abuse and sexual harassment or situations where a youth does not feel safe, the importance of and avenues for reporting incidents (see II.17.00);
- Grievance procedures and youth rights (includes PREA basic rights for LSP sites); and ACS policies for responding to incidents including the youth's right to medical, mental health, and psychiatric care regardless of the status of an investigation, and where to go if he or she has questions.

II.02.00 Youth and Parent/Discharge Resource Handbook

Upon admission to the facility, each newly admitted youth must receive a written youth handbook. Providers must address any questions or concerns youth may have regarding CTH and any information included in the youth handbook.

- Providers must develop a youth handbook and a parent handbook to be provided to both youth and parent(s), family, extended family, or other release resources.
- The youth handbook must include, but is not be limited to, the following items:
  - Information about youth's rights, including contact information for the Justice Center and the OCFS Office of the Ombudsman;
  - Information about the grievance process;
  - Information about youth's right to be free from sexual abuse and harassment, including harassment related to LGBTQ+;
  - Information about youth's right to sexual and reproductive health in accordance to the New York state law;
  - Information about youth's right to receive mail;
  - Information about prohibited disciplinary actions;
  - The policy regarding the use of physical interventions;
  - Information about youth's right to obtain basic needs while placed at the facility;
  - Information about youth's right to counsel;
  - Right to non-discrimination;
  - A brief description of CTH, the agency, and the facility program model (including phases or levels of the therapeutic model if applicable);
  - The rules of the facility including daily expectations about chores and youth's responsibilities and disciplinary action when youth are not in compliance;
  - The list of contraband or forbidden items including the process to dispose of contraband found and the process and ways in which searches for contraband will be conducted at the facility;
  - The list of permitted room items including information about youth's personal property and inventory practices;
  - The visitors and call schedule including the allotted days, times, expectations for calls and visits, and the length of calls and visits; and
  - Rules for visitors.

II.03.00 Basic Needs

Providers must provide youth with adequate nutrition, personal hygiene items, bedding, clothing, storage, space, and furniture.

Nutrition

- Providers must adhere to New York City guidelines for food procurement, preparation, and service Mayor's Executive Order #122 in each of the three (3) sections:
  - Standards for Purchased Food (specific standards by food category);
  - Standards for Meals and Snacks Served (nutrient requirements, standards for snacks and special occasions); and
  - Provider and Population-Specific Standards and Exceptions (standards for specific populations, e.g., children).
- Providers must ensure that food services are of good quality, properly prepared, served at regular hours, and sufficient in quantity. Providers must ensure that the diet meets the nutritional standard recommended by the National Research Council, and all milk and milk products are pasteurized.
  - All meals shall be served to youth three (3) times each day, at regularly scheduled intervals with no more than fourteen (14) hours between the evening meal and breakfast.
  - At least one (1) of the three (3) regularly scheduled meals in a 24-hour period shall be served hot.
- Providers must have options available to meet the dietary restrictions or needs (including allergies, pregnancy, etc.) and/or cultural or religious needs of the youth they serve (e.g., vegetarian options, kosher options, nut-free options, etc.).
- Providers must serve food, beverages, and snacks of good quality and enough quantity that is appropriate to meet the physical and developmental needs and medical conditions of the youth in care providing sufficient nutrients and calories for each child.
- Providers must incorporate youth's feedback when designing the menu and, to the extent possible, make changes to accommodate the needs of youth.
- The food menu must be posted in an area accessible to youth.

Food Safety and Sanitation

- All food service preparation and storage areas shall be maintained under sanitary conditions in accordance with the regulations promulgated by New York State Office of Children and Family Services (OCFS), the New York State Sanitary Code, and the New York City Health Code §81.
- The staff responsible for preparing meals shall have a valid New York City Food Handler's Certificate.

Personal Hygiene

- Providers must allot the time and/or resources needed for youth to maintain good hygiene.
- Providers must have adequate supplies of towels, wash cloths, linens, and bedding for use by each youth.

- Providers must supply each youth with appropriate grooming and hygiene supplies and accessories and must work actively with each youth to develop good personal hygiene practices.
  - At a minimum, each youth must be provided with toothpaste, toothbrush, soap/body wash, facial cleanser, hair grooming supplies (e.g., comb, brush), deodorant/antiperspirant, shampoo and conditioner, skin moisturizer, lip balm, shower cap, wash cloths, bath towels, feminine hygiene items (as applicable), and shower flip flops/slippers, etc.
- Staff must provide youth with expectations, instructions, and assistance in personal hygiene, grooming, and health care (e.g., washing hands before every meal, washing hands after using the toilet, and maintaining proper grooming of fingernails and toenails, hair, etc.).

Bedding

- Each youth must be provided with required bedding items. At a minimum, each youth should be provided with the following individual and clean bedding articles: two (2) bed sheets, one (1) mattress, one (1) pillow, one (1) pillowcase, and sufficient blankets to provide comfort under existing temperature.
- Providers must establish procedures for at least weekly exchange of pillowcases and bed sheets laundering.

Clothing

- Providers must supply all youth with clean washed clothing that is age-appropriate, considering individual gender expression, and youth's religious and cultural norms.
- Providers must be ready to immediately provide clothing to any youth placed at the facility on the same day of placement and to replace clothes when they are no longer in good condition and/or when youth outgrow the clothing.
- Providers must be responsible for providing clothing that is seasonally appropriate.
- Providers must have available, in sufficient quantity, for use by youth the following articles of clothing: underwear, socks, pants, tops, tee shirts, and cold weather outerwear including, but not limited to, hats, gloves, scarves, and footwear appropriate for inclement weather.
- Providers must comply with and enforce ACS Policies detailing the dress code for youth.

Storage Space and Furniture

- The furnishings contained in a facility must accommodate the characteristics of the population and, as appropriate, provide a "homelike" living environment.
- Furniture and furnishings must be clean, free of unreasonable wear and tear, in operable condition, and must be arranged to preserve the safety of the population.
- Each youth must have a separate bed, dresser or other storage space, and a closet or locker for jackets, coats and other outerwear.
- Providers must make an effort to find furniture designed in a way to limit the storage or hiding of contraband.

II.04.00 Youth Right to Privacy

To the extent possible and as appropriate, providers must allow youth to have privacy in bathrooms and sleeping areas, when being seen by medical, and when communicating with attorneys.

- Youth must be allowed to meet with their attorney in a private area.
- Closed circuit video coverage of the bedrooms of youth, bathrooms, areas used for medical exams, and areas used for confidential contact between youth and counsel or youth and representatives of the OCFS Office of the Ombudsman is prohibited unless sound is not recorded.
  - Exceptions must be approved by ACS.
- Providers must ensure youth have privacy when managing hygiene (e.g., when showering) in the bathroom area.
- Medical examinations of youth must be conducted in a private area where there are no cameras.
- Security searches (NSP and LSP sites) and strip searches (LSP sites) must be conducted in private areas in accordance to policy.

II.05.00 Youth Personal Property

Youth's personal property must be inventoried at admission. At admission, a designated provider agency staff person must meet with each youth to explain which personal property items are permissible at the facility and which are not. The staff person must explain which items are permissible and may be kept in the youth's room, on his or her person, or stored by the facility, and which are considered contraband and must be stored, disposed of, or retrieved by a parent/guardian or other authorized person.

- Staff must follow ACS policies and procedures concerning the personal property of youth, including but not limited to admission, inventory, storage, transfer, disposal requirements, and lost property.
- Providers must develop a listing of permissible personal property items which must be approved by ACS.
- The youth handbook must include the following information about youth personal property:
  - A clear statement of the youth's right to personal property;
  - A list of permissible and unauthorized personal property;
  - Information about how personal property is inventoried and stored;
  - The process by which a youth's parent/guardian or other authorized person may retrieve personal property; and
  - A sample Personal Property Inventory Form (Attachment A in the Personal Property of Youth in Juvenile Justice Placement policy).
- The youth must be informed that possession of property exceeding estimated value of $75 requires approval from the facility director or designee.
- Providers must ensure youth are made aware of property policies, including but not limited to what items are available every day, what must remain secured, and liability for lost property.
- An inventory form must be completed with youth at admission and updated/amended any time youth brings new personal items in and/or out of the facility.
  - If the youth has no personal property, the staff must check the "no" box on the inventory form.
  - The original form must be kept in the youth's case record and may be saved in an electronic file. One (1) copy of the form must be stored in the Personal Property log and one (1) must be given to the youth.
- After inventories of the property of youth are conducted, providers must note in the Communication Log and in the youth's electronic case record that an inventory of the property of youth was conducted [e.g., "Inventory was conducted for youth (first name)"].
- Providers must maintain a record of each youth's personal property in the Facility Personal Property Log, arranged in an unbound binder, and stored in a secure location readily accessible to direct care staff, including all inventories conducted at admission and upon return from each home visit or other extended absence from the facility.
- Youth's property must be stored in a secure location accessible only by staff designated by the facility director.

- The facility director or designee must oversee monthly inventory reviews and resolve any discrepancies. All reviews must be documented in the Communication Log (e.g., "Inventory Log reviewed for x, y, and z youth").
- At any time during a youth's residential placement, the youth may authorize the release of his or her property to a parent/guardian/discharge resource or other authorized person.
- Before youth go on a home pass and after they return, staff must conduct an inventory of the youth's property (e.g., items youth took but left home while on a home pass). If a youth is transferred between facilities, a staff person from the sending facility must confirm the youth's most recent Personal Property Inventory Form prior to transfer and include the form along with the youth's personal property. Staff from the receiving facility must review this inventory form with the youth and conduct an inventory of the youth's personal property.
- If a youth goes AWOC, the provider must secure all youth's property until youth returns.
  - After 180 days of the AWOC, the facility may donate a youth's unclaimed property to charity or dispose of all other unclaimed property. Staff must document all efforts to contact the youth and/or authorized person and donations or disposals of youth's personal property in the youth's electronic case record.
  - Providers must attempt to contact the youth's family members (authorized people) to return the youth's belongings in accordance to policy.
- When youth return from AWOC, providers must conduct an inventory of the youth's property within one (1) business day. This inventory must be conducted in the presence of youth. Discrepancies must be addressed.
- Providers must develop a claims process regarding the replacement of any lost or damaged permissible personal property items, available upon request, and include information about the claims process in the youth handbook.

II.06.00 Youth Access to Counsel

Providers must facilitate youth access to, and not restrict contact with, counsel and/or any other authorized legal representatives.

- All youth have the right to counsel and must have access to their attorney or authorized legal representatives (e.g., investigators, social workers, interns, or paralegals) throughout the period of residential placement.
- Type of contact can include, but is not limited to, telephone communications, uncensored correspondence by mail, and in-person visits. Contact must not be restricted, and the following guidelines must apply:
  - The facility must provide confidential settings and convenient scheduling and must respect confidentiality for phone calls or visits.
  - Staff must arrange appointments for attorneys to visit youth between the hours of 8:00 AM and 8:00 PM and make every reasonable effort to facilitate visitation while minimizing disruptions to school.
  - Youth must be permitted reasonable access to a telephone to contact attorneys upon request.
    - The requirement for reasonable access is not taken to mean immediate access. Unless exigent circumstances exist, Provider staff must work with youth and staff attorney to schedule call times that minimize disruptions to the school day or programing.
    - Youth request and any follow up (to be scheduled, attempted to call) should be logged by providers.
  - Provider must enable the youth to speak to his/her attorney privately without staff hearing the dialogue during these calls. Letters to and from attorneys may be examined for contraband but only in a manner that ensures that the letter's contents are not read and remain confidential (e.g., the letter may be opened by the youth in front of staff).
  - Telephone calls to or from an attorney must not be counted in the number of calls a youth is allotted during any particular time frame, and there must be no limitation placed on the duration of any call to or from the attorney or his or her representative.
  - Providers must provide postage stamps to youth who wish to write letters to their attorneys.
  - Attorney's requests to visit and visits must be documented in the youth's case file.
  - Upon arrival, the attorney must sign the Youth Visitor Log and present proper identification.
- A youth may refuse to meet with the attorney or representative of the attorney. If this occurs, the case planner or other staff must document such refusal in writing and present it to the attorney at the time of the visit. Staff must document the youth's refusal in the Communication Log.
- Contact with counsel must be documented in CNNX.

II.07.00 Youth Phone Calls and Facility Visits

All youth must have access to make and receive phone or video calls and visits from approved family/discharge resources. Providers will structure phone calls and visiting hours schedules and make them accessible to youth.

- Youth must be allowed a minimum of two (2) phone or video calls per week to their family/discharge resources for a minimum of five (5) minutes each. Calls must be available free of charge. If there is no response when a youth attempts the call, the youth must have the opportunity to make additional efforts to call back.
- Prohibiting calls or visits to family members/discharge resources under this threshold cannot be used as a form of discipline or punishment for youth.
- Within two (2) business days of a youth's arrival at the facility, providers must contact families and other discharge resources to schedule a visit.
- Provider agency staff must outline expectations for visitors during this contact and answer any related questions.
- Youth must be allowed to have a minimum of two (2) visits per week with the list of pre-approved family/resources unless a significant safety concern is identified and documented.
- Providers must develop and maintain a family visitation record in each youth's case record, which must include the visiting plan that outlines the planned frequency of the visits, the names of the individuals who are scheduled to visit the youth, planned and actual visits, and summary comments regarding the outcomes of such activities.
- Children under 18 may not visit a youth in a juvenile justice placement facility unless prior arrangements have been made and approved by the facility director or designee and the child is accompanied by an adult.
- All visitors age 14 and over must be required to present valid picture identification upon request.
- Telephone calls to or from an attorney must not be counted in the number of calls a youth is allotted during any particular time frame, and there must be no limitation placed on the duration of any call to or from the attorney or his or her representative.
- Youth have the right to accept or decline a visit or phone call at any time before and during the visit and call.
- Youth have the right to contact and receive visits from Justice Center, OCFS Office of the Ombudsman, ACS personnel, etc. The Office of the Ombudsman and the Justice Center's contact information must be posted conspicuously in the facility. The Office of the Ombudsman is permitted the make announced and unannounced visits to sites to meet with youth. At any time, youth have the right to decline to meet with the Justice Center and/or OCFS Ombudsman during a site visit.
- Youth have the right to receive and make phone calls to approved contacts. Providers must continue to maintain eyes on, ears on supervision of youth during phone calls. When youth are contacting the Office of the Ombudsman or his/her attorney, staff must provide eyes on supervision only.
- Youth have the right to have visits with approved contacts. Provider must maintain eyes on, ears supervision of youth during visits. When youth are visiting with an Ombudsman or

his/her attorney, youth have the right to visit with representatives in private without being supervised by provider staff.

II.08.00 Youth Rights: Sibling Visitations

Providers must arrange frequent opportunities for sibling visits, communication by telephone, letters, and or other forms of regular and meaningful contact between youth and his/her siblings.

- It is the provider's responsibility to arrange and facilitate visits and other forms of contact between the youth and his or her siblings unless a significant concern is identified and documented or prohibited by court order. This is a collaborative responsibility for crossover youth between providers and the foster care agency.
- Providers are responsible for ensuring that diligent efforts are made to facilitate regular visitation or communication between minor siblings or half-siblings who have been placed apart, unless such contact would be contrary to the health, safety or welfare of one (1) or more of the children.
- These visits must occur taking safety and security into account.

II.09.00 Youth Rights: Mail

All youth must be allowed to send and receive mail.

- Programs will structure a process for all youth to receive and send out mail in a timely manner.
- Providers must pay for and provide postage and supplies as needed and requested.
- Providers may require the youth to open their mail in the presence of staff. Providers will distribute mail within one (1) day of arrival at the facility and will post outgoing mail promptly.

II.10.00 Grievance Process for Youth and Families

Youth and their families must have an effective and independent means of reporting grievances or violations of their rights without fear of retaliation.

- Providers must establish procedures for youth and their families to present complaints and grievances about the provision of any service in accordance to ACS policies.
- Providers must provide timely feedback to youth and/or staff on grievances and rectifications when grievances are determined to be justified or valid.
- The grievance process must be documented and kept in the youth's file. It should also include any follow-up steps taken by the provider and the outcome.
- Providers must advise youth and families of these procedures and of their right to appeal thereafter to ACS.
- The grievance process must contain an appeal process which allows a youth to request a review by the provider staff at varying levels of seniority, if not satisfied with a determination.
- Providers must report monthly the number, type, and the resolution of grievances to DYFJ CTH designee.

II.11.00 Soliciting Input from Youth

Each facility must have a formal process to capture the feedback of youth.

- Providers must make all efforts to ensure youth are involved in their services, programming, and permanency planning.
- During the normal course of the day and while supervising youth, staff must actively encourage youth to express their opinions and make choices.
- Providers must have practices in place to capture and incorporate youth's feedback. Examples of such practices include quarterly surveys, interviews at case closing, weekly house meetings, and suggestion boxes checked monthly.
- All surveys and protocols should be saved in a youth satisfaction survey log book.
- Youth should be part of the decision-making team that designs incentives, recreation, and leisure activities.
- Providers should make available all opportunities for youth to participate in formal youth leadership or advisory councils. For more information, visit Youth Leadership Council (nyc.gov)
- Agency Program Assistance (APA) will review provider's protocols and practices on capturing youth feedback during its annual organizational health assessment.

II.12.00 Photography or Video of Youth

Providers must obtain ACS approval and the youth's parents'/discharge resource's approval to include CTH youth in photos, videos, or recording of any program-specific information for distribution. This does not apply to use of CCTV for monitoring purposes.

- Staff and other adults working with youth can be filmed and/or photographed as long as no youth are identifiable. Any recordings of youth (events and/or interviews) are permitted if;
  - Parental/discharge resource and youth consent are obtained, unless youth are 18 or older;
  - Recordings focus on the impact of the program in the lives of youth;
  - Youth's actual name is not used; and
  - ACS reviews all recordings to ensure youth's identities and case information remain confidential and information is appropriate for distribution.
- When submitting requests to ACS:
  - All requests must include: the name of the provider, volunteer, or media outlet to conduct the filming/recording/photography.
  - Providers must provide responses to the following:
    - Are adults being photographed and/or filmed? If yes, what is their relationship to ACS?
    - Is this a one-time event? What is the date and exact location of the event? What is the event name and purpose?
    - Is this a project that will take place over time? Does the project have a name? What is the timeframe during which the project will be photographed and/or filmed?
    - When interviewing youth, is there a request to audio record the interviews? If yes, what's the intended use of the audio recordings (e.g., posting the recording online)?
    - Have the parent/discharge resource and youth agreed to the recording and the intended subsequent use of the youth's interview?

II.13.00 Preparing Youth for Adulthood (PYA)

In accordance with Preparing Youth for Adulthood (PYA), providers must ensure all youth in placement obtain relevant services, documents, and records before they leave CTH placement.

- In compliance with Preparing Youth for Adulthood (PYA), providers must:
  - Promote the development of youth's mental, physical, and emotional well-being;
  - Set developmentally appropriate expectations that encourage youth to achieve their highest potential in interpersonal relationships, career, education, and personal interest development;
  - Make efforts for youth to have the education and vocational training they need to succeed in the job market; and
  - Enable youth to be able to plan responsibly to meet their own needs for housing, food, clothing, health and safety as they mature into adulthood.
- For youth who are 17 or older by the time of discharge, the caseworker must complete and submit the PYA checklist summary.
- In preparation for discharge, providers must use the PYA final discharge summary to assess the youth preparedness for discharge.
- Where feasible, providers must have the following documents and/or referrals in place and available to the youth/parents/discharge resource before the youth is discharged from Close to Home:
  - Official or certified copy of a U.S. birth certificate, if applicable;
  - Social security card;
  - Medical records;
  - Health insurance information; and
  - ID card (School ID, NYC ID or State ID).
- If support is needed for undocumented youth, please reach out to the ACS Office of Immigrant Services and Language Affairs at 212-676-9021

II.14.00 Credit Checks

Each youth who has attained 14 years of age must receive, without cost, a copy of any consumer report that may be on file with any of the three (3) nationwide Credit Reporting Agencies (CRAs), pertaining to the youth each year until the youth is discharged from care, and receive assistance (including, when feasible, from any court-appointed advocate for the child) in interpreting and resolving any inaccuracies in the report, see [42 U.S.C. § 675 (5) (I)].

- Consumer reports are defined in **section 1681a(d) of Title 15**.
- The three (3) nationwide Credit Reporting Agencies (CRAs) include Equifax, Experian, and Trans Union.
- Youth must receive a copy of any or all consumer reports on file with each of the CRAs.
- All known addresses, current and historic, for the youth and young adult should be included when performing the annual requests for consumer reports.
- Staff must document all efforts to assist the youth in obtaining their credit reports in the case record progress notes in CNNX. Providers must keep a record and copies of all correspondence in the youth's physical case record and note when the credit report is blank or cannot be obtained.
- For youth who do not have a Social Security Number (SSN), the consumer report request must be completed based on the name and address of the youth.
- Providers must develop a protocol for requesting consumer reports for youth. The protocol must minimally include procedures that: protect the youth's identity and personal information from misuse, securely transfer the youth's information to CRAs, and securely collect, maintain, and document the results of the annual credit checks and any attempts to resolve inaccuracies in any consumer reports.
- Providers must meet with the youth to discuss the purpose of making the request for a consumer report even if there is no consumer report on file for the youth. Providers must teach the youth the importance of protecting and safeguarding his or her personal and confidential information. This should include a discussion about the importance of protecting his or her Social Security number by not carrying his or her Social Security card and/or by not showing it to others or sharing in non-secure ways online. Staff must also discuss with the youth the importance of maintaining an accurate credit history and the value of annually checking his or her credit to protect against identity theft or mistakes.
- If a youth age 18 or older objects to having his or her consumer report requested, staff must document efforts to comply with the law in CNNX.

II.15.00 Sexual and Reproductive Health of Youth

Providers must ensure that all youth in placement who are 12 or older, youth younger than 12 who are sexually active, or youth who request information are knowledgeable about their sexual reproductive rights and have access to sexual reproductive health education, counseling, and services.

- For all youth in placement aged 12 years and older, youth under 12 years who are known to be sexually active, and upon request from any youth, regardless of age, providers are required to:
    - Provide access to the full range of sexual and reproductive health services. This includes but is not limited to wellness exams, testing and treatment for sexually transmitted infections, pregnancy testing, options counseling (to decide on parenting, adoption or abortion), prenatal care, abortion services, birth control, HIV testing, treatment, pre and post exposure prophylaxis, etc.;
    - Provide information and access to age-appropriate sexual and reproductive health education, counseling, and services. Refusal of services must be documented in CNNX;
    - Accompany youth to all sexual and reproductive health appointments if requested by the youth;
    - Offer annual gynecological examination and/or male genital examination; and
    - Within 30 days of placement and every six (6) months thereafter, and as often as needed:
        - Notify youth of their right to Sexual and Reproductive Health services (SRH);
        - Notify youth in foster care of their right to have their Case Identification Number (CIN) in the event they wish to access SRH services and resources outside of the foster care agency;
        - Administer an STI risk assessment. Testing must also be considered when a youth returns from AWOC as part of the medical clearance or if there are concerns that the youth engaged in sexual activity; and
        - Offer youth access to sexual health services.
- The environment, manner, and/or communication in which a youth learns about and accesses SRH services is required to be nurturing, affirming, and respectful.
    - Conversations on SRH information and care must be trauma-informed and responsive to each youth’s individual needs.
    - Staff must demonstrate respect by using language and approaches that are not stigmatizing or shame-inducing.
    - Staff must be especially careful to avoid shaming language, tone or body language around topics where youth are often judged, including youth who: are pregnant or parenting, want an abortion, are involved with commercial sex, talk about the pleasure they derive from sex, are transitioning their gender, have sex with people of different genders, etc.
- Staff must be respectful of the youth’s Sexual Orientation, Gender Identity, and Gender Expression (SOGIE).
- Staff must not impose their personal beliefs regarding sexual and reproductive health on youth.

- Staff may not reveal or discuss any confidential SRH information about the youth to parents/guardians, and/or foster parents, unless the youth provides consent. In New York State, youth have the right to access confidential sexual and reproductive health services at any age without the knowledge or consent of their parents/guardians, foster parents, agency staff, ACS staff, or any other person.
- Providers must develop a sexual health and pregnancy prevention strategy focused on educating young people about safer sex practices, offering consistent messaging about dual protection (e.g., condom and hormonal methods), promoting the delay of early parenting, and avoiding unintended pregnancies.
- Referrals for routine sexual and reproductive health services must be made within 30 days of the request. Referrals for emergency contraception and termination of pregnancy, however, must be made immediately following the request.
- Sexual and reproductive health information (including but not limited to copies of documents, face-to-face conversations, youth refusals to medical services, etc.) of youth must be documented in the Health Narrative tab in CNNX and may not be disclosed to anyone without the youth's written consent unless specifically authorized by law. Providers must also file copies of documents in the youth's medical record.
- Youth have the right to sexual and reproductive health information in a manner that is nurturing, affirming, and respectful. If any organization, staff member, or foster parent acts in any way to avoid, withhold or otherwise deny this right, they are in violation of ACS policy and state law. If a youth feels they were denied their rights or not treated in an affirming manner, providers should inform youth of the contact resource: SRHsupport@acs.nyc.gov.

II.16.00 Pregnant Youth, Expectant Fathers, and Parenting Youth

Providers must ensure that pregnant youth, expectant fathers, and/or parenting youth receive timely education, counseling, and services to ensure the well-being of the youth and their children and/or unborn child.

- Providers must counsel and provide up-to-date information to all youth, with special attention to parenting and expectant parents, including information on topics such as healthy intimate relationships, co-parenting, and support services related to becoming a parent.

Pregnant Youth

- If providers become aware that a youth is pregnant, that youth's case planner and health services must be informed within one (1) business day of obtaining such information.
- Discussion and counseling regarding all available options must be provided by the youth's agency physician or designee as soon as possible, but no more than five (5) business days after a pregnancy confirmation by the agency physician or other medical provider. Within two (2) weeks following the pregnancy confirmation, staff or health provider and the case planner must meet with the pregnant youth to discuss all pregnancy options.
- Providers must counsel and offer information to pregnant youth in placement that covers all relevant issues including, but not limited to:
    - Living arrangements for the infant if the pregnant youth decides to continue the pregnancy to term;
    - An objective review and discussion of all options and their implications, including continuing the pregnancy to term, adoption, or termination of the pregnancy;
    - School attendance and other education services;
    - Childcare resources and referrals for the infant; and
    - Additional services and supports that are needed in order for the pregnant youth to remain in her current placement.
- Referrals should be made to options counselors who are trained to help individuals make informed decisions about pregnancy and to discuss, in an unbiased manner, all options available to youth.
- For youth who are considering a termination of pregnancy, providers must give access to nonjudgmental, unbiased information about abortion and access to services and/or make alternative referrals to a provider who offers these services to enable youth to make informed decisions about their pregnancies.
- Provider must refer pregnant youth who are considering maintaining their pregnancy to receive prenatal care immediately.
- Provider must refer youth to a "Maternity-Mother/Child Blended" (MMCB) program as appropriate and be made aware of options for postpartum care. Such care must be consistent with the New York State Department of Health (DOH) Prenatal Care Assistance Program (PCAP) regulations.
    - Referrals to NYC Office of Placement Administration (OPA) are made through CNNX. For additional information, call – (212) 966-8000.

- If applicable, following the termination of a pregnancy, providers must offer youth trauma-informed counseling and support by an appropriate licensed mental health or social work practitioner.

Expectant Fathers

- If a youth discloses that he is an expectant father, the youth's case planner must connect him to a Fatherhood Program at least 12 weeks before the expected birth, when feasible.
- If youth discloses that he has a child, his case planner should explore available programs, offer related materials, and/or refer when appropriate.
- Providers must offer training and inform all young men about their paternity rights and responsibilities regardless of their sexual orientation and gender identity. Topics should include, but are not limited to, parenting classes, co-parenting, addressing the importance of their involvement in the lives of their children, family planning counseling, child support and custody, links to local resources, mentors, and support groups, etc.

II.17.00 LGBTQ/Transgender and Gender Non-Binary Youth (TGNB)

All LGBTQ and TGNB youth must be in facilities that are affirming of their gender identities and sexual orientation. LGBTQ and TGNB youth must feel safe, supported, and affirmed in their placement.

- Providers must adhere to this agreement, ACS policies, and all laws applicable to the care and custody of youth who identify as Lesbian, Gay, Bisexual, Transgender, Intersex, or Questioning ("LGBTQ").
- Providers must utilize best practices to facilitate positive family reunification and functioning for LGBTQ youth.
- Providers must ensure that youth who identify as Transgender or Gender Non-binary (TGNB) receive services that provide holistic support, including Health Services, and take into account the youth's general well-being.
- Staff must model appropriate and affirming behavior always. This means that bias, discrimination, bullying, or harassment by staff or by youth towards other youth and/or families must not be tolerated and must be addressed immediately. Staff can demonstrate respect and safety by:
  - Asking youth about preferred names and pronouns
  - Using chosen names and pronouns;
  - Being careful to avoid "outing" a youth;
  - Ensuring youth have privacy in bathrooms and shower stalls;
  - Allowing youth to use gender-affirming clothing and personal/grooming products; and
  - Not making assumptions about a youth's sexual behaviors based on sexual orientation, gender identity, or gender expression or making assumptions about a youth's identity based on their behavior or expression.

<u>Affirming and Safe Environment</u>

- Staff must not attempt to convince a TGNB youth to reject, modify, or disclose their gender identity or gender expression under any circumstances.
- Providers must proactively take immediate action to prevent and intervene in any cases of bias, discrimination, bullying or harassment by staff or by youth towards youth and/or families.

<u>Reporting of Incidents</u>

- When bias, harassment, and discrimination of LGBTQ/TGNB youth and/or families arise, providers are required to report those incidents to MCCU.
- The site-specific LGBTQ point person should be notified immediately to make sure that the youth's needs are addressed.
- In addition to MCCU, the LGBTQ point person will report all incidents to ACS's LGBTQ Senior Advisor at LGBTQ@acs.nyc.gov.

Admission

- During the admission and placement process, all youth must be asked privately about their gender identity, preferred name, and preferred pronouns.
- Staff are prohibited from disclosing a youth's gender identity to other individuals or agencies, without the youth's permission, unless such disclosure is consistent with state or federal law or regulation.
- Staff must inform LGBTQ and TGNB youth when and how their gender identity may need to be shared with other professionals.
- Staff must use youth's preferred first name and gender pronoun when addressing the youth

Documentation and Records

- In instances where legal name or assigned sex must be used in documentation, this must be fully explained to the youth, and wherever possible/appropriate, the youth's preferred name and pronoun must be included in documentation.
- Consistent use of preferred name/pronoun must be documented in systems of record (e.g., log books and CNNX) after an initial documentation of the legal name of youth.

Bathroom Facilities

- Bathroom facilities must consider the safety and privacy needs of LGBTQ and TGNB youth.
- Providers must proactively create policies and procedures that outline how LGBTQ and TGNB youth are able to access a private space or time in the shower and bathroom. All youth must be allowed to use individual stalls, within commonly accepted time limits, and be allowed to shower privately.

Hair, Personal Grooming, and Clothing

- TGNB youth must be permitted to use approved forms of personal grooming consistent with their gender identities.
- TGNB youth should wear approved clothing that is consistent with their gender identity.

Referrals to Transgender-Inclusive Services and Medical Transitions

- If a youth discloses that they are transgender or gender non-binary, they must be offered the opportunity for health, mental health, and other services that are transgender-inclusive and affirming.

Hormone Requests While in Care

- If a youth makes a request to begin hormone therapy while in ACS's custodial care, they must be promptly referred to a LGBTQ culturally competent medical and mental health provider for an evaluation.
- If a youth was on medically-supervised hormone therapy, it is to be continued just like any other medication. If a youth had been using non-prescribed "street" hormones, a prompt evaluation from medical/MH provider is warranted for examination and continuation of treatment. It is not best practice to abruptly stop hormone replacement therapy.
- For NSP-placed youth requesting to begin or continue hormone therapy, the medical provider, in consultation with the youth's case planner, must initiate a request for financial support and treatment through the Non-Medicaid Reimbursable (NMR) Treatment for Youth in Foster Care.

- For all youth under the age of 18 in ACS's custodial care, appropriate consent from the youth's parent/legal guardian must be first sought and obtained as required by law and/or ACS's policy.

LGBTQ and TGNB Literature and Programming

- Staff must make available LGBTQ and TGNB affirming literature and resources to all youth, including but not limited to, information about available support, website lists of community resources, books, youth rights and responsibilities, procedures for reporting complaints, and copies of related ACS policies.
- Providers must post LGBTQ/TGNB affirming art (i.e., posters), such as Pride, the Trans March, etc. throughout the facility.
- Providers are required to designate an LGBTQ point person. This person is required to receive LGBTQ cultural competency training, maintain a record of all LGBTQ-related issues that arise within their agency (including but not limited to reports of harassment or bias, and any unmet needs at the facility). In addition to MCCU, this person will report all incidents to the ACS's LGBTQ Senior Advisor at LGBTQ@acs.nyc.gov.
- Providers must refer LGBTQ youth or interested youth to LGBTQ community-based organizations.

II.18.00 Immigration Services for Youth in Placement

Providers must promptly identify the need for immigration services for youth placed at the facility. Youth who need immigration services must be referred to immigration legal services in a timely manner.

- Providers must never contact United States Citizenship and Immigration Services (USCIS) or Unites States Immigration and Customs Enforcement (ICE) to discuss a family member's or youth's immigration status or any immigration application, including Special Immigration Juvenile Status (SIJS).
- Providers are required to identify all immigrant youth in their care who do not have US citizenship or lawful permanent residence. The provider's admission form must include questions to determine the youth's country of birth.
- Providers must provide youth and their families, families who are not US citizens or do not have documentation of lawful permanent residence, the pamphlet "Immigration Assistance for Children and Families" and inform immigrant youth and their families of the availability of free or low-cost immigration services and the benefits of securing legal status.
- If a youth is found eligible to obtain lawful permanency residency status through SIJS, providers must:
    - Make reasonable efforts to secure the necessary documents, including but not limited to, passport, birth certificate, court orders and dispositions, medical examination, and other identification papers and submit the appropriate application.
- In addition, providers must:
    - Designate a SIJS/Immigration liaison or point person who will be the contact person for immigration services;
    - Document in CNNX the country of origin of youth and whether there is proof of US citizenship or lawful permanent residence in the youth's file;
    - Promptly notify the ACS unit of Immigrant Services when an immigrant youth is identified and of any referrals made to an immigration legal services provider;
    - Refer youth to an immigration legal services provider within four (4) months of being initially placed at the facility or within 60 days of determining youth's citizenship status if the initial four (4) months have passed;
        - Referrals must be documented in the FASP in CNNX as a service need.
    - Record in CNNX progress notes on all immigration related services, contacts, and actions; and
    - Provide training on SIJS and other immigration relief topics for the SIJS liaison and other staff who work directly with youth and families on SIJS.

III.01.00 Living Environment

Providers must maintain a clean and healthy environment for youth, staff, and visitors. Providers must ensure that facilities are clean, well-maintained, and free from hazards and infestations. Providers must also have temperature controls, lights, ventilation, and a fully functioning engineering system (e.g., HVAC) in place.

- Providers must maintain a setting that is as home-like and as non-institutional as possible and displays indicators of therapeutic efforts.
- The living environment must be welcoming of all youth in placement regardless of their age, developmental level, language, disability, background, sexual orientation, gender, gender identity, race, ethnicity, culture, etc.
- Facilities, including the exterior of the building, private offices, common areas, bedrooms, bathrooms, kitchens, and other spaces, must be clean, well-lit, appropriately furnished, and well-maintained.
- Providers must comply with all applicable health, building, fire, and safety regulations.
- Facilities must be free from infestation by rodents and insects, including bed bugs.
  - Providers must develop internal protocols to prevent, manage, and contain the spread of bed bugs. If staff find evidence of bed bugs (e.g., bites on a youth), they must immediately alert the facility director and report to MCCU.
  - The facility director must notify Agency Program Assistance (APA) within one (1) day of the discovery and provide the APA monitor and PPS worker with a written plan on how they will take action to address the problem.
  - Providers must conduct reasonable diligent efforts to remedy concerns within two (2) days of the discovery.
- Common areas in the facilities must be free of hazards, including but not limited to:
  - Peeling paint, cracked plaster, water stains, and holes in walls/doors/ceilings;
  - Unlit stairways/halls/entrance areas;
  - Cracked or broken windows;
  - Frayed or exposed electrical wiring;
  - Improperly stored combustible or poisonous substances;
  - Excessive litter or soil;
  - Unsanitary or unusable bathroom facilities;
  - Lack of operative charged inspected fire extinguishers;
  - Inoperable smoke or fire alarms;
  - Uncapped electrical outlets (exposed wires);
  - Extension cords;
  - Torn carpeting or unsecured rugs/runners; and
  - Holes in the flooring or missing/broken tiles.
- Facilities must have fully functioning heating, ventilation, and cooling (HVAC) systems and lighting adequate for the square footage of the facility.
- Noise levels in the facility must be conducive to a therapeutic, home-like setting at all times. Staff must be able to hear youth interactions and conduct necessary programming.

III.02.00 Accommodating Stated Capacity with Sufficient Space

Facilities must be designed to accommodate their stated capacity and have sufficient space and resources available to meet the living and service needs of their youth. Facilities must have sufficient recreation, reception, visiting, sleeping, daytime/dayroom, bathroom, clinical services, and other space and resources for their youth.

- Facilities must have adequate space, or have pre-arranged assured access to space, for outdoor recreation. The space must be able to accommodate an appropriate range of recreation activities for individual youth and/or groups (e.g., basketball, martial arts, aerobics, flag football, double-dutch, etc.) and, as applicable for the facility, must have shaded areas.
- LSP facilities must have sufficient space for indoor recreation activities that can safely accommodate large muscle activity (e.g., basketball, lifting weights, yoga, etc.).
- NSP facilities must identify space or opportunities for youth to engage in large muscle activity. NSP facilities must consider alternative space during inclement weather.
- Each living unit with eight (8) youth or less must have a minimum of two (2) sinks, two (2) toilets, and one (1) individual shower for use by youth in the unit. Each unit with nine (9) to twelve (12) youth, must have a minimum of three (3) sinks, three (3) toilets, and two (2) individual shower for use by youth in the unit.
- Staff and visitors must have separate lavatory and toilet facilities from youth.
- Facilities for specialized populations must also adhere to any specific design requirements specified by ACS or OCFS.
- Facilities must have sufficient space for the range of on-site services offered (e.g., treatment, education, visiting, and other programming).
- Individual clinical/counseling sessions must occur in a private setting.
- Providers must notify ACS in writing at least 90 days prior to any proposed changes to the facility spaces and must receive written approval from ACS prior to changing the space (See I.11.00).
- Facilities must have adequate space for storage and maintenance needs.
- Common areas must have sufficient chairs and tables to accommodate programming and recreational activities.

III.03.00 Therapeutic Culture

Providers must promote a therapeutic culture that encourages positive, respectful, and supportive interactions among youth, staff, family, and visitors.

- All persons in the facility are to be treated with respect and dignity. The culture and daily living experience must promote positive behavior, personal growth, rehabilitation, and address past experiences of trauma. Signage and posters reinforcing respectful behavior must be conspicuously posted in all shared living spaces, common areas, and in staff lounges and offices.
- Providers must promote a safe and respectful environment as it relates to all other aspects of the identity of youth (e.g., race, ethnicity, religion, language, etc.).
- Providers must promote a safe and respectful environment for lesbian, gay, bisexual, transgender, questioning/transgender non-conforming (LGBTQ/TGNB) youth and their families (See II.17.00).
- Providers must post LGBTQ/TGNB affirming art (e.g., posters) honoring Pride, the Trans March, etc. throughout the facility.

Therapeutic Interventions

- Providers must provide therapeutic interventions, peer-support, and group-work/collaboration for youth throughout placement through the end of disposition in accordance with ACS policies and the applicable program model requirements.
- Providers must provide specific targeted therapeutic services to youth that incorporate the Youth Level of Service (YLS) findings and addresses criminogenic needs as part of the treatment goals and objectives.

IV.01.00 Admission

Providers must have trained staff available to receive new admissions from ACS upon request.

- Providers must accept all youth placed by the Administration for Children's Services in its care in accordance with these Quality Assurance Standards. Providers are expected to receive and support all placed youth. Any questions or concerns regarding appropriateness of placement should be addressed to the Intake Supervisor.
  - Any concerns regarding youth placement should be addressed to Assistant Commissioner for Close to Home.
- Upon intake, the youth must be issued a youth handbook and must be oriented to the facility. This includes going through program rules, assigning youth a room or bed, introductions to staff and youth, and providing phone call to parent/discharge resource.
- Providers must have resources available for youth who do not speak English or have limited English proficiency.
- Providers must develop policies and procedures regarding the intake process for youth and clearly delineate the types and intensity of services provided to meet the needs of youth.
- Providers must have staff available during business hours to receive intakes from ACS including staff available to transport the youth from his current location to the facility.
  - ACS Intake team will attempt to provide as much advance notice as possible regarding intakes outside of business hours.
- The admission process must occur immediately upon the youth's arrival to the facility.
- At a minimum, the admission process must include the following within 24 hours of placement:
  - A photograph should be taken to capture the youth's face;
  - Notification to the parents or guardians of where the youth is placed;
  - Youth must be allowed to make a call to parent/discharge resource;
  - A review and inventory of youth's personal property;
  - Issuance of facility issued items, housing assessments/classification; and
  - Notification to MCCU that the census has changed.

IV.02.00 Admission Screenings

Providers must have screening procedures to identify youth with acute or urgent health or behavioral health needs, and those at risk of suicide, sexual aggressiveness, or victimization.

- Providers must use the DYFJ Screening Form to conduct screenings and document that screening was conducted in the Communication Log, in CNNX, and the paper record. Each youth must have a health, mental health, and a suicide prevention screening completed by a trained or qualified staff within one (1) hour of intake/admission. Trained non-clinical staff may perform the screening. All screenings must occur in a designated private location that preserves confidentiality.
- Providers must establish policies and procedures that define the screening process and clearly delineate the types and levels of actions/interventions provided to youth that meet the acute, urgent needs, or risk of aggressiveness or victimization designations.
- Providers must conduct the CSEC screenings as outlined in ACS policy.

Admission to Facility

- Providers must contact a youth's family within 24 hours of the youth's arrival at the intake facility.
- Providers must conduct a security search of each youth upon arrival to check for contraband. In accordance with ACS policies, which require the youth to wear a medical gown or robe that protects youth's privacy/is not sheer. If youth is not in a private space (e.g. bathroom stall, behind curtain, etc.), gown/robe should be worn after removing his/her upper garments and before removing all of his/her undergarments. Security searches must also include the use of a hand-held metal detector.
- Providers must prepare an inventory of each youth's clothing and personal belongings.
- For LSP sites, providers must ensure that each youth receives the education requirements related to Prison Rape Elimination Act of 2003, Pub. L. 108-79, 117 Stat. 971 ("PREA"), by distributing PREA-related materials and answering any questions youth may have about PREA.

IV.02.01 Response to Screening Results

Staff must immediately respond to all acute or urgent risks/needs identified during intake screenings by referring youth to an appropriate professional for further evaluation and/or by taking any other actions to address the health, safety, and well-being of the youth and others.

- Providers must establish procedures/protocols that clearly define responses to identified health needs including instances that require further evaluation and/or actions to address the health, safety, and well-being of the youth and others. The protocol must include documentation in CNNX and youth's medical record. All staff must be trained on the protocol and it must be available for ACS review upon request.
- Staff must immediately respond to identified urgent needs and safety concerns.
- Where the screening indicates a need for mental health services, providers must ensure that a qualified staff member or mental health professional fully assess the youth within 72 hours of the intake screening and facilitates the provision of appropriate mental health services to the youth.
  - The mental health assessment must include at minimum: obtaining the history of the youth's treatment with medications and his/her response to such treatment including allergic reactions; obtaining the youth's history of suicidal, self-harm or violent behavior; obtaining the youth's history of victimization or exposure to traumatic life events; obtaining the youth's social history; obtaining the youth's history of substance abuse; if applicable, obtaining the history of the youth's present illness(es); an assessment of the youth's current mental status including, but not limited to, suicidal and homicidal ideation; obtaining pertinent family history; conducting interviews of the youth's parent(s) and/or legal guardian(s); and a review of the youth's prior health services records.
- If a non-urgent need is identified, referrals must be made within three (3) business days.
- Providers must have staff available to respond to all acute or urgent risks and needs identified during intake screenings. This includes scheduling on-call staff that can make decisions regarding further evaluation and/or action steps following the identification of an acute or urgent risk/need.
- If an urgent medical need is identified, the youth must be taken to see an appropriate medical professional ASAP/immediately depending on the need (e.g., youth comes in and says they have diabetes and no insulin; youth complains of a headache that is unabating, youth is feverish, etc.).
- When a youth is transferred between CTH sites, youth must be medically cleared upon arrival to new site.

IV.03.00 Review and Incorporation of Admission Information

As part of the assessment process, staff must review and incorporate into the youth's juvenile justice service plan all information available from youth's time in detention (e.g., CTH pre-placement summary, the care passport, and the simplified juvenile justice service plan) and from other sources (e.g., service probation, providers, prior placement, parents and foster parents, etc.).

Initial Intake Screening

- Staff must complete an initial review of all existing documentation (e.g., assessments, recommendations, safety plans, and medications, etc.) with regards to problematic substance use, trauma exposure, depression, commercial sexual exploitation, medical, dental, psycho-social, and YLS information immediately and no later than 24 hours after the youth's admission to the facility. Additionally, providers must obtain any clarification or additional information needed of existing documentation.
  - A summary of the existing documentation must be synthesized with the intake screening and documented in CNNX.
  - This should include but is not limited to, a review of the following: 1) detention pre-placement mental health assessment; 2) care passport; 3) previous assessment completed by Family Court or Probation; 4) family contact, etc.
- Providers must create food, medication, etc. allergy lists for all youth within 24 hours of arrival to the facility.
  - The food allergy list must be posted in the kitchen area conspicuously.

Comprehensive Assessment

- Providers must conduct comprehensive assessments of each youth and include new information ongoing throughout the provision of services.
  - The assessment must include a review of dental, hearing, vision, and general physical condition; behavioral health, including mental health, substance use/abuse, risk of self-harm, traumatic stress, and risk of sexual aggressiveness or victimization; risk of sex trafficking and sexual exploitation/victimization; and psychosocial needs; education; criminogenic needs; protective and responsivity factors of family and peers; attitudes, beliefs; and pro-social skills.
  - To complete this comprehensive assessment, providers must use all available information to determine if further assessments and/or services are needed. This includes:
    - Reviewing the results of all previous screenings and assessments and performing any necessary follow up by making arrangements for treatment of any identified conditions and health/mental health needs.
    - Considering health, mental health, and/or substance use issues.
    - Using multiple sources of information to inform the assessments including the intake packet, youth interviews, observations of youth's behavior, interviews with family/guardians, probation reports, and reports from previous service providers, as applicable.

        - Including consideration of underlying causes and contributing factors for each identified risk to a youth or their siblings in the household so that the intervention strategies effectively address the risks.
        - Assessing each youth's strengths, needs, and long-term goals to formulate a service plan that includes therapeutic and long-term goals and outlines steps to achieve such goals.
    - Assessment should have criminogenic focus rooted in the Risk Need Responsivity framework and include synthesizing and utilizing information to inform and prioritize further assessment and need areas.
    - Providers must ensure that the mental health professional that performs the mental health assessment documents a written explanation of how the youth's symptoms meet diagnostic criteria for the primary diagnosis or diagnoses and which diagnoses were ruled out.
    - Providers must include documentation of a comprehensive health assessment which includes a physical exam and dental assessment within the ninety (90) days prior to placement or arrange for one within 30 days after placement.
    - Results of assessments must be documented in CNNX in biopsychosocial format and originals must be filed in the appropriate youth record.
    - If providers are unable to offer a comprehensive array of such services to youth in their care, providers must establish formal referral and treatment arrangements.
    - Any specific recommendation must be followed up on to ensure continuity of service for the youth.
- Upon identification of a youth with a pre-existing health condition (including mental health or dental conditions), providers must, in conjunction with ACS, use best efforts to contact such youth's parent/legal guardian and/or health services providers in order to obtain information required for the on-going treatment of such youth.
- Upon indication of a youth with a current clinical distress or need that requires immediate attention by a health services provider, providers must refer the youth to an appropriate health services provider and document the referral.
- In the event an active or chronic illness or condition exists, providers must coordinate and communicate with ACS and other appropriate parties, including the prior LSP or NSP, to ensure continuity of care and that the youth's health needs are being addressed.

IV.04.00 Care Coordination

Providers must designate appropriate staff to maintain care coordination for all youth from intake, through receipt of services, to discharge.

Health Records

- Providers must create, secure, maintain and update health services records for each youth and use a format, forms and/or databases approved or authorized by ACS. Providers must be responsible for the overall management of health services records. Providers must document each clinical encounter with each youth in the youth's health services record.
- Providers must maintain accurate and legible health services records.
- Providers must organize and store all health services records in such a manner to ensure that a youth's health services record can be located in an efficient and timely manner. Charts will be stored and organized in a manner that is approved by ACS.
- In the event a youth is transferred to another service provider or residential facility, providers must ensure that a copy of the youth's health services record is transferred to such new provider within 24 hours of a youth's transfer and a youth's individual supply of medication is transferred, with applicable parent consent forms, to such provider with the youth.

IV.05.00 Medical Services

Providers must provide comprehensive medical care to youth including the identification and treatment of emergency and/or serious acute health conditions. Providers must be responsible for the interim management and treatment of chronic/serious health conditions and ensure that a medical professional is on-call and available for consultation by telephone at all times.

Consent to Treatment

- Within ten (10) days of a youth's arrival at the facility, providers must request written authorization from the youth's parent or legal guardian, as appropriate, for health services for the youth including medical and/or psychological assessments, immunizations and treatment, and for emergency medical or surgical care if such becomes necessary.
- Providers must make diligent efforts to contact the youth's parent or legal guardian, as applicable, to obtain their consent for health services for the youth whenever there is a significant change in the health status of the youth requiring non-routine medical attention, surgery or administration of psychotropic medication. If consent cannot be obtained, then a court order must be sought.
- Providers must ensure that all consent forms are retained in the case record, health record, and CNNX health narrative as part of the youth's health history.

Ongoing Treatment and Evaluation

- If ACS or a youth make a request for medical services for youth, providers must assess the need for immediate treatment or medical services and schedule follow up as needed within three (3) business days. In the event a youth is not examined within such period, the provider must notify ACS and fully document the reasons why an examination was not conducted in such period.
- Providers must ensure that integrated, coordinated, and non-duplicated mental health services are provided to all youth.

Dental Services

- Providers must provide comprehensive dental care and the identification and treatment of emergency and/or serious acute health conditions to youth receiving residential services including, but not limited to:
  - Oral hygiene education;
  - Regular dental examinations and fluoride treatments, x-rays, cleanings, fillings, composite fillings, sealants, extractions (excluding molar extractions), and other standard dental treatment (e.g. crowns, posts); and
  - Follow-up treatment related to chronic and acute conditions, preparation for specialized dental services such as root canals, molar extractions, or oral surgery.
- Providers must ensure that each youth receives a comprehensive dental evaluation and cleaning within thirty (30) days of such youth's arrival at the facility unless the youth

received a comprehensive dental evaluation and cleaning within the six (6) months immediately prior to such youth's arrival at the facility, and the provider is able to obtain up-to-date health services records that includes records from the youth's most recent dental evaluation and cleaning.

- Providers will ensure that each youth receives appropriate follow-up treatment and cleaning every six (6) months while such youth is receiving residential services.

Health Education

- Providers must offer on-going preventive health services and individual health education to all youth.
- The health education topics must include the following, as relevant to the youth's needs and circumstances:
  - Information about the physical and mental effects of substance abuse and other social issues related to substance abuse;
  - The use of and effects of psychotropic medications;
  - Sexual and reproductive health topics including (a) comprehensive sexually transmitted infections (STI), and (b) HIV/AIDS education (e.g. adolescent-centered rapid and standard HIV/AIDS counseling);
  - Pregnancy and parenting information for youth (male and female) with children; and
  - Asthma, diabetes, or other chronic illnesses or conditions related to the management of and coping with such illness(es) and condition(s).

Preventive Services

- Providers must offer HIV/AIDS testing to youth and facilitate completion at the facility or offsite.
- Providers must provide and administer immunizations as appropriate and as required by law.
- Providers must provide smoking cessation services for youth.
- Providers must provide nutrition education.

Laboratory Services

- Providers must provide or purchase all laboratory and testing services required to fulfill its contract obligations including, but not limited to, conducting blood tests, urine tests, and other tests in connection with the comprehensive health assessment of a youth, and conducting appropriate chemical testing for alcohol and other drugs.
- Providers must ensure that all laboratory and testing services possess and maintain all necessary licenses, permits, or other registrations required by law in the State of New York.
- Providers must ensure all necessary and requested laboratory (e.g. blood, urine) tests are conducted and results of such tests are collected and documented, as required by law.

Infection Control

- Providers must provide an effective infection control plan that is reviewed and updated annually and, at minimum, addresses the screening and treatment of youth with communicable diseases (e.g. tuberculosis, varicella, blood-borne pathogens, meningitis,

methicillin-resistant staphylococcus aureus (MRSA), measles, gonorrhea, syphilis, lice, etc.), protocols for the temporary relocation or isolation of youth with communicable diseases, and the collection, containment and disposal of biohazardous/medical waste. Providers must incorporate all changes to the provider's infection control plan required by ACS and revise a previously approved infection control plan upon request by ACS.

General

- Providers must ensure that all health services are provided by qualified staff or a qualified health services provider as required by ACS policies. Providers must provide proof of such licensure and/or registration to ACS upon request.
- Providers must ensure required medical services are available at the facility or on an on-call basis 24 hours a day, 7 days a week.
- Providers must ensure that youth and their families are engaged in planning for the provision of medical services following the youth's release from Close to Home.

IV.06.00 Family Team Conference Model (FTC)

Providers must utilize the FTC model as a fundamental approach to treatment planning.

- The FTC model is designed to engage families, foster families, community members, relatives, and other adults who care about the youth, in open, honest, and critical decisions related to child safety, risk, well-being, placement stability, permanency, and service planning. Within this model, decisions are made jointly, and service plans are developed by the family, social and community supports, and service providers.
- Providers must participate in all FTCs.
  - The ACS CTH FTC scheduler takes the lead in coordinating all FTCs with the assistance of the provider and PPS worker. These FTCs provide a regular forum to discuss the family's progress towards the services goals and to adjust the service plan when deemed necessary.
- All FTC meetings should address aftercare planning.
- FTC meetings should include general housekeeping (e.g. parental consents) as needed.
- There are six (6) routinely scheduled FTC conferences including (see CTH timeline):

Transition Team Conference (occurs in 13-15 days following disposition)

- Providers are introduced to the youth and family in the detention facility.
- A snapshot of the youth's strengths and need areas are presented and the youth is transported to their assigned residential facility following the meeting.

Initial Team Conference (occurs within 30 days of placement)

- Providers share how the youth has been adjusting to the program.
- The need areas of the YLS are reviewed and providers should come prepared to discuss which areas they think should be prioritized for treatment.
- At the end of the meeting, a YLS informed service plan that addresses what need areas are being targeted, the goals, and the interventions/activities that will be used to achieve such goals should be fully developed (see Juvenile Justice Service Plan).

Comprehensive Team Conference (occurs in days 90-120 for 12-month placements and days 120-180 for 18-month placements)

- Providers discuss the progress occurring with the youth and family, including any barriers, and the YLS is thoroughly reviewed and updates are made as necessary.
- Aftercare planning is a major focus and specific referrals needed to help integrate back into the community are outlined.

Release Team Conference (occurs 30-45 days prior to release)

- Providers, with collaboration from the PPS, will finalize the youth's aftercare service plan that is based upon YLS results/youth developmental needs.
- Providers and PPS should establish the initial aftercare supervision plan.

Community Team Conference (occurs 45-60 days after release to aftercare)

- It is essential that providers are present during this conference to discuss how the youth is adjusting to being back in the community and what their response to services has been.
- A comprehensive review of the new YLS (IX.06.00) will take place and the PPS and provider will use this information to drive the frequency of the contacts (i.e. supervision matrix).

Graduation Team Conference (occurs 30 days prior to the end of placement)

- Providers and PPS will review the achievements and challenges and establish/reinforce ongoing service needs and referrals.
- Depending on timeframe, this can be combined with Community Team Conference with approval by PPS.

- In addition to the above six (6), Elevated Risk Conferences are held when needed (e.g., youth is an AWOC return, youth is re-arrested, youth is part of a critical incident, youth needs a change, etc.). Providers, PPS, and all networks of support participate in brainstorming how to remedy the concerns brought up while using a positive youth development and community safety lens.

IV.07.00 Juvenile Justice (JJ) Service Planning

Individual service plans must be informed by the assessed criminogenic needs of each youth. Plans must be built on the strengths of the youth and focus on identified responsivity factors that create barriers to addressing assessed needs. Juvenile Justice plans must be developed on a timely basis and include interdisciplinary input. Providers must utilize the YLS/Case Management Inventory (CMI) results to develop case management strategies and identify individualized service interventions that support progress towards improvement for each youth in care.

- Providers must create a written service plan for each youth receiving services.
- Individual service plans that include RNR (Risk, Need, and Responsivity) focused goals and action steps must be incorporated into all agency planning documents for all youth.
- The plan should limit the focus of the service plan to the top two (2) to three (3) needs for each youth that strategically can make the most impact. If the highest need areas are not selected, then include a rationale for the deviation and include the PPS team.

Service Plan Development

- Providers must ensure that all youth are encouraged to participate in the design of their service plans and goals. Providers must not exclude youth and/or youth's family from participating in the design of the youth's service plan unless the provider deems such participation inappropriate and ACS has given prior written consent.
- Providers should ensure the following educational components are being done:
  - Providers must integrate the educational plans/educational transition plan into the service plan for each youth, where practicable.
    - Providers must document progress, changes, and any other relevant information regarding the youth's education plan in CNNX within five (5) business days.
- Plans must identify risk areas that will most effectively reduce criminogenic behavior including:
  - Identification of the domains that are prioritized for treatment;
  - Specific, measurable, achievable, relevant, and timely (SMART) activities related to identified needs areas;
  - Responsivity factors that need to be addressed;
  - Youth strengths;
  - Action steps and services required to achieve goals; and
  - Assigned responsibility for actions steps.
- The JJ Service Plan must be completed by day thirty (30) of a youth admission to residential placement and is formally adopted at the Initial Team Conference.
- Service plans are reviewed monthly, at a minimum, as part of the treatment team and planning process.
- The YLS must be re-administered by the PPS prior to the Comprehensive Team Conference and prior to the Community Team Conference. This is done to monitor changes in risk, service needs of the youth, and to inform aftercare planning.

- PPS will share the results of both re-assessments with the provider.
- Providers must review the results of the YLS and use it to inform the following:
  - The in-program intensity, level of service and case planning, and service referrals during residential placement that are responsive to criminogenic needs; and
  - The selection of aftercare supervision intensity and service interventions that appropriately address risk factors and are responsive to criminogenic needs.
- During both FTCs (Comprehensive and Community) the JJ Service Plan will be reviewed and updated as necessary. The case planner is responsible for updating and documenting the service plans in CNNX.
- The purpose of reviewing the JJ Service Plan at all treatment team meetings is to ensure that the goals of the service plan are aligned with YLS need areas.
- Providers should utilize a standard form when documenting the YLS during Treatment Team meetings. The form should clearly highlight the youth's YLS domains, risk level and goals/activities.
- Service planning is an interdisciplinary and inclusive process. Team members include: youth, parent/guardian/discharge resource, all relevant NSP/LSP staff (e.g., case planner, social worker, clinical staff), ACS PPS and child and family specialist (CFS), active community-based organizations, and any other identified support in the youth's life.

IV.08.00 Engagement of Family and Youth's Support Network in Service Planning

Staff must actively engage youths' parents, guardians, discharge resources and/or other social supports in the youths' service planning and programming.

- Providers must encourage youth and their families/discharge resource to make every effort to participate in service plan meetings (treatment team, initial, comprehensive, etc.) including assessing and addressing any barriers that make it challenging to participate in the treatment team meeting (e.g., transportation, childcare, work schedule) and other service plan meetings as often as possible. Providers must make all efforts to schedule at least one (1) treatment team meeting per month to accommodate youth/family availability.
- Providers must make every effort to schedule all service planning meetings at days, times and locations that accommodate the family's needs. Providers must document attempts to engage the family in service planning.
- Providers should document invitations issued to youth and their families to attend treatment team meetings in Connections.
- If all scheduling options have been exhausted and parents/discharge resources are unable to attend meetings in person, parents/discharge resources must be allowed to participate via telephone or videoconference. In cases where teleconference strategies are not possible, the family's feedback must be formally documented and indicate if the family approves or disapproves of the recommendations presented to them.
- If families cannot participate, providers must create a mechanism that allows for youth and families to receive updates on the details of the treatment team meetings. If parents do not attend, the case planner must provide an overview of the outcome and next steps.

Family Engagement and Identification of Network Supports

- Providers must identify family resources and/or a network of support for each youth.
- Providers must sustain engagement of and outreach to a youth's family and/or network of support throughout placement, to the extent possible, and include ongoing consultation on both the planning and provision of treatment to the youth.
- Providers must perform outreach to and engage a non-custodial and/or incarcerated parent to the extent possible unless restricted by court order.

Family Therapy

- Each family must be offered family therapy, as indicated.
  - If YLS score is high or moderate in Family Circumstances/ Parenting/or as part of court order, family therapy must be offered as part of the top three treatment goals.
  - Other examples signaling need for family therapy, might include family team conference, changes to family dynamics, issues during family visits, etc.
  - If family is not willing or prepared to engage in family therapy, efforts to engage must be documented.
- Family therapy must be provided by qualified professionals (i.e. licensed clinicians and/or licensed clinical supervisors/directors.)

- Family therapy should occur from the onset of placement and through the expiration date. Best practice indicates a frequency of, at a minimum, once per month. As indicated based on assessment and YLS needs, frequency will be increased at minimum to biweekly. Dependent on needs and/or point in placement (i.e. such as preparation for release or while in aftercare), family therapy is encouraged to occur more frequently.
- During family engagement, caregivers must be provided with information on the evidence-based/informed treatment model being utilized for the youth's treatment. This includes knowledge/utilization of skills, language, and appropriate interventions used in placement. This should be completed with the goal of bridging continuity of care upon youth's transition into the community. This should be clearly captured during orientation in the Parent Handbook.
- Caregiver/discharge resource's input must be actively engaged in developing a treatment plan and goals pertaining to family therapy. This will be captured in the Service Plan Review (SPR), Family Team Conferences (FTC), and CNNX.
- Family therapy, including all attempts to hold family therapy, must be documented in CNNX.
- Treatment progress or lack of progress in family therapy must be documented, including barriers to engagement and methods to address barriers.
- Family therapy referrals (i.e. MST, FFT, outpatient family services, etc.) must be made to individuals who receive family therapy while in placement if a need persists beyond placement.

IV.09.00 Concurrent Planning

Providers must begin concurrent planning on the first day of placement to achieve permanency for youth.

- Concurrent planning for permanency must begin at admission/intake.
- Concurrent planning is ongoing and requires constant assessment.
- The goal of concurrent planning is to ensure each youth has an appropriate and stable permanency resource or, if the goal is APPLA, a significant connection to a trusted adult. This permanency resource must be in place at the time of the youth's release to aftercare.
- Efforts must be made to identify all possible resources including all biological parents, extended family, foster parents, and other potential positive adults.
- Providers must work towards reunification, while at the same time establishing an alternative permanency plan for each youth.
- Providers must engage all family members/resources of youth, including foster parents, if applicable, in planning for the youth's well-being and permanency of youth.
- Providers must maintain frequent efforts to communicate with case planning agencies and foster parents of youth about case plans, progress, and decisions.
- Concurrent plans are reviewed and updated as necessary at all team conferences and treatment team meetings.
- Providers must seek assistance from the PPS when a permanency resource cannot be located, or resources are not engaged in planning.
- Provider must make a good-faith effort to ensure all identified permanency resources are actively involved in all conferences and given an opportunity to engage and present their ideas, concerns, and opinions.
- To allow for informed decision-making, providers must ensure all involved parties have been made aware of their rights and responsibilities. This includes, but is not limited to, expectations of parents upon youth return and the consequences should those expectations not be met.
- The youth and his or her family/resources must be involved in the discussion and decision-making process to the greatest extent possible.
- Providers must identify and address the needs of all permanency resources.
- In the case of children with the permanency planning goal of another planned living arrangement with a permanency resource or adult residential care, concurrent planning should include:
  - Mobilizing and encouraging family support of the youth's efforts to function independently, and to increase his/her capacity to be self-maintaining;
  - Evaluating the ability of the parent(s) or relative(s) to establish or reestablish a connection with the youth and serve as a resource to the youth; and
  - Where appropriate, the providers should encourage an ongoing relationship between the parent(s) or relative(s) and the youth.
- Providers are responsible for recording child and resource characteristics in CNNX in accordance with OCFS Administrative Directive 18-OCFS-ADM-13 matching children to the best available foster care placement.

IV.10.00 Casework Contacts

Providers must provide casework contacts in accordance with *Title18NYCRR Parts 441.21, 423.4, and 443.4* or any successor or amended regulation.

- As defined in Title18 NYCRR Part 441.21, casework contacts with the youth is defined as individual or group face-to-face contacts between the case planner, or the caseworker assigned to the youth. Casework contacts must be made weekly with the youth.
- As defined in Title18 NYCRR Part 441.21 casework contacts with the youth's parent(s), family, extended family, or other discharge resources is defined as individual or group face-to-face contacts between the caseworker and the youth's parent(s), family, extended family or other discharge resources for the purpose of:
  - Assessing whether the youth would be safe if he or she was to return home.
  - Guiding the youth's parents or relatives toward a course of action aimed at resolving problems, supervising the youth and addressing needs of a social, emotional, or developmental nature.
- Casework contacts with the parent/family must occur at least two (2) times within the first thirty (30) days of placement but should be as often as necessary to implement the family and children's service plan.
- After the first thirty (30) days, casework contacts are to be held a minimum of one (1) time per month.
- When conducting casework contacts with the identified permanency resource, providers must continue to assess whether the youth will be safe upon return to that home.
- Casework contacts must be documented in CNNX.

Contact Type	Minimum per Month Frequency	Modality
Contact between Case Planner and Youth	2 time/month	Face to Face
Contact between Case Planner and Birth Parent/Discharge Resource	1 time/month	Face to Face
Visits between Birth Parent/Discharge Resource and Youth	1 time/week	Face to Face
Contact between Provider Agency Staff and School Personnel	1 time/month	Face to Face, Video, or Phone

IV.11.00 Behavior Management System (BMS)

Providers must have an established, program-wide behavior management system or approach that prioritizes a youth's positive, prosocial behavior, while also providing timely responses for maladaptive youth behaviors. This system must be embedded in the core program model/approach used by providers.

- Providers must develop and implement a Behavior Management System for youth in coordination with the youth and, as appropriate, his or her family and other health services providers.
- The BMS must create a standardized means to evaluate youth behavior, participation, performance, and commitment to change while in residential placement.
- In addition, the BMS must teach, and allow youth to practice, the positive prosocial skills they need to be successful in the facility and in the community.
- Providers are responsible for ensuring that all staff contributing to the implementation of systems for directing youth behavior are trained and versed in the components of the BMS.
- Providers must involve the youth in the development of rules, consequences, and rewards.
- A copy of the BMS must be provided and explained to youth and his or her family members. Youth and their family members must sign off indicating that they understand the plan.
- Providers need to track progress in the behavior management/level/phase system. Progress or lack thereof must be documented in CNNX.
- Providers must monitor the implementation of the BMS for effectiveness. Youth input should be consistently solicited.
- The BMS should be incorporated into all interactions with the youth (e.g., individual, family, group interactions, etc.).

IV.11.01 Behavior Support Plan (BSP)

Each youth's treatment team is responsible for creating a trauma-informed care plan for all youth within three (5) business days of placement in the program. The care plan must be embedded in the youth's service plan and integrate the care plan received from detention as well as any prior assessment of the individual youth's risks and needs, triggers, strengths, skills, and treatment intervention recommendations, as relevant. Providers must review, further develop, and finalize the plan at the *initial planning and support meeting* within 30 days of placement at the facility. The care plan must be reviewed in monthly treatment meetings and updated as needed throughout the youth's placement.

- A youth's BSP is a specific documented plan developed by a youth's treatment team in collaboration with the youth and his or her family. It is tailored to the youth's individual needs and used to determine intervention strategies and/or safety procedures to be used to defuse the youth's behavior(s) or concern(s). The plan must include the youth's behavior response preferences. It must include any limitations on physical interventions authorized or prohibited for the youth as well as coping and de-escalation techniques that have been identified as helpful for the youth.
- All behavior support plans (e.g., safety plan, behavior chain analysis, etc.) must be reviewed, discussed, and shared with the PPS and incorporated into the youth's Juvenile Justice Service Plan.
- The treatment team, the staff, and the youth must all be familiar with and/or trained on the BSP, including youth's triggers/cues, youth's history (e.g., physical or sexual abuse, trauma), prohibited and approved physical or mechanical interventions (LSP), and the crisis management plan for the youth. Staff must consistently reinforce adherence to the interventions and crisis prevention and management plan specified in the BSP.
- When appropriate, the BSP should incorporate Safe Crisis Management (SCM) or other approved physical intervention de-escalation techniques (e.g., TCI) and the program's model/approach techniques.
- The BSP and associated interventions/responses must be individualized and specific to meet the needs of each youth, such that youth who need a high degree of support/services receive them while youth who need a lower level of support are provided with more youth-specific interventions.
- The BSP must be clearly labeled, incorporated in the service plan, kept in the youth case file and documented in CNNX.
- Plans must be accessible and clear to staff working with the youth.
- Review the care passport with the youth and make updates as needed. Providers must review with youth and assess any necessary adjustments.

IV.11.02 Addressing Challenging or Disruptive Behavior

The safety of youth and staff is paramount to a therapeutic environment. Staff must develop and implement individualized and systemic preventive and de-escalation strategies for youth who are not successful with core program interventions and who exhibit challenging or disruptive behaviors.

- Staff must utilize strategies that address the underlying causes of problematic or undesirable behaviors, create opportunities for restoration and to practice appropriate, alternative, positive, prosocial behaviors. Staff must not engage in prohibited disciplinary practices.
  - All strategies utilized must be appropriate for the youth's age, circumstances, and developmental needs and must be approved only by supervisory staff.
  - Whenever possible, the family's input should be included, and families must be kept informed of concerns and interventions. The family's input must be documented.
  - Prohibited practices for CTH facilities include, but are not limited to, deprivation of meals, snacks, mail, personal hygiene, clothing, family visits, routine telephone calls to family, access to health and mental health interventions; corporal punishment; and pharmacological restraint and seclusion. In addition, NSP facilities are prohibited from using room isolation to manage problematic behaviors.
  - Behavior intervention policies and procedures must be documented by the program and must be provided to youth and families as part of the youth's orientation at admission and during treatment team meetings and FTCs.
- Staff must utilize and exhaust all appropriate verbal and non-physical means to de-escalate challenging youth behaviors before resorting to physical interventions unless immediate physical response is warranted to protect the safety of youth or others. Only techniques approved as part of the ACS continuum of crisis intervention strategies may be used to manage youth behaviors.
- BSPs must at a minimum identify antecedents/triggers to the targeted behaviors and strategies to eliminate/mitigate identified triggers. BSPs must be evaluated and adjusted as necessary. More intensive interventions should be developed if/when initial behavior plans do not yield desired results.
- Transfer or modification of youth must only be used once all means to address the behavior have been considered, based on documented history of attempted interventions and a continued significant safety risk, and with ACS approval.

IV.12.00 Treatment Team Meetings

Treatment team meetings must occur on a weekly basis to discuss the progress of youth and make changes to the JJ Service Plan as necessary.

- At a minimum, the interdisciplinary team must meet on a weekly basis to discuss and review the youth's progress and, if necessary, adjust the JJ Service Plan to better meet the needs of the youth.
  - The progress of each individual youth must be discussed as often as needed but at minimum once (1) per month.
- Youth with urgent issues must be prioritized.
- Providers must make and document all efforts to engage families and youth (e.g., travel support, translation services, scheduling flexibility, broadly identifying and addressing any barriers to participation) to participate in treatment team meetings at least once (1) a month.
- At minimum, health and mental health clinical staff, case planners, supervisors, and direct care staff should participate in these meetings when feasible.
- As needed to ensure continuity to the case reviews, the program director must delegate responsibility for meeting leadership (e.g., who leads the team meeting for a given youth and who makes the invitations to the meetings).
- The youth's YLS/CMI plan should be incorporated into the treatment plan.
- All information must be captured in CNNX, and treatment team meeting minutes must be documented at least monthly and as often as necessary. Documentation of treatment team meetings must be provided to ACS upon request.

IV.13.00 Suicide Prevention and Intervention

Providers must have a suicide prevention plan that addresses training, assessment, communication with and levels of supervision of suicidal youth, intervention, and follow-up to suicide attempts.

Screening

- Within one (1) hour of admission to any juvenile justice placement facility, staff members must screen the youth for suicide risk.
- If the staff member identifies any acute mental health issues including, but not limited to, suicidal ideation or intent, he or she must notify his or her supervisor, who will coordinate the development and implementation of a safety plan and make an immediate referral to a qualified mental health practitioner for further assessment, treatment, or additional referral where warranted.

Suicide Risk

- Staff must be vigilant at all times for behaviors or circumstances that may indicate a youth is at a heightened risk of suicide. Such behaviors or circumstances include, but are not limited to the following: placement within the last 72 hours; severe loss of interest in activities or relationships previously enjoyed; depressed state indicated by withdrawal, periods of crying, insomnia, lethargy, or indifference to surroundings; active discussion of suicide plans; sudden or drastic changes in eating or sleeping habits; giving away valued possessions; recent rejection/loss of a close peer (e.g., friend or love relationship); etc.

Response to a Youth Identified as a Suicide Risk

- When a youth has been assessed to be a suicide risk, it is critical for staff to have an unobstructed view of that youth at all times and implement a one to one (1:1) special watch.
  - When a facility's physical layout does not enable staff to have a clear line of sight to the youth's bedroom, ACS strongly recommends that providers explore alternate ways of achieving a clear line of sight to the youth, such as placing the youth or moving the youth to a bedroom in proximity to staff.
  - A staff member must be assigned to youth at all times.

Response to Suicide Attempts and Self-Injurious Statements and Self-Injurious Behaviors

- If a youth has attempted suicide, the staff member must immediately check for breathing and a pulse and call emergency medical services (EMS). If no pulse or breathing is detected, a trained staff member must immediately initiate CPR until a medical team arrives.
- Any staff member who discovers a youth attempting suicide must immediately intervene to stop the youth from causing further harm. The youth must immediately be examined by a qualified medical practitioner.
- Under no circumstances will a youth who attempted to harm him or herself or who made self-injurious statements be left alone. The youth must be placed on constant observation status, and a qualified mental health practitioner shall determine whether constant

observation or referral for hospitalization is more appropriate, based on an individualized assessment.

Post-evaluation Follow Up

- Once the youth's physical and mental health have been evaluated, staff must:
  - Develop a safety plan with the qualified mental health practitioner who assessed the youth and comply with any recommendations;
  - Notify the parent/guardian. The parent/guardian should also be notified when youth is placed on special watch (1:1); and
  - Immediately notify the facility's internal leadership, MCCU, and the appropriate mental health practitioner if a youth makes self-injurious statements, exhibits self-injurious behaviors, or attempts suicide.
- Any death or near death that occurs resulting from a suicide attempt or self-injurious behavior must be reported to OCFS in accordance with OCFS policy about notification of death or near death.
- This information must be documented in the Communication Log and CNNX.

Protocol

- Providers must have a written suicide prevention protocol, in accordance with the suicide prevention and intervention policy, that addresses staff training requirements; the screening and assessment of youth at intake; staff communication protocols when a youth exhibits suicidal behavior; intervention techniques and protocols; reporting and follow-up protocols in the event of an attempted suicide by a youth; and prior arrangements with a mental health facility for referral of suicidal youth for assessment and hospitalization if necessary.

Staff

- Providers must post critical emergency contact information where staff can easily access it in the event of a youth's self-injurious behavior or suicide attempt.
- Providers must train all employees who have direct contact with youth or who supervise anyone who has direct contact with youth in suicide prevention and response. Staff attendance must be documented.
  - The training must include, but not be limited to, predisposing risk (e.g., substance abuse, mental illness, prior attempts) and protective factors (e.g., family support, peer support, school connectedness, religious beliefs); strategies for recognizing verbal and behavioral cues and identifying suicidal youth despite a denial of risk; responding to self-injurious statements, self-injurious behaviors, and suicide attempts; responding to depressed youth; etc.

Facilities

- All facilities must be equipped with at least one (1) emergency response kit. Emergency response kits must be accessible to staff and must remain locked or stored when not in use.
- All bedrooms must be as suicide-resistant as is reasonably possible. For specific requirements, refer to the Suicide Prevention and Intervention CTH policy.

IV.14.00 Behavioral Health Services

Providers must establish linkages and referral protocols that specifically address the services to be provided under the individual youth's JJ Service Plan. Providers must also establish linkages with advocacy organizations for youth affected by specific behavioral and/or mental health conditions.

- Behavioral health services must be targeted to the youth's individual needs.
- Providers must ensure that mental health services are delivered by qualified licensed mental health providers and that all services are documented in CNNX.
- Providers must ensure that linkages are coordinated and followed up on to sufficiently address youth needs.
- Within the context of behavioral health services, referral and advocacy services include coordinating service delivery with external providers, monitoring youth and their families' level of participation in services provided through referral, and providing such follow-up services as are necessary and appropriate to ensure successful outcomes.
- Behavior health interventions must be tailored to the needs of the population, (e.g., CSEC, trauma informed, etc.) utilizing appropriate interventions and modalities (e.g., CBT, DBT, substance use groups, etc.).
- Treatment modalities should be evidenced in the documentation.
- Mental health providers must share information as needed with the team to develop a comprehensive service plan.
- NSP providers must:
  - Offer a comprehensive array of mental and behavioral health services or must establish formal referral and treatment arrangements with one (1) or more community based mental health providers. NSP providers must ensure youth receive needed services.
  - Write and include service plans for mental or behavioral health services in the youth's case record. Service plans must be documented in CNNX and included in the FASP.
  - Arrange for on-call availability for urgent mental health services at all times.
- LSP providers must:
  - Offer mental and behavioral health services including, but not limited to crisis intervention, research-informed/validated individual, group, and family therapies and substance abuse prevention and treatment.
  - Assign qualified staff to coordinate mental and behavioral health services.
  - Ensure that all mental health services are delivered on-site by qualified New York State licensed/credentialed mental health providers, and that all services are documented in CNNX.
- Specialized Providers must provide services to youth as specified and in accordance with their contract requirements.

<u>Group Therapy Services</u>

- Treatment Groups must be documented in a treatment group note/log and CNNX.
- Group notes should include:

- Group summary: name of facilitator; number of youth who participated; number of youth who refused to participate; the objective(s) and goal(s) of session; interventions/tools used; and skills taught/used and/or topic discussed.
- Individual notes: this should reflect the youth's level of engagement, level of participation, and sentences describing the youth's involvement/response to skills taught and/or topic discussed.
    - Individual note portion should be different across youths (i.e. should not be copied and pasted) and should reflect the youth's unique participation in each group session.
- If the group service is provided within a specialized NSP or LSP, all group notes should reflect objectives/interventions/skills related to that specialization.
- Group cancellations (if applicable) of routinely scheduled groups should be documented in CNNX. Attempted contacts, the reason for cancellation, and when the group will be rescheduled should also be noted.
- Incomplete group – i.e., didn't occur for the length of time scheduled (if applicable) should be documented in CNNX with the reason for the disruption noted.

Youth placed in Specialized Programs

Problematic Sexualized Behavior (PSB) or Sexually Abusive Behavior (SAB)

- Within 45 days of admission to PSB/SAB placement, all youth must have an initial psychosexual assessment completed and documented in the chart.
- PSB/SAB needs must be documented and addressed in the Juvenile Justice Service Plan and identify: goals to determine root cause of the nature of charges, victim(s), prior treatment, family support, and release information.
- Youth with identified PSB/SAB needs must be provided with PSB/SAB treatment (urge surfing, targeted service plan goals, accountability/ownership of behavior, collaboration with parents around addressing PSB/SAB behavior) within 14 days of assessment regardless of their placement disposition.
- Family of youth with identified PSB/SAB needs must attempt to engage in regular and appropriate family therapy sessions from the outset of placement. PSB/SAB treatment must include family reunification efforts with the objective of ensuring safety for all family members.
- PSB/SAB treatment must incorporate evidenced based work (ITM, CBT, etc.) and be clearly documented in treatment.
- In preparation for home passes, outings, and release, PSB/SAB safety plans should identify key vulnerabilities such as supervision, monitoring, and risk for re-offense. Safety plan should also incorporate support systems such as immediate and extended family, community resources and prosocial activities. Youth's plan must be in CNNX and shared and approved with the PPS in advance of activity.
- All agencies contracted to provide PSB/SAB specialized services, must be trained in PSB/SAB treatment protocols and receive yearly refreshers. Documentation of trainings must be available for ACS review.
- For providers who do not have experience with PSB/SAB treatment, youth must be referred to a mental health professional who specializes in PSB/SAB treatment.

Fire Setting

- Within 14 days of admission to placement for fire-setting all youth must have fire-setting assessment completed (through internal resources or external referrals) and documented in their case record and CNNX. Assessment will also cover the following factors:
  - Characteristics of the incident – use of accelerants, youth's description of motive(s), precipitating factors, youth's behavior once the fire was set, youth's description of others' reactions to the fire, youth's planning of the incident.
  - Fascination with fire which appears outside developmental norms; dreaming about fire.
  - Exposure to/interest in media representations of the use and effects of fire.
  - History of fire-setting and fire-play – threats of setting fires to scare/control adults, previous incidents, stealing or hoarding matches or lighters.
  - Developmental level / IQ.
  - Psychiatric disorders and history – including, but not limited to, conduct disorder with fire-setting behavior, psychotic spectrum disorders, expressions of rage or vengeance that accompany fire, impulsivity.
  - Home environment – access to fire implements, parental supervision, and discipline practices.
  - Peers – those who also engage in fire-setting behavior, those with more general delinquent profiles, and those who are socially isolated.
- Fire-setting needs must be documented and addressed in the Juvenile Justice Service Plan and identify: goals to determine root cause of the nature of charges, victim(s), prior treatment, family support, and release information.
- Youth with identified fire-setting needs must be provided with treatment (urge surfing, targeted service plan goals, accountability/ownership of behavior, collaboration with parents around addressing fire-setting behavior).
- Family of youth with identified fire-setting needs must be continuously engaged in regular and appropriate family therapy sessions from the outset of placement.
- Fire-setting treatment must incorporate evidenced based work (ITM, CBT, etc.) and be clearly documented in treatment.
- In preparation for home passes, outings, and release, fire-setting safety plans should identify key vulnerabilities such as supervision, monitoring, and risk for re-offense. Safety plan should also incorporate support systems such as immediate and extended family, community resources, and prosocial activities. Youth's plan must be in CNNX and shared and approved with the PPS in advance of activity.

Commercially Sexually Exploited Children (CSEC)

- Youth who are identified as CSEC involved need to be linked and matched with a service provider who specializes in CSEC treatment to further assess, address, and support the youth. Documentation in CNNX will reflect that youth is actively engaged with appropriate service providers to address CSEC needs.
- All NSP and LSP clinical and leadership staff must be trained in CSEC awareness and prevention as offered by ACS Office of Child Trafficking Policy and Prevention (OCTPP).
- Documentation in CNNX must reflect continuous efforts to engage CSEC concerns.
- For any youth who wishes to remove any identifying tattoos, providers must make diligent efforts to secure tattoo removal services. Providers can utilize the OCTPP for tattoo removal assistance.

Intellectual and Developmental Delayed (ID/DD) and Autism Spectrum Disorder (ASD)

- Comprehensive neurological and cognitive evaluation should be offered for youth who are suspected of or documented as having ID/DD and/or ASD. Suspicion can include marked deficits in daily living skills, limited social skills, IEP classification of DD, etc. If providers are not equipped to provide such screening, the youth must be referred out to a specialist.
- NSP and LSP programs that specialize in ID/DD must be able to demonstrate how their program model can be adapted for youth across spectrum of cognitive and developmental ability and must be reflected in treatment plans. NSP and LSP providers that do not specialize in ID/DD or ASD populations must demonstrate their ability to address ID/DD and ASD youth's individual needs within their program through referral and triage with appropriate specialized service providers.
- Providers must deliver individually appropriate encouragement and support to performing daily tasks, such as personal hygiene, toileting, eating healthy meals, and other Activities of Daily Living (ADL's) as necessary. This should be documented in CNNX and followed up with on a consistent basis.
- Specialized and non-specialized ID/DD or ASD providers must make diligent efforts to link youth and their families with services through NYS Office of People with Developmental Disabilities (OPWDD) as well as wraparound services included in NYS Children and Family Treatment and Support Services as soon as a youth is assessed and identified as ID/DD or ASD.
- Providers must ensure meaningful opportunities for youth identified as ID/DD or ASD who are 16 and older to become part of the workforce in competitive employment. Youth must be linked to an appropriate service provider to explore workforce readiness prior to release.
- Providers must ensure meaningful opportunities for youth identified as ID/DD or ASD to engage in prosocial and vocational programming and recreation.
- Programs must provide specific training around developmental disabilities and work with staff continuously to ensure sensitivity and assessment of needs.

IV.14.01 Psychiatric Referrals

Psychiatric referrals to a qualified professional must be made promptly upon identification of the need and no later than one (1) business day after the need is identified. Psychiatric follow up appointments must also be made as needed before any aftercare release and the case planner must routinely follow up on progress.

- If the need for a psychiatric referral is indicated, the referral must be made promptly upon indication of the need and no later than one (1) business day after the need is identified. Psychiatric follow up appointments must also be made before youth are released to aftercare.
- Acute behavior may warrant immediate intervention.
- Providers must obtain appropriate consent and release forms for the disclosure of confidential information and maintain frequent communication with the psychiatric services provider to effectively coordinate services for the youth.
- If not using a consultant or staff psychiatrist, staff must have a plan to address outside psychiatric service needs via a formal linkage agreement.
- Psychiatric services must be available on a regular basis.
- Psychiatric consultation and medication management must be provided when needed. If the waiting time for services is longer than three (3) weeks, providers must make a referral to the Juvenile Justice Programming Services (JJPS) for assistance.
- Providers must develop a protocol to ensure that individual emergency care information is shared with parent/discharge resource, staff, and relevant medical and health care providers in a timely manner. The protocol must also include specific instructions for facility staff pertaining to emergency psychiatric hospitalization that delineates the steps, contacts, and accompanying documentation.
- Providers must follow up on all psychiatric appointments (e.g., tracking attendance, tracking medication, medication management, any barriers/challenges in any of these areas and helping youth/family overcome them, etc.).
- Youth who are on medication must, at a minimum, meet with the psychiatrist monthly and have a physical examination every 6 months.
- Providers must monitor and record all youth’s prescribed psychotropic medication in the health tab in CNNX. The following information is required from the prescribing psychiatrist: reasons for prescribing the medication, name and dosage of medication and the date prescribed, previous non-pharmacological interventions, and expected results including side effects of the medication. This information must be provided to the youth and parent/guardian and documented in the health tab of CNNX.
- Any time youth refuse their medication, providers must document the refusal in the Communication Log (but not include the medication name).
    - A record detailing each medical refusal must be shared with the prescriber at the medication management appointment.

IV.14.02 Engagement with Mental Health Services

Providers must assign every youth a qualified mental health clinician and must make and document all attempts to ensure youth have contact with their clinician at a minimum of once (1) per week, for a duration based on the youth's mental health needs. In the event a youth does not require mental health services, the youth's case planner must continue to address needs as per YLS. at a minimum of once per week.

- Clinicians must work diligently to engage and re-engage youth in mental health services, including but not limited to, working with the staff team (i.e., team leaders, direct care workers) who may have information to share and can be used to encourage youth to participate in sessions.
- The clinician should participate in all treatment team meetings and family team conferences. When they cannot attend, a designee must attend and be able to provide relevant updates.
- Sessions and attempts to engage youth must be documented in CNNX.
- Clinicians must conduct individual, group, and family sessions based on the modality best suited for the specific individual needs of the youth and document in the health tab of CNNX (i.e., at different days, times, length of sessions, etc.).
- Documentation should reflect work that supports the youth's understanding of the relationship between automatic thoughts, feelings, and behaviors by incorporating the CBT model and be reflected in the JJ Service Plan.
- If the youth's needs are outside of the scope of the provider (e.g., speech or occupational deficits), the provider must bring a specialist to the facility or refer the youth to a specialist. Providers must coordinate with specialists as needed to ensure the youth's needs are being met.
- Mental health clinicians must incorporate, in their range of programs and services for youth, cognitive-behavioral strategies that relate to the risk-need-responsivity framework. CBT in this context would include, for example, Dialectical Behavior Therapy (DBT), Trauma-Focused CBT, etc.
- Clinicians must use interventions that are appropriate for the population's culture, age, and developmental stage.
- Other therapy services, such as Creative Arts Therapy, may also be offered by mental health clinicians if they are provided in a larger context of services that includes CBT.
- Provider agencies should engage the youth and family in planning for any continuation of mental health services that may be needed following the youth's discharge from placement.

IV.14.03 Substance Use Services

Any on-site substance abuse services must be provided by qualified clinical staff using a treatment model that has been approved by DYFJ leadership in conjunction with the Office of Alcoholism and Substance Abuse Services (OASAS) or, if that is not available within a program, services must be provided by an OASAS provider. Youth who have acute withdrawal symptoms and/or are assessed to need inpatient treatment must be referred to an inpatient OASAS facility.

- Providers must provide access to educational, counseling, and preventive services regarding substance use/abuse risk and needs assessment and such services must be included in the comprehensive service plan.
- Mental health screening and assessment must include the use of questions and instruments that gauge the youth's history (e.g., existence, extent, duration) of use or abuse of alcohol and/or other drugs.
- Under New York State law, assessment of chemical use or dependency of youth cannot include random urinalysis drug screening, nor is such screening permissible at any other time during a youth’s stay. Such testing is a violation of the Social Services regulation which governs foster children’s privacy rights, regardless of the presence or absence of consent by youth in accordance with Title 18 NYCRR Part 441.8 or any successor or amended regulation. The circumstances in which drug testing of youth is allowed are as follows:
  - A parent or guardian signs a consent for a school related testing in accordance with *NY Education Law 912-a*;
  - There is a medically necessary need as determined by a doctor and the parent, guardian, or provider;
  - The youth is in an OASAS program, and the drug tests are part of that program. The results of testing may only be used for treatment purposes, and the youth must give his/her informed consent to participate in a drug testing program; or
  - Pursuant to a court order.
  - Results must be documented in the health tab of CNNX.
- Documented history of substance abuse, screening results, etc. may be used to inform assessments for chemical dependency/use that go beyond observable behaviors (e.g., alcohol on breath, slurred speech, etc.) and must be completed by a qualified professional (e.g. CASAC, mental health clinician, etc.). When appropriate and necessary, referrals must be made to licensed providers.
- If youth require outpatient treatment, the agency must make sure they receive the necessary services. The need for substance use services and the frequency of the services must be determined by the assessment results. Youth must receive substance use services as often as needed.
- Providers must ensure that youth who use substances receive alcohol and other drug education and preventive counseling either on-site or by referral to a community-based OASAS-licensed program that is either evidence-based or on Substance Abuse and Mental Health Services Administration’s (SAMHSA) approved list of modalities.

- Youth who have acute withdrawal symptoms or are assessed to need inpatient treatment must be taken to a hospital for medical stabilization and then referred to an inpatient OASAS facility.
- Youth in inpatient substance abuse programs must stay on the facility's roster until they are released from inpatient treatment.
- If providers are not providing services directly on-site, providers must establish specific linkages (MOU) with OASAS-licensed providers as well as the ability to leverage services and resources offered at OASAS-licensed program sites to further allow both targeted substance abuse needs to be met as well as other presenting mental health needs.

IV.14.04 Responding to Acute Mental Health Crises

Providers must have a plan in place for responding to acute mental health crises.

- Providers must exhaust all options to meet youth's mental health needs within the program. If it is determined that a youth's acute or emergent treatment needs exceed the capacity of the program, it is the provider's responsibility to refer youth to the appropriate level of care immediately and to transport youth as necessary. Rationale for the referral, including previous interventions attempted, must be documented in the youth's record and contemporaneously in CNNX.
- Provider agencies must arrange for on-call availability of staff for urgent mental health crises at all times, 24 hours a day, 7 days per week including holidays and vacations. Every effort must be made to manage the mental health crises on site by a qualified health professional, but if this is not an option, providers must do the following:
  - Develop a protocol to ensure that agency staff can access emergency care information to share with mental health care providers as necessary.
  - Train staff, as appropriate, on strategies to address a youth's mental health crisis while awaiting arrival of a qualified mental health professional.
- All hospital admissions(for all youth up until the age of 18) for and releases from psychiatric care must also be reported to the ACS Mental Health Coordination Unit (MHCU) at mentalhealth.ta@acs.nyc.gov.
  - Please refer to MHCU protocol for inpatient care (11 3 10 Guidelines for the Provision of Emergency and Inpatient Mental Health Services for Children in the Foster Care and Child Protective System).
- Providers must proactively explore alternatives for emergency psychiatric services.

Court-Ordered Medical and Mental Health Services

- Providers must promptly and accurately respond to court orders related to health services for a youth including, but not limited to, orders requiring a medical, dental or psychiatric examination, or the production of health services records or other documents or reports.
- In conjunction with ACS, providers must track and monitor compliance with such court orders.
- To the extent a court order recommends, but does not require, a course of treatment or medical, dental or psychiatric examination, providers must consult with ACS and provide such course of treatment or conduct such examination as the provider deems medically appropriate.

IV.15.00 Medication

Medications must be prescribed and administered in accordance with applicable laws, rules, regulations, and ACS policies and procedures. Providers must ensure continuity of medication for youth throughout placement and when youth are released to aftercare.

- Providers must practice safe and effective procedures for the administering, storing, accounting, and discarding of medications according to applicable federal, state, and local laws and regulations and consistent with a prescriber's order.
- Providers must follow all applicable requirements concerning the administration and self-administration of medication, consent, youth refusals, over the counter medications, storage, documentation, inventories, receipt of medication, medication errors, and adverse reactions.
- Providers must facilitate the continuity of medication for youth as they are transferred from detention to NSP and LSP facilities or between facilities.
- At the time of the youth's transfer from detention to NSP or LSP facilities, between NSP and LSP facilities, or between CTH facilities and aftercare, staff must collaborate with ACS Detention and Intake and Assessment staff to confirm any medications currently prescribed and administered at the time of the youth's transfer to ensure continuity of medication administration.
- Providers must ensure the transport and transfer of the youth's medications, prescriptions and health records. The health records must be reviewed before or upon admission and release. Providers must also verify that the comprehensive health examination and updates contain an assessment of previous treatment, including whether such treatment included medication for any illness or health condition, whether the youth had any mental health conditions, and whether medication was taken on a regular or as-needed basis if such medication was part of the treatment.

<u>Medication Management</u>

- Providers must order, purchase, manage, administer, store and track all medication necessary to provide health services in accordance with ACS policies.
- Providers must maintain a supply of stock OTC medication for emergency treatment.
- Providers must make all reasonable efforts to ensure medication prescriptions are filled in a timely manner.
  - This may include requesting a short-term supply of medication to ensure timely administration or for emergency treatment.
- Medication must be dispensed in blister card packages, as feasible, that are individually-labeled for the specific youth, with their name, dosage, and instructions on the package to the extent practicable, or such other method approved by ACS.

<u>Medication Refusal</u>

- Providers must enact an approved ACS policy for when youths refuse prescribed and OTC medications. The policy must:
  - Prohibit the use of force in medication administration;

- Require that staff consult a supervisor in these instances;
- Require that staff inform the youth's prescribing doctor;
- Require staff to witness the staff member documenting and signing that the youth refused to take his or her medication;
- Require staff to notify the youth's family; and
- Describe the steps that staff must take when a medication refusal is life-threatening.

Pharmaceutical Services

- Providers must monitor prescribed medication to ensure that any necessary refills are ordered and received at least three (3) days prior to the completion of the current supply of medication.
- Providers must ensure that a youth prescribed new medication or prescribed a modified dosage of an existing medication receives such new medication or modified dosage within 24 hours of the writing of the prescription.

IV.16.00 Incorporation of Gender Responsive Programming

Providers must incorporate programming and activities that address the socially constructed gendered differences about youth's family histories, offense patterns, and their behavior needs while in the juvenile justice placement. Staff must be trained and knowledgeable about incorporating gender responsive ways to supervise, care for, and implement programming for youth.

- Providers should develop a program which invites the youth to challenge gender norms, examine gender privilege, and create balance of power among all genders.
  - Programming must contain activities related to, but not limited to, the following: gender identity, stages of life, emotional development, career path, communication, group identity, forms of expression, mental health, etc.
- Providers must ensure that the programmatic approaches used are based on the theory/theories that fit the psychological and social needs of youths' gender identification and reflect the realities of their lives (e.g., relational theory, trauma theory, substance abuse theory).
  - Program development is based on theories that are congruent, consistent and integrated. Treatment and services are based on youth's competencies and strengths and promote self-reliance.
  - Programs use a variety of interventions, behavioral, cognitive, affective/dynamic, and systems perspectives, in order to fully address the needs and strengths of youth.
- Providers Services/treatments should address youth's practical needs such as family, transportation, childcare, school, and vocational training and job placement. There are opportunities to develop skills in a range of educational and vocational areas, including non-traditional vocational skills.
- Staff should reflect the client population in terms of gender, race/ethnicity, sexual orientation, and language (bi-lingual).
  - Female and male role models and mentors are crucial and should reflect the racial/ethnic and cultural backgrounds of the program participants.
  - Cultural awareness and sensitivity are promoted using the resources and strengths available in various communities.

Gender-Specific and Gender-Responsive Service

- Providers must provide staff with training to enhance their understanding of gender-specific youth development, particularly the impact of physical, sexual, or emotional abuse.
- Programming and recreational activities must include activities that are enriching and interesting to the gender(s) of the youth population being served.
- Providers must provide a comprehensive, culturally sensitive program that includes assessment of risk factors and safety issues related to sexual exploitation and, if appropriate, individual, group, and family treatment focused on trauma to address the underlying causes of a youth's acts and designed to change the youth's behaviors in the future.

IV.17.00 Gang-involved Youth

Providers must develop and implement individualized strategies to work with youth who are gang-involved.

- All intake documents, information, and evidence of potential gang-involvement must be documented in CNNX.
- Staff must be able to recognize gang-related identifiers and must be trained to manage the influence of gangs.
- Instances of gang-related behaviors displayed by youth must be immediately addressed and documented in the Communication Log and/or CNNX.
- When appropriate, providers must address gang-related behaviors by utilizing violence prevention and mentoring programs through referrals (e.g., Cure Violence, B.R.A.G, etc.).
- These strategies must be part of the individualized service plan developed with the family and youth during Family Team Conferences. If there is documented information related to gang involvement, youth must be connected to aftercare services accordingly.
- Providers must work with the families around gang involvement by providing education, referrals, participation in treatment, etc.
- Referrals must be culturally sensitive, evidence-based/informed and matched to the particular background and individual risk factors of each youth.
- Interventions to address gang identified needs include the use of credible messengers, family engagement, positive youth development framework, CBT/DBT to help gain insight, and development of coping strategies to address possible trauma due to community violence.
- Referrals and interventions should target prevention including increased positive family/adult engagement and involvement and vocational/training and pro-social recreational services and activities.

IV.18.00 Crossover Youth

For youth who are in foster care and placed at the facility, providers must include the foster care agency when planning for the youth's needs, services, and permanency.

- Providers must review the Crossover Face Sheet that includes the child welfare history, important contacts, and the identified permanency resource, as well as the status of the child welfare case, limitations on family visits, orders of protections, etc.
- Providers must make effort to collaborate with the foster care agency to plan for programming and services and invite the foster care agency's case planner to conferences and planning meetings about the youth and document in CNNX and the FASP.
- If the foster care agency is not visiting the youth monthly or engaged in planning for the youth, providers must immediately notify PPS, the PPS director, and the Confirm/Crossover Youth Unit.
  - If a second meeting is missed, providers should notify FPS.
- For crossover youth placed at the facility, the CTH providers must attempt, at minimum once (1) a month, face-to-face contacts through home or agency visits, to engage the youth's relatives and/or discharge resource and to expand the definition of family. If face-to-face contact does not occur, diligent efforts must be documented in CNNX.
- If there is no family resource or identified foster parent planning with the youth, the foster care agency must identify a specific discharge resource at least 60 days prior to release from the facility. If the foster care agency has not done so, the provider must notify the PPS, the PPS director, and the Confirm/Crossover Youth Unit as soon as this information is known.
- For all youth in facilities who are not in foster care but whose family is unable or unwilling to plan, providers must work on engaging the family, identifying alternate discharge resources, and alerting ACS when the discharge resources of youth are not coming through, etc.

IV.19.00 Educational Services

Providers must identify the educational needs of youth, and work with students, parents/guardians, and schools to address those needs. Providers must also be responsible for advocating for the educational needs of youth.

- Providers are responsible for assuming a parental role for youth's academic needs, as appropriate. This includes, but is not limited to, advocating for the youth, monitoring evaluations, and escalating concerns, as needed.
- Providers must transport youth to and from the applicable educational institution in a timely fashion for each youth not receiving educational services at the facility, unless ACS has agreed in writing that such youth may be responsible for his own transportation.
- Providers must ensure that youth who are under compulsory attendance age receive education through the City Department of Education (DOE), Greenburgh 11 (G11), or another educational institution in good standing with the State Education Department while providing educational services to such youth.
- Providers must obtain ACS's approval prior to a youth receiving primary educational services from a non-DOE/G11 educational institution. Providers must provide proof of good standing of such educational institution to ACS in connection with a request for approval of the non-DOE educational institution.
- The provider must make best efforts to obtain and review all information received from detention (e.g., transcript, report cards, progress reports, special education records (e.g., evaluations, SEP, IEP), reading and math levels, and information from school counselors in detention) to support appropriate educational planning. In the event the provider is unable to obtain relevant educational records, they must contact the DYFJ Education Unit for assistance.
- Providers must reach out to school staff to confirm that special education services are provided to youth in accordance with the applicable youth's special education service plan, SEP or IEP.
  - In the event that the youth is not receiving appropriate special education services and the provider is unable to secure the services after communicating with school staff, the provider must contact the DYFJ Education Unit for assistance.
- Providers must establish regularly scheduled time periods after school and on weekends for youth to complete assignments and participate in enhanced learning opportunities.
- Providers must create and implement measures to coordinate, track, and ensure completion and return of school assignments and report to ACS as requested.
- Providers must ensure that youth who are beyond the compulsory attendance age or who have earned a high school diploma or a high school equivalency diploma, are connected to post-secondary education programs which must include literacy, math, life skills, and workforce development, and must be designed to provide an impactful and meaningful educational and vocational learning platform that meets youth's individual needs.
- Providers should contact ACS if they are having difficulty collaborating with a school.

Coordination with Partner School

- Providers must review the educational and developmental needs of each youth and identify any issues that require attention. Where needed, the provider must develop and implement plans to address a youth's truancy and reduce the risk that the youth's educational performance is poor. Providers must conduct ongoing monitoring and evaluation to ensure a youth's progress in areas where problems are identified. Providers must utilize local community partnerships when available to build linkages with schools to enhance the provider's ability to address education issues.

Educational Assessments

- Providers must work with the school, parents, and ACS to obtain and review up-to-date reading and math assessments (e.g. STAR assessments) for each youth. Providers should consider educational progress and results of school-aged youth's educational assessments (e.g., math and reading) to inform planning and goal setting.

Educational Planning

- Providers must review each youth's educational history and records, and work with the youth and parent/guardian to develop and update an appropriate educational plan.

Educational Programs and Services

- Providers will collaborate with schools and ACS to connect youth to educational programs and services beyond the school day, to the extent such programs and services are needed to help youth achieve their educational goals.

Facilitating and Supporting Youth Transitions to Community School and Education Programs

- Providers must support each youth's transition to a community school or education program. Staff must also work jointly with ACS and DOE transition specialists around youth transitions and progress in community schools or education programs.

Education Support Staffing

- Each agency must designate at least one person who is able to meet the educational support and advocacy needs of their youth and escalate concerns as needed. Providers will also assign staff to accompany youth to DYFJ partner schools (Passages, G11, and D.75 at St. Johns) and to provide support in the school and classes.
  - Designated provider staff will work with the DOE and ACS to meet the individual academic needs of youth through educational programming, services and planning.
  - Further, providers will work with ACS and partner school to establish healthy partnerships between youth care workers in the classroom and the educational staff.

IV.19.01 Educational Records and Assessments

Providers must use all results of school-aged youth's educational assessments (e.g., math and reading) to inform planning and goal setting.

- The provider must make best efforts to obtain and review all information available from detention (e.g., transcript, report cards, progress reports, special education records (evaluations, SEP, IEP), reading and math levels, TASC scores, and information from Passages Academy counselors in detention) prior to the transition team conference to support appropriate educational planning. In the event the provider is unable to obtain relevant educational records, they must contact the DYFJ Education Unit for assistance.

Academic Skills Assessments

- The provider will confirm whether assessments of reading and math skills have been completed by the DYFJ partner school and use the results to help inform their overall understanding of a youth's current academic functioning and any need for additional programming, activities, and/or services.
- Providers will make efforts to obtain and review results of monthly assessments conducted by DYFJ partner schools for each youth.
- Providers shall obtain the educational history of youth, including copies of updated SEPs and IEPs (from within the last year), and collaborate with DOE/G11 and other partners to incorporate agreed upon special education goals into the youth's overall education plan.
- Providers shall work with DOE/G11 to ensure all youth under their care receive a comprehensive review of educational records, graduation requirements, goals, and needs, in consultation with the school guidance counselor, by the time of the Initial Team Conference
- Providers shall collaborate with DOE/G11 and ACS to review assessment results and, as needed, collaborate with the guidance counselors and DOE, to determine if the of the youth's transition into the community.

IV.19.02 Educational Planning

Providers must review each youth's educational history and records, and work with the youth and parent/guardian to develop and update an appropriate educational plan.

- Providers must collaborate with the school to identify the education-related skills and levels of individual youth and to address the school-related socio-emotional, behavioral, and mental health needs.
- Providers must collaborate with parents/guardians/placement resources and school staff around the youth's educational needs and to develop an educational plan.
  - An educational plan addresses the academic needs of youth while in residential placement and aftercare. This plan includes in-school academic programming and services, after-school educational programming and services, and educational transition planning.
- Each youth must have a transition goal focused on his or her return to school, entry into an equivalency program, or vocational career opportunities.
- Providers must integrate the educational plans/educational transition plan into the service plan for each youth, where practicable.
- Providers must monitor the youth's progress toward each and every one of their educational goals throughout placement.
- Providers, in collaboration with schools, ACS, and parent/guardian, will make every effort to ensure SEP and IEP needs are met for each youth, where applicable.
  - Providers must work with the DOE and ACS to make sure the SEP/IEP and special education evaluations are up to date.
  - Any changes or updates made to the SEP/IEP should be reflected in the education service plan.
- Providers must work with schools, parent/foster parent, and youth to ensure that key transitions in youth's educational progress receive adequate attention. These include:
  - Assisting middle school youth with researching appropriate high schools for the high school selection process (e.g., attending school sponsored events);
  - Application to high school for eighth graders;
  - Application to higher education or vocational training for youth leaving high school or youth who have completed their high school equivalency program; and
  - Preparing youth and family for school admission interviews or school visits.
- The provider must collaborate with the DOE transition specialist to begin planning youth's educational transition by the time of the Initial FTC, and expanded upon throughout placement, as appropriate. Plans for transition must be assessed and updated with the DOE transition specialist every 30 days or as often as needed and must be reviewed at treatment team meetings and FTCs.
  - A structured transition plan should be in place by the Comprehensive Team Conference.
- Youths' educational plans, which must be developed in concert with the education district, must focus on educational achievement and functioning and help each youth make progress towards their educational goals.

    - Provider must work with guidance counselor or Educational Transitional Specialist to share information with youth and parents about how to access relevant educational programs and services, post-release (tutoring, academic remediation, vocational education, college applications, financial aid, community-based programs and activities, etc.).
- Providers must document, as needed, progress, changes, and any other relevant information regarding the youth's education plan in CNNX within five (5) business days. The education tab must also be updated at intake, upon major changes to education milestones/planning, and at least every 30 days, to report changes in the plan as needed. Documentation may include:
    - Names of the parties who attended the education meetings (FTCs, transition planning meetings, welcome meetings, IEP meetings, Student Advocacy Meetings) and the issues discussed;
    - Youth academic progress;
    - Barriers to transition;
    - Concerns of youth and family;
    - Action steps and status including supports provided; and
    - Follow up.

IV.19.03 Educational Programming and Services

Providers, in collaboration with schools, must support youth with all educational services needed, including remediation, to work towards achieving their educational goals.

- Consistent with safety, providers are expected to transport youth to school on time and keep absenteeism to a minimum, outside of exigent circumstances. Providers must strive to prevent youth from losing credit due to tardiness or absenteeism. If the youth is absent from school, providers must notify the school before the start of the school day.
- Providers must work with school leadership to ensure middle school youth attend middle school classes while in residential placement.
  - Exceptions require the written approval of the Assistant Commissioner of CTH.
- Staff must support efforts to improve youth's performance in school and to address youth's academic needs (e.g., intensive remediation to address learning challenges and meet graduation requirements).
- Staff must coordinate with school's teachers, guidance counselors, and transition specialists to determine whether youth are developing and learning at an appropriate pace.
- School counselor (e.g., education transition specialist or guidance counselor) must be invited to FTCs and other education-related meetings as appropriate, and with sufficient notice.
- Providers are expected to directly offer or link youth to programming/activities/services that support academic progress, including during out-of-school time hours. This includes basic academic support services (e.g., reading and math remediation, tutoring, credit recovery, and homework help, etc.) as well as programming/activities that involve the use of real-world skills and are likely to be engaging for youth (e.g., offering a cooking class where youth practice measuring and calculating "how much" of an ingredient they need to use, percentages, etc., or have activities that incorporate the use of a computer and teaching how to write code).
- Providers must attend educational conferences in support of the youth and family and advocate for the provision of appropriate education support as needed for all youth in residential placement.
- Providers must support youth in advocating for themselves with DOE in educational program and services planning discussions and assist youth in considering their options and articulating their concerns.

IV.19.04 Education Support Staffing

Providers are responsible for meeting the education support and advocacy needs of all youth. Providers will also assign staff to accompany youth to DYFJ partner schools and community schools, and to provide school-related support.

Communication and Records Review

- The provider will:
  - Obtain and review educational history and records for each CTH youth in the care of the provider agency.
  - Maintain consistent communication with Educational Transition Specialists and school-based social worker to ensure timely and appropriate planning (e.g., in preparation for every FTC).
  - Participate in regular DYFJ provider calls, as appropriate, education-related trainings, and meetings with DYFJ education team.

Advocacy

- The provider must conduct educational advocacy with and on behalf of the youth as appropriate by:
  - Preparing youth and family/guardians to advocate for educational interests and goals at education-related meetings and conferences (e.g., IEP meetings, Student Advocacy Meetings, educational transition planning discussions, suspension hearings, etc.).
  - Reviewing and advocating for appropriate educational programming and services for each youth in CTH placement in collaboration with youth, parent/guardian, school in placement, receiving community school, and treatment team. This includes:
    - Advocating for appropriate school placements;
    - Advocating for appropriate course programming;
    - Advocating for appropriate special education programming and services;
    - Advocating for appropriate tutoring and reading and math remediation services;
    - Identifying any social/emotional/behavioral skills that are impacting educational success and helping to craft a plan for improving those skills in collaboration with DOE, DYFJ, case planners and clinicians;
    - Participating in educational transition planning;
    - Participating in guidance and student advocacy meetings, and attending FTC meetings; and
    - Obtaining additional advocacy or technical assistance from DYFJ Education Unit and/or non-ACS educational advocates, as appropriate.
  - Assisting youth and parent/guardian to remedy educational concerns via external legal representation, when necessary.

DYFJ Partner Schools

- Staff must accompany youth to school every day, remain on-site, and supervise youth in the classroom.
- A minimum of two (2) staff must always actively supervise youth.

- For transitions to the restroom: Provider staff will communicate with School Liaisons to ensure bathroom is not occupied by another youth. Once confirmed, one (1) provider staff will accompany youth to the bathroom.

- The role of any in-class provider staff is to support the teacher and the work of the class by:
  - Helping youth understand subject matter and assignments under the guidance of the teacher;
  - Providing "eyes on, ears on" supervision;
  - Helping the teacher during activities; and
  - Helping with classroom management.
- The focus of in-class provider support may vary at times depending upon the needs of the classroom and the school, sometimes being more academic focused and other times being more behavior management focused.
- Staff must ensure their presence is not disruptive to the classroom and adhere to the school's classroom guidelines.
- If multiple providers have youth in the same on-site school, each provider must send at least two (2) staff to the school each day.
- Staff who supervise youth in school will participate in collaborative team-building trainings with schools.

Attending Community Schools or Educational Programs While in Residential Placement

- Providers must support Welcome Meetings by:
  - Collaborating with DOE Educational Transition Specialist, student and family to prepare for Welcome Meeting; and
  - Working with youth and family to address any concerns they have from the Welcome Meetings.
- The provider agency will contact the school at minimum, on a weekly basis, to assess how youth is transitioning. If concerns are identified, this will be addressed with the school immediately.
- Staff will support youth by participating in school-based meetings including IEP meetings, suspension hearings, Parent-Teacher Conferences, etc.

IV.19.05 Youth Transitions to Community School and Education Programs

Providers must support each youth's transition to an appropriate school, vocational, or employment setting. Staff must also work jointly with ACS and DOE Education Transition Specialist around youth transitions and progress in community schools or education programs.

- Provider must work with the Education Transition Specialist (or equivalent staff at non-DOE schools), youth, parent/guardian/discharge resource, PPS, and treatment team to plan for an educational transition that identifies an appropriate school placement and to advocate on behalf of the youth and parent/guardian to oversee that plans are appropriate and ultimately implemented.
- When planning for the educational transition, providers must be proactive and timely in collaborating with DOE Transition Specialist to address related concerns and opportunities, including:
  - Working to collect relevant information to support student applications and prepare youth and parent/guardian for school interviews;
  - Attempting to confirm that all the requested educational assessments and evaluations have been completed and are up to date;
  - Making all efforts to confirm that appropriate special educational services and accommodations are included in the educational transition plan, as needed, and advocate for re-evaluation if appropriate;
  - Anticipating, determining, and addressing barriers to continuity of education, such as safety concerns, medical concerns, disability benefits, counseling issues, change of address, change of guardian, etc.; and
  - Identifying community-based programs that are appropriate and beneficial to the educational success of the youth, in consultation with ACS and the Education Transition Specialist or other DOE staff.
- Providers must coordinate with DOE to ensure that youth are attending a school, or when appropriate, an accredited vocational or transitional program, that is in good standing with the New York State Education Department.
  - A school is considered in good standing if it has not been identified as a School in Need of Improvement, in Corrective Action, Planning for Restructuring, Restructuring, Requiring Academic Progress, or as a School Under Registration Review.
  - Providers must work with ACS and schools to maintain educational continuity throughout placement, from intake through aftercare (e.g., share relevant educational transition-related information with the aftercare team).

<u>Transition to Community School (NSP)</u>

- Where feasible and appropriate for the individual youth's safety, goals, and progress, youth must have an educational placement or plan identified at least eight (8) weeks before the youth's scheduled transition to aftercare based on assessments by DOE, provider, PPS, DYFJ's Education Unit, youth, and family, of youth's readiness, educational implications, and assessment of youth individual needs.

  - Providers should consider feasibility/appropriateness of transition to community school while in residential care prior to transition to aftercare.
- Transition and education planning should begin as soon as youth is placed in CTH.
- Community school enrollment timelines may vary based on provider, PPS, youth, and family assessment of youth readiness, educational implications, and assessment of youth's individual needs.
- All concerns (i.e., geographic, safety, transportation needs, etc.) about youth planning or going to community school while in placement must be discussed with PPS as soon as provider is made aware of barriers or school concerns to prevent any barriers to discharge.
- All changes in school placement must be approved by PPS.
- Providers must assist youth in making sure the transition back to community school is successful by, including but not limited to, the following:
  - Working with PPS to identify the appropriate timeline for release to community schools/education programs and discussing plans at FTCs;
  - Providing guidance with school/education program selection process (e.g., taking the youth to high school fairs, completing applications, preparing for interviews, gathering documentation, etc.);
  - Connecting the youth to receiving school's personnel and building a school-based support network to foster a positive transition;
    - Members may include guidance counselors, community mentors, coaches, clinicians, relatives, etc.
    - Education specialist will develop system of regular communication among the network to support the youth's educational goals.
  - Making appropriate efforts and requests to provide transcript, SEP/IEP (if applicable), and any other essential educational records to the youth and parent/guardian.
  - Working with families to develop and improve youths' school-related executive skills, such as school attendance, time management, organizational skills, homework completion, study skills, classroom behavior, etc.
    - Provider will assist youth and parents with accessing school resources, including databases; mobile technology; and tools to track attendance; assignments exams; and grades.
- Providers must escort the youth to and from community schools until the youth is ready to travel to and from school independently.
- Staff will support escorting youth to community schools and obtaining progress reports from schools regarding youth's academic strengths and/or concerns.
- Providers can utilize one (1) staff member to supervise/escort a youth to his/her community school if needed. An ongoing assessment must be conducted by providers to determine if additional staff are needed to escort youth to his/her community school.
- Providers will provide metro cards, bookbags and school supplies as needed.
- Providers must address school-related issues (e.g., behavioral, academic, etc.) immediately.
- The provider agency will contact the school at minimum, on a weekly basis, to assess how youth is transitioning. If concerns are identified, this will be addressed with PPS immediately.

IV.19.06 Accredited, Developmentally Appropriate Vocational Program

When appropriate, providers must assess and document vocational needs for each youth and use results to inform planning and goal setting. Youth who have already earned a high-school diploma or high school equivalency diploma must have access to an accredited vocational program that is developmentally appropriate for the youth served.

- Providers must ensure all youth under their care are comprehensively assessed for career and vocational needs at least 60 days prior to release. Using this information, providers must plan for the career and vocational aspects of the youth's transition into the community, inform the youth's service plan, and address any potential barriers.
- Assessments of career and vocational needs of youth must identify potential challenges to work or school caused by life circumstances.
- Plans for youth's vocational services must be reviewed by agency staff and PPS at transitional meetings and treatment team meetings.
- Providers must collaborate with the DOE and ACS to identify career and vocational education opportunities for youth, as feasible and appropriate, including Career and Technical Education (CTE), Career Development and Occupational Studies (CDOS), and vocational programs.
- Providers must strive to formalize partnerships with community-based workforce development providers and/or employers.
- Youth must only be referred to vocational or career training programs that offer documentation of credit toward a functional certificate/degree/license or are licensed by the New York State Education Department.
- Providers must assist youth in obtaining the necessary paperwork for registration, orientation, supplies, etc.
- Providers must ensure adequate resources are allocated from programming budget to provide career and vocational services and/or training to youth (e.g. access to community resources, access to technology, financial literacy curriculums, group sessions related to career readiness, transportation, etc.).
- Providers must ensure that youth engage in programming that promotes relational competencies including professional communication, problem solving skills, customer service skills, and professional boundaries. Providers can either use a curriculum to do it themselves or bring in an outside facilitator/program.
- Providers must submit complete applications for the DYCD Vulnerable Youth Summer Youth Employment Program where appropriate for the youth's safety, goals, and progress, facilitate youth attendance at required enrollment and orientation meetings, and support youth through the work experience.

IV.20.00 Program Model Adherence

Where an evidence-based, evidence-informed, or manualized practice model or program is used as part of providers' provision of services, providers must comply with all elements of the Program Model as set forth by the Program Model developer including all clinical, administrative and programmatic requirements.

- Providers must conduct data collection, regular and frequent supervision of direct service staff, regular and frequent consultation with Program Model consultants selected by the Program Model developer, and, with the written permission of the youth and/or family, the recording of therapeutic sessions, completion of initial and on-going training and certification requirements mandated by the Program Model, requirements related to the number of contacts with the family and the duration of intervention services, and the requirements set forth in the Program Manual.
- Providers must notify ACS in writing within ten (10) days of any changes to the Program Model requirements.

Implementation

- Providers must ensure that the Program Model developer participates upon ACS's request in implementation activities including, but not limited to, conference calls and meetings with ACS, and that the Program Model developer provides to ACS, upon request, fidelity reports or other documentation prepared by the Program Model developer regarding the provider's implementation progress and adherence to the Program Model.
- Providers must implement the Program Model to ensure the needs of youth that are identified as specialized (e.g., developmentally delayed, serious emotional disturbance, fire setters, substance use/abuse, problematic sexual behavior) are fully met.

Program Model Developer Reports

- For any provider utilizing outside consultant for Program Model development, providers must provide a copy of any model fidelity, quality assurance, or similar reports to ACS within five (5) business days of receiving such report from the applicable Program Model developer or such other period designated by ACS.

Program Model Requirements

- To ensure Model fidelity, providers must have a process of systematic collection of information related to Model implementation.
- Providers must have access to and consult with Model Consultants approved by the applicable Program Model developer to provide case consultation services.
- Providers must comply with all Program Model requirements.

IV.21.00 Programming and Activities

Providers are required to address the assessed criminogenic needs of youth through structured YLS-led programming and provide an array of activities that facilitate positive youth development. Programs and activities should promote skill development and build on the strengths and interests of youth served. Programming should be gender and culturally responsive.

Structured Programming

- Providers should have a structure program schedule in place to promote youth development activities and recreation.
- Programs should be staff lead and tied to a productive end goal.
- Structured programing should consider each youth's needs (using assessment tools such as the Youth Level of Service (YLS) Inventory) and criminogenic needs
- YLS domains for programming consideration include:
  - Family circumstances and parenting
  - Education/vocation planning
  - Use of leisure time
  - Peer relations
  - Substance abuse
  - Personality and behavior, attitude and orientation

Skill Development

- Structured programming and activities must provide youth with the opportunity to build and practice social, interpersonal, and independent living skills.
- Providers must offer individual and group-based interventions based upon the needs of the population served and periodically evaluate the needs of the group to determine what skills are the subject of focus.
- Programs must utilize evidence and trauma informed approaches to address anger management and conflict resolution.
- Providers must implement curriculums that promote independent living skills in the areas of personal care, food preparation, vocational training, financial literacy, resume writing, interview skills, health and wellness, etc.
- All programs and activities must account for the characteristics of the population including youth age, developmental level, learning style, language, gender, gender identity, race, ethnicity, religion, sexual orientation, trauma experienced, and transitioning back to community of residence when on aftercare.

Activity Restrictions

- When a qualified medical practitioner determines, upon a medical evaluation of a youth, that the youth requires a restriction on his or her physical activities due to an acute or chronic medical condition, providers must complete a Medical Activity Restriction Form with the assistance of the medical practitioner and follow the instructions on the Activity Restrictions Policy.

- If the youth is unable to attend school and/or has a chronic or acute condition that precludes full participation in class, educational materials and tutoring services, in conjunction with DOE, must be provided for the duration of the medical restriction, as practicable.

IV.21.01 Daily Schedule

Providers must maintain an accurate and readily-accessible daily schedule, in writing, for youth that covers all waking hours, 7 days per week. Youth daily schedules must incorporate structured programming time, youth activities, and leisure time.

- Providers must maximize youth opportunities for participation in, and offer a robust schedule of, supervised structured programming and activities that provide opportunities to enhance positive youth development.
- Providers are required to submit to Agency Program Assistance (APA) the planned daily schedule and recreation calendar for the current month by the tenth (10th) of every month.
- The daily schedule must be posted conspicuously in the facility in a location accessible to youth.
- Supervisors must ensure the daily schedule is being followed. Deviations from the schedule must be addressed with staff and documented in the Communication Log. All staff must be knowledgeable of the daily programming schedule.
- Breakfast, lunch, dinner, snacks, chores, hygiene, morning and bedtime routines, school activities, etc. must be structured in the daily schedule.
- Daily schedule must be updated as often as necessary to reflect accurate programming.
- The schedule should be planned to ensure no time is unstructured.
- Providers' daily schedule around bedtime/morning routines must be structured in a manner that supports consistent and timely school arrival.
- The schedule must include activities that are developmentally appropriate, and contain: sports and athletic activities, cultural enrichment activities, social activities, academic enrichment, independent living skills, vocational skills, emotional management, healing-centered services, and religious services if requested by youth.
- Activities may include those that do not have a specific youth development goal.
- Providers must offer constructive and acceptable recreation activities that promote positive youth development and must actively counsel and guide youth on choosing activities.
- Recreation time must be scheduled in the calendar and should generally occur for a minimum of one (1) hour daily.
- Any activities in youth bedroom outside of sleeping hours must be supervised and part of a daily routine.
- All activities must be documented in the Communication Log.
- Youth must not be forced to participate in programming/activities but should instead be motivated and encouraged to participate through incentives or offered suitable alternatives. If youth consistently are uninterested in participating, providers must identify barriers to participation/interest and work with the youth individually. Staff must be persistent in trying to re-engage the youth on an ongoing basis.
    - If youth refuse planned activity, another option should be made available.
- Monthly events/activities must acknowledge and incorporate, as appropriate, cultural events and holidays and must be educationally focused while being sensitive to youth and inclusive of families.

IV.21.02 Incorporation of Youth Needs, Interests, and Characteristics

Programming and activities must reflect the needs, interests, and characteristics of youth in the facility. Programming must be regularly assessed and adapted to ensure such needs, interests, and characteristics are reflective of the current youth in the program.

- Programming: engagement opportunities that promote a goal and reflect the various learning styles of youth (i.e., hands-on, classroom, group).
- Activities: recreational activity that could be just for fun.
- Youth must have an active, ongoing voice in program planning.
- As part of the process for assessing their population, providers must look at trends in YLS risk/need areas to determine appropriate programming and activities.
- Providers must review with youth routinely (at treatment team meetings, individual sessions, groups, etc.) the overall and individual youth participation in specific programming/activities to determine whether adaptations or changes are necessary to facilitate youth engagement and participation.
- Programming and activities must be appropriate for and sensitive to factors such as youth age, developmental level, language, gender and gender identity, race, ethnicity, religion, sexual orientation, parenting status, and past experiences of trauma.
- Providers should have a written protocol to incorporate youth's feedback in planning activities, requesting changes and assessing the quality of programming in place.
    - Youth must be engaged in opportunities to contribute to and provide ongoing feedback on programming.

IV.21.03 Restorative Justice Component

Programming and activities must provide each youth with the opportunity to increase his or her awareness of, and empathy for, crime victims and survivors, and increase personal accountability for the youth's criminal actions and harm to others.

- Providers must help youth gain insight and understand the impact of their past actions and behaviors, and teach youth how to make responsible, prosocial decisions in the future.
- Providers must schedule community service-based activities at minimum, quarterly, (e.g., shelters, kitchen, letter writing, etc.) and create venues and opportunities for youth to participate as safe and appropriate. Activities can take place at the facility.
  - This may include, for example, helping youth accept responsibility for harm caused by criminal actions, teaching youth about the impact of crime on victims, families, and communities, exposing youth to victim perspectives, and reparation/restorative justice activities.
- Restorative activities must be scheduled, conducted, and in accordance to the provider's program model.
- Restorative activities must be clearly reflected in documentation.

IV.21.04 Skills Development

Structured programming must be staff-lead, provide youth with the opportunity to build and practice social and interpersonal skills, and be processed with youth afterward.

- Staff must be knowledgeable about the psychosocial needs and strengths of all youth placed at the facility.
- The psychosocial needs of youth must be addressed in each individual youth’s service plan and through general programming.
- Life skills are generally defined as skills that help youth function more successfully and responsibly in everyday life situations, including social skills especially in interpersonal relationships.
  - This includes, for example, identification and avoidance of high-risk situations that could endanger self or others, communication, interpersonal relationships and interactions, anger management, non-violent conflict resolution, emotional regulation, and critical thinking, including problem solving and decision making.
- Programming must provide youth with the opportunity to build and practice other life skills, such as household management, financial literacy/independence (see separate standards below), time management, work, study habits and opportunities, planning and goal setting, daily living activities, accessing and using community resources, etc.
- Youth must have the opportunity through programming/activities to build and practice life skills, independent living skills, and daily living skills (ADL – activities of daily living), etc.
- Programs must structure activities to support lessons learned in school by reinforcing what youth learned in school. For example, cooking can help reinforce different lessons such as measuring ingredients or reading and writing recipes.
- These types of activities must be calendared on a weekly basis, at a minimum.

IV.21.05 Religion/Spirituality

Providers must allow youth the ability to practice their religion including access to religious services.

- Staff must be respectful of each youth's right to practice or not practice his or her religion.
- Providers must give youth, upon request, access to practice his or her religion and access to religious services and clergy of their faith.
- Youth cannot be required to attend religious services. Furthermore, every youth has the right to ask to be removed or separated from any religious services at any time.
- Providers may not favor any religion over any other and may not promote religious worship**.**
- Providers are prohibited from discriminating based on a youth's religious choices.
- Providers are prohibited from engaging in or promoting religious worship, instruction, or preaching, including through volunteers and religious representatives.
- Providers must accommodate youth's religious practices to the highest possible extent, without compromising the safety and security of the facility, including but not limited to: access to special apparel for religious reasons; fasting (see below for additional information); religious dietary requirements (exception: the use of alcohol or intoxicating substances); prayer at specific times throughout the day and religious holiday observance; and a youth's request to spiritual counseling from a religious representative of his or her own faith.
  - If a youth is taking medication or has any medical condition that requires treatment by a physician, fasting should be discussed and approved by the youth's treating physician.
  - Staff must be made aware of fasting youth and a staff member must be designated to monitor, in consultation with medical team, the youth throughout fast.
- All religious volunteers and representatives presiding over or participating in religious services at CTH facilities must adhere to all ACS and provider policies and must be treated as visitors (subject to all ACS and provider policies regarding visitors: must be searched for contraband, must sign the visitor's log, etc., and are subject to clearance checks).
- Staff must supervise youth in all religious services, both on site and in the community, in accordance with ACS and facility policies on staffing ratios.

IV.21.06 Exercise and Nutrition

Providers must offer youth adequate daily exercise and must provide youth with education/skills in both exercise and nutrition.

- Exercise activities must be planned in advance and included in the recreation calendar.
- Exercise can include any number of activities such as jumping rope, yoga, basketball, or other physical recreation activities that promote teamwork, motivation, self-esteem etc.
- Providers must incorporate youth's feedback when planning exercise activities if the activities do not interfere with the safety, security and health of youth.
- Providers must provide each youth the opportunity to engage in at least one (1) hour of large muscle exercise each weekday and two (2) hours each day on weekends. Youth must have regular opportunities to exercise outdoors, as permitted by weather, safety, and security.
- Youth exercise can take place in the facility or at a community location (e.g., YMCA).
- Youth on disciplinary (e.g., Egregious Behavior Protocol) status must also be provided with the opportunity to engage in exercise.
- Staff must appropriately supervise youth whose physical activities must be restricted and monitored due to a medical condition.
- Providers must offer youth education and skills for enhancing nutrition (e.g., set up a session in which youth are taught how to read food labels and make decisions about healthy food options).
- Providers must set up educational sessions to support youth with specific dietary restrictions/therapeutic diet such as diabetic, gluten-free, etc.

IV.22.00 Financial Literacy

Through the end of disposition, providers must provide opportunities for youth to develop financial literacy skills, with the goal of promoting financial responsibility and independence.

- Financial literacy curriculum must be part of the providers' programming for all youth in placement including, but not be limited to the following topics:
  - Providing access to information on financial management;
  - Understanding money in our society;
  - Introducing principles of money management: saving, spending, budgeting, investing, and debt;
  - Establishing and protecting credit: paying bills on time, role of credit cards, and role of credit scores; and
  - Employing strategies for minimizing debt.
- Before youth are released from placement, providers must assist each youth with opening a bank account, as feasible and with appropriate consent.

IV.22.01 Regular Monetary Allowances

Each youth must receive a regular monetary allowance from providers. Providers have discretion to offer financial incentives (e.g., for special program participation, for meeting established goals, for meeting certain behavioral expectations, etc.) in addition to allowances.

- At minimum, each youth is entitled to one (1) dollar per day for each day the youth is a resident of the program. At least half the amount of any allowance and any other financial incentive accumulated by each youth must remain in the youth's allowance record instead of being disbursed to the youth.
- Each youth in care must receive a regular allowance which must not be used to meet basic needs.
- Any money belonging to a youth and being kept in custody by an agency must be accounted for separately from agency funds.
- Providers must have an internal protocol to provide youth with regular allowances. The protocol must include the following components:
  - Amount of money youth will receive as allowance;
  - If the provider will create savings accounts for youth;
  - How the agency will disburse youth allowances;
  - Instances when youth can have access to their accumulated allowance;
  - How the agency will keep records of allowance transfers from agency accounts to youth account;
  - The process for documenting allowance distribution; and
  - The process for issuing final allowance payment to youth upon release or transfer from the residential placement facility.
- The documented allowance amount should be signed by the sending and receiving facility responsible for the record keeping of the youth's account.
- Youth must be allowed to use their allowances to pay for restitution, community service, or meet their court orders, as applicable.
- Providers must keep a written record of each youth's allowance and/or incentives (see sample allowance form attached to the Allowances and Financial Literacy Training policy). Providers must document:
  - The dates of every accrual of allowance and incentive money to a youth's allowance record and the amount of money provided at each transaction;
  - A receipt and record of each approved purchase made by a youth;
    - Providers must note any transactions or purchases where a receipt is unavailable or not provided.
  - The dates of each occasion when a youth is physically provided with money from his or her allowance record including a short description of the circumstances surrounding each occasion (e.g., "youth provided five (5) dollars when dropped off for home visit," or "youth provided two (2) dollars to buy snack at museum.");
  - The signature and title of the staff member who provided the youth with his or her money and who documented the record; and
  - The youth's signature for every instance he or she received money.

V.01.00 Staffing Requirements

Providers must have adequate staffing for each facility and must have access to emergency/back-up/on-call staff to meet the required staff-to-youth ratio at all times.

- Providers must meet ratio requirement as set forth in the Safety and Security section.
- Facilities are required to have on-call staff available to meet the minimum staffing ratio when additional staffing coverage is necessary or required. Outgoing shift must not leave until minimum ratios are met.
- Providers must maintain a current list of all active and inactive full-time time, part-time and per diem direct care staff for each shift, hours of coverage, and plans for emergency coverage.
- Current address and contact information must be available for all staff for emergency purposes.
- Providers must make efforts to ensure that staff vacancies are filled as quickly as possible.
- If staff are being split between programs, youth must still be able to receive all necessary services in a timely manner.
- Providers must arrange for on-call coverage, 24 hours a day, 7 days per week including holidays and vacations, for consultation by appropriate mental health and medical staff for acute and chronic conditions and emergencies. Facility supervisors or designees must be on call 24/7 in case of emergency.
  - Facilities must have a written process to escalate situations that require supervisory/managerial assistance.
  - There must be a clear chain of command available for ACS review that captures provider procedures.
  - Providers must submit an updated organization chart to ACS for review.
- All LSP facilities must always have a minimum of one (1) staff person in a central control room in each LSP program site.
  - The control room staff responsibilities include but are not limited to: maintaining facility keys and two (2)-way radios, overseeing screenings of entries and exits to and from the facility, maintaining the mechanical restraints, monitoring the CCTV surveillance system and communicating emergencies to the supervisor.
- Providers must make efforts to hire linguistically and culturally responsive staff representative of the population served and fluent in the languages spoken by participating youth and family members. This may include hiring staff from the same community where the program services are being provided.
  - When it is not feasible to hire bilingual/bicultural staff of different ethnic/cultural community groups, providers must have letters of linkage, Memoranda of Understanding (MOU), or other written agreements with community-based organizations; have language lines to communicate with families via phone calls; or have contractual arrangements with interpretation and translation service providers to serve non-English speaking children and family members.

V.02.00 Required Staff Qualifications

Providers must have appropriately qualified and trained staff to meet the needs of youth in their programs.

- Providers must comply with all minimum required staff qualifications and staffing ratios set forth in the QAS, ACS policies, the law, and, as applicable, the Program Model Requirements.
- Providers must ensure that all staff working with youth have obtained a high school diploma or high school equivalency diploma and completed the minimum hours of training set forth in the QAS, ACS policies, the law, and, as applicable, the Program Model Requirements prior to directly supervising or providing services to youth.
- Providers must make diligent efforts to hire qualified staff members that are sensitive to the cultural and linguistic needs of youth and families and are able to engage with, and offer programming and services to, individuals and families with diverse backgrounds and experiences including, but not limited to: race, gender, sexual orientation, language, immigration status and nationality, trauma, religious affiliation, physical, mental and/or emotional status.
- Providers are responsible for recruiting, hiring, training, supervising, and retaining appropriate personnel to meet the needs of the youth.
- Providers must assure all clinical staff, including physicians, nurse practitioners, psychologists, nurses, etc. are licensed professionals and meet necessary qualifications and maintain their professional license while employed with contracted agency.
  - Staff may be considered when working towards licensure under appropriate supervision.
- Interns or other temporary support may be used to support or supplement services under the supervision/direction of qualified staff.
- Providers must have the credentials of their staff available for review, including internal process of verification of credentials and documentation of degrees received, licenses, experiences, and references.
- Staff must, at minimum, meet the qualifications listed below for their appropriate positions. Any exceptions or waiver requests must be communicated to ACS in writing including details regarding the request and rationale for the staffing decision:
  - **Director/Supervisor of Social Work Services:** A master's degree in social work or graduation from an accredited school of social work and a minimum of two (2) years of experience, with at least one (1) year of experience, in a supervisory capacity in the field of child welfare, or a minimum of three (3) years of experience, with at least one (1) year of experience in the field of juvenile justice, under qualified supervision. LCSW or LMSW or Licensed Mental Health Counselor preferred.
  - **Program/Site Director:** (for General NSP or LSP Programs) A master's degree in a human service-related field preferred with three (3) years of experience working with court involved youth. At least three (3) years of experience must include working in a residential setting. A candidate may also have a bachelor's degree in a human service-related field with five (5) years documented satisfactory experience working with court-

related youth. At least three (3) years of experience must include working in a residential setting.

- **Program/Site Director:** (for Specialized NSP or LSP Programs) LMSW or equivalent licensed human services graduate degree preferred with a minimum of five (5) years documented satisfactory experience working with court-related youth. At least three (3) years of experience must include working in a residential setting and at least two (2) years working with the specific specialized population that the site will serve.
- **Assistant Site Director/Assistant Supervisor/Group Leader:** Associate degree preferred. Candidate must have at least a high school degree or equivalent diploma and have one (1) year of experience working with at-risk youth. Must be qualified by appropriate training and have experience with children living in a group living facility.
- **Youth Care Counselor/Specialist:** Must have at least a high school degree or equivalent diploma. LSP sites staff must have experience working with at-risk youth (e.g. paid, volunteer, internship, community service). Providers should make all efforts to hire staff with relevant experience working with youths.
- **Caseworker/Case Planner:** MSW or equivalent human services graduate degree (preferred) or bachelor's degree with at least two (2) years of documented relevant experience.
- **Nurse:** New York State registered professional nurse or licensed practical nurse.
- **Additional Staff:** The following positions may be hired staff or providers may utilize consultants, including but not limited to the categories included below. For each consultant utilized, providers must have a signed contract and a record of the consultative services provided. Consultants may be shared across multiple programs.
  - Psychologist: Certified as a psychologist in New York State.
  - Psychiatrist: Licensed physician with a specialized rating in psychiatry.
  - Physician: Licensed and currently registered to practice medicine in New York State.
  - Mental Health Professional: LCSW preferred or LMSW/licensed mental health professional (e.g. MHC, MFT, etc.) with equivalent human service graduate degree and at least two (2) years documented relevant experience.
  - Substance Abuse Professional: Substance use clinician who is trained in evidence-based substance abuse and meets the standards of the therapeutic model being used.
  - Dietitian: Bachelor's degree with major studies in food and nutrition and registered with the Academy of Nutrition and Dietetics.
- Other therapeutic resources
  - As necessary, LSP sites serving youth with IDD diagnoses must have access to a minimum of on-site speech and language pathology services two (2) hours per week, per youth. If a youth requires more than two (2) hours per week of speech and language pathology services, providers must ensure that the youth receives on-site services as required.
  - Providers not serving IDD youth shall supply or arrange for speech, occupational, and physical therapy as needed.
  - To the degree possible, LSP providers must supply on-site speech, occupational and physical therapy when ordered by the primary care provider.
- Request for waivers must be submitted via email with justification of the request to the Close to Home Associate Commissioner.

V.03.00 Staff Workload and Coverage

Providers must have staff, professional consultants, or close linkages with resources that are qualified to address the full range of medical, clinical, and developmental needs presented by children and adolescents in residential care.

- Providers must maintain, at a minimum, the following staff or function support:
  - Supervision of Social Work Services;
  - Site Director, Program Director, and/or Lead Supervisor;
  - Assistant Site Director, Assistant Supervisor and/or Group Leader;
  - Youth Care Counselor and/or Youth Care Specialist;
  - One (1) certified SCM/TCI trainer
  - Caseworker/ Case planner;
  - Substance Abuse Staff (Specialized Substance Abuse Program only);
  - Nurse
- Providers must have, at a minimum, access to staff to perform the following functions, either through referrals or on-site:
  - Psychiatrist
  - Psychologist
  - Mental Health Clinician;
  - Physician
  - Recreation Therapist and/or Specialist;
  - Educational/Vocational Supports;
  - Cook (must possess food handling certificate);
  - Trainer Facilitator; and
  - Therapeutic Model Consultants as needed.
- Each LSP facility must designate an existing staff member to manage PREA compliance to oversee facility's implementation of PREA and compliance with ACS policies on preventing, detecting, and responding to sexual misconduct.
- Providers must designate an agency staff person to be the LGBTQ point person. ACS must be notified upon designation.
  - The LGBTQ point person will serve as a source of support to youth and as a resource to staff on LGBTQ issues.
  - This person will schedule, and document staff training in LGBTQ issues and participate in ACS's organized forums for education and information on LGBTQ issues.
  - If applicable, the LGBTQ point person will work with providers' home finding department to identify LGBTQ friendly and affirming homes.
  - The LGBTQ point person must receive on-going regular training and education on an as-needed basis.
  - The LGBTQ point person is responsible for conducting outreach to establish a network of services for LGBTQ youth and their families/discharge resource.
- Providers must designate an agency staff person, and notify ACS upon designation, to be the Domestic Violence (DV) Services Coordinator.
  - The DV Services Coordinator will schedule and document staff training in domestic violence, and participate in ACS's organized forums for domestic violence education and

information on issues such as chemical dependency/use and domestic violence, immigration, working with abusive partners, the effects of domestic violence on children, etc.

  - The DV Services Coordinator must receive on-going regular training and education, including case conferencing, on an as needed basis.
  - The DV Services Coordinator monitors provision of domestic violence assessments with birth families and foster families, and the use of the ACS's DV Screening Tool and ACS's DV Protocol at intake and periodically afterwards, receives reports of indicated domestic violence from ACS's PPS and other referring organizations, and conducts outreach and liaison to establish a network of services for domestic violence.

- Providers must work diligently to fill vacancies and report updates to APA during the Monthly Safety/Rick Check calls.

V.04.00 Screening of Potential Employees

All potential employees, volunteers, and providers must receive all required screenings for their positions including but not limited to VPCR and SCR clearances.

- Providers are responsible for conducting verification of credentials, references and screening of all current and prospective employees.
- Staff members who have not been cleared by SCR/VPCR/Criminal background check will not be allowed to work directly with youth in care.
  - Staff may be permitted to begin required training in advance of screening so long as training is held offsite and not in CTH residences.
- Providers must annually verify that all professional licenses are active, have not expired, or have not been suspended.
  - Licensed staff include, but are not limited to, doctors, psychiatrists, psychologists, LCSWs, LMSWs, LMHCs, etc.
  - Providers must follow up in an ongoing and timely manner with any license-eligible individuals who have been hired on the condition that they receive their license within a specified period, to ensure that the condition has been met.
- Screening of all current and prospective employees should include, but is not limited to:
  - Before hiring, all applicants must complete an employment application that includes obtaining a statement or summary of each applicant's employment history, including but not limited to, any relevant child welfare experience.
  - After a conditional offer is made to a prospective employee, providers must obtain current background declarations indicating criminal conviction records and conduct a record review through the Division of Criminal Justice Services (DCJS).
  - Inquiry to the State Central Registry (SCR). Each prospective employee must receive a written notice of provider's intention to make an inquiry to SCR.
  - Confirm or review agency alerts in regard to the Justice Center's Staff Exclusion List (SEL).
    - Justice Center clearance for each individual must be conducted by providers on an annual basis.
  - Fingerprinting all prospective employees. Fee may be paid by prospective employee or providers.
  - Driver's license information for all staff approved to drive an agency vehicle.
    - Providers must annually verify that all license information is up-to-date (e.g., if a license has expired, providers must request access to see the new license).
- Providers must make employment decisions concerning prospective employees with a criminal record in accordance with the law. In the event the provider hires a candidate with a criminal record, the provider must document the basis for the decision to hire such employee, which must be signed and approved by the provider's executive director or designee, and available as requested, for ACS review. Providers may not retain an employee on a probationary basis until confirmation is received that the employee is not on the Justice Center's Staff Exclusion List (SEL).

- Providers may retain an employee on a probationary basis in accordance with Children's Services' policies, pending the results of the record review conducted by DCJS and the SCR. For such probationary hires, the provider shall keep in confidential personnel files documentation describing supervision and measures taken to ensure the safety of children with whom such staff is working, pending background clearance.
  - Providers must notify ACS of decisions to hire employees on a probationary basis pending the results of a criminal background check.
- A physical examination must be required of all staff as a condition of employment and must include an intradermal tuberculin test or Quantiferon test, with chest x-rays where such test results are positive, or candidate presents with a history of +PPD.
  - The candidate needs to be certified in writing for fitness of employment.
  - Such certification must be retained by providers and kept available for inspection.
  - Staff must be tested for TB on an annual basis.

V.05.00 Required Staff Trainings

Providers must offer, and staff must attend, all required trainings. All staff who work directly with youth, or who supervise staff who work directly with youth, must receive training. The topics covered should be aligned to the role and can include but are not limited to the following topics to ensure staff understand and comply with program expectations. The items listed below do not require standalone trainings but can be incorporated in their training requirements:

- Providers must have an annual training plan that describes the specific trainings and length of each that are required of, and offered to, each staff level.
- Providers must track and monitor staff compliance with annual training requirements and must be clearly defined in documentation found in the personnel folder, training transcripts or training logs.
- Staff must be re-trained as frequently as specified by the therapeutic models/approaches and ACS policies.

Trainings

- DYFJ Onboarding
- The Program Model
- The physical intervention/crisis management system [Safety Crisis Management (SCM), Therapeutic Crisis Intervention (TCI)]. Providers utilizing other physical interventions/crisis management models, as approved by ACS, must ensure staff are trained in the model prior to working directly with youth. If applicable, for providers that utilize SCM, providers must have at least one (1) certified SCM trainer on staff.
- Suicide prevention and intervention
- LGBTQ and TGNB affirming trainings supporting LGBTQ youth in care
- Critical thinking and decision-making skills
- Mandated reporting (Justice Center Mandated Reporter Child Abuse and Maltreatment)
- Child Abuse and Maltreatment
- Adolescent development
- Substance abuse and trauma
- Information about the NYC Department of Education (DOE) and education services, including special education services, and the importance of continued education for youth.
- First Aid
- CPR
- Fire Safety
- Workplace Violence
- Crossover Youth Model (CYM)
- Cultural competency
- Domestic violence
- Group dynamics and group facilitation skills
- Working with gang involved youth

- Connections training (completing FASP, Progress notes, etc.)
- Safety and Risk: Investigation, Synthesis, and Assessment
- AWOC
- PREA (LSP)
- Risk and Responsivity framework
- Supervisory training (administration, education, legal, support, building coaching competencies, etc., as needed)
- OSHA and Blood Borne Pathogens
- Understanding and Undoing Implicit Bias
- Program therapeutic models and approaches
- For LSP sites, all direct care staff and supervisors must be trained in the use of mechanical restraints at least every six (6) months
- Any other trainings specified by ACS
- Supervisors must continually assess the training needs of their staff relative to the population of youth in their care at the time, and tailor the trainings so that identified training needs and professional development of staff are met.

Medication Trainings

- Medication training must occur within the first 6 months of on-boarding for employee's responsible for administering medication.
- Medication administration and common psychotropic medications prescribed to the youth in placement, including the risks/side effects associated with such medication, basic information about administering medication, and the dangers that can result from missed or improperly-administered doses of medications.
- Staff not trained in self-administration of medication will not take part in the self-administration of medication until they are trained.

Other Training Requirements

- All Education Specialists must attend the ACS Office of Education Support and Policy Planning (OESPP)/DYFJ trainings on education issues for Education Specialists.
- Providers must provide trainings to all staff related to the importance of career readiness preparation for youth and the specific services/supports available at the agency.
- Staff assigned to the control room must be knowledgeable and trained in the control room policy (LSP).
- Caseworkers and nurses must be trained to deliver information on family planning and sexual health, including HIV/AIDS and youths' rights to access confidential services.
- Providers will provide training to staff regarding the involvement and responsiveness to families and placement. Families must be treated with dignity and every effort needs to emphasize they are a crucial team member.
- All NSP and LSP clinical and leadership staff must be trained in CSEC awareness and prevention as offered by ACS Office of Child Trafficking Policy and Prevention (OCTPP).

V.05.01 Staff Supervision and Coaching

All direct care staff shall receive and participate in bi-weekly individual or group supervision sessions. Supervision may occur during individual sessions, team meetings, during on the floor coaching and during model-based staff and youth group/individual activities. All supervision sessions and activities must be documented and reviewed with staff on an individual basis. All clinical, and behavioral health staff must receive at least one (1) hour of supervision (individual and/or group), at a minimum, every two (2) weeks. Caseworkers must receive at least one (1) hour of supervision (individual and/or group) every week. Newly hired probationary staff must receive weekly supervision, or more if needed, for the duration of their probationary period.

- Providers must continually assess the training needs of their staff, the effectiveness of trainings implemented, and tailor the trainings so that identified training needs are sufficiently met.
- Providers must ensure all caseworkers receive at least one (1) hour every week of individual and/or group supervision from an MSW, or equivalent human services graduate degree level supervisor. Supervisory case reviews must occur in the context of supervision (individual and/or group) with the caseworker. The case reviews must include: a thorough discussion of the preceding and current case issues and dynamics, careful monitoring of the quality of the casework provided, and clear support and guidance to staff in making critical case-related judgments and decision.
- In the case of an extended absence of a supervisor, appropriate supervision must continue.
- Supervisors must maintain an up-to-date record of supervision meetings with each of their staff.
- In addition, providers must use all available opportunities to coach staff outside of the supervision sessions (e.g., while on the floor). Informal coaching of staff does not need to be documented.
- Direct care staff shall participate in bi-weekly individual supervision, group supervision, model fidelity supervision or team meetings and providers must have a process in place to document staff's attendance and participation in supervision sessions.
  - Staff absences should be captured in the documentation of supervision sessions.
- Supervisor must evaluate all staff's performance in order to determine if supervision schedule needs to be modified in order to strengthen staff's job performance.
- Providers must document all supervision sessions, and documentation must be available for ACS's review upon request (including an agenda, sign-in sheet, and meeting minutes for all staff meetings, and trainings).
  - Model fidelity reports/supervision notes must clearly stipulate how the group leader or supervisor has provided supervision and coaching to staff on the floor.

Group Supervision

- Group supervision must take place, at a minimum, once (1) a week for all direct care staff and supervisor of direct care staff. Group supervision can include group team meetings, trainings, model fidelity group activities, etc.

- Supervision sessions should include, but are not limited to, a review of critical incidents, if any, lessons learned and action steps, upcoming mandatory and recommended trainings, facility maintenance and updates (e.g., issues that could impact safety and security), policy and practice changes (e.g., new policy trainings), issues with youth supervision, strengths, areas for improvement, etc.

Per diem/ On-Call Staff

- Supervision with per diem staff can be completed via phone as needed to accommodate the schedule of per diem staff (e.g. works full-time day job).
- Per diem/on-call staff must make all efforts to attend weekly group supervision team meetings at a minimum one (1) time every month.
- Per diem staff must participate in all mandatory trainings.
- Providers must ensure per diem staff are made aware of upcoming mandatory trainings, supervision schedule, schedule changes/shift coverage opportunities, critical incidents, and new and existing program policies and expectations.
- In addition, per diem staff must have individual supervision sessions, at a minimum but more frequent as required by the individual needs of the staff, as indicated below:
  - Per diem staff working between 0 and 40 hours per pay period will receive one (1) supervision session per month.
  - Per diem staff working between 40 and 80 hours per pay period will receive two (2) supervision sessions per month.

Aftercare Supervision

- Bi-weekly supervision may occur as individual sessions or during team meetings with one occurrence of individual supervision per month.

V.06.00 Supervisory Case Reviews of CNNX

Supervisors or designees are required to conduct and document case reviews in CNNX monthly (every 30 days) at a minimum. Review must be completed and documented no later than 10 days after the month has been completed.

- Supervisors/designees must document case review findings in CNNX.
- The supervisor must ensure that:
  - The Family Assessment Service Plan (FASP) is completed and documented in a timely manner.
  - Progress notes are of good quality; focus on permanency, well-being, and the safety of the youth; and are documented contemporaneously within five (5) business days.
  - Contacts with discharge resources including home assessments are documented in CNNX.
  - All efforts made to coordinate with PPS about the welfare of youth, including, but not limited to, approvals and meetings (e.g., SPR/FTC, Discharge planning, Red flag etc.) are documented contemporaneously in CNNX.
  - All family visits and attempts to coordinate a visit are documented in CNNX.
- Case reviews must include, at a minimum, a supervisory review of the case notes, tabs in CNNX (e.g., health, education, etc.), FASP, and an assessment of next steps for each youth on the worker's caseload.
- Reviews must include a discussion of current case issues and dynamics, monitoring of the quality of casework provided, and clear support and guidance to clinical and casework staff in making critical case related judgments and decisions.
- Supervisors must conduct case reviews to make sure that: documentation confirms the needs of the youth are being met; required contacts with youth and family members are happening; and follow up is completed with regards to education needs and medical needs, if necessary; diligent efforts are made if the youth is AWOC; etc.
- Appropriate coverage must be provided in the event of an extended absence of a supervisor to ensure case reviews are not interrupted.
- Supervisory reviews must be entered as final in Connections by the next calendar month in order to ensure meaningful communication and feedback to the case planner.

V.07.00 Performance Evaluations

All staff must receive, at a minimum, a written performance evaluation annually.

- All staff must have written tasks, standards and expectations.
- Performance evaluations of all staff must be conducted annually at a minimum.
- Staff in their probationary period must receive performance evaluations at least every six (6) months until the end of their probationary period. New staff must receive their first review within six (6) months of starting their probationary period and annually thereafter.
- Performance evaluations must be based on information from ongoing direct observation of job performance, review of documentation, and assessment/observations made during supervision.
- Results of performance evaluations must inform the goals set in the performance/goal plan for the coming year. Performance evaluations must support providers' effort to strengthen constructive behavior and reward positive performance.
- Performance evaluations must also be used to guide professional development and future training objectives for staff.
- Providers must have a process in place for addressing staff who do not meet performance expectations.
  - Providers must have a progressive disciplinary action in place in the event a staff member is not meeting performance goals after continuous supervision.
  - Employee counseling or administrative sanctions must be documented and kept in the employee record/file.
- Performance evaluations must be documented and available for review upon ACS's request.

V.08.00 Professional Boundaries

Providers must ensure that interactions between staff, youth placed at the facility, and the family members of youth are always professional.

- Providers must have mechanisms in place to ensure staff always maintain a professional relationship with youth.
- Any initiated contact with youth or youth's family should be in the context of the professional relationship. If contact is made following youth's completion of aftercare, this must be done so with prior written approval from the facility director or aftercare director.
- Staff may communicate with youth only in the context of the professional, helping relationship and not for personal or non-work-related purposes.
- Staff may support youth, or the family members of youth placed at the facility only within the context of their professional relationship.
- Staff must immediately notify their supervisor in writing whenever a relative, friend, or a person with whom the employee has or had a close personal relationship is admitted to any facility. Providers must notify ACS immediately if this situation arises.
- Staff must follow providers' conflict of interest policies regarding any business or financial relationships and not take unfair advantage of any professional relationship to advance their own interests.
- Individual staff ***must not***:
  - Accept requests from or engage in personal relationships with youth on social networking sites or other electronic media to prevent boundary confusion, inappropriate dual relationships, or harm to youth unless required by their professional role (e.g. youth is AWOC).
  - Engage in romantic or sexual contact of any kind with a youth or with a youth's family member.
  - Discuss the case history of a youth with another youth.
  - Receive a gratuity or gift from any youth placed at the facility or other person acting on the youth's behalf, or from a youth's family member.
  - Give any gift or gratuity to a youth or a youth's family member.
  - Solicit money or other items from a youth's family or friends.
- Providers must ensure all staff members are aware and familiar with this standard.
- Providers must report any violations of this standard to MCCU, their internal leadership, and ACS leadership as applicable.

VI.01.00 Family Participation

Providers must encourage families/resources and other social supports to actively participate in youth's rehabilitation, service planning and programming. Staff must actively encourage families/supports to attend Family Team Conferences (FTC).

- Providers must contact the families/resources within 24 hours of the youth's arrival in the facility.
- Families/resources must be encouraged to attend a program/facility orientation, and they must receive a family handbook, orientation to the program model, and, when feasible, an opportunity to tour the facility.
- Providers must make every effort to consistently engage youth's families/resources and other social supports in all aspects of a youth's life including, but not limited to, decisions around youth's service plan, education, medical and mental health care, development, and overall well-being.
  - Providers must attempt, at minimum once (1) a month face-to-face contact with youth's families/resources. If face-to-face contact does not occur, diligent efforts must be documented in CNNX.
- Providers must create programming opportunities for families/resources participation and make all efforts to engage families to attend. This must occur on a regular basis, but no less than bi-monthly.
  - Families/resources must also be engaged through on-site and off-site programming, that gives families/resources access to staff and services in one (1) location (e.g., Family Day or Family Night).
  - Providers should escalate concerns regarding family engagement planning or deviations from the bi-monthly requirement to DPPM.
- Providers must have staff trained to effectively engage families/resources, to recognize the challenges that families/resources face when youth are placed, and to appropriately address non-responsive and/or disengaged families/resources.
- Providers must attempt to engage caregiver/discharge resource to actively participate in developing a treatment plan and goals pertaining to family therapy. This will be captured in the Service Plan Review (SPR), Family Team Conferences (FTC) and CNNX.
- Providers must maintain communication with families/resources to inform and engage them in any decision made about their youth.
- Providers must adhere to all requirements regarding concurrent planning for permanency.
- Providers must engage alternative discharge resources as they engage families/resources.
- Families/resources must be informed and engaged (e.g., treatment team, family therapy, parent/teacher conference) if youth violate program/facility rules.

VI.02.00 Family Visits

Providers must facilitate visitation between families/resources and youth, including scheduling visits and engaging family/resources in programming and services. Each youth must have a visitation plan in place.

Visitation Plan

- Providers must develop a comprehensive visitation plan for each youth that allows the youth the opportunity to receive family/resource visits at least two (2) times/week.
- Providers must arrange and facilitate visits and other forms of communication between the youth, his family, and other discharge resources or significant adults in the youth's life, unless such visitation may place the safety of the youth at risk.
- The visitation plan may include arranging and facilitating telephone calls and ensuring that such telephone contact occurs regularly throughout the youth's receipt of services, and if necessary, providing supervision or clinical services for youth during a youth's visit with family or other discharge resource.
- Providers must obtain advance approval from ACS for the youth to leave the facility for a visit with family.

Facility Visits

- It is the provider's responsibility to arrange and facilitate visits and other forms of contact between the youth and families/resources, when safe and appropriate, unless prohibited or restricted by court order.
- Providers must provide families/resources with the schedule of visitation and this information must be conspicuously posted at the facility.
- Facilities' rules and expectations for visits must include, but are not limited to, information about general visiting days and hours; the process for setting up visitation appointments, including contact persons and appropriate phone numbers; signing the Youth Visitor Log upon arrival and departure; a listing of permissible items (to be developed by providers and approved by ACS); and search requirements for visitors and items/packages where applicable. Any non-permissible items that enter the facility are considered contraband.
- Providers must make and demonstrate efforts to provide a written copy of the Visitation and Facility Rules Guidelines, which captures rules and expectations for visits to a youth's families/resources, as early as possible after a youth's admission to a facility. This can be provided in-person (e.g., family visit, FTC) or via mail and must be signed and dated by youth and parent and available for ACS review.
- Although each facility is responsible for developing its own visitation schedule and procedures (to be approved by ACS), each youth must have a minimum of two (2) opportunities per week for families/resources visits when safe and appropriate, and youth must have a minimum of two (2) telephone calls per week for a minimum of five (5) minutes each to families/resources.
- Transportation of any approved visitors to the facility must be provided by the provider or reimbursement of costs to the visitor must be made if the facility is located outside of New York City or the visiting resource demonstrates need.

- Prior to the initial visit, providers must inform families/resources about rules and expectations for visits. Providers must have a policy and process in place for communicating with non-English speaking families/resources.
- In collaboration with PPS, the youth, his or her families/resources, and staff must develop a list of approved visitors. This listing, as well as a listing of prohibited visitors, must be maintained in each youth's case file, and staff must consult the list prior to each visit.
- Unless prior arrangements have been made and approved by the facility director or designee, children under 18 may not visit a youth in a juvenile justice placement facility without adult accompaniment.
- Providers are required to have a designated space for families/resources visits that must be youth-friendly and conducive to parent-child bonding.
- All visits between youth and their families/resources at the facility must be supervised. A staff member should remain present in the room for the duration of the visit. Providers can determine a specific post for the staff to be positioned in the visiting space. The positioning must be such that it allows for adequate eyes-on, ears-on supervision. This can include being seated at the visiting table.
- The facility director or designee may deny entry to or remove any visitor who appears to be under the influence of drugs or alcohol; is restricted by court order; is identified by a youth in a written request as someone the youth does not want visiting; is not on an approved visitors list; does not consent to being searched upon request; or does not follow facility rules and procedures for visiting.
- All visitors of youth must sign the Youth Visitor's Log, must be searched for contraband (personal searches and searches of packages), and must store their belongings in a secure area for the duration of the visit.
- Providers must not withhold visits as a form of discipline or punishment.
- Providers are responsible for documenting in CNNX any reason contact is not permitted.

VI.03.00 Home passes for NSP

Providers must offer opportunities for youth to visit their homes prior to release. These visits must be consistent with applicable ACS policies and procedures concerning community passes.

- In accordance with the CTH Guideline for Community and Extended Pass, providers must comply with the following guidelines regarding home passes:
- Providers must consider the following prior to authorizing a Community Pass:
  - Family engagement (caregiver participation in youth's service plan, family day, calls, visits, and treatment meetings).
  - Youth participation in programming and school.
  - Youth behavior in placement (incidents, substance use, relationship with staff).
  - Previous experience on passes (was youth compliant while on home pass).
  - Youth's risk for AWOC
  - Youth has been in placement for 30 days.
  - A home assessment has been completed and documented in Connections identifying that the home is found to be safe and appropriate.
  - Providers, PPS, youth, parent/discharge resource should collaborate around how to be effective in addressing family's needs while on home pass.
  - Parents/Discharge resource feedback should be considered in creating plan.
  - Identify any additional support in the community for youth and family (extended family, religious affiliations, mentors etc.)
  - Provider should formulate a plan on how a youth's time on home pass will be spent.
  - Unsupervised Home Pass
  - Providers should be in contact with youth while on home pass. Frequency of contact with youth on home pass should be based on youth YLS risk levels as follows:
  - Low risk youth will be contacted minimally once a day,
  - Moderate risk youth will be contacted minimally twice a day.
  - High-risk youth will be contacted minimally three times a day.
  - Provider should contact the Birth Parent/Discharge Resource at minimum one time per day.
  - If youth is non-compliant with community pass agreement, then Provider shall pick up youth immediately.
  - Providers will provide transportation from home visits
  - Extended Home Pass
  - Extended Home Pass shall be defined as any pass that exceed 72 hours which shall be authorized in advance by the provider (prior to youth going on home pass). The purpose of an extended home pass is to assess a youth's readiness for aftercare. Therefore, we should be working on effectively stepping down a youth from placement to aftercare. Unless authorized otherwise by the Associate Commissioner of Close to Home or designee, extended home passes should not be utilized in any other capacity as described.

- A youth shall be considered for an extended home pass as follows:
- A youth has been making progress in placement and has shown readiness to be in the community through community passes and is being explored for release from placement.
- An effective school plan must be put in place prior to an approval for an extended home pass.
- Provider's frequency of contact with youth on extended home pass should be based on youth YLS risk levels as follows:
- Low risk youth, minimally once a week
- Moderate risk youth minimally twice a week
- High risk youth minimally three times a week
- On a weekly basis, PPS and providers shall discuss whether the pass should continue and if the level of contact should be adjusted.
- PPS should contact their assigned youth, minimally once a week.
- Provider should contact the BP/DR at minimum one time per week.
- Providers should contact education stakeholders on a weekly basis to discuss youth participation.
- Extended home passes shall not exceed more than 30 days. If exceeds 30 days, then a discussion around releasing youth to aftercare should take place.
- Providers should ensure CCRS is updated accordingly
- PPS/Provider should update the youth's attorney/case planning agency of the youth's movement.
- Agency staff should ensure a seamless medical and mental health transition plan is in place by the start of the extended home pass to ensure service needs are met.
- Agency and PPS staff should plan prior to the start of an extended home pass that youth and families have the proper technology (phones with video conferencing) to ensure ongoing communication between the youth, BP/DR, agency, PPS and other service providers.
- Case planning remains with the NSP/LSP case planner. Home passes are not an opportunity for early admittance to aftercare -causes disruption in planning and conferences.
- Documentation/Communication
- Agency should submit a plan amendment in Connections and update CCRS accordingly to reflect the status/location of the youth.
- Each contact must be documented in Connections by PPS and Provider within five (5) business days.
- Any changes in the length/supervision of the passes must be documented in Connections within five (5) business days.
- Upon return from a home pass Provider and PPS must document progress and challenges that the youth/family experience and next steps.
- Providers and PPS should discuss home passes at least monthly during the treatment team meeting and document accordingly.
- On a weekly basis, Providers and PPS should discuss youths' progress and whether extended home pass shall continue.

- Any exception to the above requires the approval of the CTH Associate Commissioner or designee.

VI.04.00 Support Services for Parents, Family, Extended Family

Provider staff must assess the needs of each youth's family/resources and offer services to strengthen the family's/resources' ability to support and supervise the youth. Staff must also encourage reunification and permanency.

- Provider staff must assess the needs of youths' families/resources and provide referral services including, but not limited to therapeutic and psycho-education services; concrete supports, such as public assistance, Medicaid, food stamps, housing, job training and employment assistance, and immigration assistance; services for chemical dependency, domestic violence, health services, and mental health services, as needed.
- Providers must provide referrals for health services, health education, and other specialized support services for the family, extended family, and other discharge resources.
- If providers lack the capacity to provide mental health services to a youth's family or other discharge resources, providers must maintain referral and treatment arrangements with neighborhood-based adult mental health service providers.
- Providers must assess the need for and, if necessary, arrange for services to improve housing conditions for a youth's family or other discharge resources, as applicable. Such services must include but are not limited to:
  - Assisting such individual with obtaining any necessary home repairs;
  - Identifying and arranging for the correction of sub-standard rental housing conditions or code violations;
  - Finding suitable and adequate alternative housing; and
  - Assisting such individual in obtaining appropriate relief or other support from City and State agencies that regulate housing including assistance in obtaining legal services if necessary.
- Providers must, as appropriate, refer a member of the youth's family or other discharge resource that suffers from mental health disorder and needs supportive housing to housing services provided pursuant to the New York/New York III Supportive Housing Agreement and/or other supportive service programs.
- If the provider determines that a lack of adequate housing is the primary factor preventing a youth's release or discharge, the provider must determine, as applicable, if the family or discharge resource is otherwise eligible for a housing subsidy, and if so, make a referral to ACS for the provision of a housing subsidy.
- All referrals must be documented in CNNX.

Parenting Skills

- Providers must assess a youth's parent/guardian's need for parenting education and support.
- Providers must provide parenting education, support and skills training in a manner that is sensitive and responsive to the needs of specific parent groups, such as teen parents, immigrant parents, terminally ill parents, or parents with children with particular needs (e.g. developmental disabilities, mental illness).

VI.05.00 Family Assessment and Service Plan (FASP)

The FASP is a tool for documenting all information and casework activity related to youth in placement. It serves as both a guide and a tool for conducting and recording casework with families. The FASP provides a uniform framework for gathering and documenting assessment information, supporting and recording decisions, and developing and approving plans to address a families'/resources' most significant issues, needs, and concerns.

- Individualized Family Assessment Service Plans (FASPs) must include specific steps and services to reinforce identified strengths and meet families'/resources' needs (Reference IX.04.00 for Aftercare FASP).
- Providers must assess the birth family/caretaker for domestic violence, chemical dependency/use, mental/behavioral health issues, etc., and ensure that service goals address the needs of the families/resources.
- Plans must specify the agency team member responsible, timeframes for accomplishment of goals, and concrete actions to monitor the progress of the youth and families/resources.
- Providers, in collaboration with ACS, must create these service plans utilizing the Family Team Conferencing (FTC) model and Risk-Need-Responsivity (RNR) framework.
- FASP due dates are established in relation to the Case Initiation Date (CID).
- Providers must submit the FASP for review at least ten (10) business days prior to the due date and are responsible for the following FASPs:
  - The Comprehensive FASP is due 90 days from the CID.
  - The Initial Reassessment FASP is due 210 days [approximately seven (7) months] from the CID, and a Reassessment FASP is due every six (6) months thereafter until the case is closed.
  - Plan Amendments must be completed throughout the life of a case whenever a status change occurs between FASP cycles. If a status change occurs before the next FASP can be launched, the status change information should be recorded within that upcoming FASP rather than in a Plan Amendment. Plan Amendments should be completed within 30 days of the triggering event or change.

VII.01.00 Community Advisory Boards

Providers must develop and institute Community Advisory Boards (CABs) to help maximize community involvement and support for CTH facilities.

Purpose:

- To build and foster positive relationships between community members and Close to Home provider agencies as well as maximize community involvement in and support for CTH.

Member Expectations:

- Attend quarterly Community Advisory Board meetings to obtain information regarding the Close to Home program and the status of non-secure provider agencies/residences;
- Serve as third party program ambassadors/program advocates as needed;
- Identify and present for discussion and solution, concerns and issues affecting the community;
- Work in conjunction with community-based organizations, government, private agencies toward the betterment of the community;
- Identify community resources that are beneficial to Close to Home youth and their families;
- Plan, develop and implement community outreach informational programs, events, and community service projects;
- Provide guidance on approaches to communicating program successes; and
- Recruit and orient new members

Meeting requirements

- Community board meetings must occur at least on a quarterly basis.
  - Planned deviations from this requirement must be communicated in writing to the Associate Commissioner of Close to Home.
- Providers must submit the attendance sheet, agenda, and meeting minutes to DPPM.
- Community Boards will have clear and documented objectives and clear expectations for meetings.
- CABs must be comprised of representatives from local non-profits, businesses, mental health service providers, education providers and/or advocates, local arts groups, faith-based organizations, or other interested community members.
- Providers are encouraged to have a CAB for each facility they operate. However, due to feasibility, providers may choose to have one CAB per borough or agency but must demonstrate efforts to include at least one (1) representative from each neighborhood in which the agency operates.

- CTH providers are required to interface with their local Community Advisory Boards and local police precincts prior to opening their facilities and on an ongoing basis.
- Providers must make all efforts to ensure Community Advisory Board members do not have any conflicts of interest based on personal, business, and/or familial relationships with staff or other advisory board members.
- Providers must discuss confidentiality, roles and responsibilities of board membership, and the importance of maintaining youth privacy with Community Advisory Board Members.

VII.02.00 Record Keeping

Providers must maintain electronic and hard-copy paper case records for every youth. Providers must also maintain all log books required by ACS. Entries must be legible, made by appropriate staff within prescribed time frames, and include all relevant and appropriate information.

- The uniform case record must be kept in accordance with Title 18 NYCRR Part 428 and Part 466 or any successor or amended regulation.

Court Documents

- Upon request, providers must furnish documents to ACS personnel in ACS's Division of Family Court Legal Services (FCLS) to support their work on cases involving youth including, but not limited to, requests for case records, family team conference and other conference summaries, FASPs notes, medical records and evaluations, and any written reports prepared specifically for a court.
- Providers must ensure that all documents are furnished, whenever possible, within a reasonable time in advance of the relevant court hearing and must give FCLS Staff an opportunity to discuss the use of the documents with the provider.

Storage of Confidential Information

- Provider must keep the confidential information confidential and must use all reasonable efforts to preserve the secrecy and confidentiality of the confidential information.
- Providers must keep electronically stored confidential information in a password-protected manner.

Record Keeping and Confidentiality

- Providers must maintain adequate program files and fiscal and personnel records (to include, but not be limited to, any history of progressive discipline) and must ensure that staff follows appropriate record-keeping and retention practices and procedures for all records in the provider's possession in a manner that follows ACS Policies and the law.

Health Services Records

- Providers must document each clinical encounter with each youth in the youth's health services record.
- Providers must maintain accurate and legible health services records.
- Providers must organize and store all health services records in such a manner to ensure that a youth's health services record can be located in an efficient and timely manner. Charts will be stored and organized in a manner that is approved by ACS.
- Providers must make available all youth health records in their possession in a timely manner upon ACS request.
- Providers must utilize the formats, forms and/or databases approved or authorized by ACS (e.g. CNNX) to document the health services provided to each youth.

Monitoring

- Providers must track and report outcomes to demonstrate the effectiveness of services and collect and maintain all information and records requested by ACS.

Provision of Information to ACS

- Providers must, upon request by ACS, provide complete information and records relating to each youth.

VII.03.00 CNNX Case Record Required Documentation

Providers must ensure documentation in CNNX and the paper record is accurate, complete, and timely in accordance with required regulations and ACS recommendations. Designated staff must follow ACS guidelines regarding the information that must be documented in the case record and the location (CNNX and paper record).

- The uniform case record must be in accordance with Title 18 NYCRR Part 428 and Part 466 or any successor or amended regulation.
- Providers will designate the specific staff person(s) responsible for entering/documenting all required information into each youth's CNNX case record and his/her paper record and inform ACS of the designation.
- Designated staff must be trained in the use of electronic data systems including CNNX, CCRS, and SSPS and any subsequent tracking systems as required by ACS and OCFS.
- Case records must include, but are not limited to, the following:
  - Demographic and contact information;
  - Copies of all signed consent forms;
  - Up-to-date assessments;
  - Individual behavior plans;
  - Services provided and the youth's progress;
  - Description of services provided by referral;
  - Medical, psychiatric, chemical dependency use/prevention, treatment and aftercare, and education information (documented in line with the provider documentation procedures);
  - Documentation of routine supervisory review; and
  - RNR informed service planning.
- Providers must keep a hard copy/physical record of youth's health history or other relevant health documents not scanned or recorded in CNNX. The following must be maintained as a hard copy and outside of CNNX:
  - Application for Services (LDSS 2921): family album entries for youth freed for adoption and external documentation list/actual documents, including but not limited to:
    - Birth Certificates;
    - Medical Information and Consents;
    - Record of school placement, education reports, and evaluations;
    - Psychiatric/psychological reports;
    - Reports from other agencies;
    - Court Orders; and
    - Correspondence.

VII.04.00 Health and Mental Health Documentation in CNNX

Providers are responsible for maintaining complete health and mental health electronic documentation in the health tab in CNNX for each youth. Such information is confidential and protected by various federal and state laws, and as such, will be restricted in CNNX. Security access is provided to only those with a legitimate need to access such information.

- Providers must maintain each youth's medical record in an organized and readily transferable manner that details all critical information regarding the youth's health status and history.
- Providers must provide a youth's health
- Information to health services providers responsible for a youth's care solely to the extent necessary for the youth to receive comprehensive and appropriate treatment.
- Provider staff must not have access to the confidential information of youth except on a need-to-know basis.
- Providers must keep a hard paper record which includes the MHS report and Bellevue Report.
- The following medical and mental health information must be documented in the Health tab in CNNX, as applicable, for every youth in Close to Home
  - Youth's medical care information throughout placement in the program, including:
    - Appointments;
    - Prescriptions;
    - Parental/guardian and/or discharge resource contacts regarding medical issues;
    - Parental consent for medical/dental treatment;
    - Any referrals;
    - Testing/lab results; and
    - Diagnoses;
  - All clinical appointments:
    - Domain type (e.g. dental, developmental, mental health, physical/medical, substance abuse);
    - Appointment type;
    - Appointment date and/or diagnosis date;
    - Diagnosis (if received); and
    - Treatment recommendations.
  - Biological Family Health Information:
    - Biological mother and/or father;
    - Health information;
    - Allergies; and
    - Additional information.
  - HIV Risk Assessment:
    - Date of HIV risk assessment;
    - Risk factors;
    - Consent;
    - Date of HIV test;
    - Result of HIV test;
    - Health narrative; and

- Reports, progress notes, discharge summaries.

- Sexual and reproductive health assessment:
  - Sexual history: Active/inactive/number of partners/female or male partners or both/protected or unprotected sex;
  - History of non-consensual sexual encounters;
  - History of STI (sexually transmitted infections);
  - Method of contraception; and
  - For female: Age of menarche; last menstrual period; pap smear with results, if known; pregnancy history/abortions/ miscarriages
- Medications:
  - Medication name;
  - Medication dose;
  - Medication route;
  - Clinician who ordered medication;
  - Medication start date;
  - Medication end date (if applicable); and
  - Condition for which medication is prescribed.
- Allergies:
  - Category;
  - Allergen;
  - Allergen start date;
  - Allergen end date (if applicable); and
  - Reaction to allergen if known.
- Durable Medical Equipment:
  - Type of equipment (e.g., inhaler, crutches, eyeglasses, etc.);
  - Equipment start date; and
  - Equipment end date (if applicable).
- Emergency Room Visits
  - Hospital
  - City/town
  - Reason for ER visit
  - Date of ER Visit
  - Start time
  - End time
  - Diagnosis
  - Course of Treatment (e.g., x-rays, labs, CT scans, etc.)
  - Disposition/Recommendations, including follow up visits
- Hospitalizations (overnight stay):
  - Hospital;
  - City/town;
  - Reason for hospitalization;
  - Hospitalization start date;
  - Hospitalization end date (if applicable);
  - Check box for “psychiatric” if appropriate; and
  - Course of treatment during hospitalization (e.g. surgery, antibiotics.), plan of care upon discharge.

- Health provider information (provider name, address, phone number):
  - Primary health contacts.
  - Any specialty health care provider contacts (e.g. Pulmonologist, ENT etc.).

VII.05.00 Confidentiality and Sharing Information

For all youth placed in a CTH facility, providers must ensure the protection of the individual rights of both the parent or caretaker and the youth.

- Providers must ensure the confidentiality of youth's protected information.
- Provider staff must not have access to the confidential information of youth except on a need-to-know basis related to their work with youth.
- Youth must not have access to the confidential information of other youth.
- Providers are required to share information with ACS, the courts, OCFS, and other oversight agencies as required and/or requested.
- When communicating youth related matters in writing, staff must only use their work phone and email to ensure confidentiality is maintained.
  - Personal information (e.g., youth address, phone number, medical condition, etc.) to identify youth must not be disclosed.
- Providers must adhere to the Children's Rights of Privacy Standards which are based on the Title 18 NYCRR Part 441.18 and any successor or amended regulation.
- Youth have the right to review their own case records (electronic and/or paper). However, the format and substance of the requested information is at the provider's discretion.
  - Youth who wish to have access to their own case records must request this information in writing.
  - Providers have up to 30 days to respond to the youth's request.
- Parents are restricted from obtaining information related to their children's HIV status, reproductive health/services, and LGBTQ identification, unless the youth consents to sharing this information.
- Providers may be required to provide information about a youth including youth whereabouts or youth status by a judicial subpoena or court order.
- Providers must make all efforts to verify the identity of individuals requesting information. If you have any questions regarding the ability to share information with any individuals make a request, please reach out to DPPM for additional guidance.
- Providers must obtain a signed authorization from the youth's parent or legal guardian, as applicable, for the release of health information and/or medical records from health services providers that have previously treated the youth. If written authorization for the release of such records cannot be obtained from the parent or legal guardian, providers must notify ACS and request that ACS obtain a court order authorizing the release of such information.
  - A signed authorization is defined as a document that gives covered entities permission to use protected health information for specified purposes, which are generally other than treatment, payment, or health care operations, or to disclose protected health information to a third party specified by the individual.
- If a request for information about a youth is made via phone, providers must confirm the caller's identity prior to releasing information.
  - Confirmation can be accomplished by obtaining the caller's full name and phone number and then returning their phone call.

    - Providers must maintain confidentiality of youth and ensure that the individual requesting information is authorized to receive the documentation.
- Youth's attorney should be provided with the youth's service plan on request, including visitation with parent/guardian and any siblings, as well as any anticipated aftercare release date, if known, and the conditions that must first be met by youth to have youth released to aftercare.
- Staff must document any disclosure of confidential information in CNNX. Providers must address any breach of confidentiality by staff; providers must share with ACS any breach and any action taken against staff along with the outcome of that action.

<u>Use of Confidential Information</u>

- Providers must not use, cause, or permit the confidential information to be used for any purpose other than those purposes permitted by ACS policies and the law.

VII.06.00 Youth and Family Satisfaction Surveys

Providers must offer opportunities for youth and families to share feedback.

- For the purposes of this standard, surveys may include provider generated surveys, ACS surveys or approved third party surveys.
- Youth Surveys
    - Providers must create or adopt and implement surveys that provide opportunities for youth to offer feedback in the areas of: safety & security while in program; the living conditions and environment; understanding rules and rights; staff and youth interaction; visiting schedule and family engagement; program model; programming; and educational services.
- Family Surveys
    - Providers must create or adopt and implement surveys that provide opportunities for families to offer feedback in the areas of: orientation and welcoming experience at the facility; opportunities for visiting and maintaining contact with youth, including completeness and timeliness of the information shared with families about visiting rules and procedures; treatment planning and communications; and discharge preparations, including the incorporation of feedback and involvement in the decision-making process.
- Youth and families must be given the option of submitting surveys anonymously to ensure confidentiality and to prevent retaliation from staff.
- Questions must be clear and specific.
- Providers must use language that is easy to understand in accordance to the developmental stage and the cultural and ethnic background of youth and families.
- Survey results must be kept confidential in a secure place and used by providers solely for the purposes of improving the quality of services provided to youth and families.
- If youth and/or families decline to complete the survey, providers must have a space in the form for staff to document the reason for refusal, if known.
- Providers must offer the survey to every youth and every parent/discharge resource.
- Providers should use survey results to assess feelings of safety, families feeling supported, and effectiveness and completeness of programming.
- Results will be reviewed and discussed during team meetings and utilized to assess program implications and opportunities for improvement.

VII.07.00 Program Manuals

Providers must maintain a comprehensive program manual which includes but is not limited to: a comprehensive overview of the program model, provider administrative and organizational information, site specific information, description of program services and permanency planning, description of support services for families, case practice information, personnel policies and procedures, providers' responsibility in case flow, and record keeping and data management information. This manual must also include a directory of resources, which must be updated on a calendar basis by each provider.

- All program manuals and updates must be approved by ACS.
- Providers must set forth written plans ("Program Manual of Standards, Policies and Procedures") that detail all management systems and design/processes to ensure proper planning, implementation, and operation of programmatic, fiscal, and administrative policies and procedures.
- The program manual must include ACS and internal standards, policies and procedures.
- Providers must keep a paper copy of the manual at the facility available to staff.
- The manual must be kept current.
- Providers must notify ACS in writing within 30 days of any changes in their program manual.
- Providers must provide the program manual to ACS on an annual basis or more frequently if requested/updated.
- Providers are required to rescind, modify, and/or amend their program manual, as directed by ACS, and as often as necessary to be compliant with ACS standards, policies, and the law.
- The program manual must include, but not be limited to, information on the following items below:
  - An overview of the NSP/LSP model
    - The mission and purpose of the program
    - The goals and outcomes of the program
    - NSP/LSP general or specialized program
  - Contract agency administration and organization
    - Organizational structure (organizational chart)
    - Intra agency and community supports, linkages/agreements, and expectations
      - Linkages to and participation in community partnerships
    - Community Advisory Board (CAB): overview, and schedule
    - Board of Directors (names and roles of each member)
  - Site/Milieu
    - Shift staffing
    - Supervision structure
    - Model
  - Physical plant
    - Site capacity
    - Certificate of operation
    - Floor plan

- Division of site by group, if applicable (A/B side)
- Security alarm system and functioning
- Points of egress
- Fire alarm system
- Process of monitoring alarms
- Process of addressing work orders, needs of physical plant
- Camera purview including any blind spots
- Physical facilities and equipment
- Furnishings and environment
- Accessibility – Americans with Disabilities Act (ADA)
- Hours of operation
- Space and privacy
- Physical protection
- Space
- Disaster plan

- Personnel
  - Staffing plan (roles, numbers, requirements by type)
  - Staff qualifications by title/type
  - Culturally responsive staff that reflect the needs of the youth and community
  - Employment and probationary practices
  - Staff training requirements
  - Staff schedule
  - Approach to staff development and supervision
  - Performance evaluation process
  - Grievance policy for staff
  - Disciplinary processes
  - ACS's request to review an employee's background
  - Code of conduct
  - Employee handbook
- ACS Policies
  - ACS Policies
  - Safety Crisis Management/ Intervention Policy/ other approved interventions
  - Policy on Medication Management/Administration
  - Youth and Facility Space Search Policy
  - AWOC Policy
  - ACS Quality Assurance Standards
- Internal Protocols
  - AWOC Prevention Drill protocols
  - Bed check protocol
  - Grievance policy for youth and families
  - Incident tracking/reporting procedures
  - Boundaries training
  - Auditing and monitoring policy
  - Process for provider safety and performance monitoring
- Employment Policies
  - Non-discrimination policy (sex, gender, culture) including LGBTQ

  - Non-engagement in political activity/religion in the workplace
  - Mandated reporter policies
- Emergency Preparedness
  - Disaster and/or emergency operations plan
  - Fire safety and evacuation plan
  - Fire, and other emergency drills
- Record keeping
  - Record keeping and maintenance protocol (electronic and paper records)
  - Documentation of case records (CNNX, JJIS, etc.)
  - Confidentiality
  - Disposal of confidential data
  - Court documents and reports
  - Medical records
  - Management of consent/authorization for the release of confidential information (HIPAA)
- Data collection and evaluation
  - Quality assurance, ongoing data collection and program evaluation
- Youth rights
  - Youth rights handbook
  - Advocacy
  - Access to legal services
  - Coordinating with FCLS/interaction with family court
  - Suspected abuse or maltreatment of children/youth by an employee
- Intake, program services and permanency planning
  - Intake/Assessment protocol
  - Engagement and assessment
  - Integrated services for youth in placement
  - Coordination and service delivery
  - Health services
  - Mental health services
  - Behavior management/modification protocols
  - Substance abuse services
  - Education
  - Sexual health education
  - Health education
  - Enrichment/recreational planning
  - PYA
  - Support services for children/youth with serious health, mental, behavior or medical
  - Managing and monitoring safety and risk
  - RNR/use of YLS
  - Casework coordination with placement and permanency specialist
  - Visitation, visitation plans and family engagement strategies
  - Family assessment service plans
  - Treatment team expectations
  - Transition planning and aftercare
  - Planned release out-of-state

    - Case closing criteria and procedures
    - Medication dispensing/management
    - Interaction with criminal court
    - Attending court hearings
    - Completing court reports
- Support services for birth/extended family and other discharge resources
    - Housing and housing subsidy services
    - Transportation
- Model of care (MYSI, ITM, etc.)
    - Key components and approaches
    - Methods for evaluating model fidelity, including frequency and approach of sharing regularly with ACS

VII.08.00 Workplace Violence Prevention

Providers must develop a workplace violence prevention program.

- The program must include, but not be limited to, periodic risk assessments, implementation of measures to prevent and minimize workplace violence, a process of reporting incidents, and annual training for staff.
- Help raise the overall safety and health knowledge across the workforce through measurable actions such as trainings, drills, testing etc.
- Provide employees with the tools needed to identify workplace safety and security hazards,
- Address potential problems before they arise and ultimately reduce the likelihood of workers being assaulted.
- The training program should involve all workers, including contract workers, supervisors, and managers. Workers who may face safety and security hazards should receive formal instruction on any specific or potential hazards associated with the unit or job and the facility. Such training may include information on the types of injuries or problems identified in the facility and the methods to control the specific hazards. It may also include instructions to limit physical interventions in workplace altercations whenever possible.
- In general, training should cover the policies and procedures for a facility as well as de-escalation and self-defense techniques. Both de-escalation and self-defense training should include a hands-on component.
- Providers must submit to ACS/DPPM upon request a copy of the Workplace Violence Prevention Program and/or transcripts asserting training has taken place annually.
- Providers must incorporate amendments to the Workplace Violence Prevention Program as they occur.

VII.09.00 ACS's Policies and Procedures

All staff must have access to ACS policies/procedures. Providers must have a process in place to verify and document staff's review and understanding of all policies and procedures.

- Providers must have a mechanism in place to verify and document that staff reviewed and understood all policies/procedures.
- Providers must have and implement protocols for assessing staff understanding and adherence to policies.
- Providers must keep the sign-in sheet stored in a binder and available for review upon request.
- All staff members must receive refresher trainings as needed, or as requested and recommended by ACS.
- Providers must be compliant with and incorporate all ACS's policies and procedures.
- Deviations from the policies and procedures must be approved by ACS.
- Providers are responsible for bringing up issues with policy implementation and interpretation in a timely manner.
- Providers must develop protocols to operationalize ACS's policies and procedures.

VII.10.00 Youth Transfers and Modifications

Providers must make diligent efforts to mitigate the occurrence of upward modifications and transfers for youth in their programs. Provider requests for upward modifications must be made judiciously and only in accordance with ACS policy.

Requesting Transfer or Modification

- Modifications must be considered as an option only when all efforts to avoid the modification have been exhausted.
- Providers must show that any modification from NSP to LSP or from LSP to secure placement is appropriate and consistent with:
  - The needs and best interests of the youth;
  - The need for protection of the community; and
  - For moves from LSP to secure detention and/or NSP to LSP, that all other interventions have been exhausted or all other efforts can no longer be pursued in light of an urgent situation; or youth has demonstrated a pattern of behavior that indicates he/she poses a threat to the public safety, including the safety of his/her peers, and requires a more structured setting.
- A lateral transfer involves the transfer of a youth from one (1) facility to another (NSP to NSP or LSP to LSP) and must be considered as an option only when all efforts to prevent the move have been exhausted.
- To the extent possible, providers must enable the youth to participate in the planning process, including a discussion of the reason(s) for the transfer and an exploration of the youth's views regarding the transfer.
- Providers must notify ACS of a pattern of behaviors and/or incidents, which indicate that the youth may need to be removed from the agency. When providers wish to have a youth removed from its program, providers must send a written request for transfer (as outlined below) to ACS documenting the issues or incidents that necessitate the youth's removal from the facility.
- When safety issues are motivating the request for a transfer or modification, providers must work with the ACS PPS to help ensure that safety plans have been devised and implemented.
- Providers must make any requests for transfers in accordance with ACS policy for lateral transfers or step up/step down transfers. Providers must follow ACS policy in terms of the process for requesting a transfer (e.g., form completion, supporting documentation, etc.).
  - Providers must complete a Transfer/Modification Request Report.
  - Providers must provide PPS as much notice as possible when they are considering requesting a youth's lateral transfer to another facility. ACS agrees to respond to the request by scheduling a case conference within five (5) business days of receiving the request. If there is an urgent safety request, provider should alert ACS and request case conference within 1 business day.
  - The case conference to determine whether placement preservation is possible, possibly with additional interventions and/or services, or whether a transfer is absolutely necessary must occur within five (5) business days of ACS receiving the request for transfer.

- Providers are responsible for notifying the youth, youth's attorney, parent/legal guardian, foster care agency and foster parent, if appropriate, of the conference.

Transferring to a Limited Secure Placement Provider

- Providers must notify ACS as early as possible if the provider anticipates requesting that a youth be transferred to a limited secure placement provider.
- Providers may submit a request to transfer a youth to a provider of limited secure placement services when:
  - The youth has exhibited a pattern of behavior that clearly establishes that such youth requires more structure and supervision than (1) can be provided by the provider, and (2) the provider is required to provide;
  - The youth is a chronic and/or long-term AWOC; or
  - The youth has committed or been involved in a serious act that in and of itself is enough to warrant consideration for transfer.

Transferring to Another Provider

- Prior to a transfer, providers must ensure, except in circumstances where the purpose of the transfer is to satisfy the youth's health care and service needs, that the youth's health care and service needs are up-to-date to the extent practicable and ensure that the youth's health records are up-to-date and that all records are transferred to the new provider.
- When a youth is transferred or modified to a different facility, providers must ensure that the youth's health records are up to date and submit the paperwork to the receiving provider prior to the youth's arrival to the new facility.
  - In the event an active or chronic illness or condition exists, providers must coordinate and communicate with ACS and other appropriate parties to ensure continuity of health care and that the youth's health needs are being addressed.
    - As applicable, if youth is on medication, the sending provider must ensure that a two (2) week medication supply is included with youth's belongings.

Receiving a Transfer from Another Provider

- Within 24 hours of a youth's arrival at the facility upon transfer from another limited secure placement facility or non-secure placement facility, providers must review the documentation related to such youth's Comprehensive Health Assessment to identify any active and/or chronic illnesses or conditions and conditions. In the event an active or chronic illness or condition exists, the provider must coordinate and communicate with ACS and other appropriate parties, including the prior limited secure placement facility or non-secure placement facility, to ensure continuity of care and that the youth's health needs are being addressed.

VII.11.00 Quality Assurance/Improvement System

Providers must have an active Quality Assurance/Improvement (QA/QI) system in place, including a process for regularly reviewing documentation, incidents, compliance with ACS policies, and fidelity of any therapeutic approach/model used by the program.

- Providers must have a written quality assurance plan in place that describes the quality assurance, planning, and program evaluation procedures and protocol for services, including but not limited to,
  - Reviewing staff and program performance; and
  - Designing and implementing improvement strategies.
- Providers are required to share their routine QA/QI plans with ACS annually (e.g. for incident reporting and review, logbook review, review and analysis of performance data, etc.).
- As requested, providers will share results of any findings.
- The internal QA must ensure compliance with the core program fidelity, CTH standards, ACS's policies and recommendations via internal reviews on a regular basis and as recommended by ACS.
- Providers must respond to PAMS alerts and response requirements within the allotted time.
- Providers must respond to identified issues of concern from ACS inspections by required deadlines.
- Providers must regularly conduct video reviews of critical incidents, restraints, programming, and bed checks to ensure compliance with policies and to address staff training needs.
- Providers must utilize video reviews, documents submitted to ACS (programming schedule, census, roster, etc.), logbook documentation (Communication Log, Incident Log, MAR Log, etc.), model fidelity, incident trends, PAMS, site inspection reports, etc., received from ACS as tools for monitoring and improving program performance.
- Providers must collect and use data to identify incidents and other trends, identify deficiencies in operations, and use this information to improve program performance.
- Providers must have systems in place to ensure events and incidents are documented accurately and timely.
- Providers must document their reviews, including but not limited to, key takeaways, steps taken to address identified concerns (immediate and ongoing), including details around debriefing with youth and staff members, etc.
  - Key takeaways and lessons learned must be incorporated into trainings for staff as applicable.
- Documentation must be available for review upon ACS's request.

<u>Provider Participation in Collection of Information for Review Procedures</u>

- Providers must participate in on-going ACS assessment, evaluation, and monitoring review procedures concerning the performance of services and must provide all information appropriate to allow ACS to conduct these review procedures and complete a full review of the provider's provision of services.

- Providers’ obligations must include, but are not limited to, working with ACS and ACS consultants and monitors to ensure performance standards are maintained through site visits, Case Record reviews and evaluations, and attendance at pertinent meetings and trainings as requested by ACS.
- Providers must comply with all applicable ACS policies and procedures regarding evaluations, best practices and improvement strategies. Providers must comply with any ACS request to obtain, track or provide additional data.

VII.11.01 Collaborative Quality Improvement (CoQI)

In coordination with ACS, the provider must engage in quality improvement activities throughout each fiscal year. These efforts include active engagement and self-assessment by program leadership, effective and informed development of improvement targets and activities, and ongoing monitoring of the efficacy of activities and progress toward targets.

ACS's CoQI efforts is rooted in monthly and quarterly meetings during which ACS and the provider review an analysis of facility site assessments, critical incident data, monthly safety check data, performance data from Provider Agency Measurement System (PAMS), the agency's self-assessment of organizational health, the most recent performance reports, and other data sources. Between meetings, the provider pursues its annual improvement plan, and along with the APA team, tracks progress and coordinates technical support.

Central to CoQI are the following cyclical milestone activities, in which providers are expected to fully participate:

- Monthly Safety Check: follow-up with and confirmation of actions taken regarding youth and facility safety seen within the monthly timeframes.
- Improvement Planning Session: development of improvement plan, including targets and activities;
- Improvement Plan Assessment: review of progress by ACS and program leadership, and agreement on adjustments to plan as needed; and
- Annual Organizational Review: provider self-assessment and site review;
- Safety Plans: development of short-term improvement plans to address immediate safety concerns, conducted on an as needed basis.

VII.12.00 Safety Plans, Heightened Monitoring (HMS), Corrective Action (CAS), and Probationary Corrective Action Status (PCAS)

Providers shall comply with Safety Plans, HMS, CAS, and PCAS expectations, documentation requirements, deliverables, and benchmarks in a timely manner.

Accountability mechanisms such as Safety Plans, HMS, CAS, and PCAS are not intended to be the primary drivers of agency performance improvements. However, APA uses these tools when standard monitoring does not achieve desired results, or when a significant issue arises that necessitates immediately elevating the level of monitoring. The decision to place an agency and/or program on accountability status is not made in isolation. To inform this decision, there is a comprehensive review of all available data across many sources. There is also the inclusion of the program area on the decision towards accountability status, determination of the status level and at each interval of reassessment while on status.

At any given time during the fiscal year, and depending on the level of concern, ACS can place an agency on an accountability status. Elevation from one status to another may occur when concerns identified have not been resolved within the expected timeframes.

The following is a summary of each accountability mechanism used to address performance concerns:

Safety Plans

- Providers shall comply with the Safety Plan expectations, documentation, and deliverables in a timely manner. Safety Plans serve as a useful tool to inform providers of the facility and/or practice concerns that must be addressed before these escalate into a crisis. Safety Plans will be in effect for a minimum of 30-60 days.

Process for Safety Plans (NSP& LSP):

- DPPM utilizes formal e-mail notifications to notify the provider agency when a program is placed on a safety plan. Assessments of safety plans will occur one week prior to the 30 days to determine the program's readiness to be removed.
- If the program has met all safety plan deliverables within the 30-day period, the program will be removed from the plan, and an email notification will be sent to the agency. If the program has not completed all the deliverables, the safety plan timeframe may be extended for a minimum of 15 days.

Potential Triggers for Safety Plans (NSP & LSP)

- Safety Plans may be utilized under the following circumstances: non-critical incidents ex. multiple incidents of contraband found; outstanding safety & security facility concerns or logbook documentation concerns; reoccurring Provider Agency Measurement System (PAMS) documentation or safety alerts; staffing concerns ex. bed checks not being conducted as per policy or non-compliance with staffing ratio and non-responsiveness of management to ACS/DPPM.
  - While in a Safety Plan, providers must:

- Collaborate with APA in developing the safety plan to address the root cause of the concern and implement an action plan to address the concerns.
- Ensure all agreed-upon expectations related to the safety plan are consistently met.
- Submit required or requested documentation by the established deadlines.
- Rectify critical issues in a timely manner.
- Ensure deliverables are fully executed and implemented.
- Meet the established goals and benchmarks to be removed from the safety plan.
- While on a safety plan, communication with APA may occur as often as determined and communicated by ACS leadership.
- Provider leadership must be accessible for all site visits, meetings, and phone conferences during the safety plan review period.

Heightened Monitoring Status (HMS)

- Providers shall comply with HMS status expectations, documentation requirements, deliverables, and benchmarks in a timely manner. HMS involves an increased level of support, targeted technical assistance in a series of practice domains, and increased contact with the Close to Home provider through in-person meetings or telephone conferences and site inspections.
- HMS will be in effect for 60 to 90 days. The Divisions of Youth and Family Justice (DYFJ) and Policy, Planning and Measurement (DPPM) leadership and monitoring team will debrief all potential triggers for HMS and review CCTV recordings where applicable in-order to make an informed decision regarding an elevated status.

Potential Triggers for HMS (NSP & LSP):

- Critical Incident(s) that have a serious adverse impact to the health, safety, and/or security of youth, and the community.
- Incident categories are:
  - NSP facility AWOC due to staff failure to supervise.
  - NSP & LSP community AWOC due to staff failure to supervise.
  - LSP AWOC during community outing, which was a result of staff failure to supervise.
  - Child Abuse Allegation - Internal based on ACS CCTV review that clearly shows the act of child abuse.
  - Staff on Youth assault.
  - Group assault with injury due to failure of staff to act appropriately to prevent, mitigate or stop the assault.
  - Inappropriate or unapproved SCM techniques which cause injury to youth.
  - Lack of judgement by agency staff which causes injury to youths, or the program's inability to keep the youths safe.
  - CCTV video review shows staff failure to supervise places the youths, staff, and program at risk and creates an unsafe environment. This category can include all categories listed above or noted in the ACS Incident policy.

Corrective Action Status (CAS)

- Providers shall comply with CAS expectations, documentation requirements, deliverables, and benchmarks in a timely manner. CAS involves an increased level of support, targeted

technical assistance in a series of practice domains, and increased contact with the Close to Home provider through in-person meetings or telephone conferences and site inspections.

- Corrective Action Status will be in effect for 60 to 90 days. The Divisions of Youth and Family Justice (DYFJ) and Policy, Planning and Measurement (DPPM) leadership and monitoring team will debrief all potential triggers for HMS or CAS and review CCTV recordings where applicable in-order to make an informed decision regarding an elevated status.

<u>Potential Triggers for CAS (NSP & LSP):</u>

- LSP AWOC from the facility
- More than one facility AWOC within 30 days in which the agency supervision was not adequate to prevent the AWOC
- Re-occurrence of HMS triggers during the HMS period ex. The facility was placed on HMS due to an AWOC incident then another AWOC occurs from the facility while the program is on HMS status
- Suicide Attempt that results in death or injury to a youth or youths due to staff failure to supervise
- Failure to comply with submitting agreed-upon deliverables during the HMS period.
- While in a CAS. providers must:
    - Collaborate with the Agency Program Assistance (APA) Monitor in identifying the root cause of the incident(s) and partner with ACS to develop and implement an action plan to correct deficiencies.
    - Ensure all agreed upon expectations related to HMS/CAS are consistently met.
    - Submit required or requested documentation by the established deadlines.
    - Rectify critical issues in a timely manner.
    - Ensure deliverables are fully executed and implemented.
    - Meet the established goals and benchmarks to return to regular monitoring status; and
    - Adapt plan as needed depending on needs of program/youth.
    - While on HMS/CAS status, communication with the APA may occur as often as determined and communicated by ACS leadership.
    - Provider leadership must be accessible for all site visits, meetings, and phone conferences on a bi-weekly basis.

<u>Probationary Correction Action Status (PCAS)</u>

- Providers shall comply with PCAS expectations, documentation requirements, deliverables, and benchmarks in a timely manner. PCAS involves intake closure, an increased level of support, targeted technical assistance in a series of practice domains, and increased contact with the Close to Home provider through in-person meetings or telephone conferences and site inspections.
- PCAS will be in effect for 60 to 90 days. The Divisions of Youth and Family Justice (DYFJ) and Policy, Planning and Measurement (DPPM) leadership and monitoring team will determine if the program can step down to CAS or HMS or contract needs to be terminated.

<u>Process for HMS. CAS, and PCAS</u>

- DPPM sends a formal letter notifying the provider agency when a program or agency is placed on or removed from an elevated status. Assessment of elevated status will occur every

30 days, but status will be formally reassessed every 60 to 90 days to determine the program/agency's readiness to return to regular monitoring.

- If the program/agency has met all HMS deliverables within the 60-day period, then the program/agency placed on HMS will be returned to regular monitoring.
- If the program/agency placed on CAS has met some or all deliverables, then the program/agency can be stepped down to HMS or returned to regular monitoring. If the provider has not completed all the deliverables or has experienced a critical incident in one of the categories noted below then the program's elevated status will be extended for a minimum of 30 days.
- If concerns have not been resolved during CAS or concerns remain significant after the extended CAS period, ACS will place the program/agency on PCAS. During PCAS, the program/agency has 90 days to address all safety concerns. Failure to not address concerns may lead to termination of contract.

VII.13.00 ACS Site Inspections

Providers must be responsive and available for site inspections at the facility.

- Providers must be available for all scheduled announced inspections and have all requested materials (e.g., log books, work order logs, etc.) readily available for inspection upon ACS's arrival.
  - A supervisor or designee must be at the facility and present during the site inspection and must take part in the debriefing meeting.
  - Staff present during the inspection must be able to access the cameras and manage alarms.
  - Staff present during the inspection must have the facility keys and access to all areas of the facility.
- For unannounced inspections providers must ensure ACS is able to access the site, conduct the inspection, and that all materials are available for review.
  - If staff are not at the site, providers must be able to justify the reason (e.g., all staff transitioned youth to school).
  - The facility director or designee must be on call 24/7.
- Providers are responsible for addressing all issues of concern identified during the inspection in a timely manner.

VII.14.00 Finance and Budget

Providers must adhere to ACS financial, budget, and invoicing guidelines and rules.

- Providers must make adequate funds available to provide youth with the items needed to be successful (e.g., clothes for school, metro cards, food, tools, sports equipment, etc.).
- Fiscal issues must be addressed through appropriate documentation including annual budget guidelines, audit controls and reports, and Federal Form A-133.
- Providers must work collaboratively with their fiscal department/officer in projecting, modifying, and evaluating budgets.
- Providers must manage the budget and invoices as agreed upon by ACS.
- Provider must adhere to all guidelines in the ACS Fiscal Manual.

VII.15.00 Incident Reporting, Documentation, and Review

Providers must ensure all incidents are reported in a timely manner and documented accurately. Providers must review all critical incidents within specified timelines.

- All critical incidents must be reported immediately to MCCU and within one (1) hour of occurrence, or as soon as staff members become aware of the incident, and safety has been established.
- Any report to MCCU that requires a Justice Center or SCR call must be updated with MCCU.
- Providers must conduct a video review of all critical incidents, when video is available, (e.g., all incidents involving a physical restraint) within 48 hours, or sooner if requested by ACS to ensure policy compliance and youth safety.
- Providers must ensure that for every incident:
  - All staff who participated or witness the incident complete an incident report;
  - All incident reports are signed and dated; and
  - All incidents are documented in the Communication Log, and CNNX.
  - All incident paperwork must be maintained int the Incident Log.
  - A supervisor must review all incident forms, address discrepancies in documentation, indicate steps taken to resolve/close the incident, and document these components in the supervisor follow up section of the incident form.
- Providers must ensure incidents are reported and documented accurately and must collaborate with ACS to record, correct, update, and complete all reportable incidents.
  - When a youth is involved in an ESPI or physical incident/accident, regardless of the type and with or without visible injuries, the youth must have a health review by a medical staff member or other licensed health care professional.
    - If youth refuses to be seen by medical, a refusal form must be completed. The refusal form must be signed by youth. If the youth refuses to sign the form, then the refusal form must be signed by a supervisor and staff, and the staff must indicate in the form that the youth refused to sign.
      (1) When there is no supervisor on duty, at minimum two (2) staff must sign the refusal form.
      (2) A copy of the medical refusal form must be attached to the incident form. The original form must be filed in the record.
    - Video reviews of incidents, including a copy of the video, provider's findings and documentation requirements, must make all efforts to submit to ACS upon request within 48 hours. Providers must also make arrangements to show video onsite to ACS personnel upon request.
  - Providers must report serious accidents and incidents, and injuries involving youth to ACS and the VPCR immediately upon discovery, as applicable.
  - Reports of fatalities must be made immediately to the VPCR and then immediately to ACS. Within 24 hours of the initial notification, providers must provide ACS with a comprehensive report of the applicable fatality, accident, incident or injury. Within 24 hours of completion, providers must submit a copy of each critical incident report to ACS.

VII.16.00 Video Reviews

Providers must regularly review CCTV footage in accordance with ACS requirements to monitor, at a minimum, safety, security, programming, incidents, etc., at the facility.

- Providers must conduct video reviews on different days, at different shifts, of different programmed activities, bed checks, and incidents. Video review findings must be cross-referenced with information documented in the Communication Log. Discrepancies or other policy violations must be reported as applicable.
- At a minimum, providers should submit four (4) weekly random video reviews:
  - One (1) AM video review
  - One (1) PM video review; and
  - Two (2) overnight shift video reviews.
- Video reviews of incidents, including a copy of the video, provider’s findings and documentation requirements, must be submitted to ACS upon request within 48 hours.

VII.17.00 Overnight Unannounced Management Inspections

Providers must regularly review CCTV footage and conduct overnight unannounced site inspections in accordance to ACS requirements to monitor the safety and security of youth placed at the facility.

- Unannounced inspections must be conducted as often as necessary but at minimum on a monthly basis. All unannounced inspections must be documented in the Communication Log in accordance to the Log Book policy.
- Provider management or trained designee may conduct the unannounced site inspections.

VIII.01.00 Planning for Transition and Release to Aftercare

As part of the service planning process, providers must partner with the assigned Placement and Permanency Specialist (PPS) to plan, develop, refer, and connect youth and family to aftercare resources to meet the criminogenic, treatment, and positive youth development needs of youth.

Guidelines:

- Decisions regarding release to aftercare are meant to be collaborative between PPS and Provider agencies.
  - PPS has ultimate approval over the decision to release to aftercare.
- Planning for the transition and release to aftercare starts immediately when the youth is placed.
  - Aftercare planning must include, but not be limited to, family reunification and/or permanency planning, educational engagement, vocational and job-skills building, counseling and emotional support, and establishing a connection with community-based services for both the youth and his family, or other discharge resources, as applicable.
  - Concurrent Planning for permanency begins at the time of placement and continues throughout residential placement in accordance with Foster Care Regulations to ensure that each youth has an appropriate and supportive living environment upon release.
- The aftercare planning progress must be reviewed with the PPS at least monthly as part of the treatment team meetings and documented in CNNX.
- Staff must review and re-assess aftercare planning with the youth, family and all relevant stakeholders during planning and support meetings.
- Staff are responsible for attending and participating in all planning and support meetings.
- Staff must work with the PPS to schedule these meetings and ensure the attendance of all involved.
- Providers must work with the assigned PPS to plan for, coordinate, and monitor home visits and community passes for youth while in residence in accordance with the Community Pass Protocol.
- Providers must consider the individual youth and family needs when planning for the transition to aftercare. For example, arrangements may include:
  - Complete home assessments in collaboration with PPS and in accordance with ACS policy. Any identified issues must be addressed prior to the start of community passes.
  - Collaborate with PPS, identify and incorporate into the transition process the medical and behavioral health needs of the youth including, but not limited to, specialized medical services, psychiatric treatment, specialized psychological therapy, and substance use treatment.
  - Collaborate with the assigned PPS and DOE transition staff to ensure that the appropriate educational setting is in place and that youth attend a community school prior to being released to aftercare when the school calendar and the youth's behavior permits.
  - Work with the youth and family to match each youth's assets, strengths, skills, aptitudes, and aspirations with resources in his or her community that bolster opportunities for a successful transition back to the community.

- Schedule and provide assistance to youth and their families with transportation, if needed, to all appointments and opportunities to connect youth to identified aftercare services.
- Identify and link youth and family to services that extend beyond the end of the youth's time in Close to Home whenever possible.
- Identify and link youth and family to community-based activities and organizations to facilitate positive youth development based upon their interests and strengths.
- Connect youth and their families to pro-social and community-based services to obtain the support and services that they may need or want.
- Ensure that youth are not released prior to their expiration date without appropriate need-based services in place. Provider must make all efforts (translation support, transportation, scheduling flexibility) to ensure that youth and family are able to attend such services.

- Providers, in collaboration with PPS, are responsible for ensuring safe, timely, and appropriate release of youth from care and youth's return to the community.
- Providers must make transportation arrangements for the youth to return to the community and ensure youth have all their belongings.

Discharge to Another Planned Living Arrangement
Prior to discharging a youth to another planned living arrangement, providers must make all efforts to ensure:

- The youth is connected to a caring adult who has made a commitment to the Youth's emotional well-being beyond the age of 21 including a demonstrated willingness to provide the youth a place to live;
- The youth has safe and stable housing;
- The youth possesses all necessary government-issued documents, such as a birth certificate and social security card, and, to the extent reasonably possible, all issues related to a youth's immigration status have been resolved;
- The youth possesses all other appropriate documents;
- The youth is enrolled in an educational or vocational program, or is employed or otherwise has a stable source of income; and
- For youth who will require clinical support services, such youth has been provided guidance on the application process for supportive housing and other appropriate services available through adult social service, health (such as Community Medicaid), and mental health systems.

Planned Release Out-of-State

Release to the Youth's Parent or Legal Guardian

- To support timely processing, the ICJ should be submitted as soon as a youth's discharge resource is identified, but no later than 60 days before the applicable youth's release date, a case planner must make all efforts to begin the ICJ process. This includes completing and having the youth sign an Interstate Compact for Juveniles Form 1A (Application for Compact Services) and Form VI (Memorandum of Understanding and Wavier) and providing three (3) copies of the completed forms and a recent progress report of such youth to ACS.

- If the receiving state accepts supervision, providers must provide assistance to ACS and the receiving state in order to effectuate the release in accordance with ACS policies and the law. Such assistance may include providing transportation services, providing relevant documentation, and/or completing forms or other documents.

Release to a Person Other than the Youth's Parent or Legal Guardian

- As soon as a youth's discharge resource is identified, and at least 60 days before the applicable youth's release date, a case planner must complete and have the youth sign an Interstate Compact for Juveniles Form 1A (Application for Compact Services) and Form VI (Memorandum of Understanding and Wavier) and provide three (3) copies of the completed forms and a recent progress report of such youth to ACS.
- Upon ACS's request, providers must use all reasonable efforts to obtain a written consent executed by the youth's parent or legal guardian consenting to the youth residing with the identified individual.
- If the receiving state accepts supervision, providers must provide assistance to ACS and the receiving state in order to effectuate the release in accordance with ACS policies and the law. Such assistance may include providing transportation services, providing relevant documentation, and/or completing forms or other documents.
- In the event a youth is in the custody of ACS pursuant to a court order unrelated to a delinquency proceeding, approvals in accordance with section 374-a of the New York State Social Services Law (Interstate Compact on the Placement of Children) must be obtained. Providers must assist ACS in obtaining such approvals.

Health and Mental Health Care Related Planning

- Prior to a youth's release date and/or discharge date, providers must ensure that the youth's health care and service needs are up-to-date and must contact all individuals/entities to which the Youth was referred (e.g. health services providers, aftercare service providers, and other clinical service providers) to confirm such individual/entity has received, to the extent possible, all necessary documentation, including completing all documentation for transitioning the youth into Medicaid, as applicable, in order to ensure continuity of care. Providers must assist youth in obtaining medical coverage including by assisting with the Medicaid application process or linking the youth to low-premium health insurance options. Providers must ensure that the youth's Health Services records are up-to-date and that all such records are transferred, as appropriate, (A) to the appropriate member of the youth's family if the youth is being discharged to his family, (B) to the discharge resource if the youth is being discharged to a non-family member, and (C) the post-discharge Health Services providers.
- Providers must work with the discharge resource of the youth to identify and establish linkages with the youth's post-discharge Health Homes or other health services providers (e.g. OLP, SF, CAFTSS).
  - For youth that are enrolled in a health services program while receiving services and will continue to receive services after the release date, providers must ensure that the health care integration provider is familiar with such youth's discharge plan and with youth's family/discharge to ensure an uninterrupted continuation of services. Providers must

actively participate in any health services program meetings related to discharge planning.

Programming that Supports Transition to Aftercare

- Providers must offer an array of activities specifically intended to promote positive youth development.
- Activities must include opportunities for youth to explore and develop new interests based on youth feedback.
- Activities must facilitate the development of positive, supportive, and trusting relationships with peers and adults.
- Providers must connect youth with activities that support positive youth development as youth transition to aftercare.
- Providers must structure activities to support and reinforce lessons learned in school.
- Providers must work with youth and families to plan for a seamless transition of medical and mental health services for the youth upon release from placement.

Release

- Within two (2) days following a youth's release date, providers must prepare and submit to ACS a Health Services status summary for the youth that includes any recommended follow-up care and a summary of significant services provided to the youth while receiving residential services.
- Providers must ensure that each youth prescribed medication at the release date is provided a sufficient supply of such medication to ensure the youth has a supply of such medication that will last until the youth's next scheduled applicable health services appointment as medically necessary and consistent with this agreement, ACS policies, and the law.

VIII.02.00 Transition to Aftercare Timeline

To ensure the successful release from placement to aftercare, providers must partner with PPS and comply with all timeline requirements.

Guidelines:

Family Team Conferences

- Providers are responsible for participating in all required Family Team Conferences set by PPS.
- Aftercare should be discussed at all FTCs. For more in-depth information on all FTCs, refer to IV.06.00.
- Appropriate and necessary aftercare resources/referrals needed to help integrate back into the community are outlined and identified in the Comprehensive Planning and Support Meeting.
- Release Planning and Support Meeting:
  - This meeting must occur 30-45 days prior to the youth's release to aftercare.
  - Plan and services for aftercare are finalized as part of the Juvenile Justice Service Plan.
  - Planned release date is set.
  - Aftercare team should participate in the release conference.
  - Contact information of the aftercare team is shared with the parent/release resource.
  - Conditions of Release are reviewed and signed by youth, parent/discharge resource (if applicable), PPS and provider.

Aftercare Planning Requirements

- **Community Readiness Assessment:** Providers and PPS must conduct a joint home assessment prior to the first Community Pass. Providers must document their findings in CNNX. If any barriers are identified, providers are required to develop an action plan that resolves issues prior to the first community pass.
- **Aftercare Referrals:** Providers will complete and submit referral forms as needed to the assigned PPS 60 days prior to a youth's release from placement.
- **Transition Summary:** Providers must prepare a transition summary five (5) weeks prior to the youth's release from placement. This summary includes youth strengths, challenges, continued needs and an overview of the home assessment.
- **Community School Attendance:** Providers must collaborate with the assigned PPS and DOE transition staff to ensure that the appropriate educational setting is in place and that youth attend a community school prior to being released to aftercare when the school calendar and the youth's behavior permits.
- **Continuity of Care:** Providers must collaborate with PPS to coordinate and ensure continuity of care during the youth's transition into aftercare.

Documentation

- Providers must update the FASP by completing a plan amendment within five (5) business days from the date of release.
- The Activities section in CNNX must be updated upon release.

IX.01.00 Maintaining Continuity of Care

Close to Home providers must ensure continuity of care is maintained for each youth through the end of disposition.

Guidelines:

- For every youth that transitions to aftercare, providers must ensure there is continuity of care:
  - The ACS Aftercare Plan and Service Referral form must be completed and documented in CNNX for every youth that transitions to aftercare.
    - The NSP/LSP placement team is responsible for completing the form and sharing the information with the aftercare team and ACS.
      - Provider completes aftercare referrals 60 days prior to release
      - Aftercare Service Plan is finalized 30-45 days prior to release
- The aftercare staff in partnership with placement staff must build a relationship with the youth and his or her family/discharge resource as early as possible but no less than 60 days before discharge:
    - At a minimum, the aftercare staff must meet the youth bi-weekly while the youth is in placement.
      - Face to face must occur
      - Group session can be counted towards contact
    - The aftercare staff must participate in the release meeting, community team meeting, the graduation meeting, and any elevated risk conferences.
    - The CTH placement staff must complete the ACS aftercare referral form and share this form with their internal aftercare team, as applicable, and with PPS.
    - Once the youth is released to aftercare, providers are responsible for documenting casework contacts contemporaneously.
  - Please note dates/timelines are benchmarks and can be completed earlier as appropriate. Providers can reach out to the PPS Directors to discuss any concerns with timeline or meeting dates.

IX.02.00 Case Planner/Caseworker Functions

Every youth placed in aftercare must have a Case Planner assigned to his or her case.

Guidelines:

- The Case Planner is responsible for coordinating with the family and is the author of the FASP (i.e., the Case Planner is responsible for the entirety of its contents and the timeliness of its submission for approval).
- Only the identified ACS Case Manager may initially assign the role of Case Planner to a staff member in an agency/program (via its “Assign Unit”) in accordance with the rules below. Whenever there is only one planning agency/program serving a youth, that agency/program will always be assigned the role of Case Planner.
  - In all cases, the role of Case Planner can only be assigned to a worker in an agency/ program that is designated as a planning agency/program.
  - If the agency/program is designated as a non-planning agency/program, then it may only be assigned the role of Case Worker.
  - Once roles are assigned, Case Planners/Caseworkers can assign additional persons or reassign these roles within the same agency.
  - Only the ACS Case Manager can reassign a role to a different agency.
- Providers retains Case Planning responsibility even if the youth receives services from JJI.
  - **Note**: When both foster care and Close to Home providers are working simultaneously with the same youth and his or her family, both programs must maintain at least each program’s minimal casework contacts with the youth, but the assessment/service responsibilities of each agency must be clear and documented in CNNX so that services are coordinated and not duplicated (See IV.18.00 for more information on Crossover Youth).
- If a youth gets transferred from one CTH provider to another (non-JJI) for aftercare services, the new CTH provider will hold case planning responsibilities.
  - Once a new case planner is assigned to the case, the new agency is responsible for all case planning requirements.

IX.03.00 Casework Contacts with NSP Youth

Casework contacts must be conducted as frequently as required. During the first six (6) weeks the youth is in aftercare, providers must meet with youth face-to-face based on the youth's YLS risk levels.

Guidelines:

- For the first six (6) weeks following release, providers must meet with youth face-to-face based on the youth's YLS risk level for as detailed below:
  - High: At minimum one (1) face-to-face contact each week.
  - Moderate: At minimum one (1) face-to-face bi-weekly contact.
  - Low: At minimum one (1) face-to-face contact once a month.
    - During Community Team conference meetings and biweekly calls, providers will continually assess appropriateness of supervision levels and discuss any proposed supervision changes with PPS. If modification is approved by PPS, providers and PPS will document plan in CNNX.
  - After the first six (6) weeks, providers must coordinate with ACS PPS to determine a face-to-face meeting plan.
  - Regardless of the youth's YLS level, at least one face to face contact per month must be with the designated case planner.

***In accordance with the FFPSA a youth must be seen in person two times per months.**

Risk Level	Frequency of Contact
Low	2 Monthly
Moderate	Bi-weekly Monthly
High	Weekly Bi-weekly
Intensive	Weekly

Below are family first guidelines:

- Casework contacts consisting of at least two face-to-face contacts per month with the youth
- At least one of these contacts must include the family or permanency resource for the youth

- For youth 18 years or older, face-to-face contacts may be conducted via video call if the youth, VA, and LDSS agree to such an arrangement and the youth has the necessary technology to allow for such communications.

Casework Contacts with Release Resource

- Providers must maintain contact with the parent/discharge resource at a minimum of twice (2) a month, one (1) being face to face, to obtain updates on progress of youth.
- One (1) face to face contact for the youth and the parent/discharge resource per month must occur in the home.
- At least one (1) face to face contact for the youth and the parent/discharge resource per month must be by the case planner.

Following Arrest

- If the youth is incarcerated, providers remain responsible for conducting casework contacts with youth through the end of disposition, unless the youth is transferred to another CTH Provider prior to the end of disposition.
- If youth is out-of-state, coordinate with PPS to ensure contact occurs once (1) per month.

Case Coordination

- If youth are receiving services from other providers (e.g., outpatient MH, community based, etc.) the aftercare provider is required to collaborate with any other service providers.
- For youth who are referred to JJI, the CTH provider is required to contact youth twice (2) a month, and at least one (1) of these contacts must be face-to-face. Joint contacts are permissible. In addition, the continuity of care provider is required to contact the JJI provider weekly to support the progress of youth.
- Casework contacts must be documented in CNNX within five (5) business days of the contact date.
- Failure to conduct a casework contact must be documented in CNNX including the reason (e.g., unable to meet with youth because the youth is AWOC).

IX.04.00 Family Assessment and Service Plan (FASP) in Aftercare

Providers will complete the FASP to assess the youth and his or her family's service needs, periodically reassess those needs, and develop and revise, as necessary, individually tailored service plans for the youth and all his or her family members.

Guidelines:

- The FASP will be completed with the active participation of the youth and their family to the extent achievable. If family is not involved, all contact attempts must be noted.
- Supervisors or program directors will approve the FASPs after conducting a review of service goals and family progress.
- The FASP must inform and reflect the goals and objectives of the JJ service plan.
- The FASP must be completed at the frequency indicated below as applicable:
  - The Initial Assessment FASP begins with the Case Initiation Date (CID) plus **30 days**;
  - The Comprehensive Assessment FASP is the CID plus **90 days**; and
  - The Reassessment FASP is CID plus 210 days **or seven (7) months**.
  - A Second Reassessment, if the case remains open, is due **six (6) months** after the first Reassessment.
- The FASPs and service plan must include:
  - Detailed, case-specific documentation of risk of placement and continued eligibility and need for services;
  - Current family functioning and any changes if applicable;
  - Assessment of the service needs of all children and caregivers in the family;
  - The most significant service priorities; and
- The FASP must focus on the Permanency Planning Goal(s) and include:
  - For Comprehensive and Reassessment FASPs, specific, objective, measurable, achievable goals written in behavioral terms;
  - For Comprehensive and Reassessment FASPs, target dates for new or retained goals;
  - For Reassessment FASPs, each goal that was included in the previous FASPs appears as a retained or discontinued goal;
  - For Reassessment FASPs, explanations for all discontinued goals; and
  - For Reassessment FASPs, discussion of level of goal achievement for retained goals.
- Service Plan Development documents: Family Team Conferencing must include:
  - Family and youth participation (or lack of participation) in services planning; and
  - Concurrence, non-concurrence of family members with any aspect of the service plan.
  - Providers must conduct appropriate outreach to engage non-custodial and/or incarcerated parents to the extent necessary and required by NYS OCFS regulations to develop and successfully implement the approved service plan (i.e., visiting incarcerated parent(s), writing parents, contacting relatives of youth if there are no court ordered restrictions, etc.).
- All relevant sections of each Assessment/Reassessment and Service Plan must be completed, and the FASP must be signed by both the case planner and supervisor.
- Plan amendments must be completed prior to case closure.
- When an Assessment/Reassessment and Service Plan cross-references the progress notes, the content of the progress note entry corresponds to the cross-reference.

- Providers must maintain documentation of their case management functions, regarding approval of FASPs and Plan Amendments, case openings/intake cases, transfers of cases, changes in program choice, and case closings.
- Housing Subsidy only cases: prior to submission of each six (6) month FASP, case planners are required to conduct a home visit and assess whether the family remains eligible for subsidy as described in the ACS's memorandum entitled "*Revised Foster Care and Preventive Housing Subsidy Application and Approval Process"*, dated November 18, 2008.
- Changes in housing needs must be brought to the attention of ACS's Office of Housing Support and Services immediately and not solely at the time of the six (6) month reassessment. For questions regarding housing subsidy send questions to the ACS Housing Support and Services Unit mailbox at: acs.sm.housing.preventive@dfa.state.ny.us.
- For information on FASP while youth is in placement, refer to VI.05.00.

IX.05.00 Conditions of Release and Aftercare Compliance

Providers will support youth in ensuring adherence with the Conditions of Release (COR).

Guidelines:

- Providers will support and supervise youth to promote consistent meeting of conditions of release.
- Providers will utilize graduated responses (e.g., incentives and sanctions) to address issues of non-compliance with the COR.
  - For example, issues with curfew must be discussed with youth and their release resource to address any barriers to compliance (e.g., travel time to meet curfew).
  - The supervision plan must be adjusted as necessary.

IX.06.00 Youth Level of Service (YLS)

Providers are required to obtain the YLS assessment results from PPS for each youth in placement and share this information with their aftercare teams to preserve continuity of care.

Guidelines:

- Providers must implement YLS informed JJ service plans at all points in the youth's care.
- Between 30 to 45 days after release, PPS will re-administer the YLS. PPS will discuss reassessment at community team conference and utilize to update service plan with provider.
- In circumstances where youth do not have long periods of aftercare, providers will work with PPS to address criminogenic behaviors based on most recent YLS.
- Providers must share all YLS documentation with the aftercare team (YLS form, overall rating).
- Providers are responsible for conducting casework contacts with the youth as determined by the YLS overall score for the first six (6) weeks the youth is in aftercare.
- Providers are responsible for documenting casework contacts in CNNX.

Evaluating Youth Progress

- Providers must track the progress of each individual youth and identify strategies to help youth:
  - Remain engaged in services;
  - Remain engaged in school;
  - Avoid re-entry in the justice system;
  - Prepare youth for adulthood (PYA) (e.g., through vocational training, resume writing, work etiquette, obtaining a job, etc.); and
  - Support permanency.
- Providers must have a system in place to document, evaluate and adapt their approach based on progress of youth in the Juvenile Justice (JJ) service plan based on attainment of goals in JJ service plan, school progress/attendance and incidents.
- Providers must develop a service plan that addresses criminogenic behaviors, responsivity factors and supports youth transition back to the community.

Juvenile Justice Service Plan

- Juvenile Justice (JJ) Service Plan must be adapted to the community-based model (e.g., ITM to MST) and specify how service needs will be met (e.g., youth has substance use needs, how will they be addressed in the community) including how to partner with discharge resources/community-based partners to address criminogenic domains.
- Provider must discuss youth progress on biweekly calls scheduled by PPS and use these calls as opportunities to assess progress and barriers.
- Families need to be fully oriented and have their feedback incorporated into all aspects of service planning.
- Plan must be informed by the aftercare service model.

- Parents/guardians and permanency resources should understand the process of being revoked on aftercare.
- The service plan will help link family with resources and supports in the community based on the needs of the youth/family.

Prosocial Activities

- All youth must be linked to prosocial activities.
- Ongoing assessment and engagement are needed to ensure that youth remains consistently and actively engaged in the community including creating linkages and opportunities to develop independent living skills, opportunities to become self-sufficient, develop budgeting and financial management skills, find housing, etc.
- Workshops and activities should align with high scoring YLS domains.

IX.07.00 Education Support for Youth on Aftercare

Providers must identify the educational needs of youth on aftercare, and work with students, parents/guardians, and schools to address those needs. Providers must also be responsible for advocating for the educational needs of youth.

Education Support Staffing

- Each agency must designate staff to meet the education support and advocacy needs of their youth on aftercare.
- Provider staff will:
  - Obtain and review educational history and records from residential provider staff for each CTH youth in the care of the provider agency
  - Maintain consistent communication with school-based staff (guidance counselor, transition coordinator, parent coordinator, administrative staff) and Educational Transition Specialists to ensure timely and appropriate planning and address education-related concerns, goals, and support services
  - Participate in regular DYFJ provider calls, education-related trainings, and meetings with DYFJ Education Unit
  - Participate in education planning at Release Conferences, Community Conferences, Graduation Conferences, and all Elevated Risk Conferences

Educational Planning

- Aftercare staff must obtain and review educational records, plans, and other related information from residential provider staff and residential placement school staff (e.g., progress reports, transcripts, SEPs/IEPs, communications with receiving school that have already taken place)
- Aftercare staff must establish regular and ongoing communication with youth and family to discuss education goals, plans, progress, and any areas requiring additional support
- At least 30 days prior to release, aftercare staff must consult with DOE's Educational Transition Specialist, residential placement provider staff, and DOE staff to inform educational planning during aftercare
- Aftercare staff will work with youth and parents to identify appropriate members of an educational support network for each youth that can continue providing support after placement has expired.
  - Members may include guidance counselors, community mentors, coaches, clinicians, relatives, etc.
  - Aftercare staff will develop system of regular communication among the network to support the youth's educational goals.
- Aftercare provider must ensure youth will have necessary school-related supplies (notebooks, uniforms, etc.)
- Aftercare provider must ensure youth have transportation in place to and from school (i.e., MetroCard, directions, etc.)

- Aftercare provider will connect youth to out-of-school time education-related programming and services, in accordance with each youth's educational interests, needs, and goals (e.g., tutoring, remediation, sports, internships, mental health counseling, etc.)
- Aftercare provider, in collaboration with youth, family, and rest of education support network, will prepare youth for educational engagement after graduation from CTH placement
  - Aftercare provider will report on educational plans and action steps at Graduation Conference

Education Monitoring

- Aftercare provider must make efforts to contact community school on a weekly basis to discuss school attendance, school performance, and efforts to address educational concerns and interests.
  - Providers can escalate any concerns or difficulties regarding school contact to the DYFJ Education Unit for Support
- Aftercare provider must submit a school attendance report to DYFJ Office of Policy, Planning and Performance on a monthly basis.
- Providers must document progress, changes, and any other relevant information regarding the youth's education plan in CNNX within five (5) business days. The education tab must be updated at least every 30 days to report changes in the plan as needed. Documentation must include:
  - Weekly school attendance;
  - Names of the parties who attended the education meetings (FTCs, welcome meetings, IEP meetings, school-based meetings) and the issues discussed;
  - Youth academic progress;
  - Barriers to educational transition;
  - Concerns of youth and family;
  - Action steps and status including supports provided

Support and Advocacy

- Aftercare provider staff will support youth by participating in school-based meetings, including IEP meetings, parent-teacher conferences, suspensions hearings, etc.
  - Aftercare provider will assist youth and parent/guardian with requesting school-based meetings, as necessary.
- Aftercare provider will work with families to develop and improve youths' school-related executive skills, such as school attendance, time management, organizational skills, homework completion, study skills, classroom behavior, etc.
  - Aftercare provider will assist youth and parents with accessing school resources, including databases; mobile technology; and tools to track attendance; assignments exams; and grades.
- Aftercare provider will support youth and parents with reviewing education plans and programming and making connections to new/different programming and services, in collaboration with the Educational Transition Specialist and in accordance with each youth's educational interests and goals.

- The aftercare provider must conduct educational advocacy with and on behalf of the youth as appropriate by:
  - Preparing youth and family/guardians to advocate for educational interests and goals at education-related meetings and conferences (e.g., IEP meetings, discussions with teachers and guidance counselors, suspension hearings, etc.)
  - Reviewing and advocating for appropriate educational programming and services for each youth in collaboration with youth, parent/guardian, school, and aftercare team. This includes:
    - Advocating for new/different school placements and educational services, as needed;
    - Advocating for appropriate course programming;
    - Advocating for appropriate special education programming and services;
    - Advocating for appropriate tutoring and reading and math remediation services;
    - Identifying any social/emotional/behavioral skills that are impacting educational success and helping to craft a plan for improving those skills in collaboration with DOE, DYFJ, case planners and clinicians; and
    - Participating in educational planning.
  - Suggested protocol for education advocacy:
    - After consulting with youth and parent/guardian, attempt to resolve concern directly with school staff/administrators, including in collaboration with Educational Transition Specialist where appropriate;
    - If unable to resolve at school level, obtain additional technical assistance from DYFJ Education Unit;
    - If necessary, connect youth and parent/guardian to external educational advocates and/or legal representation.

IX.08.00 Vocational Training for Youth on Aftercare

Providers are required, when appropriate, to support youth in finding a vocational training program and assist youth with job readiness.

- Per New York City requirements youth must attend school until the end of the school year in which he or she turns 17 and may continue to attend school until the end of the school year in which they turn 21 years old.
- For youth ages 17-21, providers should discuss both academic and vocational options.
- Providers must support youth's participation in, and access to, vocational and career information and guidance, job readiness skills, job placement services, and job search techniques and training support services.
- Providers must ensure adequate resources are allocated to provide career services to youth (e.g. access to community resources, access to technology, financial literacy curriculums, group sessions related to career readiness, transportation, etc.).
- Providers must provide youth with access to wraparound supports, either internal or external, that respond to barriers to work or school provided, such as but not limited to:
  - Educational support;
  - Mental or physical health services;
  - Substance abuse services;
  - Trauma counseling;
  - Financial/benefits counseling; and
  - Parenting supports.
- Providers must identify, in consultation with the youth, vocational training providers and other relevant service providers with respect to vocational and career information and guidance and programs.
- Providers must educate youth about the importance of education, training as well as the development of skills and competencies, and pursuing a career.
- Providers must prepare the youth for successful workforce entry (resume training, financial literacy skills, etc.). Refer to Planning Youth for Adulthood (PYA) II.13.00.
- For information on vocational training while youth is in placement, refer to IV.19.06.

IX.09.00 Incentives for Youth on Aftercare

The aftercare provider must establish incentives with youth to promote and reinforce positive behavior and motivate youth to engage in aftercare services.

- Providers must allocate a portion of their aftercare annual budget to provide incentives for youth as a way of recognizing achievement, the progress of youth, and rewarding successful participation in aftercare services (e.g., school attendance, group engagement, success in the community, COR compliance, etc.).
    - The process must be documented and approved by ACS PPS leadership.
    - In accordance with provider protocol, the youth should have an opportunity to earn incentives throughout youth's time in aftercare.
    - Incentives must be distributed in a timely manner.
- Incentives may be provided to youth in the form of stipends, gift cards, movie tickets, etc.
- Providers must have a written incentive plan that addresses the following components:
    - Opportunities to earn incentives;
    - Frequency/immediacy of incentive distribution;
    - Minimum and maximum incentives each youth can receive;
    - Explain how youth can earn an incentive; and
    - Define milestones and corresponding incentives as well as how they connect to the progress of youth.
- Each youth must receive a copy of this plan during first face-to-face meeting with the aftercare provider.
    - Parents/discharge resource should be familiar with the plan.
- Every time youth receive an incentive, this information must be documented in CNNX.
- Providers must have a process for incorporating youth's feedback in deciding the types of incentives they want to offer.
- Providers must evaluate effectiveness and adjust their incentive program accordingly.

IX.10.00 Elevated Risk Conference (ERC)

An Elevated Risk Conference (ERC) can be requested and occur at any point in a youth's stay in Close to Home. An Elevated Risk Conference must be scheduled within three (3) business days of the provider learning of the occurrence of the high-risk behaviors such as AWOC, arrest, or patterns of non-compliance with conditions of release.

- The aftercare provider can request an Elevated Risk Conference when there is an indication of heightened risk to the youth (high-risk behaviors such as AWOC, arrest, or patterns of non-compliance with conditions of release such as consistently missing curfew and school truancy), there is a need to re-engage the family in services, or at any other time as determined by the provider.
  - Providers must submit a request for the ERC to PPS via email and include PPS Director(s).
  - The PPS will organize this meeting within three (3) business days of the request.
  - If the PPS does not elect to proceed with an ERC, provider may reach out to PPS Director and ED of Family Team Conferencing for clarity.
- Providers should collaborate with PPS to determine if ERC is warranted.
- Specifically, the Elevated Risk Conference is designed to:
  - Bring youth together with providers and others who are involved with youth and his or her family/release resource, to address patterns of high-risk behaviors, incidents, school concerns (e.g., truancy, incidents within school, suspension, detention, etc.) and lack of engagement in aftercare services;
  - Inform the development of interventions needed to stabilize the youth; and
  - Facilitate safety planning decisions.
- Providers must clearly document in CNNX: the name and type of meeting, the decisions made during this meeting, and the reasons for those decisions.

Examples of case situations that call for an Elevated Risk Conference:

- A youth has disengaged from services without sufficiently addressing the issues placing the youth at risk.
- A youth consistently displays a pattern of missed check-in appointments with assigned aftercare worker, school absenteeism, not attending prosocial activities, and/or is not available for home visits.
- The service model chosen for the youth does not meet the level of care that the youth or family needs.
- Additional issues/conditions have surfaced that create an increased risk to the youth. For example:
  - Arrest;
  - AWOC;
  - Not following through on services, (e.g., drug treatment, mental health service);
  - Not participating in family therapy sessions (MST); and
  - Pattern of positive toxicology reports.

IX.11.00 Crisis Response and Follow-Up

Providers are responsible for 24/7 crisis response to occur within one (1) hour of learning of the crisis.

Crisis/Incident Response and Follow Up

- A crisis is any event or incident that has the potential to pose imminent harm to youth/self or others or following any major event that has significant impact on health, safety, and wellbeing of youth or community (e.g., AWOC, arrest, hospitalization, child abuse/neglect, etc.).
- Providers must have internal protocols to respond to crises (e.g., arrest, AWOC).
  - This protocol must be submitted to DPPM for review once (1) a year or upon request.
  - Providers must share with DPPM an updated copy of the protocol when changes are made within ten (10) business days from the date of the change.
- Providers are responsible for following up and stabilizing situations as needed including providing support, guidance, mediation, referral, implementation of action plan, appropriate follow up, etc. (e.g., if the youth suffers serious injury, providers will go to the hospital; if the youth is arrested, the provider will go to the precinct).
- Providers are required to make all reasonable efforts to conduct a face-to-face response with youth/family no later than 24 hours of being notified, in but not limited to, the following situations:
  - Youth's safety, permanency is in imminent risk;
  - Youth is experiencing acute emotional or physiological distress;
  - Suicidal ideations;
  - Homicidal ideations;
  - Fatalities;
  - Serious injuries;
  - Domestic violence involving youth;
  - Arrests; and
  - Emergencies that require immediate relocation of a youth or family (e.g., fires, homelessness, etc.).
- Actions taken to respond to crises must be documented in CNNX including if a safety plan was put in place and the details of the plan.
- The parent/discharge resource of youth must be notified immediately if the youth is involved in a crisis.
- If the youth's attorney is known to the provider, they must be notified in a timely manner if the youth is arrested.
- Provider must participate in ACS-led conferences and immediately debrief with the youth and family/discharge resource to assess and process and safety plan.

IX.12.00 Incidents in Aftercare

The aftercare provider is required to notify MCCU within one (1) hour from the time staff learns an incident has occurred and follow up as indicated below.

- Providers are required to report to MCCU the incident categories included in the table below.
- Providers must respond to ACS's incident review follow up questions in a timely manner to clarify incidents.
- Providers must review GOALS incident narratives and ensure incidents are recorded accurately.

EVENT	DEFINITION
AWOC in Aftercare	Any instance where a Close to Home youth who has been placed by ACS in an aftercare program disappears, runs away, or is otherwise absent voluntarily or involuntarily for 24 hours or more without the consent of the persons(s) or aftercare program in whose care the youth has been placed. After a parent or provider reports the youth has left their supervision without permission and/or youth has failed to report to a scheduled call/appointment/group etc. with the provider or Placement and Permanency Specialist (PPS), a youth in aftercare is determined AWOC when: 1)The provider is not able to establish the youth's whereabouts within 24 hours of such report through face-to-face contact and 2)Youth's whereabouts remain unknown after 24 hours or 3) As directed by PPS
Birth	A youth in aftercare gives birth.
Child Abuse Allegation-External	Any alleged act of abuse, neglect, or maltreatment by an outside party (non-ACS/Provider Agency staff) which involves a youth that has been accepted as a report by the Statewide Central Register of Child Abuse and Maltreatment-NYS OCFS.
Child Abuse Allegation-Internal	Any alleged act of abuse, neglect, or maltreatment by ACS staff, residential foster, or Provider Agency staff which involves a youth that has been reported to the Vulnerable Persons Central Registry-Justice Center.
Community Arrest	Youth is arrested for an event that happened in the community.
Death	The death of a youth while in aftercare.
Medical Illness	A medical condition or illness, which results in youth hospitalization.
Revocation Warrant Issued	Youth has failed to comply with conditions of release. PPS will provide specific details to MCCU around reason for revocation. (Reported by PPS)

Self-Injurious Behavior	A self-injurious behavior is injury to oneself that is not life threatening.
Suicide Attempt	An act intended to end one's life, consisting in actions taken which, by virtue of the method employed and circumstances chosen, either results in or could likely result in medically serious injuries that might threaten the individual's life or have other irreversible medical consequences.

IX.12.01 AWOC Youth While in Aftercare

If the youth has left the supervision of the agreed upon residence during Aftercare without permission and is considered to be at-risk, has been missing for 24 hours, or as directed by PPS, then the youth is considered AWOC. The aftercare provider is required to notify MCCU within one (1) hour from the time staff confirms a youth is AWOC.

- If a youth misses a meeting/appointment with the provider, or if the provider becomes aware that youth missed a meeting/appointment, the provider must immediately attempt to locate youth.
- Providers may determine that a youth is at-risk and in need of immediate follow up in advance of the 24-hour mark based on the particular needs and history of the youth, including but not limited to:
  - Required medications
  - Suicide risk
- If the provider is able to speak to youth within 24 hours from the missed meeting/appointment, then the youth will not be considered AWOC. However, after speaking with youth and confirming the whereabouts of youth verbally, the provider must schedule a meeting within 24 hours and meet with the youth face-to-face to confirm in person that the youth is not AWOC.
- If the parent or discharge resource contacts the aftercare provider to report the youth missing, providers must attempt to locate and speak to the youth.
  - If successful, providers must meet in person with the youth within one (1) business day to confirm in person the youth is not AWOC.
  - If unsuccessful, providers must communicate again with the parent to confirm the youth's whereabouts remain unknown.
    - If the parent confirms the youth's whereabouts and safety, providers must meet with the youth within the next business day to confirm in person the youth is not AWOC.
    - If the parent or discharge resource reaffirms the youth whereabouts remain unknown, then, at the 24-hour mark, the aftercare provider must contact MCCU to report the AWOC.
- Provider must conduct diligent efforts for the next 30 days following AWOC or until end of disposition, whichever comes first. Diligent efforts include but are not limited to:
  - Contact/engagement of friends and family;
  - Searching for youth in the community;
  - Utilizing calls, email social media to locate youth;
  - Contacting local police precinct; and
  - Working with the ACS Investigative Consultants.
- When youth return from AWOC
  - Providers must conduct CSEC screening, which must be documented in CNNX.
  - Youth must be assessed receive a medical screening upon their return from AWOC within 24 hours of their arrival and document the results of the screening in CNNX.
- Following AWOC return and debriefing, providers will conduct an assessment to understand and address reasons for AWOC.

- When applicable, the aftercare provider must contact PPS to schedule an elevated risk conference.
- Providers must confirm in person within 24 hours from notification from a parent/youth that the youth has returned home and is no longer AWOC.
- Only after confirming in person that a youth is no longer AWOC, providers must update MCCU.
- Providers must notify MCCU when the youth is no longer AWOC (e.g., arrested, returned home).
- Providers should update MCCU if/when they learn about any instances where a youth was out of contact with youth's family members or aftercare team for a period of 24 hours or more.

IX.12.02 Reporting and Record Keeping in Aftercare

Providers are required to document the progress of youth in CNNX and other databases as required by the law and requested by ACS.

- Providers must document all relevant events in CNNX within five (5) business days including but not limited to;
  - Casework contacts;
  - Group meetings;
  - Progress of youth;
  - Changes to services plan;
  - Community referrals;
  - Contacts with the discharge resource, PPS, and other agencies involved;
  - Incidents; and
  - Diligent efforts.
- Providers must maintain documentation of their case management functions, including but not limited to, approval of FASPs and Plan Amendments, case openings/intake, transfers of cases, changes in program choice, supervisory reviews of individual cases, and case closings.
- Providers must complete FASP within ten (10) days of due date, plan amendments, medical, health and education tabs along with activity codes (CCRS) are also required to be completed timely.
- Supervisors must review CNNX and document guidance/feedback to staff in CNNX for each case at minimum once a month.

IX.12.03 Monthly Data Collection and Tracking in Aftercare

Providers are required to track monthly performance measures / census for compliance of youth safety and risk.

- Providers must participate in Monthly Safety/Risk Check calls with APA.
- Providers must complete and submit a Monthly Data Request Form by the 10th of month for Agency Program Assistance (APA) to review. The form includes census, safety, staffing, and outcomes data points, which, APA will review in preparation for the Monthly Safety/Risk Check Call.
- During the Monthly Safety/Risk Check Call, providers must be prepared to discuss the data provided to APA, provide assessments of current performance, share barriers to assess or address youth safety or risk concerns and provide strategies to address such concerns when they arise.
- Providers must follow up on APA, DYFJ, and OCFS safety/risk concerns identified during the Monthly Safety/Risk Check call and follow up on APA, DYFJ, and OCFS safety/risk concerns when needed.
- For more information about on monthly data collection and expectations, please review APA's Aftercare Monthly Safety/Risk Check Provider Protocol.

IX.13.00 QI/QA Internal Monitoring

Providers are required to have a process in place to evaluate the quality and effectiveness of the aftercare services provided

Program Performance

- Monthly, providers are required to complete and submit the DPPM form summarizing and highlighting their performance in the above metrics by the 10th of every month.
- Providers must design a process for identifying trends and tracking program performance in the following areas:
  - Youth readiness for release;
  - Timeliness and coordination of transition to aftercare;
  - That all youth are receiving needed services (e.g., mental health, substance use, concrete services) in place to meet the needs of the youth and their families;
  - Implementation of service planning and contacts based on the YLS;
  - Continuity of care for the youth;
    - Continuity of services; and
    - Continuity of education.
  - Casework contact compliance;
  - Aftercare engagement of the youth and their families;
  - Youth and family satisfaction with services provided;
  - Aftercare program (e.g., successes, barriers, best practices, and lessons learned);
  - Outcomes for youth (e.g., revocations, re-arrests, successful completion, school attendance etc.); and
  - Staffing Patterns (e.g., vacancies, new hires, terminations, etc.).
- Providers must utilize data shared by DPPM to improve performance through development and implementation of continuous quality improvement plans and process
- Program trends and performance will be discussed during bi-annual data performance meetings.
- For information on QA/QI requirements throughout placement, see VII.11.00.

IX.14.00 Revocations While on Aftercare

Decisions regarding revocation are based on the best interests of the youth and community safety and are ultimately within the authority of the ACS CTH Assistant Commissioner. Providers and ACS PPS must work collaboratively regarding revocation decisions and next steps.

- A youth who has been placed with ACS by the Family Court pursuant to a juvenile delinquency case may be released from ACS' physical custody on aftercare status before the expiration of the placement.
- During the period of release, ACS provides aftercare, which includes therapeutic support services and monitoring of the youth's progress in the community.
- Prior to a release, it is critical that a youth reviews and signs the conditions of release and expresses an understanding of ACS' expectations with respect to the youth's continued compliance and engagement with aftercare services.
- At any point during the period of release, ACS may determine that the return of the youth to the physical custody of ACS is consistent with the needs and best interests of the youth and the need for protection of the community. Upon such determination, ACS must seek to revoke the youth's release.
- Provider agencies may also reach out to the PPS Directors to request a revocation be considered.
- ACS PPS will collaborate with Provider agency to determine if revocation is in the best interest of the youth.
- If a youth is revoked, the Provider will:
  - Provider ACS with a report of the youth's progress while on aftercare
  - Participate in revocation hearings
  - Participate in Family Team Conferences
  - Document necessary information in Connections
    - Update FASP as needed
    - Update movement codes in Connections

Intake: Health/Mental Health & Suicide Risk Screening

INSTRUCTIONS: The designated person is to complete this screen for each juvenile within 1 hour of the juvenile's arrival to the facility. The juvenile will be under constant supervision and will not be assigned to a housing unit/bedroom until this screen is completed. All information on the form must be completed. The staff person completing the form will sign the form at the completion of the screening. If there is any question about a juvenile's health or well-being, the staff member conducting the screen will immediately request intervention from clinical/health services staff. If the juvenile answers "yes" to the questions below that are in bold, he/she is to be immediately referred to the appropriate services (clinical/health). The person to whom the emergency referral is made will be entered at the bottom of the form.

Youth First Name:			**Youth Last Name :**		
DOB:		**Admit Date:**		**Admit Time:**	**am** ☐ **pm** ☐
Screening Start Time :	**am** ☐ **pm** ☐				
Name of Staff:			**Title:**		

Medical and Dental Questions

Read aloud to youth: "Together we will complete this short survey. The questions I will ask you are to make sure we understand any special needs that you may have and help us to keep you safe while you are here."

Question	Yes	No
1. Are you in pain? Do you feel sick or have any rashes? Do you need medical or dental care now?	☐	☐
2. Were you being treated for medical or dental problem before you got here?	☐	☐
3. Do you use any special medical equipment (like an asthma pump, insulin pump, prosthesis, etc.)?	☐	☐
4. Are you currently taking any medicine for any reason?	☐	☐
5. Do you have any kind of allergies to food, medicine or latex?	☐	☐
6. Do you need a special diet of any kind?	☐	☐
7. **For female youth, trans. male youth, gender non-conforming or intersex youth:** Are you pregnant or do you believe you may be pregnant?	☐	☐

General Health Observations (This section documents what staff observe, * do not read this to the youth*)

8. Observe the youth's general physical condition. Do you see any signs of the following: bruises, cuts, abrasions, limp, visible vermin, scratching, excessive coughing, appearance of being under the influence of a substance or problems moving arms and legs.

Describe:

____
____
____
______

Medical Triage Instructions:

- **If "yes" to 2, 4, 5, 6, or 7**→ Notify facility leadership and medical on-call
- **If "yes" to 1, 3, or 8**→ Separate from others, seek medical assessment ASAP.

Mental Health and Suicide Questions

Question	Yes	No
1. Do you feel you need someone to talk to?	☐	☐

Screening Form - Division of Youth and Family Justice

2. Are you thinking about hurting yourself or killing yourself?	☐	☐
3. Have you injured yourself on purpose recently?	☐	☐
4. Have you ever tried to kill yourself?	☐	☐
5. Have you taken any drugs or alcohol within the past 24-48 hours?	☐	☐
Question	**Yes**	**No**
6. Do you use drugs or alcohol? How often?	☐	☐
7. What is/are your drug(s) of choice?		

General Health Observations (This section documents what staff observe, * do not read this to the youth*)

Staff: Please note any observations of the following high risk behavior: **check the boxes that apply**

☐ Argumentative ☐ Hostile ☐ Tearful ☐ Scared ☐ Sad / Miserable ☐ Sedated ☐ Sweating ☐ Shaking

☐ Odd Behavior ☐ Illogical ☐ Loud ☐ Difficulty Understanding ☐ Unaware

Other☐ (please describe):

Mental Health Triage Instructions:

- **If "yes" to 1, 5, or 6** → Notify facility leadership and make mental health referral.
  - **If yes to 5 or 6** → Also make medical referral and inform them of answer to #7.
- **If "yes" to 2, 3, 4** or any high risk behavior noted in question 8 → Notify facility leadership and mental health on-call.

Staff Signature:			**Screening End Time:**		am☐ pm☐
Housing Unit/Bedroom Assignment:		**Date Assigned:**		**Time Assigned:**	am ☐pm☐

NSP and LSP Sites Only

***Please complete if youth answered YES to any of the above questions:**

Facility Leadership Contacted:	**Yes** ☐ **No**☐	**Name:**	
Emergency Referral Made:	**Yes** ☐ **No** ☐	**Time:**	**am**☐**/pm**☐
Referral Made to:			**MH:** ☐ **Med:** ☐
	Name (Clinical/Health Services Staff):		
Special Instructions:			

*Place completed form in case file and update electronic record

DYFJ 201701

JUVENILE JUSTICE CASE PLAN

Name of Youth: ______Initial YLS/CMI: ___/___/___

Most recent YLS/CMI: ___/___/___   YLS Risk Level (circle): Low   Mod   High Very High

YLS/CMI Criminogenic Need Areas:	Low	Mod	High	Current priority for trt target? (Y/N – if yes, add description of concern)
Family Circumstances/Parenting				
Education/Employment				
Peer Relations				
Substance Abuse				
Leisure/Recreation				
Personality/Behavior				
Attitudes/Orientation				

Summary of Existing Strengths (what to enhance):

Responsivity factors to be immediately addressed as a priority and rationale:

S.M.A.R.T (Specific, Measurable, Attainable, Realistic, and Time-Sensitive) Activities based on need areas and immediate responsivity factors. (Activities may include interventions and should be limited to only what is needed with a maximum of 3 per goal. No more than 3 goals should be addressed per case plan update)

Criminogenic need/Responsivity Factor priority being addressed:
GOAL #1:
Activity #1:
Activity #2:

Progress: ____

Criminogenic need/Responsivity Factor priority being addressed:
GOAL #1
Activity #1:
Activity #2:
Activity #3:

Progress: ____

Criminogenic need/Responsivity Factor priority being addressed:
GOAL #1:
Activity #1:
Activity #2:
Activity #3:

Progress: ____

New York City
Administration for Children's Services
Division of Youth and Family Justice
Close to Home Initiative

Notification of Request for Modification of Placement

February 15, 2017

Youth Information

Name:	Date of Birth (Age):
Parent/Guardian:	Parent/Guardian Address:
Youth Current Location:	

Legal Information

Close to Home Admission Date:	Close to Home Expiration Date:
Placement Offense(s):	Docket Number:
Placement Court:	Placement Court Judge:
Pending Charges:	
Pending Court Appearance Date(s):	

Treatment Needs

Medical Diagnosis:		
Mental Health Diagnosis:		
Medications		
Medication	Dosage	Frequency

Reason for Request

Overview Narrative

Close to Home Incident Summary

Number of Total Incidents	
Number of Arrests While in CTH	
Number of AWOLS from CTH	

Incident History

Date	Type	Description

Close to Home Efforts to Maintain Youth

Date/Range	Intervention	Result

Return to Close to Home Plan

Signatures

Provider Agency Representative	**Title**	**Signature**	**Date**

Placement + Permanency Specialist	**Signature**	**Date**

Placement + Permanency Director	**Signature**	**Date**

CTH Assistant Commissioner	**Signature**	**Date**

INTERSTATE COMPACT FOR JUVENILES

FORM IA/VI

APPLICATION FOR SERVICES AND WAIVER

Form IA **APPLICATION FOR COMPACT SERVICES**

TO: ____________________________ (Receiving State) FROM: ____________________________ (Sending State)

I, ____________________________, hereby apply for supervision as a parolee or probationer to the Interstate Compact for Juveniles. I understand that the very fact that supervision will be in another state makes it likely that there will be certain differences between the supervision I would receive in this state and supervision which I will receive in any state to which I am asking to go. However, I urge the authorities to whom this application is made, and all other judicial and administrative authorities, to recognize that supervision in another state, if granted as requested in this application, will be a benefit to me and will improve my opportunities to make a good adjustment. In order to get the advantages of supervision under the Interstate Compact for Juveniles, I do hereby accept such differences in the course and character of supervision as may be provided, and I do state that I consider the benefits of supervision under the Compact to be worth any adjustments in my situation which may be occasioned.

In view of the above, I do hereby apply for permission to be supervised on ☐parole ☐probation in ________________ (Receiving State).

FORM VI **MEMORANDUM OF UNDERSTANDING AND WAIVER**

I, ____________________________, realize that the grant of ☐parole ☐probation and especially the privilege to leave the State of ______________ to go to the State of ______________ is a benefit to me. In return for these advantages, I promise:

1. That I will make my home with ____________________________ (Name, Relationship, and Address) until a change of residence is duly authorized by the proper authorities of the receiving state.
2. That I will obey and live up to the terms and conditions of ☐parole ☐probation as fixed by both the sending and receiving states. I understand and accept that a failure to comply with these terms and conditions may result in sanctions in the sending or receiving state.
3. That I will return at any time to the sending state if asked to do so by the ☐parole ☐probation authorities in that state. I further understand that if I do not obey or live up to these promises, I may be returned to the sending state. I have read the above or have had the above read and explained to me, and I understand its meaning and agree thereto.

(Juvenile's Signature) (Date) (Witness' Signature) (Date)

I, in my capacity as the placement resource for ____________________________ (Juvenile's Name) do approve and subscribe to the above Memorandum of Understanding and hereby waive any right which I may have to contest the return of the juvenile referred to herein to the sending state or jurisdiction from any state or jurisdiction within or outside the United States, in which ☐he ☐she may be found. I also undertake to cooperate with the supervising authorities and to assist them in securing the return of the juvenile referred to herein to the sending state whenever, in their judgment, such return may be necessary or desirable.

(Placement resource's signature) (Date) (Witness' Signature) (Date)

Permission is hereby granted to the above-named juvenile to apply for, reside in, and be supervised by the State of ________________ (Receiving State) provided that the receiving state accepts supervision and the juvenile complies with the terms of supervision.

(Date) **SIGNED:** (If probation, sending state's JUDGE; If parole, sending state's COMPACT OFFICIAL)

INSTRUCTIONS FOR COMPLETING ICJ FORM IA/VI

PLEASE TYPE OR PRINT LEGIBLY.

ALL MATERIALS MUST BE PROVIDED TO THE SENDING STATE'S INTERSTATE COMPACT FOR JUVENILES OFFICE FOR FORWARDING.

Form IA – Application for Compact Services

Receiving state: state in which juvenile is residing or will reside.
Sending state: state of probation/parole/adjudication; requesting state.
"I…" (blank): print juvenile's name here.
"In view of the above…": Check either "parole" or "probation" and fill in the name of the receiving state.

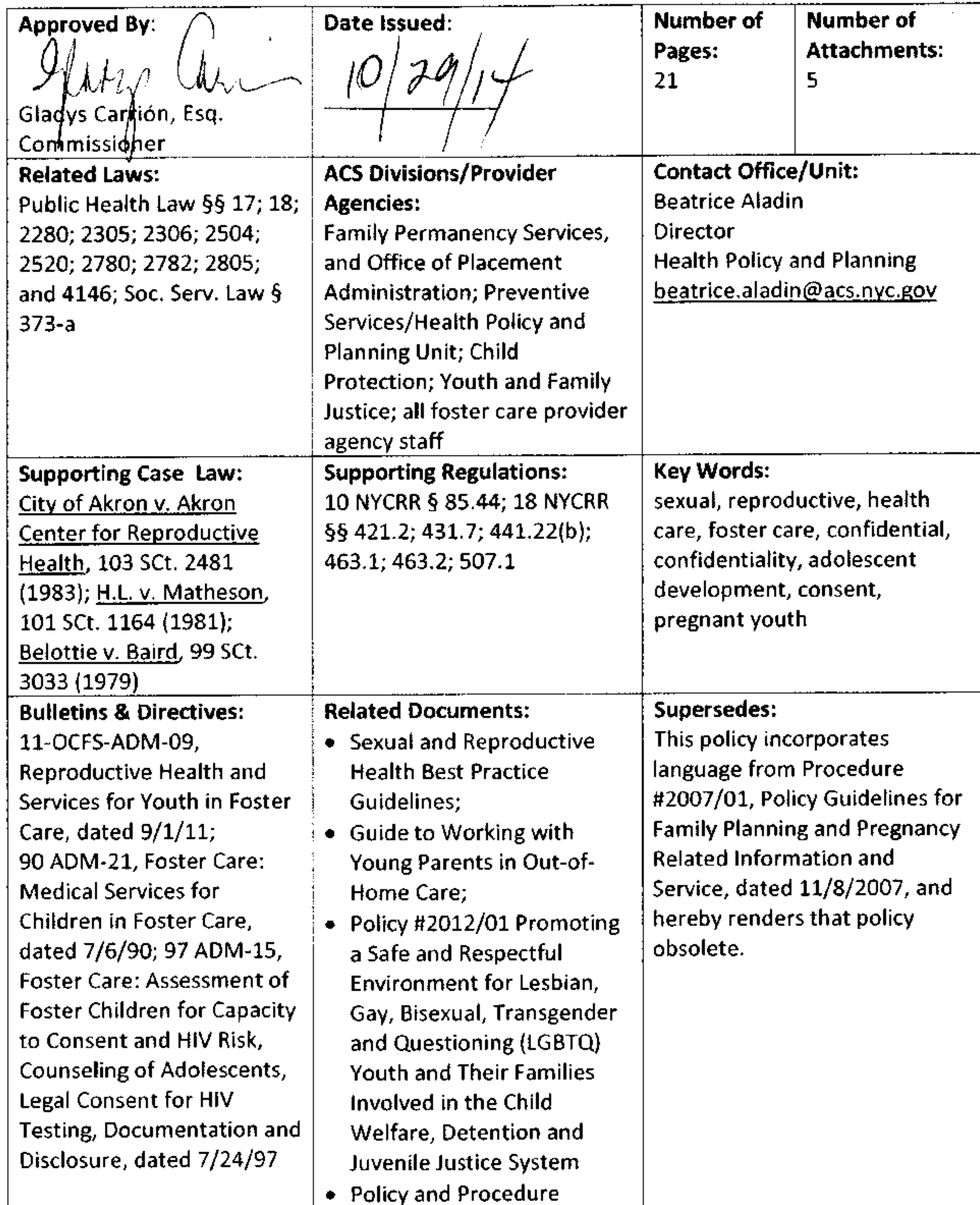
Form VI – Memorandum of Understanding and Waiver

"I,…" (blank): insert juvenile's name, check "parole" or "probation," fill in the name of the state under whose jurisdiction the juvenile is placed, and the name of the state in which the juvenile is residing or will reside.
"1": insert name, relationship, and address of home offer wherein juvenile is residing or will reside.
"2": check either "parole" or "probation."
"3": check either "parole" or "probation;" Juvenile must sign and date; Witness must sign and date.
"I, in my capacity as the Placement Resource for": Insert the name of the juvenile. The Resource Placement in the Receiving State must sign and date the Form; a witness must sign and date the Form.
"Permission is hereby granted…": insert name of state in which juvenile will reside and be supervised.
"Signature": If the juvenile is on probation, the sending state's JUDGE or court designee signs here. If the juvenile is on parole, the sending state's Interstate Compact for Juveniles official or designee signs here.

City of New York
Administration for Children's Services

Policy and Procedure
#2014/09

Sexual and Reproductive Health Care for Youth in Foster Care



Approved By: Gladys Carrión, Esq. Commissioner	**Date Issued:** 10/29/14	**Number of Pages:** 21	**Number of Attachments:** 5
Related Laws: Public Health Law §§ 17; 18; 2280; 2305; 2306; 2504; 2520; 2780; 2782; 2805; and 4146; Soc. Serv. Law § 373-a	**ACS Divisions/Provider Agencies:** Family Permanency Services, and Office of Placement Administration; Preventive Services/Health Policy and Planning Unit; Child Protection; Youth and Family Justice; all foster care provider agency staff	**Contact Office/Unit:** Beatrice Aladin Director Health Policy and Planning beatrice.aladin@acs.nyc.gov	
Supporting Case Law: City of Akron v. Akron Center for Reproductive Health, 103 SCt. 2481 (1983); H.L. v. Matheson, 101 SCt. 1164 (1981); Belottie v. Baird, 99 SCt. 3033 (1979)	**Supporting Regulations:** 10 NYCRR § 85.44; 18 NYCRR §§ 421.2; 431.7; 441.22(b); 463.1; 463.2; 507.1	**Key Words:** sexual, reproductive, health care, foster care, confidential, confidentiality, adolescent development, consent, pregnant youth	
Bulletins & Directives: 11-OCFS-ADM-09, Reproductive Health and Services for Youth in Foster Care, dated 9/1/11; 90 ADM-21, Foster Care: Medical Services for Children in Foster Care, dated 7/6/90; 97 ADM-15, Foster Care: Assessment of Foster Children for Capacity to Consent and HIV Risk, Counseling of Adolescents, Legal Consent for HIV Testing, Documentation and Disclosure, dated 7/24/97	**Related Documents:** • Sexual and Reproductive Health Best Practice Guidelines; • Guide to Working with Young Parents in Out-of-Home Care; • Policy #2012/01 Promoting a Safe and Respectful Environment for Lesbian, Gay, Bisexual, Transgender and Questioning (LGBTQ) Youth and Their Families Involved in the Child Welfare, Detention and Juvenile Justice System • Policy and Procedure	**Supersedes:** This policy incorporates language from Procedure #2007/01, Policy Guidelines for Family Planning and Pregnancy Related Information and Service, dated 11/8/2007, and hereby renders that policy obsolete.	

	2014/08 Medical Consents for Children in Foster Care	

Related Forms/Links/Sources:
A Medical Guide for Youth in Foster Care is available on line in both single page and booklet format. The guide in single page format can be viewed at:
http://www.ocfs.state.ny.us/main/publications/Pub5116SINGLE.pdf

The guide in booklet format can be viewed at:
http://www.ocfs.state.ny.us/main/publications/Pub5116BOOKLET.pdf

SUMMARY:
Youth in foster care have the right to confidential sexual and reproductive health information and services. Although sexual activity can be an anticipated part of adolescent development, because of their history of abuse and neglect, youth in foster care are often at higher risk for unsafe sexual behaviors.[1] It is for this reason that receiving high quality, preventive health care and information is so critical. This policy clarifies required casework actions pertaining to the reproductive health services for youth in foster care and describes the standards that foster care providers are expected to meet and that ACS will monitor.

[1] See 11-OCFS-ADM-09, *Reproductive Health and Services for Youth in Foster Care*.

POLICY HIGHLIGHTS

- ACS and provider agency staff must **not** impose their personal, organizational, and/or religious beliefs regarding sexual and reproductive health care services on youth in foster care.

- In New York State, youth have the **right** to access **confidential** sexual and reproductive health care services **without the knowledge or consent** of their parents or guardians.

- Provider agency staff must notify youth in foster care who are **12 and older (and youth under 12 who are known to be sexually active)** of their right to sexual and reproductive health services within 30 days of placement and every six months thereafter. If a youth is pregnant, the case planner must inform the youth immediately of her rights and the services available.

- Provider agencies must develop a sexual health and **pregnancy prevention strategy** focused on educating young people about safer sex practices, offering consistent messaging about dual protection (e.g., condom and hormonal methods), promoting the delay of early parenting, and avoiding unintended pregnancies.

- For pregnant youth who are considering termination of pregnancy, the provider agency must provide **nonjudgmental, unbiased information** about abortion and access to services and/or make alternative referrals to providers who offer these services to enable youth to make informed decisions about their pregnancies.

- Provider agencies must counsel and provide up-to-date information to all male youth with special attention to **parenting and expectant fathers**, including information on topics, such as healthy intimate relationships, co-parenting, and support services related to becoming a father.

- Provider agencies must offer meaningful access and referrals to the full range of sexual and reproductive health care as described in this policy. This includes referrals for LGBTQ-affirming services, access to contraception (including emergency contraception), testing for STIs, discussion and counseling regarding pregnancy options, etc.

TABLE OF CONTENTS

I. INTRODUCTION 4
- A. Sexual and Reproductive Health Care Services Requirements 4
- B. Sexual and Reproductive Health Services Resources 4
- C. ACS' Standard for Culturally Respectful Practice 4

II. GENERAL POLICY GUIDELINES 4
- A. Sexual and Reproductive Health Care Services for Adolescents in Foster Care 4
- B. Availability of Sexual and Reproductive Health Care Services 5
- C. Right to Confidentiality 5
- D. Age- and Developmentally Appropriate Sexual and Reproductive Health Education 6
- E. Consent for Sexual and Reproductive Health Care for Youth in Foster Care 6

III. REQUIRED ACTIONS 8
- A. Informing Youth of Their Right to Sexual and Reproductive Health Care 8
- B. Face-to-Face Discussions with Youth 8
- C. Informing Youth of Their Right to Confidential Sexual and Reproductive Health Care 8
- D. Providing Supportive Literature 9
- E. Documentation 10
- F. Referrals for Youth Requesting Sexual and Reproductive Health Care Services 10
- G. Sexually Transmitted Infection (STI) Risk Assessment 10
- H. Informing Parents/Guardians and Foster Parents of Youths' Rights to Sexual and Reproductive Health Care 11
- I. Documentation 12

IV. PROGRAMS AND SERVICES 13
- A. Assisting Youth in Accessing Sexual and Reproductive Health Care Services 13
- B. Addressing the Sexual and Reproductive Health Care Needs of Female Youth in Foster Care 14
- C. Pregnant Youth Who Decide to Maintain Their Pregnancy 16
- D. Pregnant Youth Who are Considering Termination of Pregnancy 16
- E. Documentation 16
- F. Addressing the Sexual and Reproductive Health Needs of Male Youth in Foster Care 17
- G. Support and Services for Expectant and Parenting Male Youth in Care 18
- H. Documentation 19
- I. Discharge Planning 19
- J. Provider Agency Training 19

V. ATTACHMENTS
- A. FSS-004 – Letter Informing Youth of Their Right to Confidential Sexual and Reproductive Health Care
- B. FSS-005 – Letter Informing Parents/Guardians and Foster Parents of Adolescents' Rights to Confidential Sexual and Reproductive Health Care
- C. Sexual and Reproductive Health Centers/Clinics
- D. Fatherhood Program/Provider Resource Data Base
- E. FPS-004 – Checklist for Pregnant and Parenting Youth People in Out-of-Home Care

I. INTRODUCTION

A. Sexual and Reproductive Health Care Services Requirements

The Administration for Children's Services (ACS) and foster care providers are required to provide age-appropriate sexual and reproductive health education and information to all children in foster care. This includes providing access to or arranging for reproductive health care services for youth in foster care aged 12 years and older upon request. Younger children who are known to be sexually active should also receive age-appropriate reproductive health care services.[2] The resources provided must not be limited to the provision of and access to age-appropriate sexual and reproductive health care information and services. Staff shall also provide youth with any support they need in order to access these services.

B. Sexual and Reproductive Health Services Resources

Youth in foster care aged 12 and older, and younger children who are known to be sexually active, need age-appropriate education and counseling about their reproductive rights and on reproductive health care services, including education and counseling on sexuality, pregnancy prevention, family planning, and sexually transmitted infections (STIs). New York State regulations support the rights of youth aged 12 and older and sexually active younger children to receive reproductive health counseling, education and reproductive health services.[3]

C. ACS' Standard for Culturally Respectful Practice

ACS is committed to working with children, youth, and families in a manner that is respectful of all cultural backgrounds. Accordingly, ACS and provider agency staff must be sensitive to the beliefs and values of clients when discussing or providing information about sexual and reproductive health care services. Staff should never allow their own cultural values to interfere with their responsibility to provide unbiased information and quality services.

II. GENERAL POLICY GUIDELINES

A. Sexual and Reproductive Health Care Services for Adolescents in Foster Care

For the purpose of this policy, "sexual and reproductive health care services" include, but are not limited to, the social, educational, and medical services regarding:

[2] See 11-OCFS-ADM-09.
[3] See 18 NYCRR § 463.1; 18 NYCRR § 441.22 (1) (1); 18 NYCRR § 463.2 (2) (b) (1) and 18 NYCRR § 507.1(c) - (9).

1. Sexuality education, family planning, and safer sex practices, including access to contraception methods (as well as emergency contraception such as Plan B One-Step);
2. Sexuality, sexual orientation, and gender identity;
3. Sexual abuse and sexual trauma;
4. Prevention, testing for, diagnosis, and treatment of STIs and Human Immunodeficiency Virus (HIV);
5. Responsible behavior and equal treatment between dating or sexual partners;
6. Access to gynecological care;
7. Pregnancy prevention, testing, and pregnancy options counseling, including legal and safe termination of pregnancy (abortion);
8. Access and referral to maternity care (prenatal, perinatal, and postpartum); and
9. Reproductive biology and the changes that come with adolescence.

B. Availability of Sexual and Reproductive Health Care Services

In New York State, youth have the right to access confidential sexual and reproductive health care services without their parents'/guardians' knowledge or consent. Although it is ACS' hope that youth in foster care develop trusting relationships with their foster parents and provider agency staff and can turn to them for assistance in accessing the health services that they need, for various reasons, not all youth will want to include others in their sexual and reproductive health-related decisions. It is also important to consider that in some cases, youth have maintained trusting relationships with their parents or other adult family members and may wish to seek their assistance.

C. Right to Confidentiality

1. All youth have a right to confidentiality regarding their sexual activity and any related health services they may receive. Staff should not make assumptions about a youth's sexual behaviors based on sexual orientation, gender identity, or gender expression.[4]

2. Confidentiality of a Minor's Health Care Information

   a. Unless otherwise specified by law, a medical provider may not reveal confidential health information about a patient without the permission of the person who consented to the health care.

   b. When a minor (defined as youth under the age of 18) consents to his or her reproductive health care, that health care and information is confidential and must not be disclosed, even to the minor's parents, unless an appropriate

[4] See Policy # 2012/01, *Promoting a Safe and Respectful Environment for Lesbian, Gay, Bisexual, Transgender and Questioning (LGBTQ) Youth and their Families Involved in the Child Welfare, Detention and Juvenile Justice System* available in the ACS Policy Library at http://www.nyc.gov/html/acs/html/home/policy_library.shtml.

written consent has been obtained from the youth. If a youth provides the agency with reproductive health information, or seeks reproductive medical care from a foster care provider agency on site, the information must be maintained in the Health Narrative tab in CONNECTIONS (CNNX) and may not be disclosed to any other persons without the youth's written consent unless specifically authorized by law.

3. Documentation of Confidential Health Care Information

   All sexual and reproductive health information must be documented in the Health Narrative tab in CNNX or the Health Narrative field. Agency documentation must adhere to all applicable laws governing confidentiality of health information. General CNNX progress notes must not contain confidential health information, including information regarding HIV/AIDS or reproductive health.

D. Age- and Developmentally Appropriate Sexual and Reproductive Health Education[5]

Age-appropriate sexual and reproductive health education and information must be given to all children in foster care. Provider agencies must provide children in foster care aged 12 years and older and those under 12 years who are known to be sexually active with age- and developmentally appropriate sexual and reproductive health education and counseling during routine medical appointments through the foster care agency, as well as in coordination with their schools with the knowledge of their parents/guardians. The information provided must consist of education and counseling on sexuality, pregnancy prevention, family planning, and STIs. Provision of reproductive health information and the discussion of these aforementioned topics, including a discussion of the *Letter Informing Youth of Their Right to Confidential Sexual and Reproductive Health Care* (Form FSS-004, see Attachment A), must begin when the child first arrives in foster care. The agency staff person responsible is encouraged to have the discussion at the first meeting with the foster parents and the youth, if appropriate. For children who are known to have a history of sexual abuse, this information must be conveyed with care by professional staff trained or experienced in sexual and reproductive health and knowledgeable about the impact sexual abuse and other traumas can have on child development.[6]

E. Consent for Sexual and Reproductive Health Care for Youth in Foster Care

1. Parental Consent to Health Services

   As a general rule, parents must consent to their children's health care. This rule is based on the premise that youth typically lack the intellectual maturity to make informed health care decisions. There are laws that create exceptions to this rule so

[5] See 11-OCFS-ADM-09.
[6] This trained staff person may be a case planner, supervisor, or medical or mental health professional.

that in certain situations, minors have the right to consent to their own health care in New York State.

2. Youths' Capacity to Consent

   a. In New York State, a minor may consent to his or her own reproductive health care if the treating physician determines that the minor has the capacity to consent[7]. This includes health care for family planning services, gynecological exams, PAP tests, contraceptives (including emergency contraceptives), pregnancy options counseling, counseling on sexual decision-making, abortion, treatment for STIs, and testing for HIV.

   b. For cases in which the treating physician cannot determine whether a youth has the capacity to consent, and there is doubt or question about the capacity of a youth to provide informed consent, the case planning agency must obtain an independent assessment of the mental capacity of the youth by a qualified mental health professional who is appropriately trained to make such an assessment.

   c. Both ACS and the foster care agency with which a youth is placed have a responsibility to raise any questions about the youth's capacity to consent at any point during the youth's placement. Anyone working with a youth in foster care who has doubts about the youth's capacity to consent must inform the youth's case planner. The case planner must follow up with the youth's treating physician who will determine whether the youth has the capacity to consent. If the physician determines the youth lacks such capacity, the case planner must contact the ACS Medical Consent Unit at: MedicalConsentRequests@acs.nyc.gov.

3. Pregnant and Parenting Minors

   Any minor who is the parent of a child may consent for medical, dental, health, and hospital services for him- or herself.[8] Any pregnant minor may consent for medical, dental, health, and hospital services relating to prenatal care.[9] No other person's consent is necessary. If a minor parent is in foster care and has custody of his or her child who is not in foster care, the minor parent may also give consent for health care for the child. If the minor parent and child are both in foster care, in certain circumstances, ACS may consent for the child's health care if the minor parent refuses[10].

[7] Capacity to consent means an individual's ability to understand and appreciate the nature and consequences of a proposed health care service, treatment, or procedure and to make an informed decision about the service, treatment, procedure, or disclosure of health information (Public Health Law § 2780).

[8] See Public Health Law § 2504(14).

[9] See Public Health Law § 2504(3)

[10] See Policy and Procedure 2014/08, *Medical Consents for Children in Foster Care*, 9/16/14.

4. Married Minors

   A minor who is married can consent to all of his or her own health care, including medical, dental and hospital services.[11]

III. REQUIRED ACTIONS

A. Informing Youth of Their Right to Confidential Sexual and Reproductive Health Care

It is ACS' policy that youth in foster care aged 12 years and older and youth under 12 who are known to be sexually active must be notified of their right to sexual and reproductive health services within 30 days after placement (or after reaching the age of 12) and at least every six (6) months thereafter. If a youth is pregnant, the case planner must inform her immediately about her sexual and reproductive rights and the available services. All youth must be informed of their rights via 1) a private, face-to-face discussion with the assigned provider staff person responsible for such discussions; and 2) the ACS *Letter Informing Youth of Their Right to Confidential Sexual and Reproductive Health Care*, which must be given to each youth in person.

B. Face-to-Face Discussions With Youth

1. Direct service staff responsible for face-to-face discussions with youth should either be:
   a. Qualified licensed medical, mental health, or social work practitioners trained in sexual and reproductive health; or
   b. Casework staff trained or experienced in sexual health, reproductive health care services, and youths' rights to confidential health care services.

2. In order for youth to access confidential sexual and reproductive health services on their own if they choose to do so, provider agencies must provide youth aged 12 and older with their case identification number ("CIN"[12]). Written documentation of the CIN must be included on the *Letter Informing Youth of Their Right to Confidential Sexual and Reproductive Health Care.* This documentation must also include the youth's name and date of birth. To prevent abuse or deliberate misuse of the CIN, provider staff must instruct the youth to carry a photo identification card to access services.

C. Informing Youth of Their Right to Confidential Sexual and Reproductive Health Care

1. The *Letter Informing Youth of Their Right to Confidential Sexual and Reproductive Health Care* (Form FSS-004) is the standardized letter that all provider agencies

[11] *Id.*
[12] The CIN is also referred to as the Medicaid number and is used for billing purposes.

must give to youth aged 12 or known to be sexually active every six (6) months. As this letter notes, foster parents may not withhold sexual and reproductive health information or services from foster children in their care. When a foster parent does not wish to provide information or access to these services to foster children in his or her care, the foster parent must contact the provider agency staff person identified on the letter. The staff person must help the foster parent understand that offering sexual and reproductive health care for youth is required; and if the foster parent still refuses, the provider agency is responsible for providing the youth with the necessary information, services, and assistance.

2. The provider agency staff person who reviews the letter with the youth must include his or her name and telephone number on the letter. The youth must sign, date, and return the letter to the staff person who must file it in the youth's medical record and record receipt of it in the CNNX Health Narrative field (see ACS Foster Care Quality Assurance Standards Part V(I) - Sexual Health Education and Services).

D. Providing Supportive Literature

The four documents listed below are additional resources for staff, youth, and foster parents. The *Pass it 2 Youth* pamphlet must be distributed to all youth aged 12 and older and youth under 12 years who are known to be sexually active. This pamphlet shall be accompanied by the *Letter Informing Youth of Their Right to Confidential Sexual and Reproductive Health Care* semiannually.

1. *Pass It 2 Youth: What Every Teen Needs to Know About Sexual and Reproductive Health Rights* pamphlet can be accessed through the following link: Pass it 2 Youth pamphlet.

2. *Pass It 2 Youth: What Every Teen Needs to Know About Sexual and Reproductive Health* workbook addresses sexual and reproductive health issues including, but not limited to, adolescents' rights, general health information, specific information for young men, community resources, and pregnancy prevention. The *Pass It 2 Youth* workbook will be provided to provider agencies via the Division of Family Support Services (FSS) Health Policy and Planning Unit. The workbook can also be accessed through the following link: Pass it 2 Youth workbook.

3. *The Sexual and Reproductive Health Care for Youth in Foster Care Best Practice Guide*, designed for ACS and foster care agency staff, outlines the basic foundation of this policy. The best practice guide describes when and how to provide information and services and assists providers and staff in understanding their role under the policy. It suggests strategies to enhance practice skills and offers recommendations for integrating the components into the work of child welfare staff. The guide can be accessed through the following link: Sexual and Reproductive Health Care for Youth in Foster Care Best Practice Guide.

4. *A Medical Guide for Youth in Foster Care* is an OCFS publication available through the OCFS website on the "Publications" page under "Adolescents in Care." The guide is available in single page and booklet format. The guide can be accessed through the following link: http://ocfs.ny.gov/main/publications/Pub5116SINGLE.pdf.

E. Documentation

A copy of the *Letter Informing Youth of Their Right to Confidential Sexual and Reproductive Health Care* (Form FSS-004) or the agency's standardized letter informing a youth of his or her right to confidential sexual and reproductive health care and the date it was given to the foster parent[13] and parent/guardian must be filed in the youth's medical record. Documentation of the face-to-face discussion, the delivery of the standardized written letter, and the provision of supportive publications must be recorded in the CNNX Health Narrative field.

F. Referrals for Youth Requesting Sexual and Reproductive Health Care Services

1. Referrals for youth who request routine appointments for sexual and reproductive health services shall be made within 30 days of the request. Referrals for emergency contraception and termination of pregnancy, however, must be made immediately following the request. Female youth who disclose having had sexual intercourse during the immediately preceding 72 hours, without benefit of any form of contraception, must be referred for counseling and offered emergency contraception, such as Plan B One-Step.

2. Foster care staff (case planners, administrators, health care and social service providers) are responsible for providing meaningful access to the full range of family planning and pregnancy-related services and information to all youth in their care aged 12 and older, and to children under the age of 12 who are known to be sexually active, without regard to level of care or permanency planning goal. It is ACS' expectation that family planning and pregnancy-related services are provided through direct on-site services or through other community-based service providers. Additional resources are available in the *Pass It 2 Youth* pamphlet and the Sexual and Reproductive Health Centers and Clinics list (see Attachment C).

G. Sexually Transmitted Infection (STI) Risk Assessment

1. Risk Assessment

Within 30 days of placement and every six (6) months thereafter, foster care providers are required to administer an STI risk assessment to all youth aged 12 and

[13] See 18 NYCRR 441.22.

older or under 12 if known to be sexually active. Agencies may choose to use the *Mandated Family Planning Risk Assessment Form* (Form FSS-11[14] issued by ACS) or their own equivalent form. Agencies that choose to develop or use their own assessment tools should use Form FSS-11 as a template and must include all of the questions posed.

2. Testing and Treatment

STI testing should be a routine part of primary care for sexually active youth. Testing should also be considered when a youth returns from an absence without permission (i.e., AWOL) if there are concerns that the youth engaged in sexual activity. Health care practices should follow the current STD Treatment Guidelines, which are available from the Centers for Disease Control and Prevention (CDC) website or through the following link: http://www.cdc.gov/STD/treatment/2010/default.htm.

H. Informing Parents/Guardians and Foster Parents of Youths' Rights to Sexual and Reproductive Health Care

1. Informing Parents/Guardians

a. It is ACS policy that within 30 days of placement in foster care, the case planner will provide the parents/guardians of a youth 12 years of age and over or under 12 years and known to be sexually active with the *Pass It 2 Youth* pamphlet and the ACS *Letter Informing Parents/Guardians and Foster Parents of Adolescents' Rights to Confidential Sexual and Reproductive Health Care* (Form FSS-005, see Attachment B). The case planner must send these documents to each parent/guardian whose rights have not been terminated or surrendered. This standardized letter informs parents/guardians of their children's rights to confidential sexual and reproductive health care and privacy regarding information concerning that care, within applicable law. The letter also states that parents/guardians may not withhold sexual and reproductive health information or services from their children in foster care. Although parents/guardians may not have provided the consent for sexual and reproductive health services, it is nevertheless important that they be familiar with their children's rights to care and be educated about the importance of their children receiving sexual and reproductive health information and services. The case planner must not reveal to the parent/guardian that the child is known to be sexually active unless that information came from the parent/guardian, or the child has consented to such disclosure.

[14] FSS-011 was formerly known as CM-1036 and can be accessed through the following link: FSS-011 Mandated Family Planning Risk Assessment Form.

b. In addition to the letter, provider agency staff must have face-to-face conversations with parents/guardians regarding their children's rights to confidential sexual and reproductive health care. Such discussions may be incorporated into an existing meeting among the parents/guardians, foster parents, and provider agency, such as at a Family Team Conference. As stated above, in the course of the discussion, staff may not reveal or discuss any confidential sexual and reproductive health information about the youth.

2. Informing Foster Parents[15]

a. Within 30 days of a youth's placement in foster care and annually thereafter, the foster parents of a youth 12 years of age and over or under 12 years and known to be sexually active, will receive the *Pass It 2 Youth* pamphlet and the *Letter Informing Parents/Guardians and Foster Parents of Adolescents' Rights to Confidential Sexual and Reproductive Health Care*. Provider agencies must send these documents to each foster parent caring for any foster child 12 years of age and over or under 12 years and known to have been sexually active.

b. The letter also states that foster parents may not withhold appropriate sexual and reproductive health information or services from foster children in their care.

c. In addition to the letter, provider agency staff must have an annual face-to-face conversation with each foster parent regarding adolescents' rights to sexual and reproductive health services. Unlike discussions with youth, which must be private, discussions with the foster parent about these rights and services may be incorporated into an existing meeting between the foster parent and provider agency.

i. To avoid creating an uncomfortable situation for the youth, the provider agency staff member should not have this conversation in front of the youth unless the youth wishes to be part of the discussion. In the course of the discussion, staff may confirm the delivery of sexual and reproductive health information to the young person but may not reveal or discuss any confidential health information or health care provided to the young person.

I. Documentation

A copy of the *Letter Informing Parents/Guardians and Foster Parents of Adolescents' Rights to Confidential Sexual and Reproductive Health Care* (Form FSS-005) or the standardized agency letter containing the same information and the date it was given to

[15] See 18 NYCRR § 441.22(l)(1); 11-OCFS-ADM-09; 90-OCFS-ADM-21.

the foster parent and parent/guardian must be filed in the youth's medical record. Documentation of the delivery of the *Letter Informing Parents/Guardians and Foster Parents of Adolescents' Rights to Confidential Sexual and Reproductive Health Care* and other literature as well as the face-to-face discussion must be recorded in the CNNX Health Narrative field.

IV. PROGRAMS AND SERVICES

A. Assisting Youth in Accessing Sexual and Reproductive Health Care Services

1. All foster care provider agencies must offer meaningful access and referrals to the full range of sexual and reproductive health care as described herein to youth 12 years and older and children younger than 12 if they are known to be sexually active. Provider agencies must adhere to ACS policy and the terms of their contracts regarding comprehensive sexual health information and services for youth in their care. State and federal laws mandate that family planning services, including contraception, must be provided to youth in foster care who request such services; and youth who enter ACS custody already on contraception (e.g., birth control pills) shall be able to continue. Youth must be encouraged to make independent and informed choices regarding the measures they will take to avoid unintended pregnancies and STIs. Contraception services may either be provided by the youth's physician or by referral to a community health care provider who will make a determination regarding the youth's capacity to consent to a particular service or treatment.[16] Provider agencies must also offer access to LGBTQ-affirming services[17] [e.g., the Callen-Lorde Health Clinic's Health Outreach to Teens (HOTT) Program and the Health and Education Alternatives for Teens (Heat) Program].

2. ACS and provider agency staff must not impose their personal, organizational, and/or religious beliefs regarding sexual and reproductive health care services on youth in foster care. Provider agencies must distribute and use the Sexual and Reproductive Health Centers and Clinics list when alternative resources are needed. Additionally, if a youth requests an escort to medical appointments, provider agencies shall promptly identify a responsible individual (e.g., case planner, foster parent, mentor) to accompany the youth to the appointment and all related sexual and reproductive health procedures. It remains the responsibility of the provider agency case planner to make certain that the youth has timely and adequate support and access to sexual and reproductive health and follow-up services.

3. Provider agencies must develop a sexual and reproduction health services strategy to address the issue of staff and foster parents who have difficulty reconciling their obligations to youth with their personal values. Staff must talk to their supervisors,

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[16] See 11-OCFS-ADM-09.

[17] See Policy #2012/01, *Promoting a Safe and Respectful Environment for Lesbian, Gay, Bisexual, Transgender and Questioning (LGBTQ) Youth and Their Families Involved in the Child Welfare, Detention and Juvenile Justice System*.

and foster parents must speak to their case planners about ways to manage their feelings so that they are able to provide youth in foster care with all of the information and services they need. Case planners must document discussions, including topic areas discussed, in the CNNX Health Narrative field.

4. Provider agencies must develop a sexual health and pregnancy prevention strategy focused on educating young people about safer sex practices, offering consistent messaging about dual protection (e.g., condom and hormonal methods), promoting the delay of early parenting, and avoiding unintended pregnancies. Discussions must be confidential and occur at least every six (6) months. Discussions may happen in a formal or informal setting but must be private and be clearly documented in the CNNX Health Narrative field.

B. Addressing the Sexual and Reproductive Health Needs of Youth in Foster Care

1. Gynecological Services[18]

   a. As part of routine medical care, all eligible youth aged 12 and over or at the onset of puberty must be referred for annual gynecological services. This care includes all female youth who are thinking about becoming sexually active or who are already sexually active, or when there are medical concerns such as menstrual problems. This care may include counseling, consultation, and determination of when a pelvic examination is appropriate.

   b. If the youth refuses services, the provider agency staff person is responsible for documenting the youth's refusal in the medical record. In addition, the provider staff person must continue to engage the youth to consider the benefits of receiving sexual and reproductive medical services.

   c. Human Papillomavirus (HPV) vaccinations should be administered as a routine immunization to all females aged 11-12[19] and over who have not yet received the vaccination, regardless of whether they are sexually active or already infected with HPV.

   d. In the event that an eligible youth provides information that indicates the need for more immediate gynecological attention, the provider agency shall arrange for such care regardless of the date of the last examination.

2. Support and Services for Pregnant and Parenting Youth in Care

   a. ACS has issued a booklet entitled, *Guide to Working with Young Parents in Out of Home Care*. Staff should use this guide in conjunction with the *Checklist for*

[18] *Ibid.*
[19] See 11-OCFS-ADM-09, page 5.

Pregnant and Parenting Young People in Out of Home Care (see Attachment E). Additionally, ACS has developed the *Sexual and Reproductive Health Best Practice Guide* to assist and continue to support improved practices among foster care agencies, foster parents, and parents to better support foster care youth who are sexually active. A link to this guide can be found above in section III(D)(3).

b. Provider agency staff must counsel female youth as to the advisability of testing for pregnancy at any time that a pregnancy is reasonably suspected due to late or missed menses or for some other reason[20]. In the event that a foster parent or provider agency staff member other than an on-site medical staff person employed by the agency becomes aware that a youth is pregnant, that youth's case planner must be informed within 24 hours of obtaining such information. Provider staff and foster parents must approach a possible pregnancy with sensitivity to the young person's feelings and must involve her in conversations about her reproductive health rather than merely having such discussions about her.

c. Provider agencies must counsel and offer information to pregnant youth in foster care that covers all relevant issues including, but not limited to:

   i. Living arrangements for the infant if the pregnant youth decides to continue the pregnancy to term;
   ii. The pregnant youth's decision about whether to involve her parents, foster parents, and/or the baby's father in planning (this discussion should include an assessment of the safety of the youth's relationship with the baby's father);
   iii. An objective review and discussion of all options and their implications, including continuing the pregnancy to term, adoption, or termination of the pregnancy;
   iv. School attendance and other education services;
   v. Childcare resources and referrals for the infant; and
   vi. Additional services and supports that are needed in order for the pregnant youth to remain in her current placement. (Note: this conversation may include the foster parent with the youth's consent.)

d. Discussion and counseling regarding all available options must be provided as soon as possible, but no more than five (5) days after a pregnancy confirmation.[21] Within two (2) weeks following the pregnancy confirmation, the case planner shall meet with the pregnant youth to determine whether the youth would like any information in order to be adequately educated and informed about all pregnancy options. The case planner may not delay a

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[20] See 11-0CFS-ADM-09.

[21] *Ibid.*

pregnant youth's termination procedure for failure to have such a meeting. The case planner must also confirm that the youth's decision was made solely by the youth and that another individual has not coerced her into making a decision to maintain or terminate the pregnancy. The case planner must offer the youth an opportunity to meet with a health care provider, counselor, and/or her attorney if the youth wishes additional assistance in the decision-making process.

e. The case planner must also ask the pregnant youth about whether she wants to notify her parent or legal guardian about the pregnancy. No disclosure to the youth's parent or legal guardian may occur unless the youth gives written consent. The case planner must document discussions, including topic areas discussed, in the CNNX Health Narrative field.

C. <u>Pregnant Youth Who are Considering Maintaining Their Pregnancy</u>

Pregnant youth who are considering maintaining their pregnancy must receive prenatal care immediately, as well as postpartum care. Such care must be consistent with the New York State Department of Health (DOH) Prenatal Care Assistance Program (PCAP) regulations.[22] Care must include a referral to a community prenatal care provider who will be responsible for the obstetrical medical care. The first prenatal care appointment must occur as soon as possible after the youth has decided to continue her pregnancy, preferably within one week.

1. Prenatal/postpartum care must be consistent with current professional standards of care. The American College of Obstetricians and Gynecologists (ACOG) Standards for reproductive health and the birth process must be employed.

D. <u>Pregnant Youth Who Are Considering Termination of Pregnancy</u>

For pregnant youth who are considering termination of pregnancy, the provider agency must provide nonjudgmental, unbiased information about abortion and access to services and/or make alternative referrals to providers who offer these services to enable youth to make informed decisions about their pregnancies. Following termination of a pregnancy, the provider agency must offer youth trauma-informed counseling and support by an appropriate licensed mental health or social work practitioner.

E. <u>Documentation</u>

All sexual and reproductive health information related to continuing or terminating a pregnancy must be documented. The case planner must document face-to-face discussions about these two issues in the CNNX Health Narrative field.

[22] See 10 NYCRR § 85.44.

F. Addressing the Sexual and Reproductive Health Needs of Male Youth in Foster Care

1. Primary Care

   As part of primary care services related to sexual and reproductive health care for male youth, clinicians must discuss and manage male adolescent sexual and reproductive health on a regular basis (i.e., annually and as needed). Case planners must refer all eligible male youth (from the age of 12 and over or at the onset of puberty or if they are known to be sexually active or thinking of becoming sexually active) for sexual and reproductive health services. This care may include obtaining a youth's sexual history, conducting an appropriate examination, offering patient-centered (i.e., youth, parent, foster parent, or trusted individual) and age-appropriate anticipatory guidance, and providing appropriate vaccinations.[23]

2. The male genital examination is important for screening and diagnostic purposes beyond the need to screen for testicular cancer. Despite the lack of evidence supporting screening for testicular cancer, the genital examination should be included as part of a male's routine physical examination as well as when a male patient presents with genital complaints.

3. If a youth refuses services, the provider agency staff person is responsible for documenting the youth's refusal for services in the medical record. In addition, the provider staff person must continue to engage the youth to consider the benefits of receiving sexual and reproductive medical services.

4. Provider agencies must remain informed about any new recommendations regarding the administration of the HPV vaccine to male youth and be ready to incorporate them in their provision of services. Routine vaccinations against HPV should be given to male adolescents beginning from ages 11 to 12 years old. The series can be initiated as early as age 9, and it is recommended that catch-up vaccinations begin between ages 13 through 21 among males who have not been vaccinated previously or have not completed the three-dose series through age 21.[24]

5. In the event that an eligible youth provides information that indicates the need for more immediate medical attention, the case planner shall arrange for it regardless of the date of the last examination.

6. The parent's/guardian's signed consent for routine medical treatment is sufficient for the HPV vaccination; no additional consent is required.

[23] Marcell, A. V., et.al. (2011). "Male Adolescent Sexual Reproductive Health Care," Pediatrics 128(6):e1658.
[24] See http://www2.aap.org/immunization/izschedule.html.

G. Support and Services for Expectant and Parenting Male Youth in Care

1. Provider agencies can refer to the *Sexual and Reproductive Health Care for Youth in Foster Care Best Practice Guide,* the *Pass It 2 Youth: What Every Teen Needs to Know About Sexual and Reproductive Health* workbook, and the Fatherhood Program/Provider Resource Data Base (see Attachment D) as resources when having discussions with male youth who are expectant fathers. The guide and workbook serve as supportive materials that may assist agency staff in having open and informative conversations with males who are parenting or are expectant fathers.

2. If a male youth discloses to a foster parent or provider agency staff person that he has impregnated another youth, his case planner must immediately connect him to a fatherhood program. If the pregnant youth is also in foster care, the case planner must notify her case planner of the pregnancy within 24 hours.

3. Provider agencies must counsel and provide up to date and useful information to all male youth with special attention to parenting and expectant fathers that covers all relevant issues including, but not limited to:

   a. Identifying trusted, non-judgmental, and positive individuals in whom male youth can confide;
   b. Promoting responsibility and encouraging expectant fathers to talk openly with expectant mothers;
   c. An objective review and discussion of all options and their implications, including continuing a pregnancy to term, adoption, or termination of a pregnancy, and the provision of support services to assist young men learning to raise a child;
   d. Co-parenting arrangements for the infant if the pregnant youth decides to continue the pregnancy to term and raise the child with the expectant father (this discussion should include an assessment of the safety of the young man's relationship with the expectant mother);
   e. School attendance and other education services;
   f. Information about job training;
   g. Information and support services related to becoming a father;
   h. Information about responsible fatherhood, resources, and referrals for the infant;
   i. Information on budgeting and conflict resolution;
   j. Information on healthy intimate relationships, responsible behavior, and support with co-parenting; and
   k. Information on DNA testing and establishing paternity if paternity has not already been legally established and, when relevant, child support and custody.

H. Documentation

All sexual and reproductive health information related to male adolescents' sexual and reproductive health needs must be documented. The case planner shall document face-to-face discussions about these issues in the CNNX Health Narrative field.

I. Discharge Planning

Discharge planning for youth who are leaving care shall include planning for access to sexual and reproductive health care services. This may include, but is not limited to, arranging for future medical appointments and acquiring any necessary medication.

J. Provider Agency Training[25]

Provider agencies must offer separate training sessions on sexual and reproductive health services for youth in care, foster parents, and parents/guardians. Each of these trainings must be offered at least four (4) times a year. Agencies must also give youth the option to receive individual trainings. If possible, a training option that involves both parents and youth should be provided to promote dialogue around sexual and reproductive health.

1. Direct Service Staff

Provider agencies must offer mandatory training twice a year for all direct service staff regarding sexual and reproductive health rights and services. Non-direct service staff must be encouraged to attend these trainings to enhance their knowledge about these topics. These training sessions must be LGBTQ-affirming and include, but not be limited to:

a. Adolescent development (including sexual orientation and gender identity) and the response to trauma, and adolescent sexual and reproductive health needs;
b. The impact of sexual abuse and other maltreatment on sexual decision-making, including the decision to become a parent;
c. Sexual and reproductive health care services available to teens;
d. Consistent messaging about dual protection (e.g., condoms and hormonal methods);
e. Information about adolescents' rights to confidential care;
f. Guidance on how to talk to teens and parents about sexual and reproductive health issues;
g. The impact of culture and ethnicity on sexual and reproductive health care; and
h. The challenges of being a parent.

[25] The individuals conducting the following trainings must have experience working with or have training in sexual and reproductive health matters.

2. Paterity Rights of Male Youth

a. Provider agencies must offer training and inform all young men about their paternity rights and responsibilities regardless of their sexual orientation and gender identity. Topics should include parenting classes, family planning counseling, and links to local resources, mentors, and support groups.

b. Agencies must also provide training for young fathers addressing the importance of their involvement in the lives of their children, as well as support in creating a positive co-parenting relationship with the mother(s) of their child(ren). Provider agencies shall make efforts to help young fathers develop a strong sense of sexual responsibility and an understanding of the implications of fatherhood.

3. All Youth

Provider agencies must offer all youth aged 12 years and older ongoing training (e.g., one-on-one, group, video or webinar, etc.) on matters pertaining to adolescent sexual and reproductive health. Such training must be LGBTQ-affirming and address issues including, but not limited to:

a. Reproductive biology and the changes that come with adolescence;
b. Sexuality and sexual orientation;
c. Gender identity, including related topics such as puberty blockers and hormone replacement therapy;
d. Responsible behavior and equal treatment between dating or sexual partners;
e. Safer sex practices and access to contraception methods;
f. Consistent messaging about dual contraception (e.g., condoms and hormonal methods);
g. STIs, including HIV;
h. Maternity care (prenatal, perinatal, and postpartum) and termination of pregnancy;
i. Gynecological care;
j. Adolescents' rights to confidential sexual and reproductive health care;
k. The impact of culture and ethnicity on sexual and reproductive health care;
l. Commercial sexual exploitation and the vulnerability of adolescents in child welfare, including information about appropriate interventions and mental health services; and
m. The challenges of being a parent.

4. Foster Parents

Provider agencies must offer ongoing training (e.g., one-on-one, group, video or webinar, etc.) to foster parents in matters pertaining to adolescent sexual and

reproductive health. This training must be LGBTQ-affirming and address issues including, but not limited to:

a. Talking to teens about sexual and reproductive health issues;
b. Human sexual development, including sexual orientation and gender identity;
c. The impact of sexual abuse and other maltreatment on sexual development and decision-making, including the decision to become a parent;
d. How to assess the need for specialist care and selecting an appropriate provider;
e. Consistent messaging about dual protection (e.g., condoms and hormonal methods);
f. Youths' rights to confidential sexual and reproductive health care; and
g. Commercial sexual exploitation and the vulnerability of adolescents in child welfare, including information about appropriate interventions and mental health services.

5. Parents/Guardians

Foster care provider agencies must offer trainings (e.g., one-on-one, group, video or webinar, etc.) to parents/guardians that are LGBTQ affirming and address issues including, but not limited to:

a. Talking to teens about sexual and reproductive health issues;
b. Human sexual development, including sexual orientation and gender identity;
c. The impact of sexual abuse and other maltreatment on sexual development and decision-making, including the decision to become a parent;
d. How to assess the need for specialist care and selecting an appropriate provider;
e. Consistent messaging about dual protection (e.g., condoms and hormonal methods);
f. Youths' rights to confidential sexual and reproductive health care; and
g. Commercial sexual exploitation and the vulnerability of adolescents in child welfare, including information about appropriate interventions and mental health services.

ATTACHMENT A

Letter Informing Youth of Their Right to Confidential Sexual and Reproductive Health Care

NAME OF YOUTH________________________ DATE OF BIRTH ___________

YOUTH'S CIN (MEDICAID #):

As you make decisions about your health, it is important for you to be able to receive support from a number of different people, including your foster parent(s), parent(s)/guardian(s) and foster care agency staff. As a young person, you have certain rights concerning your medical needs, including sexual and reproductive health information and services. You also have the responsibility to make sure that any medical providers you go to on your own know about the other health services and medication(s) you are receiving.

You have the right to learn about:

- contraception and safer sex practices, including safer sex supplies such as barrier methods such as condoms, dental dams, and finger condoms;
- prevention of pregnancies;
- responsible behavior;
- healthy and unhealthy relationships;
- sexual orientation and gender identity; and
- prevention of and testing and treatment for sexually transmitted infections (STIs), HIV and AIDS;

You have the right to access contraceptives and safer sex supplies, including emergency contraception (the "morning after pill" or Plan B).

All female youth have the right to a gynecological exam and maternity care (prenatal, perinatal and postpartum) and termination of pregnancy. All male youth have the right to sexual and reproductive health services, including information about safer sex and delaying fatherhood.

The foster care agency and/or foster parent must give you support in making sure you receive information and services. Even if your foster parent is not supportive about these issues, this should not affect your ability to access information and services. The agency gave a similar letter to your foster parent informing him/her of your sexual and reproductive rights.

You have the right to privacy regarding your sexual and reproductive health. You can receive sexual and

reproductive health services (prevention, testing and treatment for STIs, pregnancy testing, abortion services, and contraception) without anyone knowing about it, including your parents/guardians and foster parents, foster care agency staff, or anyone else.

Your medical information may only be shared when required by law. In this event, the foster care agency will follow the law and will only share the information necessary. You will be told, as required by law, when the information is shared.

Along with this letter, the foster care agency will give you a pamphlet about your right to confidential sexual and reproductive health care (*Pass It 2 Youth: What Every Teen Needs to Know About Sexual and Reproductive Health Rights)* and your rights and options if you or your partner is pregnant.

Your foster care agency has given you a CIN, which stands for Child Identification Number (Medicaid #), will allow you to access sexual and reproductive health-related services and resources outside of your foster care agency. Your CIN (Medicaid #) is also listed at the top of this letter. To prevent abuse or deliberate misuse, only share your CIN with appropriate staff and keep the letter in a safe place. When you have a doctor's appointment or visit a health clinic for services, take this letter and a photo identification card with you. You can ask the clinic or hospital to make a copy of the letter so you can keep the original.

Someone from your agency will speak to you about this information. If you have questions, and/or would like to talk about your sexual and reproductive health needs you can contact him/her at:

Staff Person's Name ___________________________ Telephone Number ____________________

If you need help finding a health clinic in your neighborhood, have questions, or are unable to access information or services related to your sexual and reproductive health, you may call the
Children's Services Office of Advocacy at 212.676.9421.

I have read, discussed, and I understand the information in this letter.

Signature of Youth ______________________________ Date ______________________________

Administration for Children's Services

ATTACHMENT B

Letter Informing Parents/Guardians and Foster Parents of Adolescents' Rights to Confidential Sexual and Reproductive Health Care

Youth in foster care constantly face difficult life decisions that affect their future. Communicating accurate information with youth in a non-judgmental way about their rights to confidential sexual and reproductive health services is critical in helping them make informed decisions regarding their sexual health. As a parent/guardian/foster parent, you must be aware that youth 12 years and older and certain youth under 12 years in foster care have certain rights concerning their medical needs, including sexual and reproductive health information. It is important to be open and available to talk to youth about these situations, and be a resource for support and information.

Youth in foster care have the right to learn about:

- contraception and safer sex practices;
- safer sex supplies, including barrier methods such as condoms, dental dams, and finger condoms;
- prevention of pregnancies;
- prevention of, testing and treatment for, sexually transmitted infections (STIs), HIV, and AIDS;
- responsible behavior;
- sexual orientation and gender identity;
- healthy and unhealthy relationships

Youth in foster care have the right to access contraceptives and safer sex supplies.

All female youth have the right to a gynecological exam and maternity care (prenatal, perinatal and postpartum) and termination of pregnancy.

All male youth have the right to sexual and reproductive health services, including information about safer sex and delaying fatherhood.

The foster care agency and/or foster parent must give support to youth in care in receiving information and services.

Young people have the right to privacy in all issues regarding their sexual and reproductive health. Young people can receive sexual and reproductive health services (prevention, testing and treatment for STIs, pregnancy testing, abortion services, and contraception) without anyone knowing about them, including parents/guardians and foster parents, foster care agency staff, or anyone else.

Along with a letter, every youth will receive a pamphlet describing his/her rights to confidential sexual and reproductive health care (*Pass It 2* Youth*: What Every Teen Needs to Know About Sexual and Reproductive Health Rights)* and his/her rights and options if the youth is pregnant or has gotten someone pregnant. A copy of this pamphlet is included with this letter for your information.

The foster care agency has issued documentation to your child/foster child with his/her Child Identification Number (CIN), which is the youth's Medicaid #. This will allow him/her to access sexual and reproductive health-related services and resources outside of the foster care agency. This number must only be used by the youth.

A representative from your agency will speak to the youth in your care about the information in this letter. You and/or the youth may contact the following person from your agency if either of you have questions about sexual and reproductive health issues or the rights of youth to confidential health care:

Staff Person's Name______________________________ Telephone Number______________________________

If you have questions or if the youth in your care is unable to access information or services related to sexual and reproductive health, you may call the **Children's Services Office of Advocacy at 212 -676-9421.**

I have read, discussed, and I understand the information in this letter. After signing the document please return to agency staff person.

NYC Administration for Children's Services

Signature of Parent/Guardian/Foster Parent____________________________ Date _______________

Printed Name___________________________ Relationship to Child ___________________________

NYC Administration for Children's Services

ATTACHMENT C

Sexual and Reproductive Health Centers/Clinics

CLINICS	PHONE NUMBERS
Bronx	
Bronx Health Center	718. 320.4466
Jacobi Hospital/Clinic – Gun Hill	718.918.8850
Jacobi Hospital/Clinic - Tremont	718.918.8700
Planned Parenthood - The Bronx Center	212.965.7000
Brooklyn	
CABS Health Center	718.388.0390
Caribbean House Health Center	718.778.0198
Coney Island Hospital/Clinic	718.616.4392/3191
Dr. Betty Shabazz Health Center	718.277.8303
HEAT Program	718.467-4446
Kings County Hospital/Clinic	718.245.5495/ 3502
Planned Parenthood - Boro Hall Center	212.965.7000
Manhattan	
Callen-Lorde Health Outreach to Teens (Project HOTT)	212.271.7212
Community Health Care Network of NYC	212.545.2400
Community League Health Center	212.781.7979
Downtown Health Center	212.477.1120
Gouverneur Hospital/Clinic	212.238.7244/ 7601
Harlem Hospital/Clinic	212.939.8229/ 8262
Helen B. Atkinson Health Center	212.426.0088
Metropolitan Hospital	212.423.8811/ 7662
Planned Parenthood - Margaret Sanger Center	212.965.7000
The Door	212.941.9090
The Young Men's Clinic	866.463.2778
PFLAG (Parents, Families and Friends of Lesbians and Gays)	212. 463.0629
Queens	
Long Island City Health Center	718.482.7772
South Queens Clinic	718.883.6699/ 2558
Queens Health Center	718.657.7088
Staten Island	
Planned Parenthood - Staten Island Center	212.965.7000
Teen R.A.P.	718.226.6262

Attachment D

Fatherhood Program/Provider Resource Data Base

Office of Child Support Enforcement
NYC Human Resources Administration
Parent & Community Outreach

Program/Provider Name	Services Offered	Website Link
BRONX		
Bronx Workforce1 Career Center 358 East 149th St. Bronx, NY 10455 718-960-7099	Workforce 1 Centers provide job search resources, career counseling, assistance creating resumes and cover letters, and job placement services. The Center is a partnership of agencies and organizations providing a full array of services.	www.nyc.gov/workforce1
Visiting Nurse Service of New York Agency Location: 107 East 70th St NYC, NY 10021 800 675-0391 **Program Site:** **Friends Program** 389-391 East 153rd St. Bronx, NY 10455	Visiting Nurse Service provides workshops on parenting skills, child development, anger management, legal counseling, and job readiness.	www.vnsny.org

Legal Information for Families Today (LIFT) Agency Location: 350 Broadway, Suite 400 NYC, NY 10013 646 613-9633 212 343-1122	LIFT provides fathers 24 years and older with individual/family and group counseling, anger management workshops, mediation/conflict resolution training, parent/child rearing classes, educational/ career/employment counseling, visitation arrangements, and family budgeting services.	www.liftonline.org
Claremont Neighborhood Centers, Inc. Program Site: 489 East 169thStreet Bronx, NY 10456 718 588-1000	Claremont Neighborhood Centers provides fathers 24 years and older with group and individual/ family counseling, mediation/conflict resolution/ training, parenting skills, educational workshops, family budget and consumer education, visitation arrangements, and mentoring. They also offer an eight week summer camp for children of fatherhood program participants, ages 5-12 years old.	www.claremontneighborhoodcenters.org
Friends of Island Academy Agency Location: 330 West 38th Street, 3rd Floor NYC, NY 10018 212 760-0755	Friends of Island Academy offers workshops, counseling, support, employment, parenting classes, anger management	www.foiany.org

Program Site: **Parkside Community Center** 29 10/2972 Bronx Park East Bronx, NY 10467	counseling, child support and legal assistance, career development, housing and educational assistance.	
Fund for the City of New York/Center for Court Innovation Agency Location: 520 Eighth Avenue, 18th Floor Forest Hills, NY 11375 718 397-3050	The Center for Court Innovation provides individuals on parole with drug treatment, transitional employment and vocational services, health care and mental health treatment and other services.	www.courtinnovation.org
Inwood House **Fathers Count Program** 522 Courtland Ave. Bronx, NY 10451 718 742-8100 **Contact:** Andrew Ross aross@inwoodhouse.com	The Fathers Count Program provides parenting and family planning classes, educational and vocational referral and placement, recreational activities, counseling, a safe, supportive atmosphere, and positive peer influence.	www.inwoodhouse.com
South Bronx Concerned Citizens Inc. Fathers First 1019 Avenue of Saint Johns Bronx, NY 10455	South Bronx Concerned Citizens provides support groups, education and advocacy to fathers.	www.sbccinc.net
Citizens Advice Bureau (now BronxWorks) 2054 Morris Avenue Bronx, NY 10453 (718) 365-0910 cabinfo@cabny.org	BronxWorks provides services for immigrants, homeless individuals and families, people with and families impacted	www.bronxworks.org

	by HIV/AIDS, and adults making the transition from welfare to work.	
BROOKLYN		
Brooklyn Workforce1 Career Center 9 Bond St., 5th Floor Brooklyn, NY 11201 718-246-5219	Workforce1 Centers provide job search resources, career counseling, assistance creating resumes and cover letters, and job placement services. The Center is a partnership of agencies and organizations providing a full array of services.	www.nyc.gov/workforce1
Family, Fathers & Children 563 Sterling Pl. Brooklyn, NY 11238 718 287 9044 **Contact:** Ellen Edelman eedelm@aol.com	Family, Fathers & Children provides cooking services for children with incarcerated fathers.	No website
Ralph Lincoln Service Center, Inc. Agency Location: 261 Buffalo Avenue, Suite 2 Brooklyn, NY 11213 718 604-1358	Ralph Lincoln Service Center provides help with parenting skills, individual and family counseling, mediation and conflict resolution, mentoring, group counseling and visitation assistance.	No website
Coalition for Hispanic Family Services Agency Location: 315 Wyckoff Avenue, 4th Floor	The Coalition for Hispanic Family Services provides fathers and those in father-like roles 24	hispanicfamilyserviceny.org

Brooklyn, NY 11237 718 497-6090	years and older with individual and group counseling, visitation, partner mediation, parenting classes, and anger management workshops.	
Catholic Charities Neighborhood Services, Inc. Agency Location: 191 Joralemon Street Brooklyn, NY 11201 718 722-6000 **Program Site:** **Project Bridge** 52 Wilson Avenue Brooklyn, NY 11237	Catholic Charities Neighborhood Services provides individual and family counseling, visitation, group counseling, parenting skills, educational and vocational counseling, budget & finance and independent living skills.	www.ccbq.org
Legal Information for Families Today (LIFT) Agency Location: 350 Broadway, Suite 400 NYC, NY 10013 646 613-9633 212 343-1122	LIFT provides fathers 24 years and older with individual/family and group counseling, anger management workshops, mediation/conflict resolution training, parent/child rearing classes, educational/ career/employment counseling, visitation arrangements, and family budgeting services.	www.liftonline.org
Family & Community Support Services Agency Location: 1195 St. Marks Avenue Brooklyn, NY 11213 718 771-3136	Family & Community Support Services provides young fathers 16-24 years old with individual, family and group counseling, parenting classes, anger	www.fcss.org

Family & Community Support Services 124 Utica Ave. Brooklyn, NY 11213 718 771 3136 www.fcss.org **Contact:** Maurice Lauriano **Program Site:** **Beacon** 1137 Herkimer St. Brooklyn, NY 11233	management classes, skill empowerment workshops and mentoring.	
Fund for the City of New York/Center for Court Innovation **Agency Location:** 520 Eighth Avenue, 18th Floor Forest Hills, NY 11375 718 397-3050	The Center for Court Innovation provides individuals on parole with drug treatment, transitional employment and vocational services, health care and mental health treatment and other services.	www.courtinnovation.org
The New York Society for the Prevention of Cruelty to Children Agency Location: 161 William Street, 9th Floor NYC, NY 10038 212 233-5500	The New York Society for the Prevention of Cruelty to Children provides supervised visitation for children with their non-custodial parents; promotion of healthy parenting through skills training, education and guidance; trauma recovery for children from physical or sexual abuse, family violence, parental substance abuse and parental mental illness; group counseling to "high-risk" children in New York City public	www.nyspcc.org

	schools; sexual abuse prevention workshops geared towards children in grades K-3; child permanency mediation; resiliency restoration training for child welfare agencies to help staff during times of grief, stress and loss; and education on legislative action.	
Counseling Service of EDNY 180 Livingston St. Suite 301 Brooklyn, NY 11201 718 858-6631 **Contact:** Catherine Rossi Catherine.rossi-berna(csedny.org	Counseling Service of EDNY provides men 18-25 years old involved in the criminal justice system with an alternative to incarceration through drug counseling and fatherhood classes.	www.csedny.org
Enhanced Employment Initiative EAC NYC Task 175 Remsen St. Brooklyn, NY 11201 718 237-9404 **Contact:** Alma Radoncic aradoncic(nyctask.org	Enhanced Employment Initiative provides employment services and fatherhood workshops on topics such as child support for the formerly incarcerated. Only available by referral from the DA's office.	www.eacinc.org
Man-Up 200 Gold St. Brooklyn, NY 11201 718-875-8801 **Contact:** Antionette Brembridge ABrembridge(CCBQ.org	Man-Up provides men 16-24 years old, noncustodial parents and the unemployed with counseling, job readiness and parenting classes which focus on engaging fathers in their children's lives; as	www.ccbq.org

	well as summer employment, a food pantry and anger management and life skills. Walk-ins, referrals, or the formerly incarcerated may participate.	
Puerto Rican Family Institute Responsible Fatherhood/Healthy Marriage Initiative 217 Have Meyer St. 4thFloor Brooklyn, NY 11211 718 963-4430 Ext. 4501 **Contact:** Martha Mendez Mendez@prfi.org	The Puerto Rican Family Institute offers workshops on responsible fatherhood, anger management, and couples' relationship enhancement. They provide metro cards, child care, snacks and certificates. They teach fathers self esteem and how to balance work and family.	www.prfi.org

Fathers in Training for Fatherhood 515 Stanley Ave. Brooklyn, NY 11207 646 419-0906 www.fit4fathers.org **Contact:** Lance Cruell	Fathers in Training offers parenting skills classes, domestic violence counseling, anger management, transitional/post-incarceration release counseling, adult basic education, GED/SAT/computer training, HIV/AIDS related services, network social services and child/youth at risk prevention services.	www.fit4fathers.org
Center for Employment Opportunities Fatherhood Initiative 32 Broadway New York, NY 10004 212 422 4430 www.ceoworks.org **Contact:** Alba Rivera	The Center for Employment Opportunities provides young fathers 18-25 years old with intensive job coaching, mentoring and parenting skills.	www.ceoworks.org
Dads Embracing Fatherhood Williamsburg Works/St. Nicholas NPC 790 Broadway Brooklyn, NY 11206 718 302 2057 **Contact:** Theresa Dobie tdobie(stnicksnpc.com	Dads Embracing Fatherhood provides job readiness skills, parenting classes and child support workshops.	www.stnicksnpc.org/
Brooklyn Male Involvement Healthy Start Brooklyn 485 Throop Ave Brooklyn, NY 11221 646 253 5607 **Contact:** Dennis Smith dsmith3(health.nyc.gov	Brooklyn Male Involvement provides families with outreach and case management, activities to improve parent-child and family relationships, and help	http://www.fphny.org/phealthystart.php

	accessing healthcare and improving self-sufficiency.	
Working Parents Program **The Osborne Association** 175 Remsen St. 8th Floor Brooklyn, NY 11201 718 637 6560 **Contact:** Jose	The Working Parents Program provides formerly incarcerated men with parenting skills, cognitive and economic literacy enhancement and other services.	www.osborneny.org
P.A.P.A. Teen Father Program **Lois aida, Inc** 710 East 9th St. New York, NY 10009 212 353-0272 info(loisaidainc.org **Contact:** Julio Cesar Diaz	The P.A.P.A. Teen Father Program offers parenting awareness and 12 Steps to Fatherhood workshops, job skills, paid internships, reading for two and counseling.	www.loisaidainc.org
Rise Up & Walk Youth Outreach Center, Inc. 1958 Fulton St. Suite 401 Brooklyn, NY 11233 **Contact:** Clyde Evans Clyde.evans(riseupnwalk.org 718 221-1154	Rise Up & Walk offers mentoring for boys in school and help reconnecting fathers to families.	www.riseupnwalk.org
MANHATTAN		
The Northern Manhattan Pre-natal Partnership, Inc Agency Location: 127 West 127th Street NYC, NY 10007 212 665-2600 **Contact:** Thomas Goggans	The Northern Manhattan Pre-Natal Partnership provides non-custodial parents 24 years and older with individual and family counseling, parenting	http://www.sisterlink.com/

	classes, employment assistance, male group meetings, and empowerment workshops.	
East Harlem Employment Services, Inc. Agency Location: 240 East 123rd Street, 3rd Floor NYC, NY 10035 212 360-1100	East Harlem Employment Services offers parent skills training, career exploration, visitation arrangements, job readiness skills, employment assistance and career development workshops.	www.striveinternational.org
Union Settlement Association Agency Location: 237 East 104thStreet NYC, NY 10029 212 828-6000 Program Site: Washington Houses Community Center 1775 3rd Ave (98th St.) New York, NY 10029 646 245-5076 **Contact:** Richard Reeves www.unionsettlement.org	The Union Settlement Association provides individual and family counseling for young fathers, group counseling, peer counseling, father-to-father mentoring, parenting skills training, mediation/conflict resolution training, visitation arrangements and job readiness.	www.unionsettlement.org.contact
Fund for the City of New York/Center for Court Innovation Agency Location: 520 Eighth Avenue, 18thFloor Forest Hills, NY 11375 718 397-3050 **Program Site:** **Midtown Community Court**	The Center for Court Innovation provides fathers 24 years and older with individual/family and group counseling, peer or father-to-father mentoring, mediation/conflict resolution training,	www.courtinnovation.org

314 West 54th Street NYC, NY 10019	parenting classes, family budget and consumer education, visitation arrangements, educational and employment counseling, college preparation, educational workshops, job readiness and employment assistance.	
Inwood House 320 East 82nd St. New York, NY 10028 212-861-4400 www.inwoodhouse.com	Inwood house provides services for pregnant teens and the Fathers Count program for young fathers.	www.inwoodhouse.com
The New York Society for the Prevention of Cruelty to Children Agency Location: 161 William Street, 9th Floor NYC, NY 10038 212 233-5500	The New York Society for the Prevention of Cruelty to Children provides supervised visitation for children with their non-custodial parents; promotion of healthy parenting through skills training, education and guidance; trauma recovery for children from physical or sexual abuse, family violence, parental substance abuse and parental mental illness; group counseling to "high-risk" children in New York City public schools; sexual abuse prevention workshops geared towards children in grades K-3; child permanency	www.nyspcc.org

	mediation; resiliency restoration training for child welfare agencies to help staff during times of grief, stress and loss; and education on legislative action.	
Legal Information for Families Today (LIFT) Agency Location: 350 Broadway, Suite 400 NYC, NY 10013 646 613-9633 212 343-1122	LIFT provides fathers 24 years and older with individual/family and group counseling, anger management workshops, mediation/conflict resolution training, parent/child rearing classes, educational/ career/employment counseling, visitation arrangements, and family budgeting services.	www.LIFTonline.org
CHIPP (Children of incarcerated Parents Program, NYC Children's Services) 212-487-8274/8266/8631 7 12-483-559/5600, 9 17-572-1769 **Contact:** Paula Y Fendall	CHIPP provides incarcerated parents and youth with help facilitating parent/child visits, sibling visits, and case conferences.	www.nyc.gov/html/acs/home.html
WDC (Dominican Woman's Development Center) Families in Action 1780 Amsterdam Ave. (W148 St) New York, NY 646-410-0311 **Contact:** Rosa Lavergne, PhD familiesinaction@dwdc.org	WDC provides parents with workshops on creating a safe, loving environment, promoting family integrity, establishing healthy house rules and meeting children's emotional, spiritual, educational, and	www.dwdc.org.

	physical needs through active participation in their lives.	
STRIVE **Dads Embracing Fatherhood** 240 East 123rd St. New York, NY 10035 212 360-1100 **Contact:** Ernest Johnson EJohnson@striveinternational.org	STRIVE offers workshops, employment services, training (parenting skills, relationships and fatherhood), case management, fatherhood counseling, career development, job placement assistance and enhancement activities (planned activities for fathers and their children).	www.strive.org
Mount Sinai Medical Center **Young Fathers Program** **Fathers Helping Fathers Program** Klingenstein Pavilion 1176 Fifth Ave. NYC, NY 212 241-4645 **Contact:** Gregory Mudd Gregory.Mudd@mountsinai.org	Mount Sinai Medical Center offers support groups; individual, couple & family counseling; and a summer employment & training program, as well other employment and educational opportunities.	www.msmc.com
Youth at Risk Fatherhood Program 116 John St., Suite 2200 New York, NY 10038 212 791-4927 ext. 231 **Contact:** Kirk Francis KirkFrancis@nyyouthatrisk.org	Youth at Risk provides fathers and expecting fathers 16 to 25 years old with educational workshops, individual & group counseling, peer support, mentoring, job assistance, vocational & educational support, parenting classes,	www.nyyouthatrisk.org

	conflict mediation, GED tutoring & prep and financial literacy. Weekly unlimited Metro cards are available.	
Neighborhood Defender Service of Harlem 317 Lenox Avenue, 10th Floor New York, NY 10027 212-876-5500	Neighborhood Defender Service provides formerly incarcerated individuals with individual/family and group counseling, parenting classes, peer counseling, father-to-father mentoring, mediation/conflict resolution training, family budget and consumer education, visitation arrangements, and employment assistance.	www.ndsny.org
Connect NYC **Men in Dialog/Hombres Dialogando** 3 West 29th St. New York, NY 10001 212 685 0015 **Contact:** Marlon Walker mwalker(connectnyc.org	Connect NYC offers peer to peer education for men/fathers, DV education for workers and services for men and women.	www.connectnyc.org
Diligent Dads **Neighborhood Defender Service** 317 Lenox Ave New York, NY 10027 212 876 5500 **Contact:** Robert Sanchez rsanchez(ndsny.org	Diligent Dads provides individual, family and group counseling, family court advocacy, paralegal services, family mediation and family retreat events.	http://www.ndsny.org/

D-UP **Dads United for Parenting; Nurturing Fathers Program** 314 W. 54th St New York, NY 10019 646 264 1329	D-UP offers workforce development, educational and training programs, as well as DV, homelessness, and substance abuse referrals.	No website
SEEDCO **Parent Support Pilot** 915 Broadway, 17th Fl. New York, NY 10010 212 204-1335 **Contact:** Linda Rodriquez	SEEDCO provides employment assistance and case management services.	www.seedco.org
Single Parent Resource Center **Single Fathers** 228 East 45thSt. New York, NY 10017 212 951-7030 x 237 **Contact:** Neil Pollicino	The Single Parent Resource Center provides training and preparation for navigating social service systems.	www.singleparentusa.com
Upper Manhattan Workforce1 Career Center 215 W 125th St. 6th Floor New York, NY 10027 917-493-7063 **Contact:** Jose Flores	Workforce1 Centers provide job search resources, career counseling, assistance creating resumes and cover letters, and job placement services. The Center is a partnership of agencies and organizations providing a full array of services.	www.nyc.gov/workforce1
Ecumenical Community Development Organization 475 Riverside Dr Ste 253 New York, NY 10115	The Ecumenical Community Development Organization offers	www.ecdo.org

212-870-2135	housing development, housing management, employment and placement services. Their services also include the ECDO ChildStart Center, the Youth Employment Program (YEP), tenant advocacy and technical assistance.	
Loisaida Inc. (Main Program Office) 12 Avenue D (Near Houston Street) New York, NY 10009 Tel: 212.353.0272 Fax: 212.473.5462	Loisaida provides after school programs, youth development, adolescent pregnancy and HIV prevention programs.	www.loisaidainc.org
Audubon Partnership for Economic Development 513 W 207th Street, New York, NY 10034-2645 Phone : (212) 544-2400 Fax: (212) 544-0248 info@audubonpartnership.org	The Audubon Partnership for Economic Development provides small business owners and entrepreneurs with one-on-one guidance to access financing and other business services.	www.audubonpartnership.org
The Educational Alliance 197 East Broadway New York, NY 10002 212.780.2300 info@edalliance.org	The Educational Alliance offers individual, group and family therapy with experienced professionals.	www.edalliance.org
The Doe Fund, Inc. 232 East 84th Street New York, NY 10028 Phone 212-628-5207	The Doe Fund provides individuals on parole with paid work, substance abuse	www.doe.org

Fax 212-249-5589	services, education, and mentoring, job training, preparation and placement and long-term follow-up services.	
CUNY Black Male Initiative **Contact:** Elliott Dawes, Director of the CUNY Black Male Initiative at Elliott.Dawes@mail.cuny.edu	CUNY's Black Male Initiative provides help for underrepresented groups and formerly incarcerated individuals to enroll in colleges, access to college-prep GED courses, and a survey of workforce development opportunities in New York City's construction industry.	www.cuny.edu/academics/initiatives/bmi.html
Northern Manhattan Improvement Corporation 494 W 158th St New York, NY 10032 212-368-0230	The Northern Manhattan Improvement Corporation offers housing, immigration, adult basic education and GED-Prep classes, employment and training, homelessness prevention and legal services.	www.nmic.org
QUEENS		
Forestdale, Inc. Agency Location: 67-35 112th Street Forest Hills, NY 11375 718 263-0740 **Program Site:** **Allen AME** Multi-Center	Forestdale provides clients referred from Family Court, ACS, Church groups and other organizations (and walk-ins on a case by case basis) with parenting workshops, job readiness	http://forestdaleinc.org/

114-02 Guy Brewer Blvd Queens, NY **Jamaica Neighborhood Center** 161-06 89th Avenue Jamaica, NY 11432 Quaker House 137-16 Northern Blvd Flushing, NY 11354	placement, anger management, domestic violence services, supervised visitation, dad-to-dad mentoring, counseling and crisis intervention.	
Fund for the City of New York/Center for Court Innovation Agency Location: 520 Eighth Avenue, 18th Floor Forest Hills, NY 11375 718 397-3050	The Center for Court Innovation offers individual/family and group counseling, peer or father-to-father mentoring, mediation/conflict resolution training, parenting classes, family budget and consumer education, visitation arrangements, educational and employment counseling, college preparation, educational workshops, job readiness and employment assistance.	www.courtinnovation.org
Legal Information for Families Today (LIFT) Agency Location: 350 Broadway, Suite 400 NYC, NY 10013 646 613-9633 212 343-1122	LIFT provides fathers 24 years and older with individual/family and group counseling, anger management workshops, mediation/conflict resolution training, parent/child rearing classes, educational/ career/employment counseling, visitation	www.liftonline.org

	arrangements, and family budgeting services.	
The New York Society for the Prevention of Cruelty to Children Agency Location: 161 William Street, 9thFloor NYC, NY 10038 212 233-5500	The New York Society for the Prevention of Cruelty to Children provides supervised visitation for children with their non-custodial parents; promotion of healthy parenting through skills training, education and guidance; trauma recovery for children from physical or sexual abuse, family violence, parental substance abuse and parental mental illness; group counseling to "high-risk" children in New York City public schools; sexual abuse prevention workshops geared towards children in grades K-3; child permanency mediation; resiliency restoration training for child welfare agencies to help staff during times of grief, stress and loss; and education on legislative action.	www.nyspcc.org

Fortune Society Father's Group 29-76 Northern Boulevard Long Island City, NY 11101 212-691-7554 **Contact:** Sophia Strong sstrong(fortunesociety.org	The Fortune Society provides fathers who have a prior criminal record with free legal help with court/family court cases from an on-staff attorney, child support workshops, GED classes and individual/group counseling.	www.fortunesociety.org
Visiting Nurse Service of New York **Fathers First Initiative** **Children & Family Services** **Early Head Start** 86-0 1 Rockaway Blvd Rockaway Beach, NY 11693 718-318-8040 **Contact:** Jomael Young Jomael.young(vnsny.org David Jones- Director DJones(vnsny.org	The Visiting Nurse Service's Fathers First Initiative provides fathers with group sessions and other counseling services, child care, job referral and paternity testing.	www.vnsny.org
Work Force 1 LaGuardia Community College Community Based Organization Programs 29-10 Thomson Avenue, Rm X-400, 4thFl Long Island City, NY 11101 718-609-2130 **Contact:** Racheal Walker RWalker(Lagcc.Cuny.edu CBO Coordinator	Workforce1 Centers provide job search resources, career counseling, assistance creating resumes and cover letters, and job placement services. The Center is a partnership of agencies and organizations providing a full array of services.	www.nyc.gov/workforce1
Rockaway Development & Revitalization Corporation 1920 Mott Ave. Far Rockaway, NY	The Rockaway Development & Revitalization Corporation provides	www.rdrc.org

718-327-5300 **Contact:** Rene McWilliams RWilliams@RDRC.org	noncustodial parents 16-45 years old with income execution, job search help, referral and readiness workshops and mentoring.	

ATTACHMENT E
Checklist for Pregnant and Parenting Young People in Out-of-Home Care

The checklist for Pregnant and Parenting Young People in Out of Home Care ("PPYP Checklist") is a tool for case planners to use in planning for youth who become pregnant or are parenting. The purpose of this checklist is to assist case planners securing services for pregnant and parenting youth in foster care. One of the main goals for this population is to emphasize comprehensive planning that promotes well-being, avoids placement disruptions, and supports permanency planning for the youth and their children.

This checklist can be used by caseworkers, administrators, foster parents, direct care workers, and other staff within the provider agencies to help:

- Promote the development of youths' mental, physical, and emotional well-being;
- Set developmentally appropriate expectations that encourage youth to achieve their highest potential in interpersonal relationships, career, education, and personal interest development;
- Make efforts for youth to have the education and/or vocational training they need to succeed in the job market; and
- Enable youth to be able to plan responsibly for themselves and their children's needs for housing, food, clothing, health and safety as they mature into adulthood.

The PPYP Checklist will also assist case planners in ensuring new parents are fully supported in learning how to parent, in accessing services for their children's needs, and in continuing to develop as individuals.

Note that the PPYP Checklist is not a substitute for the Preparing Youth for Adulthood (PYA) Checklist. Case planners should continue to use the PYA Checklist in planning for youth who are expectant parents ages 14 and up.

The checklist is used to aid in the following situations:

- Initial service planning – The case planner should complete the checklist in the initial stage of case management/case planning for a pregnant/parenting young person to identify appropriate service needs.
- In preparation for Family Team Conferences – The case planner can use the checklist to identify areas that should be discussed during Family Team Conferences.
- Post-Conference follow-up – The case planner should identify what services/needs identified at a conference are still unaddressed and need follow-up with other service providers.

To maximize the helpfulness of the PPYP Checklist, it should be used in conjunction with the *Guide to Working with Young Parents in Out of Home Care,* developed by a working group of NYC Children's Services and parent and child advocates released in 2012.

Checklist for Pregnant and Parenting Young People in Out of Home Care Child's Name:

Case Name: ____

Case Number:____________________ CIN:______________

Permanency Goal: ___________________________________

Expected date of delivery (birth):______________________

Date of most recent Family Team Conference (FTC): _____

Scheduled date of next FTC: __________________________

(Optional) Name and address of expectant father:_________

Is there a partner involved? Y/N Name:_________________

Names of people invited to the Family Team Conference:

____

____

____

____

Does the young person have other children? If so, list names and dates of birth: ___________________

____

Date of next Permanency Hearing in Family Court: _______________________

Is the agency facilitating the young parent's attendance at the court appearance? What is the plan?

____

____

____

MATERNAL HEALTH	YES	NO	N/A	FOLLOW UP
1. Is the pregnant young person attending prenatal visits? The health care provider will develop a schedule for prenatal care based upon the young person's individual needs, but prenatal exams are generally scheduled: • Monthly from week one to week 28 of pregnancy • Bi-weekly from week 29 through week 36 • Weekly from week 37 until the date of delivery Provider Name and Contact Info:				
2. Is this a high-risk pregnancy?				
3. Has the health care provider identified any health issues related to the pregnancy?				
4. If the pregnant or parenting young person needs specialized services or has special needs (e.g., mental health, medical diagnosis, developmental disability), have services been put in place for her? Specialized Service Provider Names & Contact Information:				
5. Is the young person attending Lamaze or other birthing classes?				
6. Has breastfeeding been discussed with the pregnant young person?				
7. Has the young person been provided with a doula?				
8. Have a doctor and delivery hospital been identified? Doctor: Hospital:				
9. Does the young woman have someone to accompany her during delivery?				
10. Has the pregnant young person been referred to the Nurse Family Partnership (first-time mothers must be referred by the 28th week of pregnancy) or Healthy Families New York (will work w/mothers who have more than one child)?				
11. If the pregnant young person resides in a foster boarding home, is the foster parent involved in the young person's pregnancy and health care needs?				
12. Is pregnant young person getting exercise?				
13. Has the young person been provided with nutrition counseling including information about WIC and food stamps - even if the young person is not currently eligible?				
14. Has smoking cessation been discussed with the pregnant young person?				

15. Have any substance abuse problems been addressed sufficiently with the young person?				
16. Date of last physical exam:				
17. Date of last vision exam:				
18. Date of last dental exam:				
19. Did the young person deliver already? If NO, skip to the next section (EDUCATION). Delivery Date: (Circle one) Cesarean Vaginal Birth				
20. Has the importance of well family care, including well baby visits, been fully explained to the young parent?				

EDUCATION	YES	NO	N/A	FOLLOW UP
1. Is the young person enrolled in an educational program? If so, type of Program: School: Grade: Number of credits: Regents or RCT exams passed: Identify the young person's long-term educational goals:				
2. Does the young person have an IEP? Date of last IEP: Recommended placement and services: Is the young person appropriately placed? Is she receiving all mandated services?				
3. Does the young person receive tutoring or other homework help? Name/Type of provider:				

RELATIONSHIPS	YES	NO	N/A	FOLLOW UP
1. Does the young person visit with family/friends?				
2. Does the young person have a relationship with her birth mother?				
3. Does the young person have a relationship with her birth father?				
4. Does the young person have relationships with siblings or extended family members?				

5. If not, what follow-up should be done to encourage relationships with her birth family (regardless of her permanency planning goal)?				
6. Is the young person involved with the child's father?				
7. Is the child's father providing financial support?				
8. Is the agency facilitating visits with the child's father?				
9. Does the young person have relationships with the child's paternal resources?				
10. Does the young person have a partner other than the child's father?				
11. Are there concerns regarding the young person and her relationship with the child's father or her partner? If so, detail the concerns under the comments section and detail necessary follow-up.				
12. Does the young person have a good relationship with the foster parent and/or staff where she lives?				
13. Has the young person identified a supportive relationship with anyone not asked about above?				

SERVICES	YES	NO	N/A	FOLLOW UP
1. Is the young person receiving counseling? Provider/Type: Location/Frequency:				
2. Are supportive parenting services being provided (e.g., parenting education, medical home visiting programs, Baby and Me, etc.)?				
3. Have arrangements been made for the young person to attend and participate in parenting classes?				
4. Has the agency provided assistance in applying for entitlements if appropriate?				
5. Has the young person received a Child Care/Head Start referral? Has the young person been referred for an eligibility interview? Interview date:				
6. Has the young person applied to a LYFE program? If so, has she been accepted? Where?				
7. Who provides child care for the young parent?				

PARENTING QUESTIONS	YES	NO	N/A	FOLLOW UP
1. Has the young person been provided written information about her ability to make confidential health care decisions for herself and her baby?				
2. Are reproductive health and pregnancy prevention discussed with the young parent on an ongoing basis?				
3. Has there been ongoing discussion with the young parent about repeat pregnancy and family planning?				
4. Does the young parent have custody of all of her children?				
5. Are any of the young parent's children in foster care? 5a. If yes, is reunification the plan?				
6. Does the young parent keep her baby safe?				
7. Has the agency provided the young parent with a clear indication of safety expectations?				
8. Is shared parenting encouraged with the father?				
9. Does the young parent utilize the Early Intervention Program?				
10. Does the young parent demonstrate an understanding of good nutrition for herself and for her baby?				

BABY	YES	NO	N/A	FOLLOW UP
1. If the young parent is breastfeeding, are the feedings successful?				
2. Is the young parent receiving assistance in scheduling and attending well baby visits?				
3. Has the young mother been provided with written information about immunizations?				
4. Is the baby receiving immunizations?				
5. Are there any medical concerns with the baby?				
6. Are there any safety concerns with the baby?				
7. Who does the young parent turn to, and how often, for answers to questions, information, etc. about parenting?				
8. Does the young parent know the names and phone numbers of her doctor and/or the pediatrician of her child? Doctor Name & Contact Information: Pediatrician Name & Contact Information:				

Complete the following PERMANENCY questions only for young or expecting parents under age 14. For those ages 14 and up, use the PYA Checklist instead. Then complete CONFERENCE PLANNING on the last page of this document.

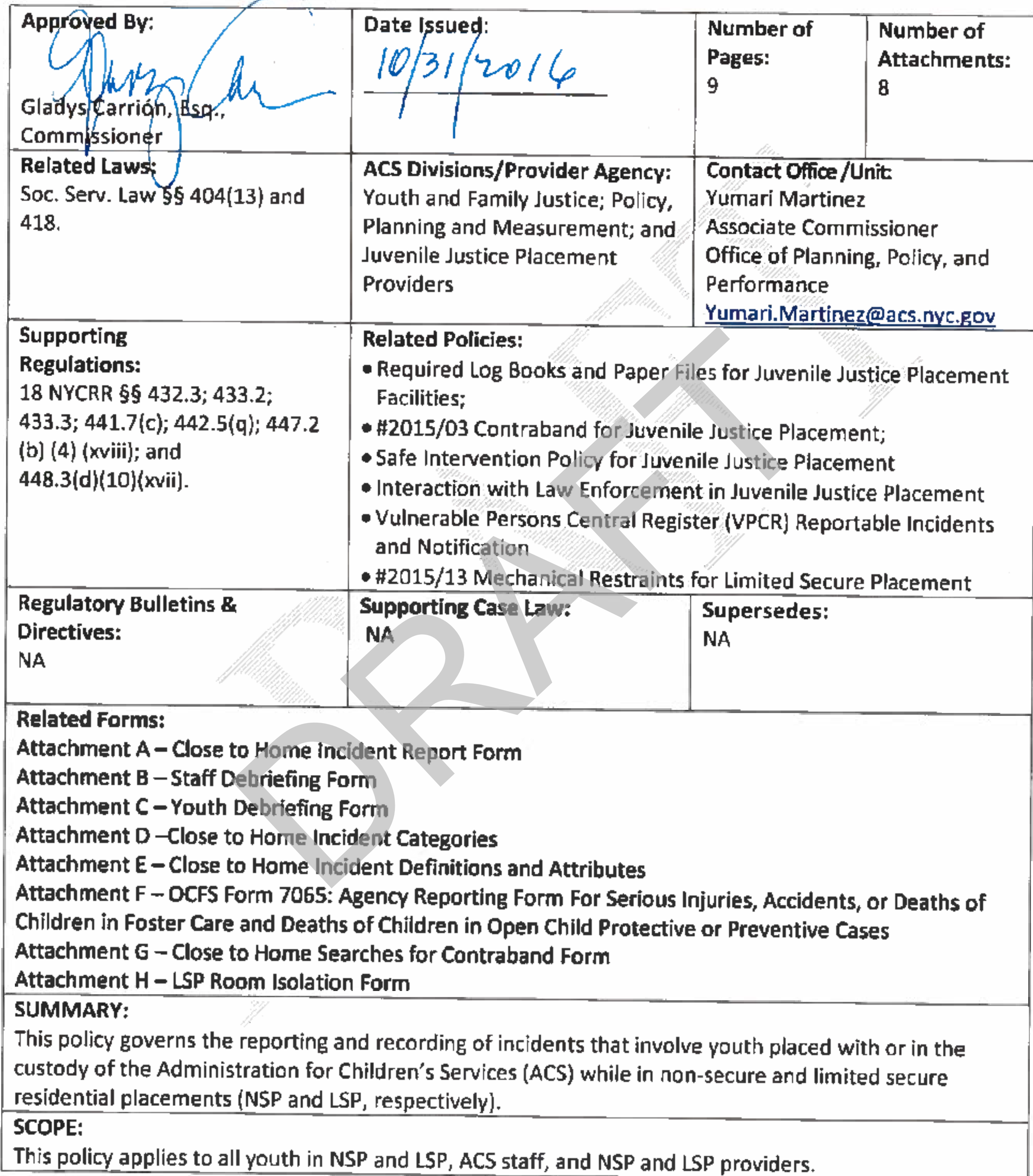
PERMANENCY	YES	NO	N/A	FOLLOW UP
1. Is the current foster care placement stable at this time?				
2. Is the current placement appropriate as a mother-child placement?				
3. Is a placement transfer pending?				
4. Has a referral been made to the ACS Office of Placement Services for a transfer?				
5. Have the young person's placement options been fully discussed with her?				
6. Does the young person have viable permanency resources?				
7. Have other permanency placements/resources been explored?				
8. Does the young person's PPG need to be changed?				
9. Is the young person involved in planning for permanency?				
10. Has the young person been provided with a written copy of her latest permanency report?				
11. Does the young person receive the additional $55/month (as of 2009) for diaper allowance? Amount:				
12. Is the young person a US citizen, or does the young person possess a green card?				
13. Does the young person know who her attorney is? Name: Phone:				
14. Does the agency allow the young person to use an agency phone to call her attorney?				
15. Did the young person attend her most recent Permanency Hearing? Next PH Date:				
16. Did the young person attend the most recent Family Team Conference? Date:				
17. Has notice of the next conference been provided to the young person? Date of FTC:				

CONFERENCE DISCUSSION ISSUES
1.
2.
3.
4.

City of New York
Administration for Children's Services

Policy and Procedure
#2016/xx

Incident Reporting for Juvenile Justice Placement



Approved By: Gladys Carrión, Esq., Commissioner	**Date Issued:** 10/31/2016	**Number of Pages:** 9	**Number of Attachments:** 8
Related Laws: Soc. Serv. Law §§ 404(13) and 418.	**ACS Divisions/Provider Agency:** Youth and Family Justice; Policy, Planning and Measurement; and Juvenile Justice Placement Providers	**Contact Office /Unit:** Yumari Martinez Associate Commissioner Office of Planning, Policy, and Performance Yumari.Martinez@acs.nyc.gov	
Supporting Regulations: 18 NYCRR §§ 432.3; 433.2; 433.3; 441.7(c); 442.5(q); 447.2 (b) (4) (xviii); and 448.3(d)(10)(xvii).	**Related Policies:** • Required Log Books and Paper Files for Juvenile Justice Placement Facilities; • #2015/03 Contraband for Juvenile Justice Placement; • Safe Intervention Policy for Juvenile Justice Placement • Interaction with Law Enforcement in Juvenile Justice Placement • Vulnerable Persons Central Register (VPCR) Reportable Incidents and Notification • #2015/13 Mechanical Restraints for Limited Secure Placement		
Regulatory Bulletins & Directives: NA	**Supporting Case Law:** NA	**Supersedes:** NA	

Related Forms:
Attachment A – Close to Home Incident Report Form
Attachment B – Staff Debriefing Form
Attachment C – Youth Debriefing Form
Attachment D –Close to Home Incident Categories
Attachment E – Close to Home Incident Definitions and Attributes
Attachment F – OCFS Form 7065: Agency Reporting Form For Serious Injuries, Accidents, or Deaths of Children in Foster Care and Deaths of Children in Open Child Protective or Preventive Cases
Attachment G – Close to Home Searches for Contraband Form
Attachment H – LSP Room Isolation Form

SUMMARY:
This policy governs the reporting and recording of incidents that involve youth placed with or in the custody of the Administration for Children's Services (ACS) while in non-secure and limited secure residential placements (NSP and LSP, respectively).

SCOPE:
This policy applies to all youth in NSP and LSP, ACS staff, and NSP and LSP providers.

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I. PURPOSE

This policy governs the reporting and recording of incidents that involve youth placed with the Administration for Children's Services (ACS) Division of Youth and Family Justice (DYFJ) while in non-secure and limited secure placements (NSP and LSP, respectively).

II. POLICY

A. All incidents involving youth, ACS staff, contracted facilities, or their staff require appropriate attention and immediate reporting by staff to the ACS Movement Control and Communications Unit (MCCU). All incidents shall be reported accurately, thoroughly, and immediately, no later than one (1) hour of occurrence or as soon as staff members become aware of an incident. All incidents shall be documented and recorded on ACS incident reporting forms and in appropriate log books, paper files, and databases as described below.

B. The reporting requirements of this policy **<u>do not</u>** negate any other reporting requirements such as those to the Department of Investigation (DOI) under Executive Order #16, to the Statewide Central Register of Child Abuse and Maltreatment (SCR) of the Office of Children and Family Services (OCFS), or to OCFS under state regulations.[1]

C. Reporters include ACS staff members, contracted residential providers, interns, or volunteers who are involved with, have witnessed, or have discovered an incident.

III. INCIDENT CATEGORIES

A. ACS requires a high level of transparency and communication relative to the operations of residential programming. Formal reporting is required for two types of incidents: reportable incidents and critical incidents.[2] Both incident types shall be reported on the Close to Home Incident Report Form (Attachment A).

B. <u>Reportable Incident</u> - An event which **might affect** the health, safety, and/or security of (1) youth in ACS physical or legal custody; (2) staff; (3) family; and/or (4) the community.

C. <u>Critical Incident</u> - A reportable incident which is likely to have **a serious impact** which adversely affects the health, safety, and/or security of (1) youth; (2) staff; (3) family; and/or (4) the community (e.g., birth and death), **or has a significant impact** on a facility or the agency.

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[1] See 18 NYCRR § 432.3.

[2] These are reporting requirements in addition to mandatory reporting requirements under Social Service Law. All affected staff members are mandated reporters and remain subject to all mandated reporting requirements.

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IV. NOTIFICATION

A. Reporting Responsibility

Any provider agency staff member, contractor, intern, or volunteer, or ACS employee who is involved with, has witnessed, or has become aware of an incident shall immediately report the incident to his or her immediate supervisor or any supervisor at a facility site. This **does not** negate any other reporting requirements such as those to the Justice Center, to DOI under Executive Order #16, to the SCR, or to OCFS.[3]

B. Notification to Parents/Guardians

1. The youth's parent/guardian shall be notified of all incidents related to the youth. The facility administrator or case manager shall verify that for all incidents, the notification be made as soon as possible but no later than eight (8) hours from the commencement of the incident.

2. Whenever possible, the youth should be present during the notification to the family and the youth shall have an opportunity to speak with his or her parent/guardian. The family notification shall be documented on the Close to Home incident report form, and/or in the youth's electronic case record.

3. AWOLs and Program Absences

    a. The provider must notify the youth's parent/guardian as soon as possible, but no later than two (2) hours after learning of the AWOL or program absence except when parental rights have been terminated or surrendered, or the parent cannot be located.

    b. If the youth is currently known to ACS in a child protective case,[4] the provider must notify the youth's foster parent and/or foster care provider case planner as soon as possible, but no later than two (2) hours after learning of the AWOL or program absence.

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[3] See 18 NYCRR § 432.3.

[4] See Article 10 (a subject child in a child protective case), Article 10c (a destitute child) or Article 7 of the Family Court Act (a Person in Need of Supervision [PINS]); see section 358-a of the Social Services Law (a child placed via a voluntary placement agreement).

C. Notification to the Justice Center

1. All incidents of abuse and neglect and significant incidents[5] for youth in Close to Home facilities must be reported to the VPCR.

2. Incidents requiring Justice Center notification shall be called in or electronically submitted to the Justice Center **immediately**[6] unless reporting must be delayed for the sole purpose of preventing harm.

3. Provider staff shall call the VPCR Hotline at the following phone numbers which operate 24 hours per day seven (7) days per week and can accommodate non-English speakers through its interpreter services:

   a. 1-855-373-2122;
   b. 1-855-373-2124 for a youth fatality in an NSP or LSP facility; or
   c. 1-855-373-2123 for hearing impaired individuals calling in a report.

4. The reporter shall record the assigned Justice Center case identification number and the name of the Justice Center employee who accepted the report on the Close to Home Incident Report Form and in the Facility Activity/Communication Log Book, and shall provide that information to MCCU.

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D. Notification to the SCR – Home Passes Only

Provider staff shall call the SCR hotline on the following numbers which operate 24 hours per day seven (7) days per week if there is a suspicion of child abuse or neglect for youth returning from a home pass:

1. Mandated reporters: 1-800-635-1522; or
2. Callers who are deaf or hard of hearing: 1-800-638-5163.

Staff shall document the SCR case ID number in CONNECTIONS (CNNX) and any necessary incident reports.

E. Notification to MCCU

1. All incidents shall be reported by phone immediately to MCCU and no later than within one (1) hour of their occurrence or as soon as staff members become aware

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[5] See 18 NYCRR § 433.2. A significant incident is an incident, other than an incident of abuse or neglect, that because of its severity or the sensitivity of the situation may result in, or has the reasonably foreseeable potential to result in, harm to the health, safety, or welfare of a person receiving services.
[6] See ACS Policy and Procedure *AWOLs and Program Absences from Juvenile Justice Placement Facilities*; see *Vulnerable Persons Central Register (VPCR) Reportable Incidents and Notification*.

of the incident. Any report to MCCU shall occur after the Justice Center or SCR has been notified where such notification is required. The facility director or designee shall be responsible for reporting the incidents to MCCU.

2. When calling MCCU to report an incident, the following information shall be provided:

   a. Date and time the incident occurred;
   b. Facility residential sub-location;
   c. Location within the community where the incident took place (including the address), if applicable;
   d. Name and title of person reporting the incident and the person's relationship to the incident;
   e. Name of youth involved and role in the incident;
   f. Name(s) and title(s) of staff involved in the incident or present at the scene of the incident;
   g. All agencies, authorities, victims, and/or any individuals involved besides the youth or staff;
   h. Brief chronological description of the incident including circumstances/actions leading up to the incident, de-escalation strategies attempted if applicable, and the resolution of the incident;
   i. Initial follow-up action taken including medical services and mental health services referrals;
   j. Any obvious injuries and/or complaints of injuries, including how the injuries occurred and any subsequent medical treatment and/or observations provided;
   k. All contraband discovered, if applicable;
   l. Parties or agencies involved or notified of the incident including parents/guardians, local law enforcement, EMTs, or other uniformed services responding to the scene. If law enforcement is involved, staff must obtain the name and badge numbers of those that responded to the event;[7]
   m. Justice Center or SCR case identification number and the name of the Justice Center or SCR employee who accepted the report (if applicable);
   n. Types of physical interventions used and the duration of the physical interventions, if applicable; and
   o. Any other pertinent information that is not included in the above.

4. If notification to MCCU occurs before all required information is available, reporters shall update MCCU as soon as additional required information becomes available.

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[7] See ACS Policy and Procedure *Interaction with Law Enforcement in Juvenile Justice Placement*.

V. DOCUMENTATION

A. Providers must maintain all incident reports and supporting documentation in the Incident Reports File, arranged chronologically in an unbound binder, and stored in a secure location readily accessible to direct care staff.[8] These files shall include the Close to Home Incident Report Form and all items pertinent to the incident including addenda and medical reports, if applicable. In addition and in accordance with the ACS policy *Log Books and Paper Files for Juvenile Justice Placement Facilities*, the following files must be maintained and stored **separately** in a secure location readily accessible to direct care staff:

1. Searches for Contraband File
2. Physical Restraints File[9]
3. LSP Mechanical Restraints File[10]
4. LSP Room Isolation File[11]

B. Staff members directly involved or witness to an incident – Any provider agency staff member, contractor, intern, or volunteer who was either directly involved in, witness to, or became aware of an incident shall, at the conclusion of the incident:

1. Record clearly in the appropriate log books and paper files[12] and on the appropriate incident report form a summary of the incident that includes the information in section IV. E. 2. a-o. above;[13]

2. Handle any discovered contraband in accordance with the ACS contraband policy.[14] A record of the contraband is to be made in the facility Searches for Contraband Form (Attachment D) for that date and the tour of duty;

3. Record any incident involving the use of a physical intervention in the appropriate paper file by the staff and supervisors involved in the incident. Note: OCFS requires the use of the New York State Automated Restraints Tracking System (ARTS) as the system of record for tracking physical interventions; and

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[8] See ACS Policy and Procedure *Required Log Books and Paper Files for Juvenile Justice Placement Facilities*.
[9] See ACS Policy and Procedure *Safe Intervention Policy for Juvenile Justice Placement*.
[10] See ACS Policy and Procedure #2015/13, *Mechanical Restraints for Limited Secure Placement*.
[11] See ACS Policy and Procedure #2015/10, *Room Isolation in Limited Secure Juvenile Justice Placement*; see 18 NYCRR § 450.7(e)(9).
[12] See ACS Policy and Procedure *Required Log Books and Paper Files for Juvenile Justice Placement Facilities*.
[13] ACS staff, contractors, or volunteers without access to facility-based log books and paper files must complete and submit a Close to Home Incident report Form to the DYFJ Field Operations Director of Incident Review.
[14] See Policy and Procedure #2015/03, *Contraband for Juvenile Justice Placement*.

4. Submit the appropriate completed Close to Home incident report form to the supervisor/manager on duty. The following protocols shall be followed when completing an incident report:

   a. Any staff member who is required to prepare an incident report for either a reportable or a critical incident shall do so within one (1) hour of the time of the occurrence, where practicable.

   b. In the case of any staff incapacity or injury which requires the staff member to leave the facility during his or her shift, the staff member shall provide a verbal report to his or her supervisor or the supervisor's designee as soon as is practicable. The staff member shall then submit the Close to Home Incident Report Form as soon as is practicable.

   c. Staff members are responsible for writing their incident reports to reflect only their own observations. Staff members who discuss their written statements with other staff or who otherwise submit false reports are to be reminded that making intentionally false statements is strictly prohibited and may lead to prosecution and/or disciplinary action.

   d. The incident report must be completed independently from other staff involved or alleged to be involved in the incident. Under no circumstances shall staff members be allowed to compare their reports with or among each other.

   e. The incident report shall be typed or written legibly and with sufficient detail and clarity so as to allow for a reader to recreate the events described based on the written descriptions provided. At the conclusion of the written statement in the space provided near the signature line, staff members must include the date and time that the report was completed and signed.

   f. If a staff member determines that he or she has made an error or omission in the incident report, he or she shall submit an addendum to his or her supervisor.

C. Supervisors/managers/directors who were not involved in or witness to an incident and who receive incident reports shall:

   1. Confirm that staff completed all required reports independently, without having discussed the reports with other staff, and in a timely manner;

   2. Gather all incident reports from staff, visitors, youth (if youth are willing to provide or write statements), and other witnesses to and/or participants in the incident;

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3. Assess whether an incident report can be obtained from staff who may have been injured or incapacitated during the incident;

    a. Assess whether a verbal report can be provided by the staff member who is injured or incapacitated. All verbal reports shall be immediately converted to written reports by the receiving supervisor.

    b. Upon the injured or incapacitated staff member's return to duty, the supervisor shall obtain a written incident report from the staff member.

4. Review all reports and confirm that they are legible, detailed, complete, signed by all required parties, and accurate. If necessary, obtain additional information or clarification by directing staff to submit a second written report (addendum). All addenda must be submitted by the staff person and assessed by the supervisor within 24 hours of the incident. Any further addenda shall be treated as additional information requiring another call to MCCU;

5. Document in the Follow-Up Section provided on the relevant incident reports all corrective actions taken, intervention methods used during the incident, the type(s) of injury sustained, if any, outcomes of incident debriefing if appropriate, and resolution of the incident;

    a. Any required medical or mental health follow-up, staff and youth debriefing follow-up, and any recommendations shall be included.

    b. At the conclusion of the supervisor's entries, in the Follow-Up Section in the space provided near the signature line, staff must include the date and time this section was completed and signed.

6. Document in CNNX and any other record-keeping system used by the agency any additional follow-up beyond the first 24 hours until all information is received;

7. Submit the incident reports with any addenda to the appropriate supervisor;

8. Place copies of the incident report and any addenda in the case files of all youth involved;

9. Verify that all reports associated with an incident and debrief outcomes are documented in the youth's electronic case record and any other record-keeping system used by the agency;

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10. In the event of a fatality or a near fatality,[15] the facility director or designee must immediately:

    a. Notify the Justice Center (see section IV. C.);

    b. Contact the OCFS New York City Regional Office via telephone at 212-383-1788;

    c. Contact MCCU;

    d. Email the completed OCFS form 7065, *Agency Reporting Form for Serious Injuries*,[16] *Accidents, or Deaths of Children in Foster Care and Deaths of Children in Open Child Protective or Preventive Cases* to the OCFS New York City Regional Office;

    e. Mail hard copies of the report within five (5) days of the incident's occurrence to OCFS; and

    f. In the event of a fire,[17] the facility director must immediately notify OCFS via telephone and send a written report to OCFS within 10 business days.

11. In addition to MCCU and other required contacts, the facility director or his or her designee shall contact the Associate Commissioner for Close to Home or his or her designee via telephone to notify him or her of the pertinent facts and any incident involving:

    a. The death of a youth;
    b. Any injury to a youth which requires the services of a physician and which, in the opinion of the physician, may cause death, serious disability, or disfigurement;
    c. Any suicide attempt requiring off-site emergency medical attention;
    d. Any fires;
    e. Absences without leave (AWOLs) from LSP; or
    f. Any allegations of sexual abuse of youth or staff.

D. <u>Debriefing of Incidents with Staff/Youth</u>

1. The facility director, supervisor, or a designee shall facilitate a debriefing process with all staff involved in any youth-related incident before the staff involved in the

[15] See 18 NYCRR § 441.7 (c).
[16] A serious physical injury or accident resulting in a medical treatment, hospitalization or death of a child in foster care; see OCFS form 7065
[17] See 18 NYCRR §§ 442.5(q); 447.2 (b) (4) (xviii); and 448.3(d)(10)(xvii).

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incident depart the facility, where practicable. Each incident shall result in both a staff debriefing and a separate youth debriefing. Provider staff shall maintain required staff ratios during debriefings.

2. **Staff debriefing** shall include all staff present during the incident. The process shall examine the circumstances and outcome of each incident, and identify corrective action that may be needed. The staff debriefing must be documented in the appropriate log books, paper files, incident report forms, and in ARTS. In the case of any staff incapacity or injury which precludes their participation in the debriefing process, an additional debriefing shall occur upon their return to the facility.

3. **Youth debriefing** shall occur following all incidents, after a cool down period. All youth directly involved in an incident shall meet with the facility director, supervisor, or designee facilitating the debriefing and others to process events leading up to and during the incident. Each youth's Behavior Support Plan (BSP) must be reviewed with the youth and changes to the BSP shall be made as needed.

4. Both the **Staff Debriefing Form** (Attachment B) and the **Youth Debriefing Form** (Attachment C) must be completed in the event of a physical intervention restraint.

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DIVISION OF YOUTH AND FAMILY JUSTICE
CLOSE TO HOME INCIDENT REPORT FORM

DIRECTIONS: **PRINT or TYPE all information and complete the entire form, including an Emergency Safety Physical Intervention Form for all restraints. All ORIGINAL Incident Reports are to be forwarded to the NSP or LSP Facility Director or designee. All incidents must be called in to MCCU within one (1) hour of occurrence.**

Provider Agency: ______________________________ **Facility Name:** ____

Facility Address: _______________________________ **Facility Type (circle one):** **NSP [ ]** **LSP [ ]**

Full Name of Report Writer: ____ **Title:** _________________________

Incident Type: **Reportable [ ]** **Critical [ ]** **Incident Date:** ___/___/____ **Time:** ________________ **AM/PM**

MCCU Incident Report #: ____

Youth's Name: _____________________________ Role in Incident: Victim [ ] Subject/Aggressor [ ]

Youth's Name: _____________________________ Role in Incident: Victim [ ] Subject/Aggressor [ ]

Youth's Name: _____________________________ Role in Incident: Victim [ ] Subject/Aggressor [ ]

Youth's Name: _____________________________ Role in Incident: Victim [ ] Subject/Aggressor [ ]

Youth's Name: _____________________________ Role in Incident: Victim [ ] Subject/Aggressor [ ]

Youth's Name: _____________________________ Role in Incident: Victim [ ] Subject/Aggressor [ ]

All staff involved (full names and titles):

____

____

____

Witnesses (full names, titles, and indicate if youth, staff, or other):

____

____

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Incident Narrative: Provide a detailed chronological description of the incident in your own words. Include the "who/what/where/when/why/how" of the incident and the circumstances or actions that led up to the incident. You must include all steps taken to de-escalate the situation, any medical or mental health referrals made, and the name/badge numbers of any law enforcement, EMT, or other uniform services responding to the scene of the incident. If an ESPI/physical restraint was used, describe youth and staff positioning.

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Did the incident result in a child abuse allegation or significant event? Yes [ ] No [ ]

If Yes, Date Reported to SCR/VPCR: ___/___/______ Accepted: Yes [ ] No [ ]

SCR/VPCR Number: _____________________________ Party Accepting the Complaint: _______________________________

Signature of Report Writer: ____ Date Submitted: ___/___/_____

Supervisor's Follow-up Narrative: *Include all medical and/or mental health follow-up information if referrals were made*
____
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____

Were facility activities canceled due to this incident? [ ] Yes [ ] No

Was a Staff Debriefing completed? Yes [ ] No [ ] Date: _____/_____/_______ Time: _______________AM/PM

[If all staff involved in the incident did not participate in a staff debriefing, describe in Supervisor Follow-Up Narrative]

Was a Youth Debriefing completed? Yes [ ] No [ ] Date: _____/_____/_______ Time: _______________AM/PM

Conducted By: __________________________________Title: _______________________ Agency: ____________________

Supervisor reviewed and initialed all accompanying **Restraint Forms** for all youth restrained: Yes [ ] No [ ] N/A [ ]

Supervisor placed all **Restraint Forms** in the **Physical Restraints Log**: Yes [ ] No [ ] N/A [ ]

Supervisor placed Mechanical Restraint Form(s) in the **LSP Mechanical Restraints Log**: Yes [ ] No [ ] N/A [ ]

Supervisor Signature: ____ Title: _________________________

Date Reviewed: ____/___/____

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DIVISION OF YOUTH AND FAMILY JUSTICE
CLOSE TO HOME PHYSICAL RESTRAINT FORM

DIRECTIONS: **Complete this form for each youth involved in a restraint and attach it to the accompanying incident report. Your supervisor will review this form with you during incident debriefing.**

Name of Youth: ____ **MCCU Incident #:** _________________________________

Name(s) of Staff who administered the restraint:

____

____

____

Was an emergency safety physical intervention used? [ ] Yes [ ] No If yes, check all of the technique(s) used below:

Lower Level emergency physical interventions: [indicate the amount of time the youth was in a physical intervention]

TCI	Breaking up a Fight ________________	Standing Hold ______________				
ESPI	Hook Transport and Assist to Seated /Kneeling Position ________________	Multiple-Person Upper Torso Assist ______________	Cradle Assist (Single Person) ______________	Upper Torso Assist ______________	Cradle Assist to Seated/Kneeling Position ______________	Crossed Arm Assist ______________

Higher Level emergency physical interventions: [indicate the amount of time the youth was in a physical intervention]

TCI	Supine – Seated Hold ________________	Small Child ______________				
ESPI	Upper Torso Assist to Seated/Kneeling Position ________________	Side Assist ______________	Multiple-Person Supine Torso Assist ______________	Sitting Up From a Supine Position ______________	Multiple-Person Seated/Kneeling Upper Torso Assist ______________	Multiple–Person Seated/Kneeling Bicep Assist ______________

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Other Intervention Used – Provide Explanation:

____

____

Time Restraint(s) Started: _______________AM/PM **Time Restraint(s) Concluded**: _______________AM/PM

Duration of Restraint(s): _________**minutes** ___________ **seconds**

Reason for Restraint(s): Youth presented risk of physical injury to self or to others [ ]

Youth clearly indicated physical attempt to AWOL and presented danger to self or others [ ]

Limited Secure Placement ONLY:

Was the youth transitioned into mechanical restraints? Yes [ ] No [ ]

If yes, please complete an **LSP Mechanical Restraints Form**

Staff Signature/Title: ____ Date Submitted: ___/____/____

Supervisor Initials: ________________ Date Reviewed by Supervisor: ______/______/________

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DIVISION OF YOUTH AND FAMILY JUSTICE
LIMITED-SECURE PLACEMENT MECHANICAL RESTRAINT FORM

DIRECTIONS: **Complete this form for each youth involved in a mechanical restraint and attach it to the accompanying incident report form. Your supervisor will review this form with you during incident debriefing.**

Name of Youth: ____ MCCU Incident #: _________________________________

Name(s) of Staff who applied the mechanical restraint(s):

____

____

____

Time Mechanical Restraint Applied: _________________ AM/PM

Time Mechanical Restraint Removed: ____________________ AM/PM

Duration of Mechanical Restraint: ________________ **minutes**

When was the parent/guardian notified about the ESPI/physical restraint(s) and/or mechanical restraint(s)?

Date: _____/_____/_______ Time: _______________AM/PM

Document all efforts taken to notify the parent/guardian if staff could not reach the parent/guardian.

____

____

____

____

Staff Signature/Title: ____ Date Submitted: ___/____/____

Supervisor Initials: ________________ Date Reviewed by Supervisor: ______/______/________

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ACS DIVISION OF YOUTH AND FAMILY JUSTICE
CLOSE TO HOME STAFF INCIDENT DEBRIEFING FORM

Instructions: To be used after all youth-involved incidents. A supervisor with training in SCM or TCI shall document **all** staff members involved in an ESPI/physical restraint on 1 Staff Debriefing Form.

Date: _____________ Time: ___________________ Agency and Facility Name: ______________________________________

Youth Name(s): ____________________________ ____________________________ ________________________

Staff Involved in the incident: ______________________________________ Title: _________________________________

Staff Involved in the incident: ______________________________________ Title: _________________________________

Staff Involved in the incident: ______________________________________ Title: _________________________________

Facilitator's Name: ____ Title: _________________________________

Incident #: ____ Date of Incident: __________________________________

Was youth injured? □ **Yes** □ **No** **Time:** ________ **AM/PM** **If yes, which youth:** _________________________________

1. Could anything have been done to prevent injury to the youth?

____ ____

____

____

____

Was staff injured? □ **Yes** □ **No** **If yes, which staff member:** ____

2. Could anything have been done to prevent injury to staff?

____

____

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ACS DIVISION OF YOUTH AND FAMILY JUSTICE
CLOSE TO HOME STAFF INCIDENT DEBRIEFING FORM

Staff Debriefing: Ask the following questions of staff directly involved in an ESPI/physical restraint.

1. What were the precipitating events that led to the physical restraint? ____

   ____

   ____

2. What primary or secondary strategies were utilized to prevent the use of ESPI/Physical Restraint?

   ____

   ____

3. What worked well during this incident (e.g., techniques, interventions)? ______________________________________

   ____

   ____

4. Is there anything that you would have done differently in this incident? _______________________________________

   ____

   ____

5. Do you feel that you need additional support or training? □ Yes □ No If yes, please explain:

   ____

   ____

6. How did you feel helped or hindered by other staff and supervisors present? _________________________________

   ____

   ____

7. Was the Behavior Support Plan (BSP) followed? □ Yes □ No □ No Plan in Place. If no, please explain:

   ____

   ____

8. If yes, what changes, if any, do you recommend be made to the BSP? _______________________________________

   ____

   ____

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9. Do you have any other suggestions to help avoid a similar situation in the future? ______________________________

____

____

10. If other youth were involved in the incident, how was the incident debriefed with them? ________________________

____

____

11. How was the incident debriefed with uninvolved youth (e.g., circle up, group meeting)? _________________________

____

____

_________________________________	_______________________________	_________________________
Supervisor Signature	Title	Date

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ACS DIVISION OF YOUTH AND FAMILY JUSTICE
CLOSE TO HOME STAFF INCIDENT DEBRIEFING FORM

ACTIONS FOR DIRECTOR OR DIRECTOR'S SUPERVISOR(S)

1. Video review ☐ Yes ☐ No Date of Review: ____________________________

2. Photograph(s) review:

   a. Photograph(s) taken ☐ Yes ☐ No Date of Photographs: __________________________

   b. Photograph(s) reviewed ☐ Yes ☐ No Date of Review: ______________________________

3. Youth debrief complete ☐ Yes ☐ No

4. All incident reports collected and reviewed ☐ Yes ☐ No

5. Medical reports, if any, collected and reviewed ☐ Yes ☐ No

6. VPCR contacted, if applicable ☐ Yes ☐ No

7. Notification to parent/guardian ☐ Yes ☐ No Date of notification: _________________________

   Method of Notification: __________________ Notification Documented in: ________________________________

9. Follow-up [write "N/A" if not applicable]

   a. Staff training needs identified: ____

   ____

   b. Youth needs identified: ____

   ____

   c. Programming needs identified: ____

   ____

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______________________	______________________	______________________
Signature	Title	Date

ACS DIVISION OF YOUTH AND FAMILY JUSTICE
CLOSE TO HOME YOUTH INCIDENT DEBRIEFING FORM

Instructions: To be used after all youth-involved incidents. Debriefing begins when the individual youth and staff involved are calm. Explain to the youth why he/she is there and state the process and the point of the debriefing. The Facilitator should be someone trained in facilitation. Staff conducting the debriefing shall complete this form. Staff shall document only 1 youth per Youth Debriefing Form, even if more than 1 youth was involved in the incident. Note: If an ESPI/physical restraint resulted in a child abuse allegation, the staff named in the allegation must not participate.

This form is to be attached to the original Incident Report. A copy of this form is to be placed in the youth's Case Management Folder.

Today's Date: ________________ Youth Name: ____

Agency and Facility Name:____

Is the staff member involved in the ESPI/physical restraint present? [ ] Yes [ ] No

Incident #: _____________________ Date: ____________________ Time: _____________(AM/PM)

Staff Member(s) Involved in ESPI/physical restraint:

Name: _________________________________ ______ Title: __________________________________

Name: _________________________________ ______ Title: __________________________________

Name: _________________________________ ______ Title: __________________________________

Facilitator's Name: ____Title: _______________________

Other Participants in Conference (list names and titles):

____

____

____

____

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1. Can you describe the incident as you experienced it? [What were your thoughts at the time? How were you feeling (e.g., what were you upset about)?]

____
____
____
____
____

2. What were the results/outcomes of your actions? [What were the consequences (e.g., how you felt, loss of privileges, injury, disruption of program, potential new charges, family)?] Are any of the consequences important to you?

____
____
____
____
____

3. How are you feeling now?

____
____
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____

4. Do you think there was anything you could have done differently? [Was there a more positive way to handle the issue/problem? What could you do differently in the future? What skills might you use? What did staff do that was helpful? Is there anything staff could have done differently?]

____
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____

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5. What do you take responsibility for? What actions will you commit to that can assure us that your safety and respect and everyone else's safety and respect are maintained (e.g., I can do the following…)? What needs to be done in order for you to return to program safely? Will you respond more positively? Do you understand the consequences for future negative behavior?

____
____
____
____
____

6. Staff shares with the youth their interpretation of the incident [as a reality check]. Connect the incident to a pattern of the youth's behavior (if one exists). Clarify his/her pattern of behavior. Document the youth's response.

____
____
____
____
____

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_________________________________ _________________

Youth Signature Date

_________________________________ ________________ _________________

Facilitator Signature Title Date

_________________________________ ________________ _________________

Other Participant Title Date

_________________________________ ________________ _________________

Other Participant Title Date

NYC Administration for Children's Services

CRITICAL INCIDENTS	REPORTABLE INCIDENTS
Any Reportable Incident that Occurs in the Community	Accident
Arrest	Classroom Disruption
Attempted AWOL	Contraband
AWOL	Destruction of Property
Community Arrest	Facility Plant Management Event
Birth	Inappropriate Sexual Behavior
Child Abuse Allegation - Internal	Inappropriate Statement
Child Abuse Allegation - External	Manager Requested Report
Community Altercation	Medical Illness
Community Assault	Physical Aggression
Death	Physical Altercation w/o Injury (YOY)
Fire	Physical Assault w/o Injury (YOY, YOS)
Group Altercation (YOY, YOS)	Security Breach
Group Assault (YOU, YOS)	Self-Injurious Behavior
Inappropriate Sexual Behavior - Immediately Reportable	Self-Injurious Statement
Major Disorder	Theft/Stolen Property
Miscarriage	Threat of Physical Injury to Youth
Physical Altercation with Injury (YOY)	Threat of Physical Injury to Staff
Physical Assault with Injury (YOY, YOS)	Vehicular Accident
Physical Restraint	
Program Absence	
Suicide Attempt	

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DIVISION OF YOUTH AND FAMILY JUSTICE
CLOSE TO HOME INCIDENT DEFINITIONS

EVENT	DEFINITION
AWOL	1. The youth has left the supervision of the facility without permission, has been missing for 24 hours, and Children's Services has issued a warrant. The 24 hour count begins at the point where the youth has gone missing. OR 2. On a supervised off grounds trip or a home visit, the youth has left the presence of the person responsible for the supervision of that youth without such person's permission, has been missing for 24 hours, and Children's Services has issued a warrant. The 24 hour count begins at the point where the youth has gone missing. OR 3. On an unsupervised off grounds trip or home visit, the youth has not returned to the facility on the assigned date and at the assigned time, has been missing for 24 hours, and Children's Services has issued a warrant.
Attempted AWOL	A youth has attempted an AWOL as defined above.
Community Arrest	A youth is arrested for a crime in the community unrelated to an event in a placement facility **or** is arrested while AWOL.
Birth	A youth in placement gives birth.
Child Abuse Allegation-Internal	Any alleged act of abuse, neglect, or maltreatment by **ACS or Provider Agency staff** which involves a youth that has been accepted by the State Central Register-NYS OCFS. All allegations of child abuse, neglect, and maltreatment shall be called into the State Central Register and must also be reported to MCCU. Reports to MCCU must include the name of the SCR person taking the report and the SCR number.
Child Abuse Allegation-External	Any alleged act of abuse, neglect, or maltreatment by any **non-ACS or Provider Agency staff** which involves a youth that has been accepted by the State Central Register-NYS OCFS. All allegations of child abuse, neglect, and maltreatment shall be called into the State Central Register and must also be reported to MCCU. Reports to MCCU must include the name of the SCR person taking the report and the SCR number.
Community Altercation with or without Injury	Any intent by reciprocal aggressors, to cause physical injury to another person in the community. **Participants:** The event-type classification must define the parties involved in the altercation as follows (Aggressor-on-Victim): Youth-on-Youth (YOY), and Youth-on-Staff (YOS), or Youth-on-Other (YOO). **Injury:** This classification requires Medical Assessment of the reported injury.

DRAFT

DIVISION OF YOUTH AND FAMILY JUSTICE
CLOSE TO HOME INCIDENT DEFINITIONS

Community Assault with or without Injury	Any intent, by an aggressor(s), to cause physical injury to a non-aggressor. **Participants:** The event-type classification must define the parties involved in the altercation as follows (Aggressor-on-Victim): Youth-on-Youth (YOY), and Youth-on-Staff (YOS), or Youth-on-Other (YOO). **Injury:** This classification requires Medical assessment of the reported injury.
Death	The death of a youth, ACS, or Provider Agency employee, contracted staff member, Department of Education employee or visitor while.
Fire	A fire that occurs in any facility, vehicle, or any other location. Additionally, fire alarms resulting in response from fire department and any false reporting or setting off fire alarms by youth.
Group Altercation with or without Injury	Any intent, by five or more reciprocal aggressors, to cause physical injury to each other or staff. **Participants:** The event-type classification must define the parties involved in the altercation as follows: Youth-on-Youth (YOY), Youth-on-Staff (YOS) **Injury:** This classification requires Medical Assessment of the reported injury.
Group Assault with or without Injury	Any intent, by five or more aggressors, to cause physical injury to a non-aggressor. **Note:** if a youth is assaulted and physically reciprocates in self-defense, the incident shall be classified as a Group Assault. **Participants:** The event-type classification must define the parties involved in the altercation as follows (Aggressor-on-Victim): Youth-on-Youth (YOY), and Youth-on-Staff (YOS). **Injury:** This classification requires Medical assessment of the reported injury.
Inappropriate Sexual Behavior – Immediately Reportable	An incident that involves soliciting, forcing, coercing, or requesting a staff or youth to engage in any behavior which is determined by staff to be of a sexual nature.
Major Disorder	Any incident that seriously disrupts the operation of the facility e.g., riots, and serious breaches of security or mechanical breakdowns (see Security Breach).

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DIVISION OF YOUTH AND FAMILY JUSTICE
CLOSE TO HOME INCIDENT DEFINITIONS

Medical Illness	An unintended incident caused from a medical condition or illness, which results in urgent/emergency medical treatment for youth. Only illnesses that result in unscheduled medical treatment, including calls to 911, trips to the Emergency Room or urgent care centers, or unscheduled visits to medical professionals.
Miscarriage	A miscarriage by a youth in ACS care.
Physical Altercation With Injury	Any intent, by two to four reciprocal aggressors, to cause physical injury to another youth or staff, which results in injury and medical treatment to any participant. **Participants:** The event-type classification must define the parties involved in the altercation as follows (Aggressor-on-Victim): Youth-on-Youth (YOY), and Youth-on-Staff (YOS) **Injury:** This classification requires Medical Assessment of the reported injury.
Physical Assault with Injury	Any intent, by an aggressor (s), to cause physical injury to a non-aggressor which results in injury and medical treatment to any participant. **Note:** if a youth is assaulted and physically reciprocates in self-defense, the incident shall be classified as a Physical Assault. **Participants:** The event-type classification must define the parties involved in the altercation as follows (Aggressor-on-Victim): Youth-on-Youth (YOY), and Youth-on-Staff (YOS). **Injury:** This classification requires Medical assessment of the reported injury.
Program Absence	1. The youth has left the supervision of the facility without permission and has been missing for less than 24 hours. OR 2. On a supervised off grounds trip or a home visit, the youth has left the presence of the person responsible for the supervision of that youth without such person's permission and has been missing for less than 24 hours. OR 3. On an unsupervised off grounds trip or home visit, the youth has not returned to the facility on the assigned date and at the assigned time and has been missing for less than 24 hours.
Suicide Attempt	An act intended to end one's life, consisting in actions taken which, by virtue of the method employed and circumstances chosen, either results in or could likely result in medically serious injuries that might threaten the individual's life or have other irreversible medical consequences. The determination of a suicide attempt is made exclusively by the ACS Executive Director.

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DIVISION OF YOUTH AND FAMILY JUSTICE
CLOSE TO HOME INCIDENT ATTRIBUTES

EVENT	DEFINITION
Accident	An unintended incident not caused by a medical condition or illness, which results in an injury to a resident or staff.
Classroom Disruption	Any instance of youth leaving the classroom without permission which causes an interruption or disorder in a classroom or school setting. This incident category includes all disruptions, regardless of length of time of the interruption.
Contraband	**Illegal Items:** Those articles, the possession of which is prohibited under any law applicable to the general public Items which are believed to have been used in the commission of a crime, but would otherwise be legal (i.e. bed sheet believe to have been use dot choke another youth or staff member or book used as a weapon to cause serious injury) **Potential Injury Causing Items:** Those articles, which are readily capable of being used to cause injury including, but not limited to, firearms, cartridges, knives, razor blades, explosives, or sharpened objects. **Prescription Meds and OTC Meds:** Prescription medications that are not lawfully issued to the bearer or over the counter (OTC) medications that are not authorized or issued to the bearer. **Illegal Substance/Drugs** **Unauthorized Items:** (i.e. tobacco products, lighters and matches)
Destruction of Property	An incident which involves destroying city or agency property (e.g., a piece of furniture, light fixture, door). If a youth or staff member strikes or throws property, but no damage occurs to the property, staff or other residents, then call MCCU and classify the act as a Physical Aggression with no injury.
Facility Plant Management Event	Any instance of an infrastructure and/or plant management issue at a facility that significantly impact operations or security and require immediate repair (e.g. flood in youth sleeping area). Any incident involving a malfunction/breakdown of hardware, plant management equipment, electronic equipment, plumbing, or any machinery that affects the operation of a facility or vehicle. Such a breakdown can occur in any facility, court building or vehicle.

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DIVISION OF YOUTH AND FAMILY JUSTICE
CLOSE TO HOME INCIDENT ATTRIBUTES

Inappropriate Sexual Behavior	An incident that involves any physical contact that upon review by staff is determined to be of a sexual nature. Or An incident that involves a youth or staff engaging in any behavior which is determined by staff to be of a sexual nature. Or An incident that involves exposing or simulating the exposure of private parts in a lewd or obscene manner. Note: The use of sexually obscene language intended to offend another without any intent to engage in inappropriate sexual behavior should not be classified under this event-type.
Inappropriate Statement	A statement made by a youth that is deemed inappropriate due to its nature be that sexual, vulgar, and/or AWOL.
Manager Requested Report	An event that cannot be classified under any other event-type definition, but that is reported under the instruction of an ACS Executive Director, a Provider Facility Director or above, or a Commissioner-level manager. (This includes Medication Errors.)
Physical Aggression	Any act that involves flipping or throwing objects; striking property (without damage to property); or approaching staff or youth in a hostile manner with no assault or physical injury. **Note:** If damage occurs to property during the act of physical aggression, then classify the incident as ***Destruction of Property.***
Physical Altercation w/o Injury	Any intent, by two to four reciprocal aggressors, to cause physical injury to another youth or staff, which does not result in injury or medical treatment to any participant. **Participants:** The event-type classification must define the parties involved in the altercation as follows: Youth-on-Youth (YOY), and Youth-on-Staff (YOS)
Physical Assault w/o Injury	Any intent, by an aggressor(s), to cause physical injury to a non-aggressor which does not result in injury or medical treatment to any participant. **Note:** if a youth is assaulted and physically reciprocates in self-defense, the incident shall be classified as a Physical Assault. **Participants:** The event-type classification must define the parties involved in the altercation as follows (Aggressor-on-Victim): Youth-on-Youth (YOY), and Youth-on-Staff (YOS).

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DIVISION OF YOUTH AND FAMILY JUSTICE
CLOSE TO HOME INCIDENT ATTRIBUTES

Security Breach	An incident that poses a risk to the security of staff or youth, but does not disrupt the operation of a facility—e.g., unauthorized movement, lost, misplaced, unattended items, discovery of an open door, Major security hardware or equipment failure, bomb threat, or loss of tools, sharps or utensils. Any possession or importation of unauthorized articles by youth or staff that could be used as a security breach item should go under the Contraband event category as a Security Breach Item.
Self-Injurious Behavior	A self-injurious behavior is injury to oneself that is not life threatening. The ACS Executive Director shall review categorization of a self-injurious behavior.
Self-Injurious Statement	Any statement made by a youth that suggests that a youth is contemplating self-injury. This includes non-verbal statements; self-injurious behavior should not be classified under this event-type. The ACS Executive Director shall review categorization of a self-injurious statement.
Suspected or Observed Contraband	Any time contraband (as defined in the "Contraband" event) is seen, suspected, smelled or observed, but is not able to be retrieved.
Theft/Stolen Property	Any act of removing or possessing an item that belongs to another youth, staff, or facility without the expresses written or verbal approval of that youth or staff.
Threat of Physical Injury to Youth	An incident which involves making a verbal, written or gestured threat of physical harm or injury against any youth.
Threat of Physical Injury to Staff	An incident which involves making a verbal, written or gestured threat of physical harm or injury against any ACS or Provider staff member.
Vehicular Accident	Any vehicular accident (e.g. hitting another vehicle, being hit by another vehicle, or ACS or Provider vehicle malfunction) that does not result in medical treatment for youth or staff

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DIVISION OF YOUTH AND FAMILY JUSTICE
CLOSE TO HOME INCIDENT ATTRIBUTES

ATTRIBUTE ASSOCIATED WITH EVENTS	DEFINITION
Injury A	An injury requiring clinical treatment beyond what can be provided by a layperson with over-the-counter products. Categorization is made by medical staff.
Injury B	An injury that is treatable by a layperson with over-the-counter products such as ibuprofen, antibiotic ointment, etc. Categorization is made by medical staff.
EMS (911)	Any time 911 is called, for support by emergency medical services for medical or mental health reasons, by ACS or by Contract Agency Staff.
Police (911)	Any time 911 is called, for support by the police, by ACS or by Contract Agency Staff.
Arrest	Any time a youth is arrested for an event that occurred while in placement or on aftercare.
Loss of Consciousness	Any incident that may result in the occurrence of a youth's loss of the ability to perceive and respond.
Hospital Admission	Any time a youth is admitted to the hospital.

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OCFS-7065 (3/2008)

NEW YORK STATE
OFFICE OF CHILDREN AND FAMILY SERVICES

AGENCY REPORTING FORM FOR SERIOUS INJURIES, ACCIDENTS, OR DEATHS OF CHILDREN IN FOSTER CARE AND DEATHS OF CHILDREN IN OPEN CHILD PROTECTIVE OR PREVENTIVE CASES

INSTRUCTIONS

Call the appropriate Regional Office to report a serious injury, accident or death of a child in foster care or a fatality involving a child in an open protective or preventive case within 24 hours of death or as soon thereafter as the agency becomes aware of the injury, accident or death.

This form is to be filled in by an agency official to report:

- A serious injury or accident resulting in a medical treatment, hospitalization or death of a child in foster care.
- The death of a child in an open protective case.
- The death of a child in an open preventive case.

The form must be completed and sent to the appropriate Regional Office of the New York State Office of Children and Family Services (OCFS) within 72 hours of the injury, accident or death.

Check Case Type (Please check all that apply):
☐ Foster Care ☐ Protective ☐ Preventive

Was the SCR called? ☐ Yes ☐ No | Was an SCR report registered ☐ Yes ☐ No

Date of Death/Injury: CIN#: Date of Birth:

Name of Child:

Agency or Individual having legal custody:

Address:

City: State: Zip Code:

List any witnesses to the ☐ injury, ☐ accident or ☐ death:

Address:

City: State: Zip Code:

Describe the circumstances of child's accident or injury, or cause of death. Details should include the date, time, location, and person responsible for the child's care.

For a report involving a serious injury or accident of a foster child, describe the agency's actions following the accident or injury.

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For a report involving the death of a child in foster care or in an open preventive or protective case, report the name, address and telephone number of the child's parents or legal guardian.

For a report involving the death of a foster child, indicate if the parents were notified, describe when and the method of notification.

Attending Physician's Name: (if any)

Hospital, clinic or other treatment facility to which child was taken:

☐ For serious injury or accident involving a foster child, note where the child is now.

☐ For all reports, check if a hospital or medical report is attached.

☐ If a hospital or medical report is not attached, check if such a report has been requested.

Date the OCFS Regional Office was notified by telephone:

Name of Agency Caller:

Name of the Regional Office:

Name of representative contacted:

Additional comments to supplement the above information or to clarify the child's situation, condition, prognosis, official cause of death, etc.

Signature of individual completing the form: **X**

Name of Agency:

Date form completed:

Title of Agency Official:

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To be completed by the OCFS Regional Office

Date Received in Regional Office:	OCFS Fatality Report Number (RO/Year#):
Reviewed by (Name of Regional Director):	
Additional information that is needed by Regional Office:	
Follow-up action assigned to:	

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ACS DIVISION OF YOUTH AND FAMILY JUSTICE
CLOSE TO HOME SEARCHES FOR CONTRABAND FORM

Dates Logged: ____________________
Provider Agency and Facility Name: ____
Facility Address: ____

Date of Search	Circle Shift of Search	Area of Search	Circle Contraband Found	List Specific Type of Contraband Found If None Found, List "None" If Money Found, Indicate Amount	Circle Category of Search	Circle Type of Search (Circle all that apply)	Name of Staff who Conducted the Search	Name and Signature of Staff who Found Contraband	If contraband was found, what did the staff do with the contraband?	Voucher #	Signature of Supervisor on Duty During the Search
	AM PM NIGHT		Weapon Drugs Security Risk Item Unauthorized Property		Scheduled Unscheduled	Living Area Pat Frisk Security Search Strip Search*					
	AM PM NIGHT		Weapon Drugs Security Risk Item Unauthorized Property		Scheduled Unscheduled	Living Area Pat Frisk Security Search Strip Search*					
	AM PM NIGHT		Weapon Drugs Security Risk Item Unauthorized Property		Scheduled Unscheduled	Living Area Pat Frisk Security Search Strip Search*					
	AM PM NIGHT		Weapon Drugs Security Risk Item Unauthorized Property		Scheduled Unscheduled	Living Area Pat Frisk Security Search Strip Search*					
	AM PM NIGHT		Weapon Drugs Security Risk Item Unauthorized Property		Scheduled Unscheduled	Living Area Pat Frisk Security Search Strip Search*					
	AM PM NIGHT		Weapon Drugs Security Risk Item Unauthorized Property		Scheduled Unscheduled	Living Area Pat Frisk Security Search Strip Search*					
Page Totals	**AM=** **PM=** **NIGHT=**		**W=** **D=** **SRI=** **UP=**		**S=** **U=**						

Signature of Facility Director: ______________________________ **Date:** ____________________ **Page Number:** ____________

*LSP only

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ACS DIVISION OF YOUTH AND FAMILY JUSTICE
CLOSE TO HOME
ROOM ISOLATION FORM

DATE: ____________________

YOUTH'S NAME & DOB:____________________________

LSP PROVIDER/FACILITY: ____

Reason for Room Isolation (include an explanation of what interventions were tried unsuccessfully):

____

____

Items not allowed in Room: ____

Authorization provided by: _________________________________

Room Isolation Start Time:__________AM / PM End Time: _________ AM / PM
(circle AM or PM)
Use additional sheets as necessary.

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PARENT/GUARDIAN NOTIFICATION			
Time	**Staff Person Making Notification**	**Contact Made? (yes or no)**	**Notes**

MEDICAL SERVICES PROVIDED **YOUTH IS PRESCRIBED MEDICATION? [YES] [NO]**					
During 1st hour of room isolation, medical staff should examine the youth for health issues. If medical staff is not available, the Facility Director or designee must determine whether the youth has any obvious injuries or a known medical problem. Document below.					
Time	**Medical Screening/ Service Provided**	**Provided By**	**Location**	**Logged By**	**Does the Youth Need Follow Up?**

CLINICAL SERVICES PROVIDED				
Time	**Clinical Service Provided**	**Provided By**	**Logged By**	**Does the Youth Need Follow Up?**

FOOD / DRINKS PROVIDED				
Time	**Meal or Snack?**	**Served/Refused**	**Logged By**	**Notes**

BATHROOM BREAKS					
Time	**Logged By**	**Time**	**Logged By**	**Time**	**Logged By**

NYC
Administration for Children's Services

ACS DIVISION OF YOUTH AND FAMILY JUSTICE
CLOSE TO HOME
ROOM ISOLATION FORM

OBSERVATION NOTES (include any steps taken to reduce the amount of time in room isolation)	**Time and Logged By**

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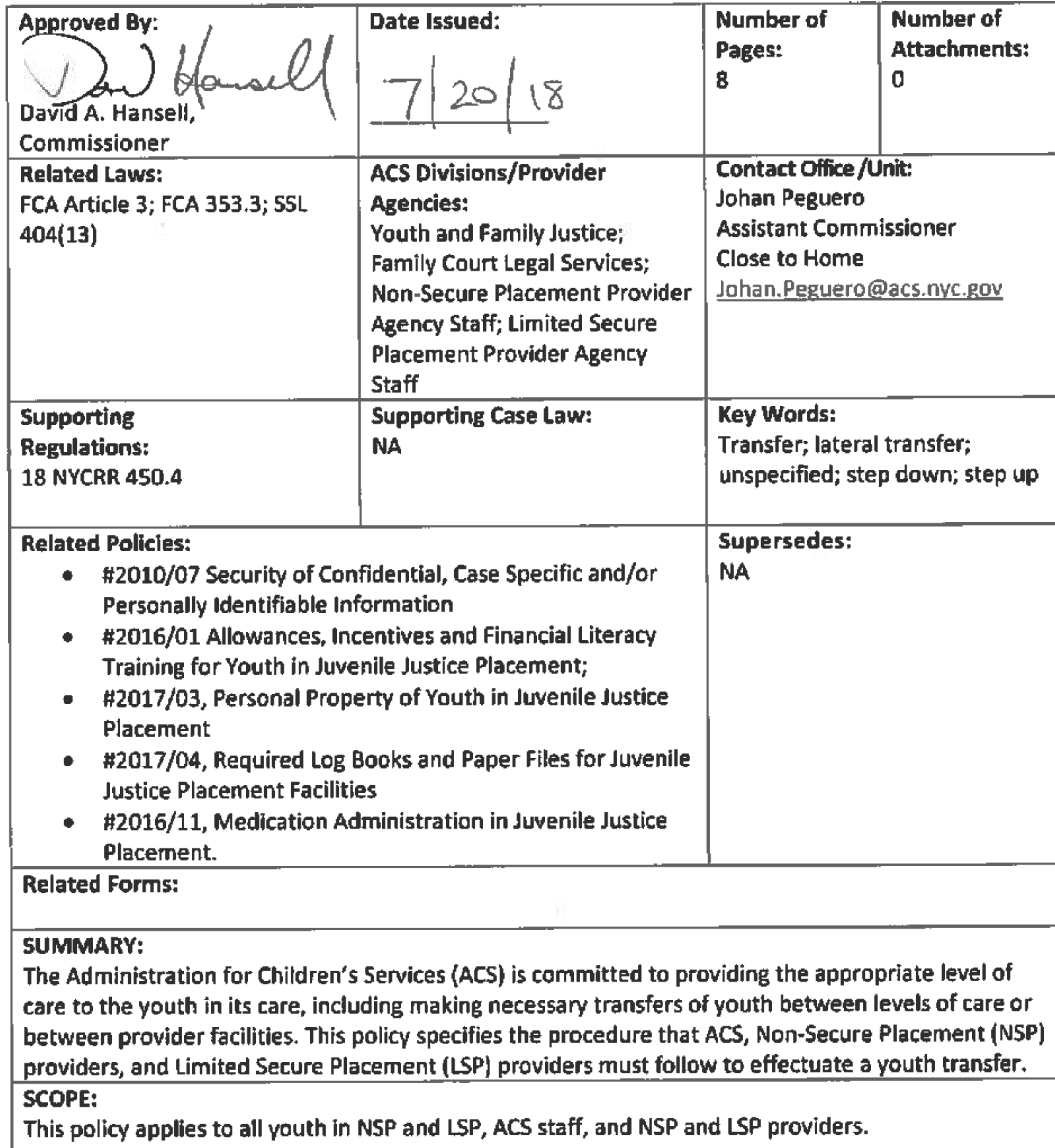
cc: LSP provider, ACS Case Record, DYFJ Director

City of New York
Administration for Children's Services

Policy and Procedure
#2018/03

Transfers in Juvenile Justice Placement



Approved By: David A. Hansell, Commissioner	**Date Issued:** 7/20/18	**Number of Pages:** 8	**Number of Attachments:** 0
Related Laws: FCA Article 3; FCA 353.3; SSL 404(13)	**ACS Divisions/Provider Agencies:** Youth and Family Justice; Family Court Legal Services; Non-Secure Placement Provider Agency Staff; Limited Secure Placement Provider Agency Staff	**Contact Office /Unit:** Johan Peguero Assistant Commissioner Close to Home Johan.Peguero@acs.nyc.gov	
Supporting Regulations: 18 NYCRR 450.4	**Supporting Case Law:** NA	**Key Words:** Transfer; lateral transfer; unspecified; step down; step up	
Related Policies: • #2010/07 Security of Confidential, Case Specific and/or Personally Identifiable Information • #2016/01 Allowances, Incentives and Financial Literacy Training for Youth in Juvenile Justice Placement; • #2017/03, Personal Property of Youth in Juvenile Justice Placement • #2017/04, Required Log Books and Paper Files for Juvenile Justice Placement Facilities • #2016/11, Medication Administration in Juvenile Justice Placement.		**Supersedes:** NA	
Related Forms:			

SUMMARY:
The Administration for Children's Services (ACS) is committed to providing the appropriate level of care to the youth in its care, including making necessary transfers of youth between levels of care or between provider facilities. This policy specifies the procedure that ACS, Non-Secure Placement (NSP) providers, and Limited Secure Placement (LSP) providers must follow to effectuate a youth transfer.

SCOPE:
This policy applies to all youth in NSP and LSP, ACS staff, and NSP and LSP providers.

I. Introduction

A. The Administration for Children's Services (ACS) is committed to providing the appropriate level of care for youth in its care. Youth placed in Close to Home have the greatest opportunity to succeed when they are afforded the ability to develop and maintain consistent healthy relationships with adults and peers. This is achieved through preserving a youth's placement and minimizing transitions while in placement.

B. For the purposes of this policy:

1. A step down transfer occurs when a youth is transferred to a lower level of care, such as when a youth in a limited secure (LSP) facility is transferred to a non-secure placement (NSP) facility; and

2. A step up transfer occurs when a youth with an unspecified dispositional order is transferred to a higher level of care, such as when a youth in an NSP facility is transferred to an LSP facility. Note: A step up transfer is different from a modification,[1] which is the placement of a youth with an NSP dispositional order in an LSP facility after the court grants a modification petition.

C. The lateral transfer of a youth in a juvenile justice placement with ACS shall be considered only as an option when all efforts to prevent the move have been exhausted, or when the youth must be moved to a specialized program. A lateral transfer occurs when a youth in an NSP facility is transferred to another NSP facility or when a youth in an LSP facility is transferred to another LSP facility. The lateral transfer of a youth in a juvenile justice placement with ACS shall be considered as an option only when all efforts to prevent the move have been exhausted or when a youth's newly identified needs require more specialized care.

D. This policy establishes procedures that ACS staff, NSP provider staff, and LSP provider staff must follow when all efforts to preserve placement have not resulted in stabilizing a youth's disruptive behavior.

Note: If a judge's placement order states that the youth's placement is unspecified, the youth may be moved between ACS levels of care at the discretion of ACS without another court order, and thus is not a modification. If the placement order does specify "NSP," a youth's move from an NSP to an LSP is a modification. See I. B. 2 above.

[1] A modification occurs when a youth, who was initially placed by the court specifically in one level of care, is placed in a higher level of care (i.e., NSP to LSP, LSP to secure placement) after the court has granted a modification petition.

II. Procedure

A. Determining Whether a Transfer is Appropriate

1. ACS and provider agencies may consider effectuating a **step down transfer** of a youth from an LSP facility to an NSP facility when the youth's behavioral needs can be managed at a lower level of care but the youth is not yet ready to return to the community.

2. ACS may consider a **transfer** when:

   a. There is a substantial change of circumstance;
   b. The transfer is in the best interests of the youth and his or her family; [2]
   c. Care and treatment in the current placement is no longer suitable for the youth; and/or
   d. The transfer is necessary to preserve the safety and security of youth, staff, and/or the surrounding community.

3. ACS may consider effectuating a **transfer** after a Family Team Conference (FTC) has occurred where one (1) or more of the following conditions exist:

   a. All options have been considered and exhausted and the youth has exhibited a pattern of behavior that suggests that a different setting would best serve the youth's needs. In such instances, providers must fully describe and document all steps taken to address the youth's behaviors, and explain why the provider feels that moving the youth to another facility is an appropriate intervention.

   b. The youth is engaged in a long-term[3] absence or a pattern of absences without consent (AWOCs), and/or the youth's bed at the program was filled by another youth due to a long-term AWOC.

   c. The youth has committed or been involved in an act which in and of itself is enough to warrant consideration for an emergency transfer. As a result of this act:

      i. An order of protection has been issued prohibiting the youth from having contact with other youth or staff in the program; or

      ii. The youth's behavior has resulted in the victimization of another youth in the program.

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[2] See SSL § 404(13)(c); 18 NYCRR 450.4(d).
[3] For the purposes of this policy, a long-term absence without consent is over 30 days.

d. The youth requires a specialized level of care that another program can provide.

B. Family Team Conference (FTC)

ACS will coordinate and schedule at least three (3) Family Team Conferences (FTC) at crucial moments during the youth's placement. Participants include the youth, his or her family and discharge resources, NSP or LSP provider staff, and other stakeholders, where practicable. In addition to ongoing Treatment Team meetings, FTCs are designed to proactively address each youth's individualized needs through the development of positive interventions focused on reducing risk and preserving the youth's current placement.

C. Emergent Team Conference (ETC)

Emergent Team Conferences (ETCs) are designed to address the needs of youth who are continuously unreceptive to treatment, have not adapted to the program, and have responded to targeted positive interventions with a pattern of disruptive and unsafe behaviors.

1. ETCs take place in person and are facilitated by ACS Close to Home Family Engagement Conference Facilitators (FECF).

   a. ACS is responsible for scheduling the ETC.

   b. The youth must always be present for an ETC. If a youth is unable to attend a scheduled ETC, the FECF shall coordinate with the people in section c. below to reschedule the meeting.

   c. Invited parties shall include but not be limited to provider staff, appropriate ACS personnel, the youth's family, the youth's attorney, and any other identified supports where practicable.

   d. The purpose of the meeting is to discuss existing behavior management and safety plans, any additional strategies the provider has attempted, and potential interventions that have not yet been explored.

   e. During the conference, the parties shall:

      i. Review all relevant incidents and disruptive or unsafe behaviors;
      ii. Review all interventions attempted to resolve/mitigate the youth's behavior;
      iii. Reach a consensus and develop a joint understanding of antecedents and consequences of the identified behaviors; and

iv. Determine if any other interventions can be employed and explore all potential strategies to preserve placement.

f. Following the ETC, ACS shall make a determination of whether to transfer the youth or preserve the youth's placement. Only the Associate Commissioner of Close to Home or designee can approve a transfer.

g. If a determination is made that additional interventions must be taken to preserve the youth's placement, a follow-up meeting to evaluate their effectiveness shall be established prior to the conclusion of the ETC.

2. If the parent/guardian is unable to attend the conference, ACS shall immediately notify the parent/guardian by phone that the conference was held and that a decision was reached to transfer the youth. ACS must also notify the Family Court Legal Services (FCLS) attorney and the youth's attorney of the move.

D. <u>Transfer Procedures</u>

Immediately upon approval of any transfer by the Associate Commissioner of Close to Home or designee, the procedure described below is to be followed in all transfer proceedings, with the exception of an emergency transfer necessitated by the circumstances as described in section II.A.3.c. above.[4]

1. Note: For confidential information sent by email, the provider shall password protect all documents and shall verify the email addresses of the intended recipients.[5]

2. The Placement and Permanency (PP) Director must immediately notify the ACS Intake and Assessment Unit of the anticipated move.

3. The PP Director shall notify the youth's current residential placement provider of the decision to proceed with the transfer.

4. The following must occur within a maximum of three (3) business days:

   a. The ACS Intake and Assessment Unit shall collaborate with the PPS team to identify an appropriate placement. Once a new facility is identified for the youth, a member of the Intake and Assessment team must notify both the sending provider and the receiving provider of the transfer.

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[4] In the event an emergency transfer must be effectuated, notification to the youth's parent/guardian and the youth's attorney must be made within one (1) business day.

[5] See ACS Policy and Procedure #2010/07, *Security of Confidential, Case Specific and/or Personally Identifiable Information*.

b. The sending provider shall send a copy of the entire case file and any completed assessments of the youth, where applicable, to the assigned PPS.[6]

5. ACS must provide all intake paperwork and any other relevant documents to the receiving provider. This includes all assessments, information about any medication the youth is currently taking, and any allergies that the youth has.

E. Movement

1. In planning for and facilitating the youth's physical transfer to the new facility, the sending provider must adhere to all provisions of the ACS Policy and Procedure #2017/03, *Personal Property of Youth in Juvenile Justice Placement* to make sure that the youth's belongings are properly inventoried, accounted for, and transferred to the new location. A plan for forwarding the youth's case file materials and medical history (if under 18), any accumulated allowance funds,[7] and medications,[8] if any, must also be established.

2. Before the physical transfer of the youth, the PPS must arrange a transfer conference between the sending provider and the receiving provider to discuss the youth's treatment needs. If a face-to-face conference cannot be held, it may be held via conference call.

   a. This conference must be facilitated by ACS.

   b. The youth and the youth's parent/guardian must be invited to this conference. If the youth refuses to attend, the refusal must be documented in CNNX.

   c. During the conference, the receiving provider must present its program model, plan for educating the youth while in placement, expectations for the youth in the new setting.

   d. Upon initiation of the youth's physical transfer, the sending provider must notify the ACS Movement Control and Communications Unit (MCCU) of the youth's transfer, and record the transfer in the Facility Activity/Communication Log Book. The receiving provider shall notify MCCU of the youth's arrival at

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[6] Assessments may include, but are not limited to, psychiatric evaluations, psychosocial assessments, treatment plans, and medical examinations.
[7] See ACS Policy and Procedure # 2016/01, *Allowances, Incentives and Financial Literacy Training for Youth in Juvenile Justice Placement*.
[8] See ACS Policy and Procedure #2016/11, *Medication Administration in Non-Secure Placement and Limited Secure Placement Facilities;* 18 NYCRR 357.3(b)(1).

the new facility and record the new intake in the Facility Activity/Communication Log Book.[9]

e. ACS must coordinate transportation of the youth to the new facility as soon as possible following the transfer conference.

f. Note: The sending provider is responsible for transporting youth to the new facility unless the youth is in the custody of an ACS Detention facility. If the youth must be transported from ACS Detention to the new facility, the receiving provider is responsible for transportation of the youth.

F. Documentation

1. All transfers must be properly documented in all required computer systems including but not limited to Juvenile Justice Information System (JJIS), CNNX, and Child Care Review System (CCRS).

2. The sending provider must complete a plan amendment in CNNX.

3. The receiving provider must update CNNX; however, there is no need for an additional OCFS LDS- 2921 "New York State Application for Certain Benefits and Services" to be completed.

4. The PPS must update the youth's CNNX case record with the new provider case planner information. Within one (1) business day of a youth's physical transfer to a new facility, the PPS must assign a role in CNNX to the receiving provider.

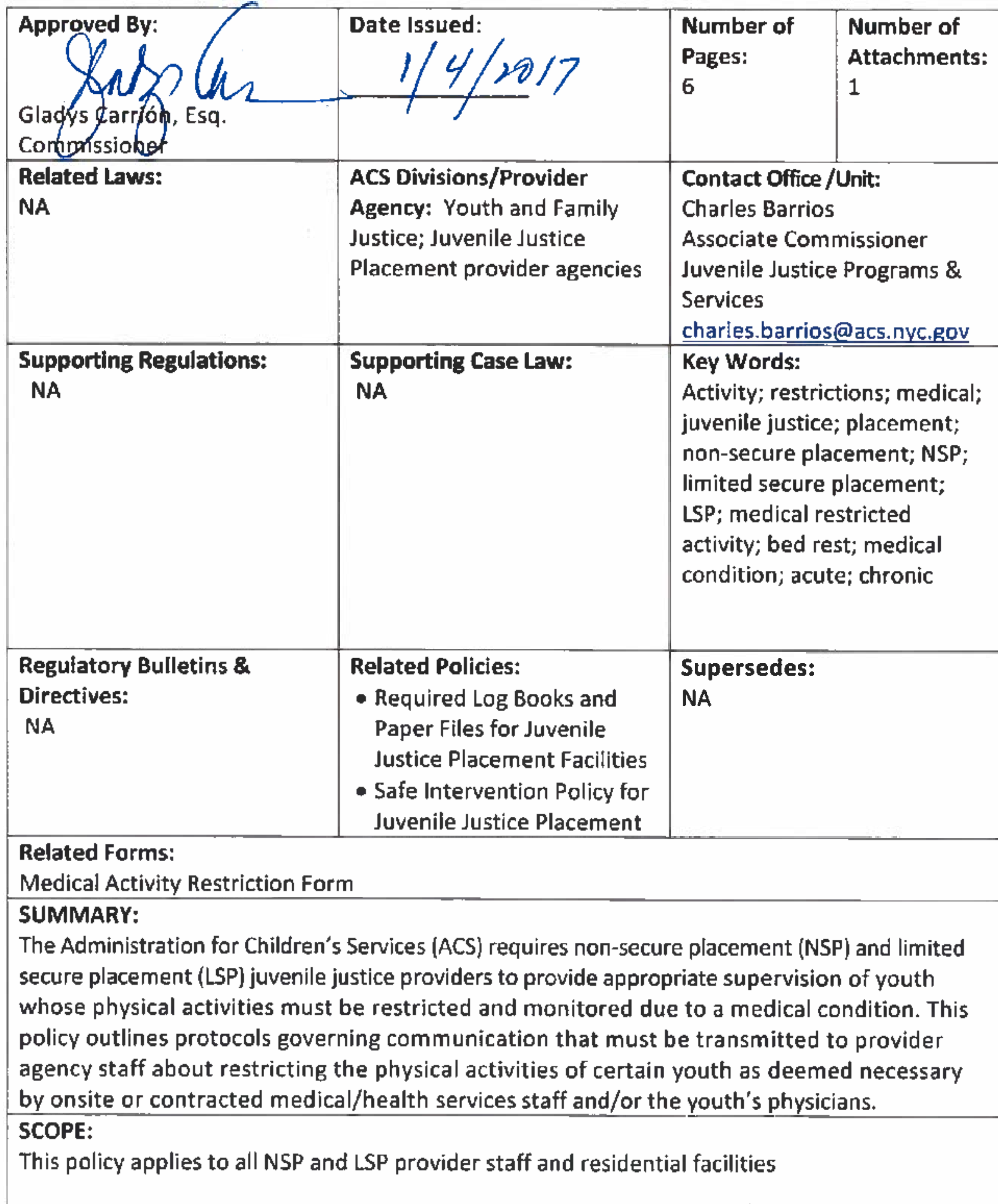
5. MCCU must update the new provider location for the youth in JJIS.

[9] See ACS Policy and Procedure #2017/04, *Required Log Books and Paper Files for Juvenile Justice Placement Facilities*

City of New York
Administration for Children's Services

Policy and Procedure
#2017/01

Activity Restrictions Due to Medical Reasons for Youth in Juvenile Justice Placement



Approved By: [signature] Gladys Carrión, Esq. Commissioner	**Date Issued:** 1/4/2017	**Number of Pages:** 6	**Number of Attachments:** 1
Related Laws: NA	**ACS Divisions/Provider Agency:** Youth and Family Justice; Juvenile Justice Placement provider agencies	**Contact Office /Unit:** Charles Barrios Associate Commissioner Juvenile Justice Programs & Services charles.barrios@acs.nyc.gov	
Supporting Regulations: NA	**Supporting Case Law:** NA	**Key Words:** Activity; restrictions; medical; juvenile justice; placement; non-secure placement; NSP; limited secure placement; LSP; medical restricted activity; bed rest; medical condition; acute; chronic	
Regulatory Bulletins & Directives: NA	**Related Policies:** • Required Log Books and Paper Files for Juvenile Justice Placement Facilities • Safe Intervention Policy for Juvenile Justice Placement	**Supersedes:** NA	

Related Forms:
Medical Activity Restriction Form

SUMMARY:
The Administration for Children's Services (ACS) requires non-secure placement (NSP) and limited secure placement (LSP) juvenile justice providers to provide appropriate supervision of youth whose physical activities must be restricted and monitored due to a medical condition. This policy outlines protocols governing communication that must be transmitted to provider agency staff about restricting the physical activities of certain youth as deemed necessary by onsite or contracted medical/health services staff and/or the youth's physicians.

SCOPE:
This policy applies to all NSP and LSP provider staff and residential facilities

I. INTRODUCTION

The New York City Administration for Children's Services (ACS) requires juvenile justice placement providers to provide appropriate supervision of youth whose physical activities must be restricted and monitored due to a medical condition. This policy provides protocols governing communication that must be transmitted to provider agency staff regarding the need to restrict the physical activities of certain youth as deemed necessary by medical professional staff and/or the youth's physicians.

II. DEFINITIONS

A. Acute Medical Condition: A medical condition of an abrupt onset and short in duration, usually requiring immediate medical attention.

B. Behavior Support Plan (BSP): A specific documented plan developed by the treatment team, in conjunction with the youth and the youth's family or other persons of significance to the youth, which is tailored to the youth's individual needs and used to determine intervention strategies and/or safety procedures to defuse behavior(s) of concern. The plan must include any limitations on physical interventions authorized or prohibited for the youth.

C. Care Coordination: An administrative function that helps make sure that the needs of youth at risk for adverse health conditions are met, and that options for health services and information sharing across departments, functions, and sites are similarly met.

D. Chronic Medical Condition: A medical condition of long duration or frequent recurrence.

E. Facility Activity/Communication Log Book: A log book in which provider staff make entries throughout each shift. These entries include census information, observations of all youth in the facility, the "tone" of the facility, activities and events, and any incidents that take place.[1]

F. Qualified Medical Practitioner: A physician, physician assistant, nurse practitioner, licensed practical nurse, dentist, or registered nurse employed by ACS, the Office of Children and Family Services (OCFS), the Office of Mental Health (OMH), or a hospital, and/or working for or contracted by an ACS-contracted juvenile justice placement provider agency to provide health care services to youth in NSP or LSP facilities.

[1] See ACS Policy *Required Log Books and Paper Files for Juvenile Justice Placement*.

III. PROTOCOL

A. Procedure Following a Medical Examination

1. When a qualified medical practitioner determines, upon a medical evaluation of a youth, that the youth requires a restriction on his or her physical activities due to a specific medical condition, the following must occur:

   a. Provider administrative staff (e.g., the facility director or the director's designee) shall fully complete a Medical Activity Restriction Form (Attachment A) with the assistance of the medical practitioner.

   b. The information documented on the form shall include the specific type of activity restriction that is required (i.e., medical restricted activity or bed rest; see Section III. B. below), with the justification for the restriction. The medical information, a description of the condition, treatment recommended, and specific type of activity restriction deemed appropriate must be documented in the youth's case record by provider staff that are assigned to the youth and/or have primary planning responsibility for the youth.

      Note: For privacy and confidentiality, the medical information, a description of the condition, and treatment recommended by the qualified medical practitioner must **not** be included on the Medical Activity Restriction Form.

2. If the restriction is due to a **chronic medical condition** that is unlikely to change with medical treatment, the youth shall be placed on an indefinite restricted activity status. If at any time any changes are made to the youth's medical status, the form and the youth's Behavior Support Plan (BSP) must be revised accordingly. While on physical restriction for a chronic medical condition, the provider agency shall prepare an alternative recreation schedule for the youth and attach it to the youth's medical activity restriction form.

3. If the restriction is due to an **acute medical condition**, the youth shall be placed on medical restriction until he or she is physically cleared by a qualified medical practitioner. Where practicable while on physical restriction for an acute medical condition, the provider agency shall prepare an alternative recreation schedule for the youth and attach it to the youth's medical activity restriction form. Designated provider agency administrative staff members shall note the date the restriction is discontinued on the Medical Activity Restriction form and in the youth's BSP. A notation of the discontinued activity restriction shall also be entered into the youth's case record by the provider which is assigned to the youth and/or has primary planning responsibility for the youth.

4. Upon discovery of a medical condition requiring activity restriction, the original Medical Activity Restriction Form shall be placed in the medical file so that it can be updated as necessary by designated provider agency administrative staff members. Designated provider agency administrative staff members shall make copies and distribute the form to the provider's case planning staff and/or staff that is assigned to the youth. Such staff shall then distribute copies to the following:

   a. Facility Director;
   b. The youth's parent/guardian;
   c. School and direct care staff;
   d. Clinical and case planning staff;
   e. Recreation staff; and
   f. The designated ACS Placement and Permanency Specialist (PPS).

B. Types of Activity Restrictions

There are two (2) types of activity restrictions: Medical restricted activity and bed rest.

1. **Medical Restricted Activity:**

   Youth placed on medical restricted activity for chronic or acute conditions shall not perform any rigorous activities and any activities requiring an unnecessary level of physical exertion.

2. **Bed Rest:**

   Youth placed on bed rest for chronic or acute conditions shall be assigned to their rooms as determined by the medical/health services staff and/or the youth's physician; bed rest encompasses all of the limitations of medical restricted activity. Youth placed on bed rest activity restriction are prohibited from attending regularly programmed activities. The provider agency shall develop an alternative treatment plan to minimize clinical service interruption and make accommodations for the provision of mental health, behavioral health, substance abuse, and/or therapeutic treatment for the duration of the medical restriction, where practicable.

C. Educational Access

1. If a youth is placed on **Medical Restricted Activity Status**, an assessment must be made as to whether the youth can attend regularly scheduled academic programing or activities. If the youth is unable to attend school and/or has a chronic or acute condition that precludes full participation in class, educational

materials and tutoring services must be provided for the duration of the medical restriction, as practicable.

2. If a youth is placed on **Bed Rest Status**, the youth's access to the school and special outings shall be prohibited. Educational materials and tutoring services must be provided for the duration of the medical restriction, as practicable.

D. Medical/Health Services Staff Duties

1. The provider's administrative staff shall complete and immediately update the Medical Activity Restriction Form and the youth's BSP whenever there is any change in the youth's medical condition.

   Note: Distribution of the Medical Activity Restriction Form shall be repeated any time an activity restriction is updated, changed, enhanced, or discontinued (see Section III. A. 4).

2. If the medical professional staff is located on site, the medical professional staff shall provide verbal notification to the facility director whenever placing a youth on an activity restriction due to medical reasons and shall provide copies of the Medical Activity Restriction Form to the provider's case planning staff and/or staff assigned to the youth mentioned above in Section III. A. 4.

3. These updates and notifications shall be done in the context of care coordination to make sure that services are planned, provided, and alternative programming are coordinated by the medical/health services staff and with the provider's case planning staff, ACS Division of Youth and Family Justice (DYFJ) staff, and the youth and family, as appropriate.

E. Case Planning Staff Duties

1. At the beginning of each work day, the facility director or the director's designee shall review with case planning staff and/or staff assigned to the youth regarding which youth are on medical restriction and conduct any necessary follow-up with the medical professional.

2. Provider agency staff shall make the appropriate entries in the Facility Activity/Communication Log Book during their shifts so that details are provided regarding youth on medical restricted activity. Entries shall explicitly state the type of restriction (e.g., Medical Restricted Activity or Bed Rest) on which the youth has been placed.

3. Designated provider agency staff members shall notify the parent/guardian of a medical professional's decision to restrict a youth's activities due to medical reasons.

The parent/guardian shall be notified as soon as possible but no more than eight (8) hours after the determination is made.

4. Care coordination is the responsibility of provider agency staff, includes verifying that the youth's medical and behavioral health needs are identified, and shall be:

   a. Youth-centered;
   b. Consumer-directed and family-focused;
   c. Culturally competent;
   d. Linguistically appropriate; and
   e. Strengths-based.

DIVISION OF YOUTH AND FAMILY JUSTICE
CLOSE TO HOME MEDICAL ACTIVITY RESTRICTIONS FORM

DIRECTIONS: **PRINT or TYPE all information and complete the entire form. Once complete, a copy of the form must be submitted to the youth's parent/guardian and the assigned Placement and Permanency Specialist (PPS). In addition, the completed form must be distributed to the facility director, clinical/case planning staff, recreational specialists, direct care staff, and school staff.**

Youth Name: ____ **Date:** ___/___/__________

Provider Agency: ____

Facility Name: ____

Facility Address: ____

Medical Professional's Name/Title: ____

The above youth has the following restrictions due to a medical condition or alert:

____

____

____

____

____

____

____

____

Date of Reevaluation: ___/___/______ **Date of End of Restriction:** ___/___/______

Facility Director/Designee Name: ____

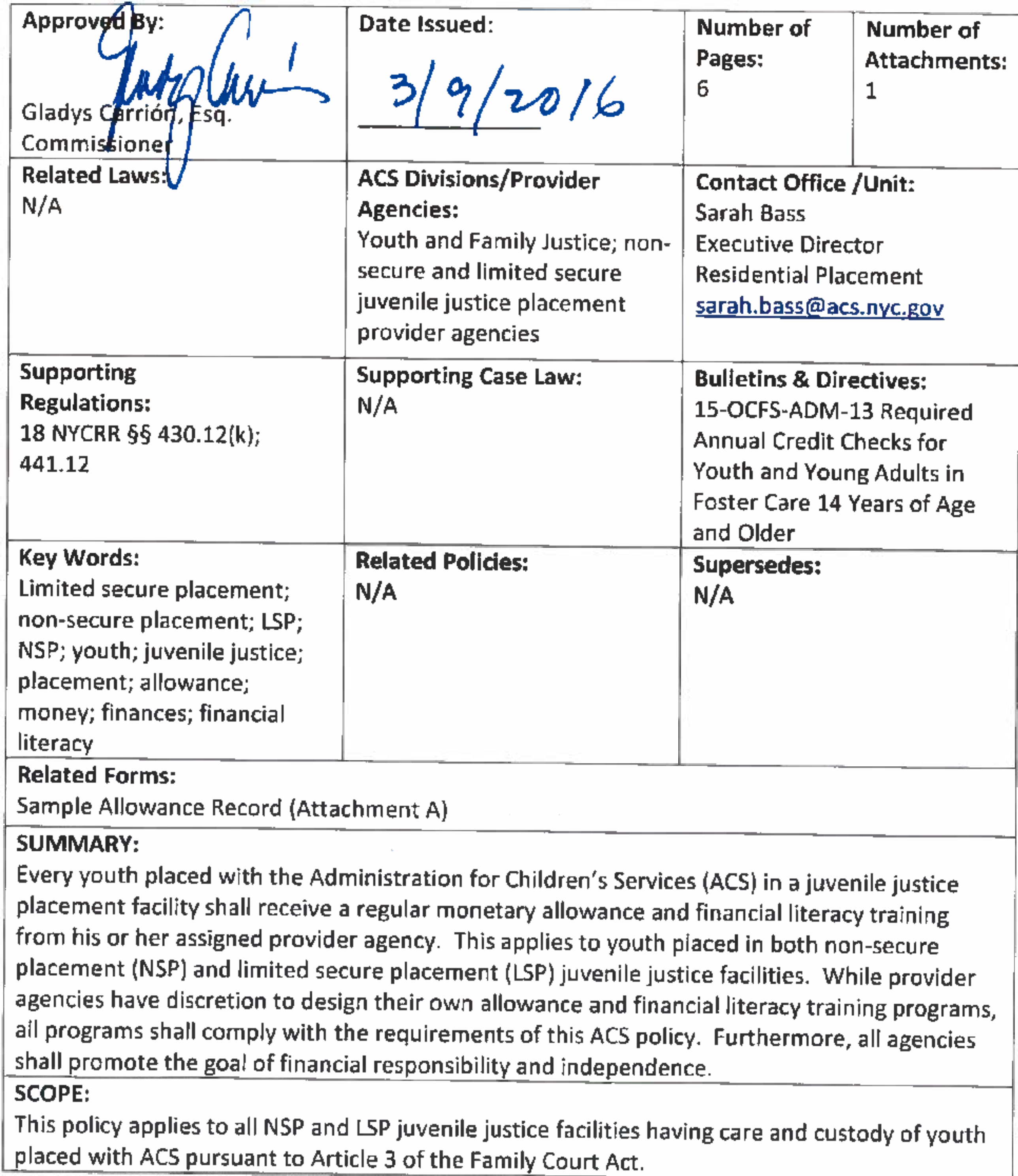
Facility Director/Designee Signature: ____

Date Signed: ___/___/______

City of New York
Administration for Children's Services

Policy and Procedure
2016/01

Allowances and Financial Literacy Training for Youth in Juvenile Justice Placement



Approved By: Gladys Carrión, Esq. Commissioner	Date Issued: 3/9/2016	Number of Pages: 6	Number of Attachments: 1
Related Laws: N/A	**ACS Divisions/Provider Agencies:** Youth and Family Justice; non-secure and limited secure juvenile justice placement provider agencies	**Contact Office /Unit:** Sarah Bass Executive Director Residential Placement sarah.bass@acs.nyc.gov	
Supporting Regulations: 18 NYCRR §§ 430.12(k); 441.12	**Supporting Case Law:** N/A	**Bulletins & Directives:** 15-OCFS-ADM-13 Required Annual Credit Checks for Youth and Young Adults in Foster Care 14 Years of Age and Older	
Key Words: Limited secure placement; non-secure placement; LSP; NSP; youth; juvenile justice; placement; allowance; money; finances; financial literacy	**Related Policies:** N/A	**Supersedes:** N/A	

Related Forms:
Sample Allowance Record (Attachment A)

SUMMARY:
Every youth placed with the Administration for Children's Services (ACS) in a juvenile justice placement facility shall receive a regular monetary allowance and financial literacy training from his or her assigned provider agency. This applies to youth placed in both non-secure placement (NSP) and limited secure placement (LSP) juvenile justice facilities. While provider agencies have discretion to design their own allowance and financial literacy training programs, all programs shall comply with the requirements of this ACS policy. Furthermore, all agencies shall promote the goal of financial responsibility and independence.

SCOPE:
This policy applies to all NSP and LSP juvenile justice facilities having care and custody of youth placed with ACS pursuant to Article 3 of the Family Court Act.

I. Introduction

A. All youth placed with the Administration for Children's Services (ACS) on juvenile justice cases shall be entitled to a monetary allowance. This requirement applies to youth residing in both non-secure placement (NSP) and limited secure placement (LSP) juvenile justice facilities. Once a youth receives his or her allowance, it belongs solely to the youth and shall not be used to meet his or her basic needs.

B. Provider agencies shall have the discretion to offer additional financial incentives separate and apart from an allowance. Such financial incentives may include, but not be limited to, money for special program participation, for meeting established programmatic goals, and meeting certain behavioral expectations. Once a youth receives such money, the funds belong solely to the youth and shall not be used to meet his or her basic needs.

C. Provider agencies shall also educate youth in various topics of financial literacy. In doing so, ACS and provider agencies shall help promote financial responsibility and independence among youth in NSP and LSP. Topics that provider agencies must include in their financial literacy training program curricula include how to create and adhere to a budget, the importance of saving, and the role of credit cards and paying bills in establishing credit and minimizing debt.

D. Each provider agency must create internal policies for providing youth with regular allowances and financial literacy training that comply with the requirements of the New York State Office of Children and Family Services (OCFS) regulations and this policy. These policies shall cover such issues as the amount of money youth will receive as allowance, whether the provider agency will create savings accounts for youth, how the agency will disburse youth allowances, when youth can have access to their accumulated allowance, and how the agency will keep records of allowance transfers from agency accounts to youth accounts.

II. Youth Allowances

A. Providing Youth with an Allowance

1. Every youth placed with ACS on a juvenile delinquency case shall receive a regular allowance, appropriate to the age of the youth. This allowance shall not be used to meet the youth's basic needs.

2. Youth allowances, once accrued, belong solely to the youth. If a youth is transferred to the care of a different provider agency or is discharged from care, the remainder of the youth's allowance (i.e., whatever accumulated allowance funds the youth has not spent) shall be provided to the youth or to the person or

agency authorized to act as the custodian of such money, as may be appropriate.

3. Youth allowances shall not be tied in any way to a youth's academic performance, discipline, or participation in treatment programs.

4. Provider agencies shall have some discretion in determining the amount of allowance, but at minimum, each youth is entitled to one (1) dollar per day for each day the youth is a resident of the program.[1]

5. Provider agencies may allow youth to earn financial incentives as part of their financial literacy program, a behavior management program or for completing certain chores or projects as long as the financial incentives systems are clearly outlined, in writing, for all youth to understand.

6. Each provider shall establish and maintain an internal record of allowances and incentives accrued for each youth. The allowance record shall reflect a current balance of allowances and incentives maintained by the provider on the youth's behalf.

7. At least half the amount of any allowance and any other financial incentive accumulated by each youth shall remain in the youth's allowance record instead of being disbursed to the youth. The contents of the youth's allowance record will be provided to him or her at the time of program discharge (i.e., when a youth completes his or her court-ordered placement and will not return to the placement). If the youth is not being discharged to the community from the program, the undisbursed portion of their accumulated funds will be provided to the person or agency authorized to act as custodian of such money.

8. Providers may choose to vary allowance amounts based on age, but shall provide the same allowance to all youth of the same age in their care. For example, while an agency may provide 16-year-old youth in its care with more allowance than it provides to 13-year-old youth, it must provide all 16-year-old youth with the same allowance.

9. Allowance accruals shall be entered into a youth's allowance record on a regular and consistent basis as determined by the individual program. For example, agencies may choose to make allowances available once per week, once every two (2) weeks, or once per month. All youth in the same facility shall accrue their allowances on the same schedule.

10. The residential provider agency shall be responsible for youth allowance, including

[1] Youth shall accrue allowances when they are on authorized home visits or are hospitalized as long as they remain on the official census of the assigned provider agency.

if the youth is also involved in a child welfare case. The case planning agency (i.e., the foster care agency) is not responsible for paying the allowance.

B. Youth Access to Their Allowance and Financial Incentives Monies

1. Provider agencies shall design and implement a system for disbursement of monies from a youth's allowance record. Provider agencies shall set their own rules about when youth can have access to their funds.

2. Provider agency staff shall not disburse accrued money directly to any youth until the youth is either leaving the facility, being transported for a home visit or is actually ready to pay for a non-contraband, facility-approved item.

3. If a youth is provided money to make a purchase while in the presence of staff (e.g., during a planned outing), staff shall supervise the purchase to help answer any questions the youth might have, reinforce financial literacy concepts, and prevent the youth from purchasing anything considered to be contraband. Following the youth's purchase, staff shall record the transaction, with a purchase receipt, in appropriate agency allowance ledgers and return any unspent funds to the youth's allowance record.

4. When allowance and incentive money is not in use by the youth, the money shall be kept by the provider agency and documented in the youth's allowance record. Allowance and incentive money shall be kept separate from agency funds at all times.

C. Record-Keeping Requirements

1. Provider agencies, whenever possible, shall attempt to establish bank savings accounts for youth in their care by accompanying youth to the bank and helping them to open savings accounts.

2. Providers shall keep a written record of each youth's allowance and/or incentives, similar to the sample form attached to this policy as Attachment A. This written record shall include, at a minimum, the following information:

   a. The dates of every accrual of allowance and incentive money to a youth's allowance record and the amount of money provided at each transaction;

   b. The signature and title of the staff member who makes the transaction from the youth's allowance record;

   c. A receipt and record of each approved purchase made by a youth;

d. The dates of each occasion when a youth is physically provided with money from his or her allowance record, including if the youth receives some of his or her money upon leaving for a home visit or to purchase something while in the community, and the amount of money provided on each occasion;

e. A short description of the circumstances surrounding each occasion that youth are physically provided with any of their allowance money (e.g., "youth provided five (5) dollars when dropped off for home visit," or "youth provided two (2) dollars to buy snack at museum"); and

f. The signature and title of the staff member who provided the youth with his or her money.

3. In addition to the recording requirements above, each time a youth either receives a routine transaction involving money going into his or her allowance record, or physically receives cash from his or her allowance record for a home visit or other legitimate purpose, the youth must sign his or her written allowance record.

III. Financial Literacy Training

A. Provider agencies shall offer financial literacy training to the youth in their care. Provider agencies have discretion to design their own programs, but all programs must seek to encourage and empower youth to value and strive toward financial independence. Provider agencies can choose to design their financial literacy training programs by planning lectures and interactive discussion groups, using workbooks, and/or showing relevant educational films.

B. Provider agencies shall encourage each youth to establish a relationship with a community bank and open a savings account whenever practicable.

C. While each provider agency's financial literacy training program may be different in design, all programs shall include, but not be limited to, training on the following topics:

1. Financial literacy: What this means to youth;
2. Access to information on financial management;
3. Understanding money in our society;
4. Practicing money management: Saving, spending, budgeting, investing, and debt;
5. Establishing and protecting credit: Paying bills on time, the role of credit cards, and the role of credit scores; and
6. Strategies for minimizing debt.

D. Provider agency staff shall assist all youth over the age of 14 in obtaining a copy of their credit report from each of the three (3) credit reporting agencies each year until

discharged from care. Staff shall assist youth in interpreting and resolving any inaccuracies in the report.[2]

E. Websites for Youth Financial Literacy Training

1. USMINT.org
2. Investopedia.com
3. FDIC.gov
4. Themint.org
5. Cuna.org
6. Nefe.org
7. Bankit.com
8. Mymoney.gov
9. Jumpstart.org
10. Creativewealth.net
11. Practicalmoneyskills.com
12. 360financialliteracy.org
13. Nea.org (National Education Association)

[2] See 18 NYCRR 430.12(k) and 15-OCFS-ADM-13.

Attachment A

Sample Allowance Record

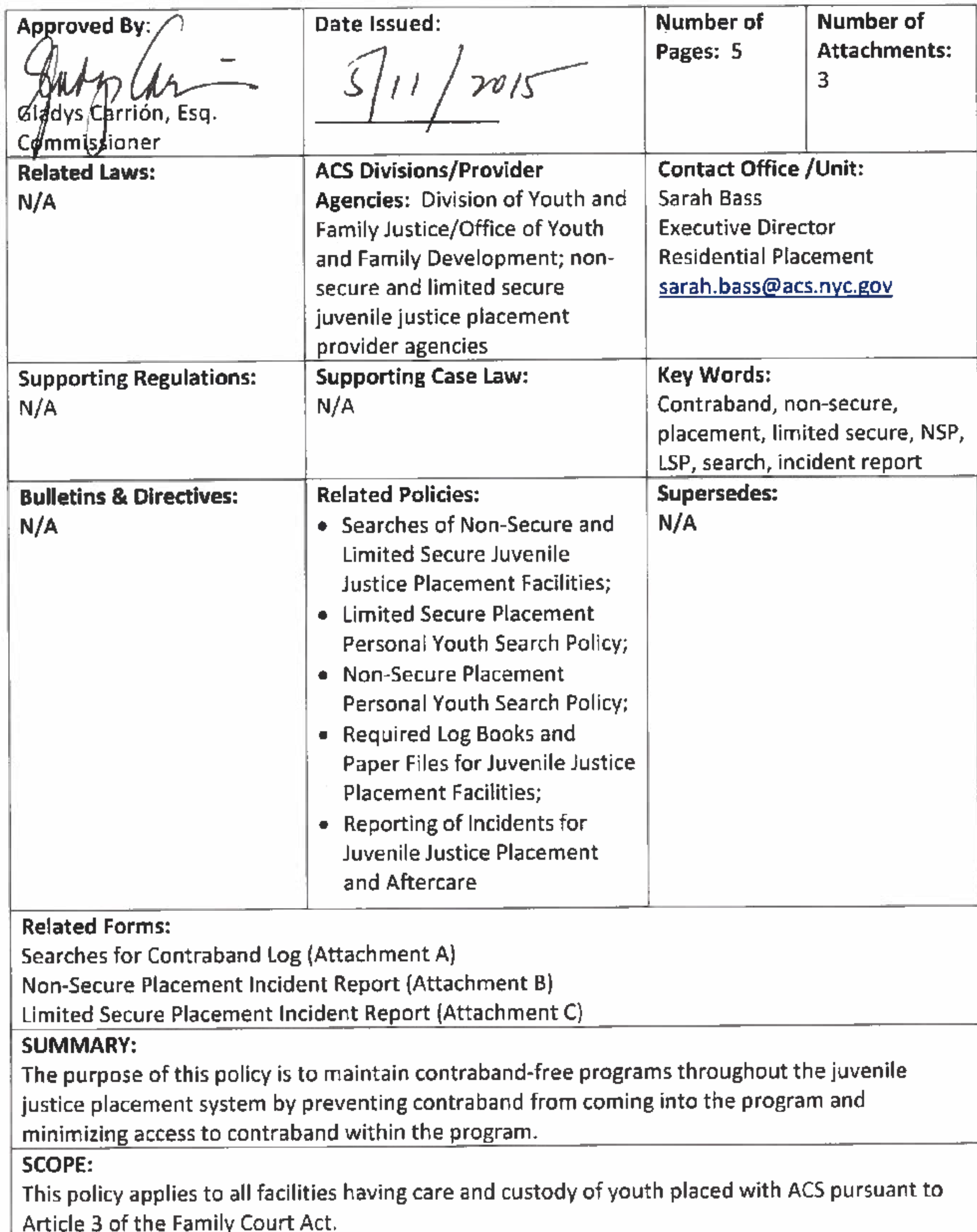
Name of Youth: _________________________
Date of Placement: ______________
Agency/Facility: _________________________

Date of Account Activity	**Description of Account Activity** **(i.e., regular allowance or withdrawal of allowance money for home visit)**	**Allowance Amount**	**Amount of Withdrawal**	**Balance**	**Signature of Staff Member**	**Signature of Youth**
1/1/2015	Weekly allowance	$7.00	----	$7.00		
1/8/2015	Weekly allowance	$7.00	----	$14.00		
1/15/2015	Weekly allowance	$7.00	----	$21.00		
1/17/2015	Money provided to youth to buy takeout food on weekend	----	$7.00	$14.00		
1/22/2015	Weekly allowance	$7.00	----	$21.00		
1/25/2015	Money provided to youth for home visit	----	$6.00	$15.00		
1/29/2015	Weekly allowance	$7.00	----	$22.00		

City of New York
Administration for Children's Services

Policy and Procedure
#2015/03

Contraband Policy for Juvenile Justice Placement



Approved By: Gladys Carrión, Esq. Commissioner	Date Issued: 5/11/2015	Number of Pages: 5	Number of Attachments: 3
Related Laws: N/A	**ACS Divisions/Provider Agencies:** Division of Youth and Family Justice/Office of Youth and Family Development; non-secure and limited secure juvenile justice placement provider agencies	**Contact Office /Unit:** Sarah Bass, Executive Director, Residential Placement, sarah.bass@acs.nyc.gov	
Supporting Regulations: N/A	**Supporting Case Law:** N/A	**Key Words:** Contraband, non-secure, placement, limited secure, NSP, LSP, search, incident report	
Bulletins & Directives: N/A	**Related Policies:** • Searches of Non-Secure and Limited Secure Juvenile Justice Placement Facilities; • Limited Secure Placement Personal Youth Search Policy; • Non-Secure Placement Personal Youth Search Policy; • Required Log Books and Paper Files for Juvenile Justice Placement Facilities; • Reporting of Incidents for Juvenile Justice Placement and Aftercare	**Supersedes:** N/A	

Related Forms:
Searches for Contraband Log (Attachment A)
Non-Secure Placement Incident Report (Attachment B)
Limited Secure Placement Incident Report (Attachment C)

SUMMARY:
The purpose of this policy is to maintain contraband-free programs throughout the juvenile justice placement system by preventing contraband from coming into the program and minimizing access to contraband within the program.

SCOPE:
This policy applies to all facilities having care and custody of youth placed with ACS pursuant to Article 3 of the Family Court Act.

I. Purpose

The following policy regarding contraband is to be implemented in non-secure and limited secure juvenile justice residential placement (NSP and LSP, respectively) programs. The primary responsibility of the Administration for Children's Services (ACS) and juvenile justice placement provider agencies ("provider agencies") is to protect the safety and security of the youth in care, staff, and communities. The purpose of this policy is to maintain contraband-free programs throughout the juvenile justice placement system by preventing contraband from coming into the program and minimizing access to contraband within the program.

II. Policy

It is the policy of ACS that all items and materials deemed contraband shall be controlled and made inaccessible to youth in juvenile justice placement. Each provider agency shall develop, implement, and enforce operational procedures that detect and control the introduction, fabrication, possession, and conveyance of contraband within its programs. Each facility shall have a secure location for storing contraband. Consistent with existing ACS policies regarding personal and facility searches, staff shall conduct periodic searches for contraband. Staff training curriculum shall include lessons on the items that constitute contraband; control of contraband; confiscation of contraband; and notification/ documentation procedures following the discovery of contraband.

III. Definitions

A. Contraband is defined to include:

1. **Illegal items**: Those articles, the possession of which is prohibited under any law applicable to the general public;
2. **Potential injury causing items**: Those articles, which are readily capable of being used to cause injury including, but not limited to, firearms, cartridges, knives, razor blades, explosives, and/or sharpened objects;
3. **Prescription medication or over-the-counter medication**: Prescription medications that are not lawfully issued to the bearer or over-the-counter (OTC) medications that are not authorized for or issued to the bearer;
4. **Illegal substances/drugs** and any drug paraphernalia;
5. **Unauthorized items** including, but not limited to:
   a. Alcohol or alcoholic beverages
   b. Tobacco products (e.g., cigarettes, chewing tobacco, electronic cigarettes)
   c. Hazardous materials (e.g., gasoline, poisons, unapproved cleaning fluids, acids, potentially explosive substances)
   d. Pornographic materials
   e. Needles
   f. Mace or pepper spray
   g. Matches or lighters

   h. Cell phones
   i. Money, credit cards, or checks
   j. Electronic devices
   k. Keys
   l. Any other item that is prohibited by the regulations and policies of ACS and/or the rules of the individual facility.[1]

B. Secure Location: A locked storage box or similar locked receptacle in a secured area.

IV. Confiscation, Storage, and Chain of Custody

A. Staff shall immediately confiscate all contraband found in the possession of youth that can be safely handled and move it to a secure location.

B. Facility staff may not move contraband that cannot be safely handled or moved (e.g., potentially explosive devices); rather, staff shall notify appropriate emergency authorities to handle and dispose of this contraband.

C. The number of staff members handling contraband shall be restricted to as few as possible as authorized by the facility director or designee.

D. Vouchering

   1. Provider agencies shall voucher all contraband found. Each voucher shall contain the following information, and staff shall provide a copy of the voucher to the youth unless doing so would compromise an investigation.

      a. Youth's name, address, date of birth
      b. Youth's date of admission
      c. Detailed description of each item
      d. Detailed description of where and how the contraband was found
      e. Provider staff member's name and signature who first discovered the contraband
      f. Date the voucher was completed and signed

   2. After seizing contraband that can be safely moved, the staff member must place it in a contraband envelope or other container that can be locked or sealed, along with a copy of an Incident Report (Attachment B or C) that includes a description of the time, manner, and location of the seizure. The staff member shall then seal and sign the envelope or other container and move it to the designated secure location.

[1] Each provider agency shall develop a listing of permissible items which must be approved by ACS.

3. All illegal Items shall be turned over to local law enforcement authorities; these include weapons of any type or illegal drugs. Staff shall move such items to the designated secure location until they can be retrieved by law enforcement. In the event that a law enforcement official refuses to take items, staff shall note the name and badge number of the official and the instructions received in the Searches for Contraband Log (Attachment A).

4. It is critical that provider agencies maintain a clear chain of custody for each contraband item that will be turned over to local law enforcement. The provider shall include a chain of custody procedure within its agency contraband policy that articulates the vouchering process, as well as the process for when the item(s) exchange custody both within the facility and when they are turned over to local law enforcement.

5. Subject to number 6 below, unauthorized items shall be properly inventoried, recorded, and signed for by the youth and shall be:

   a. Returned to the youth upon release from the program or facility; or
   b. Retrieved by the youth's parent, guardian, or other discharge resource as permitted by the facility director; or
   c. Discarded if perishable or a potential health hazard; or
   d. Discarded or donated if unclaimed after a period of 30 days following the youth's release.[2]

6. Contraband being held as evidence in an investigation may not be returned to the individual from whom it was confiscated until the investigation has concluded. If the youth has not yet been released, the contraband may be retrieved by a parent/guardian/other discharge resource or held until the youth's release from residential placement.

V. Notification

A. All provider agencies shall post a list of prohibited items and contraband on the wall in all living units, as well as at the facility entrance for visitors to see.

B. Provider staff must notify the shift supervisor (and anyone else deemed appropriate by the facility director or designee) following the discovery of contraband and shall document the names of the persons receiving such notification in the Searches for Contraband Log.

C. Provider agencies are required to report contraband retrieval to the Division of

[2] The provider shall make best efforts to notify the youth's parent/guardian/other discharge resource prior to discarding or donating any items.

Youth and Family Justice ("DYFJ") Movement Communication and Control Unit ("MCCU") in accordance with the *Reporting of Incidents for Juvenile Justice Placement and Aftercare* policy.

D. If the contraband is an illegal item, the provider must promptly notify proper law enforcement authorities and document the names of the persons receiving such notification in the Searches for Contraband Log.

E. If the contraband is an illegal item, and the person found to be in possession of such contraband is an NSP or LSP employee[3], the proper law enforcement authorities and ACS shall be immediately notified, and the names of the persons receiving such notification shall be documented in the Facility Activity/Communication Log. The provider shall also follow internal staff disciplinary procedures.

F. If the contraband is an illegal item, and the person found to be in possession of such contraband is a visitor to the facility, staff shall immediately end the visit, notify the proper law enforcement authorities and ACS, and document the names of the persons receiving such notification in the Facility/Activity Communication Log.

VI. Documentation

A. All contraband items discovered must be recorded in the Searches for Contraband Log (Attachment A) by the supervisor on duty. If no contraband is found, the supervisor shall document that in the Log.

B. Following confiscation of contraband, staff shall provide the youth with a copy of the voucher.

C. When releasing illegal items to law enforcement officials, the supervisor on duty shall request that the law enforcement official sign the Searches for Contraband Log to verify receipt.

D. The staff member(s) who discovered the contraband must fill out and submit an Incident Report form.

E. The provider must document the discovery of contraband and provide a description of the steps taken to confiscate the items. These details must be documented in CONNECTIONS.

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[3] An employee shall not be considered to be in "possession" of the contraband he or she has confiscated so long as the employee follows the procedures set forth in this policy.

NYC – ACS OFFICE OF YOUTH AND FAMILY DEVELOPMENT
JUVENILE JUSTICE PLACEMENT SEARCHES FOR CONTRABAND LOG

Dates Logged: ____________________
Provider Agency and Facility Name: ____
Facility Address: ____

Date of Search	Circle Shift of Search	Area of Search	Circle Contraband Found	List Specific Type of Contraband Found If None Found, List "None" If Money Found, Indicate Amount	Circle Category of Search	Circle Type of Search (Circle all that apply)	Name of Staff who Conducted the Search	Name and Signature of Staff who Found Contraband	If contraband was found, what did the staff do with the contraband?	Voucher #	Signature of Supervisor on Duty During the Search
	AM PM NIGHT		Weapon Drugs Security Risk Item Unauthorized Property		Scheduled Unscheduled	Living Area Pat Frisk Security Search Strip Search*					
	AM PM NIGHT		Weapon Drugs Security Risk Item Unauthorized Property		Scheduled Unscheduled	Living Area Pat Frisk Security Search Strip Search*					
	AM PM NIGHT		Weapon Drugs Security Risk Item Unauthorized Property		Scheduled Unscheduled	Living Area Pat Frisk Security Search Strip Search*					
	AM PM NIGHT		Weapon Drugs Security Risk Item Unauthorized Property		Scheduled Unscheduled	Living Area Pat Frisk Security Search Strip Search*					
	AM PM NIGHT		Weapon Drugs Security Risk Item Unauthorized Property		Scheduled Unscheduled	Living Area Pat Frisk Security Search Strip Search*					
	AM PM NIGHT		Weapon Drugs Security Risk Item Unauthorized Property		Scheduled Unscheduled	Living Area Pat Frisk Security Search Strip Search*					
Page Totals	**AM=** **PM=** **NIGHT=**		**W=** **D=** **SRI=** **UP=**		**S=** **U=**						

Signature of Facility Director: ______________________________ **Date:** ____________________ **Page Number:** ____________

*LSP only

Attachment B

NYC - ACS DIVISION OF YOUTH AND FAMILY JUSTICE
NON-SECURE PLACEMENT INCIDENT REPORT

***Print or Type all Information** (must complete entire form – including a Physical Restraint Form for each youth that was restrained)*

All ORIGINAL Incident Reports are to be forwarded to the NSP Facility Director or designee. All immediately reportable incidents must be called into MCCU within one (1) hour of occurrence. All reportable incidents must be called into MCCU by the end of the shift the incident occurred.

Full Name of Report Writer: ____ Title: ___________________________________

Incident Date: ___/___/____ Time: _______ (AM/PM) MCCU Incident Report #:________________ Time Reported to MCCU: ______

NSP Provider Agency and Facility Name: ____

Location: ________________________ Sub-location: ______________________________ Location Detail: ______________________

Staff involved (use full names, titles, and role): ____

____

Witnesses (use full names, titles, and indicate if youth, staff, or other): ____

____

Youth's Name: _____________________________ Role in Incident: [ ] Victim [ ] Aggressor [ ] Subject

Mental Health Referral [ ] Yes [ ] No Medical Referral [ ] Yes [ ] No Was youth restrained? [ ] Yes [ ] No If yes, complete Physical Restraint Form

Was a Youth Debriefing completed? [ ] Yes [ ] No Date: _____/_____/_____ Time: ________ AM/PM Staff Name: ______________________

If injury, indicate type: [ ] Type A [ ] Type B Indicate cause of injury: [ ] Incident [ ] Restraint [ ] Escape/Escort
If additional injury, indicate type: [ ] Type A [ ] Type B Indicate cause of injury: [ ] Incident [ ] Restraint [ ] Escape/Escort
If additional injury, indicate type: [ ] Type A [ ] Type B Indicate cause of injury: [ ] Incident [ ] Restraint [ ] Escape/Escort

---

Youth's Name: _____________________________ Role in Incident: [ ] Victim [ ] Aggressor [ ] Subject

Mental Health Referral [ ] Yes [ ] No Medical Referral [ ] Yes [ ] No Was youth restrained? [ ] Yes [ ]No If yes, complete Physical Restraint Form

Was a Youth Debriefing completed? [ ] Yes [ ] No Date: _____/_____/_____ Time: ________ AM/PM Staff Name: ______________________

If injury, indicate type: [ ] Type A [ ] Type B Indicate cause of injury: [ ] Incident [ ] Restraint [ ]Escape/Escort
If additional injury, indicate type: [ ] Type A [ ] Type B Indicate cause of injury: [ ] Incident [ ] Restraint [ ] Escape/Escort
If additional injury, indicate type: [ ] Type A [ ] Type B Indicate cause of injury: [ ] Incident [ ] Restraint [ ] Escape/Escort

---

Youth's Name: _____________________________ Role in Incident: [ ] Victim [ ] Aggressor [ ] Subject

Mental Health Referral [ ] Yes [ ] No Medical Referral [ ] Yes [ ] No Was youth restrained? [ ] Yes [ ] No If yes, complete Physical Restraint Form

Was a Youth Debriefing completed? [ ] Yes [ ] No Date: _____/_____/_____ Time: ________ AM/PM Staff Name: ______________________

If injury, indicate type: [ ] Type A [ ] Type B Indicate cause of injury: [ ] Incident [ ] Restraint [ ]Escape/Escort
If additional injury, indicate type: [ ] Type A [ ] Type B Indicate cause of injury: [ ] Incident [ ] Restraint [ ] Escape/Escort
If additional injury, indicate type: [ ] Type A [ ] Type B Indicate cause of injury: [ ] Incident [ ] Restraint [ ] Escape/Escort

[Attach additional documentation if identifying more than 3 youth participants]

AWOL [ ] Reported to Police Department: [ ] Yes [ ] No Precinct: ______ Reported to Parent/Guardian: [ ] Yes [ ] No

Reported to Family Court: [ ] Yes [ ] No Reported to OCFS: [ ] Yes [ ] No

CONTRABAND [ ] Search Type: _____________________ List Contraband Found in Incident Narrative

MANAGER REQUESTED EVENT [ ] Reason: ____

Incident Narrative: Provide a detailed chronological description of the incident. If an ESPI or TCI physical restraint was used, describe exactly youth and staff positioning. Provide an observation of youth and situation prior to the incident. Steps taken to de-escalate the situation must be included in the incident narrative.

____

____

____

____

____

Incident Narrative (continued):

____

Staff Signature/Title: ____ **Date Submitted:** ______/______/________

Supervisor's Follow-up Narrative: This must include any medical and/or mental health follow-up information if medical and/or mental health referrals were made.

____

Supervisor reviewed and initialed all the accompanying Physical Restraint Forms for each youth involved in a restraint: [ ] Yes [ ] No

Were facility activities canceled due to this incident? [ ] Yes [ ] No

Was a Staff Debriefing completed? [ ] Yes [ ] No Date: _____/_____/_______ Time: _______________ AM/PM
[If all staff involved in the incident did not participate in a staff debriefing – must explain in Supervisor's Follow-Up Narrative]

Was a Group Debriefing completed? [ ] Yes [ ] No Date: _____/_____/_______ Time: _______________ AM/PM

Debriefing By: [ ] Non-ACS Staff [ ] ACS Staff NAME: __________________________

Did the incident result in a child abuse allegation? [ ] Yes [ ] No
If Yes: Date Reported to SCR/VPCR: _____________ Accepted: [ ] Yes [ ] No
Indicate SCR/VPCR Number: ______________________ Party Accepting the Complaint: _______________________

Supervisor Signature/Title: ____ **Date:** ______/_____/_______

Physical Restraint Form

Complete this form for each youth that was restrained and attach it to the accompanying incident report form. ***[Staff only need to complete the Physical Restraint Form for each youth the staff restrained.]***

Name of Youth: ____ **Incident Number:** _________________________

Name of Staff(s) who administered the restraint: ____

____

[MCCU will need to know the specific ESPIs administered by each staff]

A. Was an escape technique used? [ ] Yes [ ] No If yes, check the technique(s) used:

[ ] Pivot and Parry [ ] Deflecting a Swing (TCI) [ ] Forearm Choke Escape [ ] Scribe a Circle [ ] Bite Release

[ ] Front Choke Escape [ ] Rear Choke Escape [ ] Little Finger Roll [ ] Two Handed Wrist Grab [ ] Hair Pull Assist (front and rear)

[ ] One Arm Grab Escape (TCI) [ ] Two Arm Grab Escape (TCI) [ ] One Arm Two Hands Grab Escape (TCI) [ ] Forearm Twist [ ] Bar Arm Choke Escape (TCI)

B. Was an escort technique used? [ ] Yes [ ] No If yes, check the technique(s) used:

[ ] Extended Arm Assist (Single Person) **[ ]** Multiple Person Extended Arm Assist **[ ]** Multiple Person Bicep Assist

C. Was an Emergency Safety Physical Intervention Used (ESPI)? [ ] Yes [ ] No (If yes, check the technique(s) used below:

Lower Level ESPIs:

[ ] Upper Torso Assist **Minutes in ESPI ___** [ ] Multiple Person Upper Torso Assist **Minutes in ESPI ___**

[ ] Cradle Assist (Single Person) **Minutes in ESPI ___** [ ] Cradle Assist to Seated/Kneeling Position **Minutes in ESPI ___**

[ ] Hook Transport and Assist to Seated /Kneeling Position **Minutes in ESPI ___** [ ] Standing Hold (TCI) **Minutes in ESP ___**

[ ] Breaking up a Fight (TCI) **Minutes in ESPI ___** [ ] Standing Hold (TCI) **Minutes in ESPI ___**

Higher Level ESPIs:

[ ] Upper Torso Assist to Seated/Kneeling Position **Minutes in ESPI ___** [ ] Side Assist **Minutes in ESPI ___**

[ ] Multiple – Person Seated/Kneeling Upper Torso Assist and Bicep Assist **Minutes in ESPI ___**

[ ] Multiple Person Supine Torso Assist **Minutes in ESPI ___** [ ] Sitting up from a Supine Position **Minutes in ESPI ___**

[ ] Supine – Seated Hold (TCI) **Minutes in ESPI ___** [ ] Small Child (TCI) **Minutes in ESPI ___**

Other Intervention Used – Provide Explanation:

____

____

____

Time Restraints Started: ____________________________ **Time Restraints Concluded:** _______________________ **Duration of Restraints:** _________

Reason for Restraint:

[ ] Youth presents a risk of physical injury to self or to others

[ ] Youth clearly indicates that the youth physical attempting to AWOL and represents a danger to self or others

If only one staff participated in the ESPI/TCI Intervention, describe the specific emergency circumstances in which this occurred:

____

____

Describe an additional details of the ESPI/TCI Intervention(s): ____

____

____

Was the parent notified about the ESPI/TCI Intervention(s)? [ ] Yes [ ] No If not, discuss why and document all efforts taken to notify the parent.

____

Staff Signature/Title: ____ **Date Submitted:** ______/______/________

Supervisor Initials: ________________ **Date Reviewed by Supervisor:** ______/______/________

Attachment C

NYC - ACS DIVISION OF YOUTH AND FAMILY JUSTICE
LIMITED SECURE PLACEMENT INCIDENT REPORT

Print or Type all Information ***(Complete entire form, including a Physical Restraint Form or a Mechanical Restraint Form for each youth restrained.)***

All ORIGINAL Incident Reports are to be forwarded to the LSP Facility Director or designee. All immediately reportable incidents must be called into MCCU within one (1) hour of occurrence. All reportable incidents must be called into MCCU by the end of the shift the incident occurred.

Full Name of Report Writer: ____ Title: ___________________________________

Incident Date: ___/___/____ Time: _______ (AM/PM) MCCU Incident Report #:________________ Time Reported to MCCU: ______

LSP Provider Agency and Facility Name: ____

Location: ________________________ Sub-location: ______________________________ Location Detail: ______________________

Staff involved **(use full names, titles, and role): ____**

____

Witnesses (use full names, titles, and indicate if youth, staff, or other): ____

____

Youth's Name: _____________________________ Role in Incident: [ ] Victim [ ] Aggressor [ ] Subject

Mental Health Referral [ ] Yes [ ] No Medical Referral [ ] Yes [ ] No Was youth restrained? [ ] Yes [ ] No If yes, complete Physical Restraint Form

Was a Youth Debriefing completed? [ ] Yes [ ] No Date: _____/_____/_____ Time: ________ AM/PM Staff Name: _______________________

If injury, indicate type: [ ] Type A [ ] Type B Indicate cause of injury: [ ] Incident [ ] Restraint [ ] Escape/Escort
If additional injury, indicate type: [ ] Type A [ ] Type B Indicate cause of injury: [ ] Incident [ ] Restraint [ ] Escape/Escort
If additional injury, indicate type: [ ] Type A [ ] Type B Indicate cause of injury: [ ] Incident [ ] Restraint [ ] Escape/Escort

Youth's Name: _____________________________ Role in Incident: [ ] Victim [ ] Aggressor [ ] Subject

Mental Health Referral [ ] Yes [ ] No Medical Referral [ ] Yes [ ] No Was youth restrained? [ ] Yes [ ]No If yes, complete Physical Restraint Form

Was a Youth Debriefing completed? [ ] Yes [ ] No Date: _____/_____/_____ Time: ________ AM/PM Staff Name: _______________________

If injury, indicate type: [ ] Type A [ ] Type B Indicate cause of injury: [ ] Incident [ ] Restraint [ ]Escape/Escort
If additional injury, indicate type: [ ] Type A [ ] Type B Indicate cause of injury: [ ] Incident [ ] Restraint [ ] Escape/Escort
If additional injury, indicate type: [ ] Type A [ ] Type B Indicate cause of injury: [ ] Incident [ ] Restraint [ ] Escape/Escort

Youth's Name: _____________________________ Role in Incident: [ ] Victim [ ] Aggressor [ ] Subject

Mental Health Referral [ ] Yes [ ] No Medical Referral [ ] Yes [ ] No Was youth restrained? [ ] Yes [ ] No If yes, complete Physical Restraint Form

Was a Youth Debriefing completed? [ ] Yes [ ] No Date: _____/_____/_____ Time: ________ AM/PM Staff Name: _______________________

If injury, indicate type: [ ] Type A [ ] Type B Indicate cause of injury: [ ] Incident [ ] Restraint [ ]Escape/Escort
If additional injury, indicate type: [ ] Type A [ ] Type B Indicate cause of injury: [ ] Incident [ ] Restraint [ ] Escape/Escort
If additional injury, indicate type: [ ] Type A [ ] Type B Indicate cause of injury: [ ] Incident [ ] Restraint [ ] Escape/Escort

[Attach additional documentation if identifying more than 3 youth participants]

AWOL [ ] Reported to Police Department: [ ] Yes [ ] No Precinct: ______ Reported to Parent/Guardian: [ ] Yes [ ] No

Reported to Family Court: [ ] Yes [ ] No Reported to OCFS: [ ] Yes [ ] No

CONTRABAND [ ] Search Type: _____________________ List Contraband Found in Incident Narrative

MANAGER REQUESTED EVENT [ ] Reason: ____

Incident Narrative: Provide a detailed chronological description of the incident. If an ESPI or TCI physical restraint was used, describe exactly youth and staff positioning. Provide an observation of youth and situation prior to the incident. Steps taken to de-escalate the situation must be included in the incident narrative.

____

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Incident Narrative (continued):

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____

Staff Signature/Title: ____ Date Submitted: ______/______/________

Supervisor's Follow-up Narrative: This must include any medical and/or mental health follow-up information if medical and/or mental health referrals were made.

____
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____

Supervisor reviewed/ initialed all the accompanying Physical Restraint or Mechanical Restraint Forms for each youth involved in a restraint:
[ ] Yes [ ] No

Were facility activities canceled due to this incident? [ ] Yes [ ] No

Was a Staff Debriefing completed? [ ] Yes [ ] No Date: _____/_____/_______ Time: ________________ AM/PM
[If all staff involved in the incident did not participate in a staff debriefing – must explain in Supervisor's Follow-Up Narrative]

Was a Group Debriefing completed? [ ] Yes [ ] No Date: _____/_____/_______ Time: ________________ AM/PM

Debriefing By: [ ] Non-ACS Staff [ ] ACS Staff NAME: ___________________________

Did the incident result in a child abuse allegation? [ ] Yes [ ] No
If Yes: Date Reported to SCR/VPCR: ______________ Accepted: [ ] Yes [ ] No
Indicate SCR/VPCR Number: _______________________ Party Accepting the Complaint: _______________________

Supervisor Signature/Title: ____ **Date:** _____/_____/_______

Physical Restraint Form

Complete this form for each youth that was restrained and attach it to the accompanying incident report form. ***[Staff only need to complete the Physical Restraint Form for each youth the staff restrained.]***

Name of Youth: ___________________________________ **Incident Number:** ______________________

Name(s) of Staff who administered the restraint: ____

____

[MCCU will need to know the specific ESPIs administered by each staff]

A. Was an escape technique used? [ ] Yes [ ] No If yes, check the technique(s) used:

[ ] Pivot and Parry
[ ] Deflecting a Swing (TCI)
[ ] Forearm Choke Escape
[ ] Scribe a Circle
[ ] Bite Release
[ ] Front Choke Escape
[ ] Rear Choke Escape
[ ] Little Finger Roll
[ ] Two Handed Wrist Grab
[ ] Hair Pull Assist (front and rear)
[ ] One Arm Grab Escape (TCI)
[ ] Two Arm Grab Escape (TCI)
[ ] One Arm Two Hands Grab Escape (TCI)
[ ] Forearm Twist
[ ] Bar Arm Choke Escape (TCI)

B. Was an escort technique used? [ ] Yes [ ] No If yes, check the technique(s) used:

[ ] Extended Arm Assist (Single Person) **[ ]** Multiple Person Extended Arm Assist **[ ]** Multiple Person Bicep Assist

C. Was an Emergency Safety Physical Intervention Used (ESPI)? [ ] Yes [ ] No (If yes, check the technique(s) used below:

Lower Level ESPIs:

[ ] Upper Torso Assist **Minutes in ESPI ___** [ ] Multiple Person Upper Torso Assist **Minutes in ESPI ___**

[ ] Cradle Assist (Single Person) **Minutes in ESPI ___** [ ] Cradle Assist to Seated/Kneeling Position **Minutes in ESPI ___**

[ ] Hook Transport and Assist to Seated /Kneeling Position **Minutes in ESPI ___** [ ] Standing Hold (TCI) **Minutes in ESP ___**

[ ] Breaking up a Fight (TCI) **Minutes in ESPI ___** [ ] Standing Hold (TCI) **Minutes in ESPI ___**

Higher Level ESPIs:

[ ] Upper Torso Assist to Seated/Kneeling Position **Minutes in ESPI ___** [ ] Side Assist **Minutes in ESPI ___**

[ ] Multiple – Person Seated/Kneeling Upper Torso Assist and Bicep Assist **Minutes in ESPI ___**

[ ] Multiple Person Supine Torso Assist **Minutes in ESPI ___** [ ] Sitting up from a Supine Position **Minutes in ESPI ___**

[ ] Supine – Seated Hold (TCI) **Minutes in ESPI ___** [ ] Small Child (TCI) **Minutes in ESPI ___**

Other Intervention Used – Provide Explanation:

____

____

____

Time Restraints Started: __________________________ **Time Restraints Concluded:** _____________________ **Duration of Restraints:** _________

Reason for Restraint:

[ ] Youth presents a risk of physical injury to self or to others

[ ] Youth clearly indicates that the youth physical attempting to AWOL

If only one staff participated in the ESPI/TCI Intervention, describe the specific emergency circumstances in which this occurred:

____

____

Describe an additional details of the ESPI/TCI Intervention(s): ____

____

____

Was the parent notified about the ESPI/TCI Intervention(s)? [ ] Yes [ ] No If not, discuss why and document all efforts taken to notify the parent.

____

Staff Signature/Title: ____ **Date Submitted:** ______/______/________

Supervisor Initials: ________________ **Date Reviewed by Supervisor:** ______/______/________

Mechanical Restraint Form

Complete this form for each youth that was mechanically restrained and attach it to the accompanying incident report form. ***[Staff only need to complete the Mechanical Restraint Form for each youth the staff restrained.]***

Name of Youth: ____ Incident Number: ________________________

Name(s) of Staff who applied the mechanical restraints: ____

____

Mechanical Restraints used: [ ] Handcuffs [ ] Foot Cuffs [ ] Flex-Cuffs

Time Mechanical Restraints Applied: ___________________________ Time Mechanical Restraints Removed: ____________________

Duration Mechanical Restraints Used: _________

Reason for Mechanical Restraints:

[ ] Youth presented a risk of physical injury to self or to others

[ ] Youth was attempting to AWOL

[ ] Transport ***(Parental notification not required)***

Describe any additional details of the Intervention(s):

____

____

____

Was the parent notified about the mechanical restraint? [ ] Yes [ ] No If not, discuss why and document all efforts taken to notify the parent.

____

____

Staff Signature/Title: ____ Date Submitted: ______/______/_________

Supervisor Initials: ________________ Date Reviewed by Supervisor: ______/______/______

LENGTH OF STAY PROTOCOL (UPDATED)

SUGGESTED FORMAT: ADMINISTRATIVE MEMO FROM DYFJ LEADERSHIP TO CTH STAFF & PROVIDER AGENCIES

Overview Statement

The number of youth placed in Close to Home (CTH) has steadily decreased over the past several years, yet their average length of stay has increased. A review of recent (2019) data revealed that the average length of stay in CTH placement was nearly 10 months or approximately 305 days. This is significantly longer than what was anticipated based on existing CTH business processes and planned timelines.

The Division of Youth & Family Justice (DYFJ) wants to ensure that youth do not spend more time in residential placement than is necessary to ensure public safety and maximize programmatic benefit to youth. Our overall goal is to safely align the duration of CTH placements with what the research shows produces the greatest benefit to youth and the community (see attached LOS Research Summary). With that in mind, ACS and provider agency staff must commit to:

1) A standard presumptive length of stay for youth;

2) Regular on-going communication between all stakeholders;

3) Active family engagement throughout the planning process;

4) Providing opportunities for youth to participate in normative community activities; and

5) Tracking the length of time youth spend in care and adherence to planned protocols.

1. **Within 48 hours of admission into a CTH facility, ACS and provider agency staff will provide youth and families a projected release date (in writing), based on a presumptive 6-month length of stay.** The initial CFS summary report will include the projected release date and assigned PPS worker's contact information. Additionally, , youth shall receive from the provider agency during orientation to the assigned facility a handbook which clearly outlines the presumptive length of stay and general behavioral expectations; and will be made aware that their behavior and skill attainment while in the program will directly impact their projected release date in both a positive and negative manner. *Guidance Regarding CTH Release Readiness and Impact on Projected Release Date* (attached) provides more information on release criteria and process details. Families will also receive this information via a family Handbook (or other written orientation materials) from the provider agency; they shall also be made aware that this general information will be available on the ACS/DYFJ website.

    A. The presumptive 6-month length of stay shall be applicable to ALL YOUTH assigned to Close to Home programming, regardless of docket length or placement classification (NSP or LSP), unless otherwise stated in the youth's dispositional order

    B. Cross-over youth and those young people with limited permanency options at intake shall also be provided a projected release date based on a presumptive 6-month length of stay. ACS and provider agencies shall work diligently to identify alternative permanency resources or feasible independent living opportunities for ALL CTH youth from the point of intake; no youth should remain in CTH placement solely because of permanency barriers. CTH providers must document diligent efforts to engage families,

foster care case planners and all others who have a role is establishing permanency for youth in care.

2. **Regular, on-going communication between youth, PPS and provider agency staff is integral in planning for a young person's successful transition from Close to Home residential programming to aftercare within the projected time frame.** ***Concurrent planning must be done by CTH provider, foster care agencies and PPS. However, if a foster care agency is involved the foster care case planner will take the lead for crossover youth.*** Progress relative to behavior and skill attainment and a youth's projected release date shall be discussed with youth every two weeks**;** documentation of these LOS Marker discussions must be maintained in *Connections*. PPS and program provider staff should engage in pre-meeting conversations via phone calls, emails, and face-to face or virtual conversations to determine areas of concentration and focus for upcoming meetings; and should use the *CTH Release Readiness Checklist* as a reference. CFS summary reports of all conferences shall include updates on program progress, permanency resources, and any impact on projected release date.

   The bi-weekly LOS Marker discussions will occur in two separate settings:

   a. Individualized, youth-specific discussions will occur during monthly treatment team meetings with program staff, youth and families; and

   b. Discussions will also occur during follow-up check-in meetings with youth facilitated by the assigned Placement and Permanency Specialist (PPS). Staff should use attached *Guiding Questions for LOS Check-In Meetings* (attached) document as a resource in facilitating these meetings.

3. **Family and other support resources must be actively engaged in discussions regarding youth progress in care and impact on Length of Stay. This engagement should begin during the initial Family Team Conference and continued at every treatment conference thereafter.** All potential permanency resources should be included in these discussions. If young person is a crossover youth, his/her assigned foster care agencies must be included in these meetings, as well.

4. **Successful community reintegration is a priority; and all CTH youth must be provided with opportunities to participate in neighborhood-based activities while in residential care.** Such opportunities may include community field trips, day visits (supervised and unsupervised), participation in community-based education and/or youth development programming, independent travel, overnight home passes (including extended home passes). Staff must develop the necessary supports to assist young people through particular challenges they may experience in such activities.

5. **Promoting Adherence to Length of Stay Protocol**

   PPS Directors will be responsible for the on-going monitoring of all elements of the protocol outlined here within, including documentation of bi-weekly meetings, youth behavioral progress, challenges and strategies to overcome such challenges.

Guidance Regarding Close To Home Release Readiness and Impact on Projected Release Date

Establishing a projected release date at intake, based on a six-month presumptive length of stay, is fundamental to a youth's safe transition from Close to Home Residential Care to the community (on aftercare) six months from the date of disposition if he/she is determined to be "ready for release". The actual release date, however, is flexible and dependent on several factors.

RELEASE CRITERIA

Release determinations shall be based on behavior while in placement, academic progress made and/or effort demonstrated, a youth's mastery of pro-social skills, progress and efforts made towards goal achievement, and successful participation in pro-social and community-based activities.

Challenges that could potentially impact the projected release date should be identified as early as possible during youth's residential stay. Strategies for addressing identified challenges should be discussed regularly, and at all treatment meetings and conferences with youth and families. Such barriers may include youth safety, family dynamics, health/mental health conditions, independent living and employment/vocational opportunities (if appropriate), and other factors not directly related to a youth's actions. Strategies to overcome such challenges must be developed and documented in Connections.

The above factors, specific to the individual youth, as well as ancillary external factors, shall be assessed regularly by both PPS and CTH provider agency staff utilizing objective standardized tools, including the YLS and the *CTH Release Readiness Checklist* (completed monthly). *See attached*.

EARLY RELEASE TO AFTERCARE

Based on assessment results and with the recommendations of the contracted CTH provider agency, with endorsement from assigned PPS, a petition for early release to aftercare, sooner than the projected release date, can be made on behalf of a youth. Such petition requires a formal narrative report prepared by CTH staff containing the rationale for early release to aftercare; a description of exceptional progress in youth's behavior, academics, pro-social skills, personal goals achievement, and successful participation in community-based activities.

The narrative report must also speak to an absence of any major behavioral incidents and barriers to release (based on completed checklist). Additionally, the report must contain a personal statement from the youth directly to CTH leadership explaining why they believe early release to aftercare is appropriate.

Completed early release requests will be submitted on behalf of the youth to Associate Commissioner for CTH, or their designee, who will make the final determination as to whether or not the youth will be approved for release to aftercare prior to projected release date.

A youth must be in care for a minimum of 90 days before petitioning for early release. Release decisions must be made within seven days of presentation to leadership and will be communicated in writing to the young person and his/her permanency resource. All early release decisions are considered final.

When a decision is made to release a youth early, the provider agency will have up to 30 days (from the date of decision) to release the youth to aftercare. Youth must continue to make positive progress during the release planning period, however; the planned release can be delayed if youth displays serious behavioral concerns or other significant release challenges arise. The decision to suspend the early release plan must be provided in writing to youth and permanency resource and documented in Connections.

A youth can re-petition after 30 days of receiving a negative release decision.

EXTENSION OF PROJECTED RELEASE DATE

Contracted CTH provider agencies may submit a recommendation to extend a youth's projected release date beyond the 6-month presumptive length of stay to appropriate PPS Director. Such a recommendation requires a formal narrative report detailing specific concerns and/or examples of behaviors which demonstrate the young person has not made significant progress toward the achievement of behavior and skill attainment goals.

The lack of supports or access to resources necessary to work through barriers to successful transition should also be highlighted in a recommendation to extend care. However, neither parent refusal nor lack of other permanency resource shall be considered sufficient rationale to extend a youth's time in care beyond projected release date.

Any recommendation to extend a youth's time in CTH residential programming beyond eight months must be presented to CTH leadership for approval.

CLOSE TO HOME
RELEASE READINESS CHECKLIST

YOUTH NAME: ____ YOUTH DOB:_____________

CASE/ ID #:_________________________ LENGTH OF DOCKET:___________ DATE OF LAST YLS:_____________

PLACEMENT PROVIDER AGENCY (OR AGENCIES): ____

TYPE OF PLACEMENT(S) NSP LSP HAS YOUTH BEEN IN CTH PREVIOUSLY? YES NO

CURRENT PLACEMENT ADMISSION DATE: _______________________ DATE OF RELEASE: __________________

Has an individualized youth treatment plan, based on strengths and needs, been developed in partnership with relevant stakeholders? YES NO

Are there clearly defined goals for re-entry included in the youth's case plan?

Educational goals:	YES	NO	NA
Career goals:	YES	NO	NA
Health/Mental Health/	YES	NO	NA
Substance Abuse Treatment goals:	YES	NO	NA
Family & Relationship goals:	YES	NO	NA
Vocational/Employment goals	YES	NO	NA
Other goals:	YES	NO	NA

What has been done to prepare youth to meet their personal re-entry goals? *Check all that apply*

___Comprehensive Permanency Planning

- __Regular communication with family
- __ Active family involvement in conferencing and other activities
- __Identified permanency resources
- __ Permanency plan in place
- __ Other:

___School Transitional Planning

__ Improved Academic Progress

__ Participation in Tutoring/Educational Support Services, if needed

__ Identified “home” school for return

__ Other:

___ Continuity of Health/Mental Health Services

__ Participation in therapeutic interventions

__ Taking prescribed medications regularly

__ Development of Relapse/Re-offense Plan

__Medicaid Coverage enrollment, if appropriate

__ Referrals to clinical services

__ Other:

__ Access to Personal Vital Documents

___ Participation in Positive Youth Development Activities

__Engaged in recreational activities

__Workforce Development Workshops/Employment Participation

__ Demonstration of mastery of Pro-Social Life Skills

__ Acknowledgment of Individual Successes/Achievements

__ Other:

___Linkage to Community-Based Resources

__Spiritual/Religious Connections

__Volunteer/Community Service Programming

__Connected to an Adult Mentor

__Other:

What, if any, barriers to meeting re-entry goals exist? *Check all that apply*

__Goals not clearly defined in planning document

__Case Plan Incomplete

__ Limited Permanency Options

__ Limited availability of Transitional Independent Living Program, if necessary

__Irregularity in Scheduling/Facilitation of Conferences

__ No Relapse/Re-Offense Plan

__Lack of Family Participation

__Existing Orders of Protection

__Scheduling Conflicts

__Cultural Differences

__Fractured Relationships

__Current Family Crisis

__Developmental Difficulties of Parent/Guardian

__On-going court matters:

__ Youth Behavioral Concerns

__Re-arrest
__AWOCs
__Reportable incidents
__ Frequent demonstration of poor decision-making
__ Other:

__Recent substance abuse
__ Negative Peer Relations and/or Gang Involvement
__ Limited Resources for Wrap-around Services
__ Poor Youth Engagement in Service Planning
__ Personal Safety Concerns:
__ Other:

Other Notable Information:

Guiding Questions for Length of Stay Check-In Meetings

- What, if any, positive changes do you see in yourself since you have been in placement/since we last spoke?

- What skills have you developed and how do you think they may be useful as you transition back home? Are there other skills that you want to develop/further develop?

- How would you describe your academic progress? What are your goals while in care and upon returning to the community? Do you have any specific concerns about your school performance?

- Are there things you are struggling with? What are the biggest challenges you are facing in placement? What support/assistance/opportunities do you think you need to overcome these challenges?

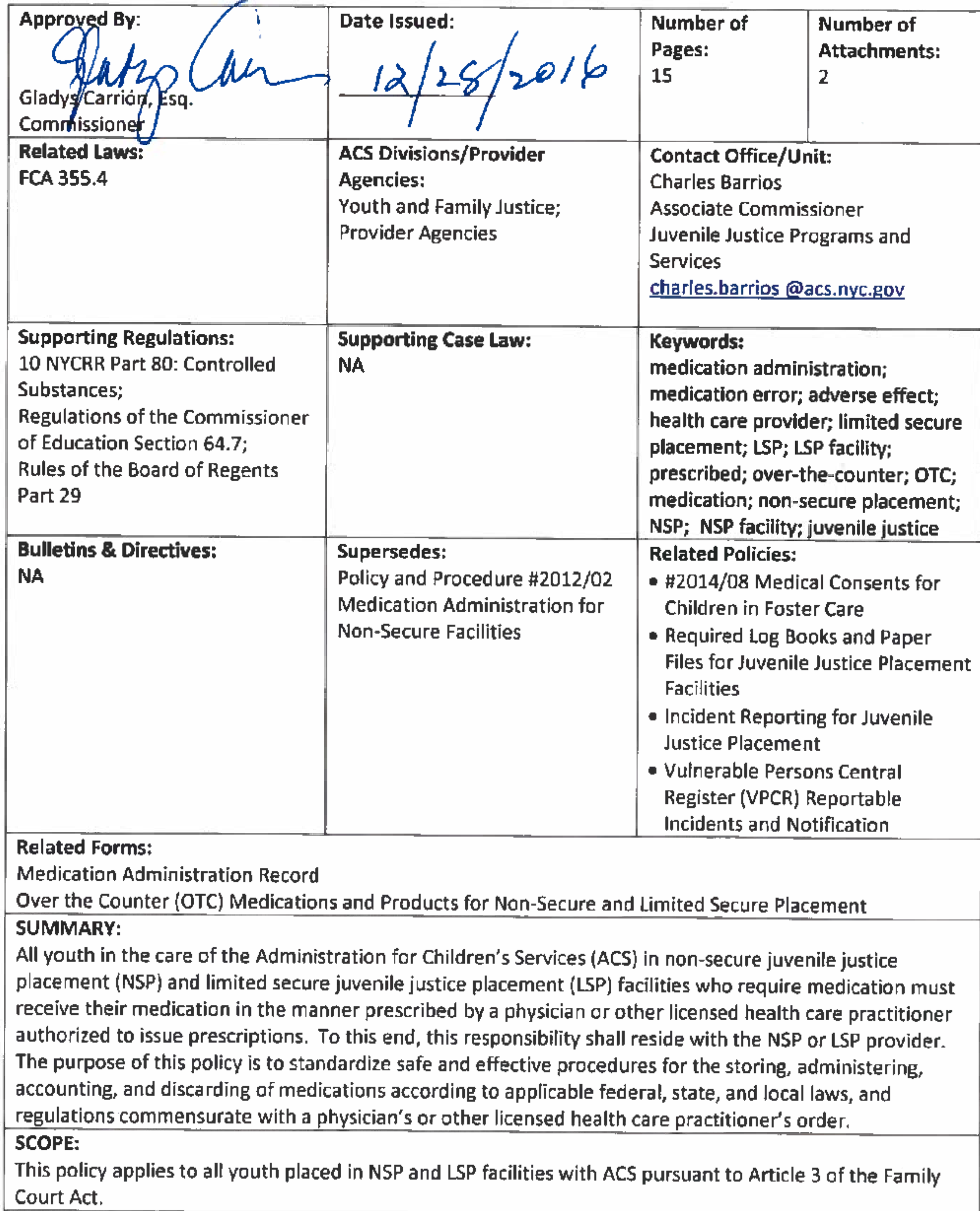
- Describe your permanency plan. Where will you be going after placement? Are you in regular communication with your permanency resource? Have there been any challenges or changes in relationship dynamics? Do you have other support resources whom you stay connected to?

- What specific activities and/or resources would you like to participate in while on aftercare and why?

The City of New York
Administration for Children's Services

Policy and Procedure
2016/11

Medication Administration in Juvenile Justice Placement



Approved By: [signature] Gladys Carrión, Esq. Commissioner	**Date Issued:** 12/28/2016	**Number of Pages:** 15	**Number of Attachments:** 2
Related Laws: **FCA 355.4**	**ACS Divisions/Provider Agencies:** Youth and Family Justice; Provider Agencies	**Contact Office/Unit:** Charles Barrios Associate Commissioner Juvenile Justice Programs and Services charles.barrios @acs.nyc.gov	
Supporting Regulations: 10 NYCRR Part 80: Controlled Substances; Regulations of the Commissioner of Education Section 64.7; Rules of the Board of Regents Part 29	**Supporting Case Law:** **NA**	**Keywords:** **medication administration; medication error; adverse effect; health care provider; limited secure placement; LSP; LSP facility; prescribed; over-the-counter; OTC; medication; non-secure placement; NSP; NSP facility; juvenile justice**	
Bulletins & Directives: **NA**	**Supersedes:** Policy and Procedure #2012/02 Medication Administration for Non-Secure Facilities	**Related Policies:** • #2014/08 Medical Consents for Children in Foster Care • Required Log Books and Paper Files for Juvenile Justice Placement Facilities • Incident Reporting for Juvenile Justice Placement • Vulnerable Persons Central Register (VPCR) Reportable Incidents and Notification	

Related Forms:
Medication Administration Record
Over the Counter (OTC) Medications and Products for Non-Secure and Limited Secure Placement

SUMMARY:
All youth in the care of the Administration for Children's Services (ACS) in non-secure juvenile justice placement (NSP) and limited secure juvenile justice placement (LSP) facilities who require medication must receive their medication in the manner prescribed by a physician or other licensed health care practitioner authorized to issue prescriptions. To this end, this responsibility shall reside with the NSP or LSP provider. The purpose of this policy is to standardize safe and effective procedures for the storing, administering, accounting, and discarding of medications according to applicable federal, state, and local laws, and regulations commensurate with a physician's or other licensed health care practitioner's order.

SCOPE:
This policy applies to all youth placed in NSP and LSP facilities with ACS pursuant to Article 3 of the Family Court Act.

Table of Contents

I. INTRODUCTION **3**
II. DEFINITIONS **3**
III. POLICY AND PROCEDURE **4**

A. PRESCRIBED MEDICATIONS 4
B. CONTINUITY OF MEDICATION 4
C. SELF-ADMINISTRATION OF MEDICATION 5
D. PHOTOGRAPHING YOUTH AND USE OF PHOTOGRAPHS 6
E. CONSENT 6
F. ADMINISTRATION AND SUPERVISED SELF-ADMINISTRATION OF PRESCRIBED MEDICATIONS 6
G. OVER -THE-COUNTER (OTC) MEDICATIONS 8
H. RECORDING THE ADMINISTRATION AND SELF-ADMINISTRATION OF ALL MEDICATIONS 9
I. YOUTH TRAINING 10
J. DAILY INVENTORY BY STAFF 10
K. DELIVERY AND RECEIPT OF MEDICATIONS FROM A PHARMACY 11
L. TRANSFER OF MEDICATIONS BETWEEN JUVENILE JUSTICE FACILITIES 12
M. MEDICATION FOR YOUTH ON TRIPS, HOME VISITS, AND COURT APPOINTMENTS 12
N. MEDICATION STORAGE 13
O. DISPOSAL OF MEDICATION 14
P. MEDICATION ERRORS AND DRUG REACTIONS 14
Q. ALLERGIC OR ADVERSE REACTIONS TO MEDICATION 14
R. EPINEPHRINE AND OTHER EMERGENCY MEDICATIONS 15
S. MEDICATION REFUSAL 15

I. Introduction

A. The following policy was developed for use in the non-secure placement (NSP) and limited secure placement (LSP) systems of the New York City (NYC) Administration for Children's Services (ACS), the spirit of which rests firmly on the premise that youth placed in residential settings shall be placed in programs that are close to home, and for only as long as is necessary to maintain public safety and impart the skills and tools each youth needs to succeed in the community. All juvenile justice placement settings are to prioritize youth-centered programming and strive to provide youth with the full range of individual supports they need to achieve their treatment goals. Like the youth in NSP and LSP programs, families are to be treated with utmost dignity and respect, and shall be integrated into programming and treatment as full partners throughout the period of each youth's placement and aftercare. Communities and the natural resources they possess are to be valued and relied upon as part of the formula for success in each case. The primary responsibility of all those associated with the juvenile justice placement system is to protect the safety and security of communities, and the safety and security of the youth in placement.

B. All youth in the care of ACS in NSP and LSP facilities who require medication must receive their medication in the manner prescribed by a physician or other licensed health care practitioner authorized to issue prescriptions (hereafter, "prescriber"). To this end, this responsibility shall reside with the NSP or LSP provider. The purpose of this policy is to standardize safe and effective procedures for the storing, administering, accounting, and discarding of medications according to applicable federal, state, and local laws, and regulations commensurate with a physician's or other licensed health care practitioner's order.

II. Definitions

A. Cheeking - Pretending to swallow medication, but actually hiding it between the gum and the cheek or under the tongue.

B. Direct Care Staff - NSP and LSP non-medical staff members providing care to youth in NSP or LSP facilities.

C. Epinephrine Auto-Injector - A pre-filled syringe containing a single injectable dose of the stimulant to be used as an emergency measure for the treatment of severe respiratory distress resulting from an allergic reaction.

D. Medical Staff Member (aka licensed health care practitioner) - A physician, physician assistant, nurse practitioner, licensed practical nurse, dentist, or registered nurse employed by the NSP or LSP provider to provide health care services to youth in NSP or LSP facilities.

E. Medication Administration - The process by which a single dose of medicine is provided by medical staff members to and taken by a patient.

F. Medication Error - Occurs whenever prescribed or over-the-counter (OTC) medication is administered inconsistently with a prescription or order issued for a youth by a qualified licensed health care practitioner. Medication errors include, but are not limited to, incorrect dosages, unauthorized dosages, medication that is contraindicated, and medication administered to the wrong youth.

G. Over-the-Counter (OTC) Medications - Medications or products that may be purchased without a prescription, such as Tylenol. OTC medications cannot be given to a youth in NSP or LSP without an order or a standing order from a licensed prescribing health care practitioner.[1]

H. Prescription Medications - Medications that can only be obtained with a written dispensing order from a physician or other licensed health care practitioner authorized to issue prescriptions.

I. Standing Orders – A pre-written medication order and specific instructions from the licensed health care practitioner to administer a medication to a person in clearly defined circumstances.

J. Supervised Self-Administration of Medication - The act of a youth taking or applying his or her own medication under the supervision of an NSP or LSP trained direct care staff members.

III. Policy and Procedure

A. Prescribed Medications

Medications shall be prescribed only by a physician or licensed health care practitioner authorized to issue prescriptions following a medical examination of the youth, and administered according to directions on labels of prescriptions issued by a physician or licensed health care practitioner. Prescribed medications supplied for one youth shall not be administered to another youth.

B. Continuity of Medication

1. NSP and LSP provider staff shall collaborate with ACS Detention and Intake and Assessment staff to confirm any medications currently prescribed and administered at the time of the youth’s transfer from Detention to NSP or LSP facilities, or between NSP and LSP facilities.

[1] See Section III. G. 5.

2. Each NSP or LSP provider shall designate trained direct care staff to transport and transfer the youth's medications and prescriptions to the NSP and LSP provider site locations during transport of the youth.

3. Upon arrival at the NSP and LSP provider site, medical staff members at an NSP or LSP facility shall review each youth's Health Services records containing screening and assessments conducted prior to the applicable youth's transfer to the NSP or LSP facility; such screening and assessments are conducted by a secure facility, a provider of non-secure detention services, or other residential services.

4. Medical staff members shall verify that the comprehensive health screening and update of the youth contains an assessment of previous treatment, including whether such treatment included medication for any illness or health condition, whether the youth had any mental health conditions, and whether medication was taken on a regular or as-needed basis if such medication was part of the treatment.

C. Self-Administration of Medication

1. Note: Only medical staff may administer medications to youth.

2. Each NSP or LSP provider shall designate trained direct care staff members to supervise the self-administration of medications by youth when there are no medical staff members at the facility, and only those designated trained direct care staff members may supervise the self-administration of medications by youth.

3. Medical staff members shall remain accessible to all direct care staff via phone call and/or email for consultation and additional guidance in the self-administration of medication by youth and/or issues concerning medication errors.

4. Direct care staff must receive training before they may supervise the self-administration of medications by youth. Training shall include a review of the medication administration protocols and procedures. This review shall include how to maintain and update a youth's Medication Administration Record (MAR) [Attachment A] when medication is self-administered by a youth, expectations regarding the MAR, communication between direct care staff and medical staff members, procedures for verifying youth identities prior to supervising the self-administration of medication, and methods for reinforcing medication training (e.g., refresher courses, unit meetings, team meetings, and supervision).

5. **Note: Medication training programs for provider agency staff must be approved by ACS.**

D. Photographing Youth and Use of Photographs

1. Direct care or medical staff members shall take two (2) photographs of each youth upon admission to the facility. The photographs must depict the youth's face, head, and shoulders, and may not depict a full body image. Staff shall take updated photographs if the youth's appearance changes. One (1) photograph shall be maintained with the youth's health record, and the second photograph shall be attached to the youth's MAR.

2. Each time a youth is given medication, the medical staff members administering the medication or the trained direct care staff member supervising the self-administration of the medication shall compare the youth to his or her photograph.

E. Consent

1. In accordance with federal, state and local laws, regulations, and policies, and ACS Policy and Procedure #2014/08, *Medical Consents for Children in Foster Care*, informed consent for medications prescribed for anything other than routine medical, dental, and mental health services and treatment must first be sought from a youth's parent or caretaker, unless the parent's rights have been terminated or surrendered. Routine mental health treatment shall not include the administration of psychiatric medication unless it is part of an ongoing mental health plan or otherwise authorized by law.

2. Exceptions

    a. Youth may provide consent in matters regarding their own sexual and reproductive health. For example, consent from a parent or guardian is not required prior to prescribing any form of birth control or treatment for sexually transmitted infections (STIs). NSP and LSP providers must take appropriate measures to protect a youth's confidentiality in these instances.

    b. Youth who are 18 and older, youth who are married, and youth who are parents may consent for their own medical, dental, and health services.

F. Administration and Supervised Self-Administration of Prescribed Medications

1. Medical staff members administering prescribed medications and trained direct care staff supervising the self-administration of prescribed medications by youth shall follow the "Five Rights" of medication administration, which are as follows:

    a. Right Person: Verify that the picture of the youth on the MAR depicts the youth present to take the medication. The staff member must ask the youth to provide his or her full name and date of birth.

b. Right Medication: Verify that the medication to be administered matches the prescribed medication for the youth on the medication chart.

c. Right Dosage: Verify that the dosage on the chart matches the dosage on the prescription labels.

d. Right Route: Verify that the route method of administration or self-administration on the prescription bottle is the same as on the medication chart (e.g., by mouth or topical).

e. Right Time: Medications shall be administered or self-administered within the time ordered or within 60 minutes before or after the time designated.

2. All medical staff and trained direct care staff members must wash their hands and/or wear gloves prior to handling any medication, and must wear gloves when handling tablets or capsules.

3. Medical staff and trained direct care staff members shall read the medication's name, dosage, and interval from the MAR.

4. Medical staff and trained direct care staff members shall read the label on each package twice.

5. If the medication is a liquid suspension or emulsion, the medical staff or trained direct care staff must shake the bottle well before pouring a dose, unless otherwise directed by the prescribing physician or other prescriber. To pour a liquid, medical staff members shall hold the bottle with the label in the palm of the hand to avoid staining the label.

6. When measuring liquid medication using a medicine cup, medical staff or trained direct care staff shall place the medicine cup on a stable surface, observe at eye level, and mark the desired volume on the cup.

7. If the medications are to be used in the eye, the medical staff members must make every effort to avoid contact between the tip of the dropper or ointment tube and the youth's eye or surrounding area. The trained direct care staff member supervising the self-administration of a medication for the eyes must direct the youth to avoid contact between the tip of the dropper or ointment tube and the youth's eye or surrounding area. Each youth must have his or her own labeled dropper or tube, which shall be indicated on the MAR.

8. If the medications are packaged for external use (i.e., medications are applied to the skin, eyes, nose, or other mucous membranes), the medical staff members shall use

caution and wear gloves when applying such medications. The contents of these containers shall not be allowed to become contaminated. The containers shall be kept tightly closed when stored and disposed of appropriately prior to the expiration date.

9. The medical staff members administering the medication or the trained direct care staff member supervising the self-administration of medication shall remain with the youth until the medication has been fully administered (i.e., swallowed, topically applied, injected, or inhaled).

10. If a youth has a history of medication cheeking, a staff member shall ask the prescriber to determine if the medication prescribed to the youth allows for crushing and how to best administer or self-administer the medication in a crushed form without impacting the desired effect. If the prescriber determines that the medication may be crushed without losing its effectiveness, the staff member shall crush all of the youth's medications that have been determined to be medically appropriate to be crushed. The staff member shall also ask the prescriber if there is a liquid version of the medication that could be used instead.

11. Whenever medication that must be swallowed is administered or self-administered, medical staff members administering the medication or the trained direct care staff supervising the self-administration of medication shall ask the youth to open his or her mouth in order to check the youth's mouth to confirm the youth swallowed the medication and did not cheek it. This staff member must also ask the youth to lift his or her tongue in order to look under the youth's tongue.

G. Over-the-Counter (OTC) Medications

1. A standard supply of over-the-counter (OTC) medications and products shall be maintained under lock and key at each NSP and LSP facility (Attachment B).

2. When a licensed health care practitioner authorized to issue prescriptions orders the use of an OTC product, a medical staff member shall set up the MAR from the order indicating the date, time, youth's name, type of medication(s) administered, quantity of medication administered, and name and contact information of the prescribing licensed health care practitioner authorized to issue prescriptions. An NSP or LSP medical staff or a trained direct care staff member shall indicate the name of the staff administering or supervising the self-administration of the OTC medication.

3. Medical staff members shall administer or the trained direct care staff members shall supervise the self-administration of the OTC medication or product as the label on the medication or product describes, unless otherwise ordered by a licensed health care practitioner. A youth shall not handle the bottles, containers, and/or packaging of the OTC medication. The medical staff members shall administer the correct

dosage to each youth as directed. When there are no medical staff members on-site, a trained direct care staff member may supervise the self-administration of the OTC medication by the youth.

4. The medical staff member shall administer or the trained direct care staff member shall supervise the self-administration of the OTC medication or product only for the period directed. If a medical condition continues to exist and a trained direct care staff member supervised the self-administration of medication by youth, then the direct care staff member must contact a licensed health care practitioner for further instructions.

5. Rather than contacting a licensed health care practitioner multiple times (as in section 4 above), a staff member may do one of the following:

   a. Request that the licensed prescribing health care practitioner write initial standing orders for OTC medications (including dose, schedule, and target symptoms) that are specific to an individual youth. Such orders will only apply to that specific patient/youth. Then, every time that youth is given the medication, the licensed prescribing health care practitioner can be informed after the fact in order for the administering medical staff member to note it in the progress notes and sign the MAR; or

   b. Develop specific written protocols at intake for OTC medication, including doses, target symptoms, and symptom/response monitoring. A licensed prescribing health care practitioner must review and approve any such written protocols.

6. Twice a month, a designated staff member must check the locked medical cabinets and storage containers to confirm that adequate supplies of the OTC medications and products are present and that none of the medications have passed their expiration date.

H. Recording the Administration and Self-Administration of All Medications

1. The medical staff member administering any medication to a youth or the trained direct care staff member supervising the self-administration of medication by a youth must record the event on the MAR and initial the amount of medication administered or self-administered in the box on the MAR that corresponds to the time that the medication was given.

2. If, for any reason, a youth does not receive the medication (e.g., the youth refused or the medication is not in stock), the staff member must indicate the corresponding reason code as indicated in the instructions section of the MAR. All relevant boxes on the MAR shall be completed.

3. If a youth refuses medication for any reason, then the medical staff members administering the medication or the trained direct care staff member supervising the self-administration of the medication shall sign the form and note on the form that the youth refused the medication. The staff member shall document whether the refusal was prompted by a presenting complaint or whether the medication was part of the youth's treatment plan. A witness shall be present when this form is signed. The witness shall print his or her name and sign the form as well.

4. The staff member shall inform the prescriber that the medication was refused. The staff member shall inform the youth that the staff member must call the youth's parents/guardians to inform them of the youth's refusal to take the prescribed medication. Staff members shall document the youth's refusal to take the medication in the Facility Activity/Communication Log Book.[2]

I. Youth Training

NSP and LSP providers must verify that youth are able to administer their own medication. In the event a youth is unable to do so, a medical staff member shall provide training to the youth on how to administer his or her own medication. Staff members shall document whether a youth has been trained to self-administer medication on the MAR.

J. Daily Inventory by Staff

1. Staff members shall document and maintain an inventory of all medications administered to youth in the NSP or LSP facility.

2. Each day, a designated staff member shall count each remaining dosage of medication in the medication box that is in blister packaging. To facilitate the daily counting of medications, medical staff members shall request that pills be dispensed in blister packaging whenever feasible. Medication that is not dispensed in blister packaging shall be counted daily and handled accurately so that the medication does not become degraded from mishandling. For controlled substances, the pill count shall be witnessed by an additional staff member. Staff members shall record the remaining amount of each medication and their initials on a sheet or in a medication file that coincides with the MAR for each youth who is prescribed and is taking medication.

3. Staff members shall immediately report any discrepancy in the count to the facility director or his or her designee. The facility director or designee shall report the discrepancy to the Division of Youth and Family Justice (DYFJ) Movement

[2] See ACS Policy and Procedure *Required Log Books and Paper Files for Juvenile Justice Placement Facilities*.

Communication and Control Unit (MCCU). An incident report shall be written and submitted in accordance with ACS policy.[3]

K. Delivery and Receipt of Medications from a Pharmacy

1. All medications delivered to an NSP or LSP facility from a pharmacy when medical staff are on site must be received by medical staff members. When medical staff members are not on site, all medications delivered to an NSP or LSP facility from a pharmacy shall be received by trained direct care staff.

2. Medical staff members and trained direct care staff members who are accepting medications shall sign for receipt of the medications. The receipt must indicate the name of each medication and the amount of each medication received. This receipt must be maintained in a designated area located with or near the prescribed medication.

3. Prescribed medications delivered from pharmacies must have the youth's name and the prescriber's name and contact information on the label. This shall be verified by medical staff or trained direct care staff members.

4. Upon the receipt of prescribed medication, a medical staff member must check the label on the bottle or packaging to confirm that it includes the following information:

   a. The youth's name;
   b. The date the prescription was filled;
   c. The name of the medication;
   d. The dosage;
   e. The total dosages packaged;
   f. Instructions on when and how often to administer the medication;
   g. Special instructions, if applicable (e.g., take with food, take on empty stomach, shake well before using); and
   h. Warnings, if applicable (e.g., medication may cause constipation, headache, or other drug reactions).

5. Medical staff members shall immediately report any discrepancy in the labeling of medications to the facility director or his or her designee. The facility director or designee shall contact the pharmacy to address the discrepancy and to resolve it.[4]

6. When no medical staff members are on site, trained direct care staff must document in the Facility Activity/Communication Log Book that a prescription shipment was

[3] See ACS Policy and Procedure *Incident Reporting for Juvenile Justice Placement*.
[4] The facility director can designate medical staff to report discrepancies.

delivered and that the facility director and medical staff members have been informed of the delivery.

a. As soon as possible, staff shall appropriately secure the medications in a designated locked cabinet, refrigerator, or freezer, as appropriate, inaccessible to youth.

b. Trained direct care staff must inform medical staff members via phone call and/or email that a delivery was received. The delivery shall be recorded on a sheet or medication file for the medical staff members to review upon arrival to the facility.

L. <u>Transfer of Medications Between Juvenile Justice Facilities</u>

1. Prior to transport to another facility, medical staff members shall determine that the youth's health record is up to date and complete, including the MAR.

2. When a youth is transferred to another juvenile justice placement facility (e.g., a lateral transfer or transfers between NSP and LSP facilities),[5] a medical staff member shall place all of the youth's remaining medication, a prescription for 30 days of medication, and the youth's MAR in a sealed envelope, labeled or stamped "confidential," with a receipt. All medication must be in the original pharmacy containers or manufacturer packaging. The receipt must be signed and dated, including the time, by the medical staff member who seals the envelope. The medical staff member must provide the sealed envelope to the direct care staff member transporting the youth to the new facility.

3. A medical staff member at the transferring facility shall indicate on the MAR the date the medication was transferred and to whom from the receiving facility was the medication transferred.

M. <u>Medication for Youth on Trips, Home Visits, and Court Appointments</u>

1. Medical staff members shall administer medications as prescribed (within 60 minutes before or after the designated time) before youth go off-site on trips, home visits, or court appointments.

2. When a youth is on a home visit for more than a day or longer than the dosage time period and a prescribed medication is required, the following procedure shall be followed:

[5] See ACS Policy and Procedure, *Transfers in Juvenile Justice Placement*.

a. The medical staff members shall provide only the amount of medication necessary for the period of the home visit to the parent, legal guardian, or other person(s) approved for home visits. Medications in cream or liquid form shall be sent in their entirety with instructions and with the directive to return the entire medication at the end of the home visit.

b. The following information must be provided to the parent or guardian or other person(s) approved for home visits and shall include:

   i. The medication's purpose and possible side effects;
   ii. The method by which the youth must take the medication (e.g., swallowing tablets, whether the medication must be crushed, and the use of protective gloves with ointments);
   iii. The importance of giving medication at the prescribed time and its safe storage, including refrigeration as needed;
   iv. Instructions for returning unused medication to the facility; and
   v. The name and contact information for a staff member at the facility so that the parent/guardian can call if he or she has questions or concerns about how to administer the medication or about adverse reactions.

c. The parent, legal guardian, or other person(s) approved for home visits shall sign for the medication for each visit and a copy of the parent's or legal guardian's signature shall be maintained in the youth's health record.

3. Direct care staff members who accompany youth on off-site trips shall supervise the self-administration of medication by a youth if the youth must take his or her medication during the period away from the facility. Staff shall carry emergency medications for allergic reactions and asthma of those youth on off-site trips.

N. <u>Medication Storage</u>

1. All medications shall be stored in secure areas that are not accessible to youth, but are readily accessible to medical staff members for the administration of the medications or to trained direct care staff members who supervise the self-administration of medication by youth.

2. All medications, including controlled substances, shall be stored in double-locked storage containers or cabinets. Controlled substances shall be kept in stationary, double-locked cabinets. Both inner and outer cabinets shall have double key-locked doors with separate keys for each door.

3. Medication requiring refrigeration must be kept inside a locked box in a refrigerator that medical staff members use solely for the purpose of storing medications.

O. Disposal of Medication

1. Each facility shall have a documented process for the disposal of medication that is approved by a prescriber. The process for the destruction of controlled substances must comply with the New York State Department of Health's regulations and applicable federal, state, and city laws, rules and regulations. Medical staff members at each facility shall be responsible for the disposal of medication.

2. The disposal process for medications must include procedures for the disposal of outdated, spoiled, and contaminated medications.

P. Medication Errors and Drug Reactions

1. If a medication error and/or drug reaction occurs, a staff member must contact a medical staff member immediately in order to determine what, if any, treatment must be provided to the youth as a result of the medication error. If the staff member cannot reach the youth's physician or the treating physician affiliated with the NSP or LSP provider, the staff member must immediately contact emergency medical personnel or a poison control center (1-800-222-1222 or 212-POISONS [212-764-7667]) for assistance.

2. Staff members must immediately report medication errors and/or drug reactions to the facility director or designee and shall record the information in an incident report. Once a medication error and/or drug reaction is discovered, the event must be reported to MCCU within **one (1) hour** of the occurrence.

3. In addition, medication errors that result in an adverse effect on a youth shall be reported to the New York State Vulnerable Persons Central Register (VPCR).[6]

4. If a youth is not administered his or her medication by a staff member for a reason other than refusal, the staff member shall record the information in an incident report and report the incident to MCCU.

5. If a staff member cannot account for the youth's medication, the staff member shall record the information in an incident report and report the incident to MCCU.

Q. Allergic or Adverse Reactions to Medication

1. Direct care staff must consult with a medical staff member and contact emergency medical personnel immediately if a youth has an allergic or adverse reaction to medication. If the youth's physician or a physician affiliated with the NSP or LSP

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[6] See ACS Policy and Procedure *Vulnerable Persons Central Register (VPCR) Reportable Incidents and Notification*; see ACS Policy and Procedure *Incident Reporting in Juvenile Justice Placement*.

provider is unavailable for consultation, staff must contact emergency medical personnel.

2. The medical staff member must consult with a licensed prescribing health care practitioner immediately if a youth has an allergic or adverse reaction to medication.

3. Medical staff members administering medications must document all allergic or adverse reactions in the MAR.

R. Epinephrine and Other Emergency Medications

1. The NSP or LSP provider may maintain a supply of prescription medications for use in emergency situations, such as albuterol and other drugs that may be needed to respond to medical emergencies when there is a medical staff member on site. Medical staff members must review the expiration date of these medications twice a month.

2. Epinephrine shall be administered by medical staff members to youth or youth shall self-administer under the supervision of medical staff members or trained direct care staff. Trained designated direct care staff or medical staff members shall administer epinephrine if the youth is incapable of doing so. Designated trained direct care staff shall administer other, non-injectable emergency medications when the medication is prescribed by a physician or other licensed health care practitioner authorized to issue prescriptions and there is an accompanying order that is documented in the MAR.

3. Immediately following the use of epinephrine, direct care or medical staff members shall call 911 and the youth must be transported by ambulance to an emergency room. As soon as is practicable, provider agency staff shall contact the facility director and the youth's parent or guardian.

S. Medication Refusal

Each NSP and LSP provider must enact a policy approved by ACS for when youth refuse to take prescribed medications, including OTC medications. The policies must:

1. Prohibit the use of force in medication administration;
2. Require that staff consult a supervisor in these instances;
3. Require that staff inform the youth's prescribing doctor;
4. Require staff to witness the staff member documenting and signing that the youth refused to take his or her medication;
5. Require staff to notify the youth's family; and
6. Describe the steps that staff must take when a medication refusal is life-threatening.

ACS Division of Youth and Family Justice (DYFJ)

Medication Administration Record

CONSENT GRANTED	
By	
On	at
As per	

Facility:		
Name:	DOB:	Dorm/Unit:
Allergies:		
Medication Name & Dosing Schedule:		

Diagnosis:	Date Ordered:	Start Date:	Stop Date:

Prescriber:																															
Administrative Date:																															
Administration Time:																															
Remaining amount of Medication:																															
Staff Supervising Administration																															
Staff Initials																															

CONSENT GRANTED	
By	
On	at
As per	

Allergies:			
Medication Name & Dosing Schedule:			
Diagnosis:	Date Ordered:	Start Date:	Stop Date:

Prescriber:																															
Administrative Date:																															
Administration Time:																															
Remaining amount of Medication:																															
Staff Supervising Administration																															

When medication is not administrated, staff administrating the medication must indicate reason:

Key: 1-Patient Refused 2-Medication Unavailable 3-Patient in Court 4-Other: ___________________________________

ACS Division of Youth and Family Justice (DYFJ)

Medication Administration Record

CONSENT GRANTED	
By	
On	**at**
As per	

Facility:		
Name:	DOB:	Dorm/Unit:
Allergies:		
Medication Name & Dosing Schedule:		

Diagnosis:	Date Ordered:	Start Date:	Stop Date:

Prescriber:																															
Administrative Date:																															
Administration Time:																															
Remaining amount of Medication:																															
Staff Supervising Administration																															
Staff Initials																															

CONSENT GRANTED	
By	
On	**at**
As per	

Allergies:			
Medication Name & Dosing Schedule:			
Diagnosis:	Date Ordered:	Start Date:	Stop Date:

Prescriber:																															
Administrative Date:																															
Administration Time:																															
Remaining amount of Medication:																															
Staff Supervising Administration																															

When medication is not administrated, staff administrating the medication must indicate reason:

Key: 1-Patient Refused 2-Medication Unavailable 3-Patient in Court 4-Other: ___________________________________

NYC Administration for Children's Services

Attachment B

Over The Counter (OTC)
Medications and Products for Non-Secure and Limited Secure Placement

All NSP and LSP facilities shall maintain the OTC medications and products listed below on hand in a locked cabinet:

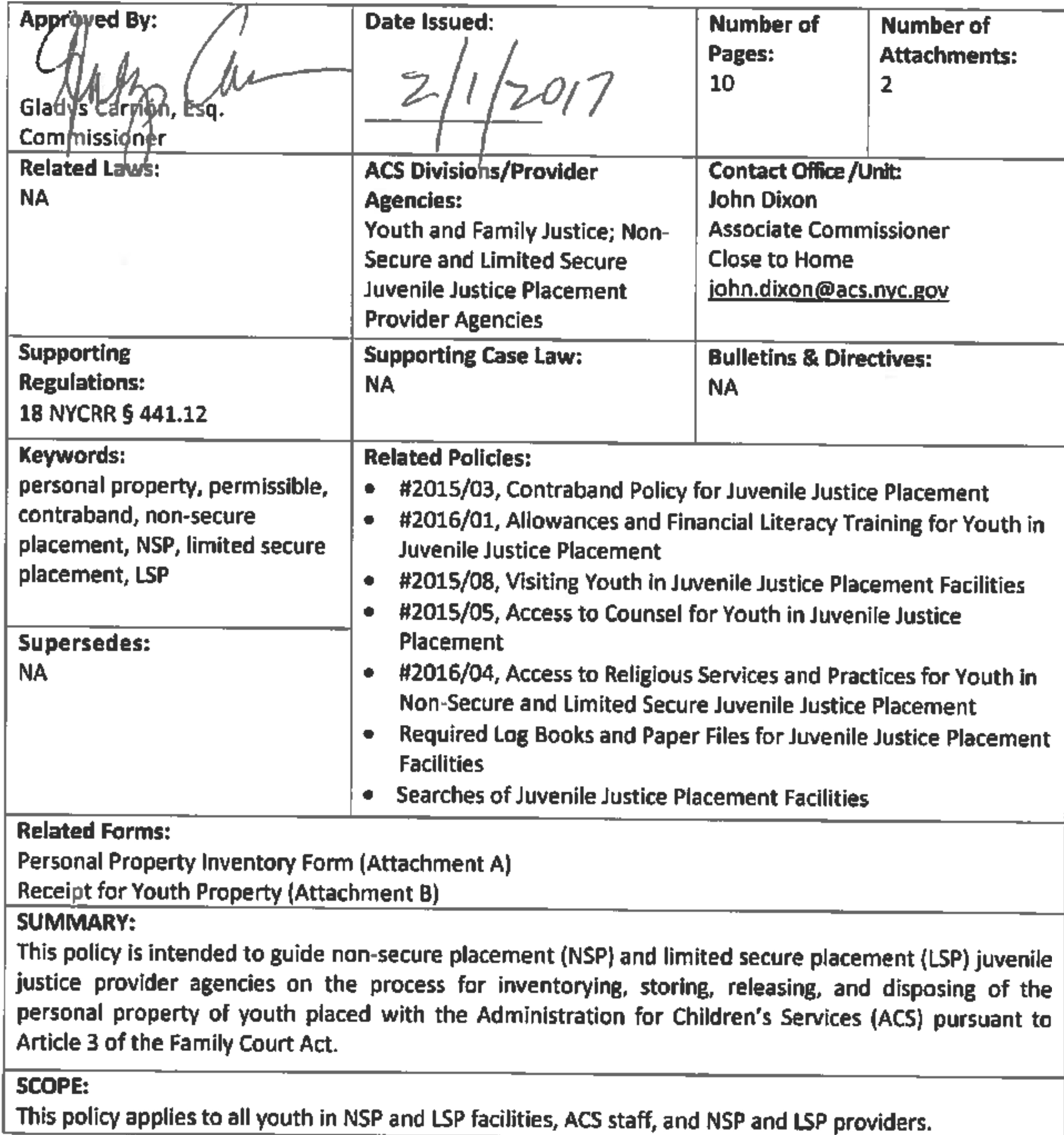
- **Robitussin Cough Syrup (decongestant) Alcohol-free, where possible***
- **Advil/Motrin 200 mg***
- **Tylenol***
- **Chloroseptic Throat Spray***
- **Pepto-Bismol***
- **Hydrocortisone Cream**
- **Bacitracin***
- **Metamucil***
- **Benadryl***
- **Salt for gargling**
- **Peroxide Ben-gay***
- **Bandages**
- **Melatonin**

Generic substitute permitted

City of New York
Administration for Children's Services

Policy and Procedure
#2017/03

Personal Property of Youth in Juvenile Justice Placement



Approved By:	Date Issued:	Number of Pages:	Number of Attachments:
Gladys Carrión, Esq. Commissioner	2/1/2017	10	2

Related Laws:	ACS Divisions/Provider Agencies:	Contact Office /Unit:
NA	Youth and Family Justice; Non-Secure and Limited Secure Juvenile Justice Placement Provider Agencies	John Dixon Associate Commissioner Close to Home john.dixon@acs.nyc.gov
Supporting Regulations: 18 NYCRR § 441.12	**Supporting Case Law:** NA	**Bulletins & Directives:** NA

Keywords:	Related Policies:
personal property, permissible, contraband, non-secure placement, NSP, limited secure placement, LSP **Supersedes:** NA	• #2015/03, Contraband Policy for Juvenile Justice Placement • #2016/01, Allowances and Financial Literacy Training for Youth in Juvenile Justice Placement • #2015/08, Visiting Youth in Juvenile Justice Placement Facilities • #2015/05, Access to Counsel for Youth in Juvenile Justice Placement • #2016/04, Access to Religious Services and Practices for Youth in Non-Secure and Limited Secure Juvenile Justice Placement • Required Log Books and Paper Files for Juvenile Justice Placement Facilities • Searches of Juvenile Justice Placement Facilities

Related Forms:
Personal Property Inventory Form (Attachment A)
Receipt for Youth Property (Attachment B)

SUMMARY:
This policy is intended to guide non-secure placement (NSP) and limited secure placement (LSP) juvenile justice provider agencies on the process for inventorying, storing, releasing, and disposing of the personal property of youth placed with the Administration for Children's Services (ACS) pursuant to Article 3 of the Family Court Act.

SCOPE:
This policy applies to all youth in NSP and LSP facilities, ACS staff, and NSP and LSP providers.

I. Purpose

It is the policy of the Administration for Children's Services (ACS) that all of a youth's personal property such as clothing, valuables, and money shall be appropriately secured while a youth is in non-secure placement (NSP) or limited secure placement (LSP). This policy is intended to guide NSP and LSP juvenile justice provider agencies on the process to inventory, store, release, and dispose of the personal property of youth who have been placed with ACS pursuant to Article 3 of the Family Court Act.

II. Terms

A. Permissible Personal Property – Items which the facility permits youth to keep in their rooms or on their person after they have been properly inventoried.

B. Personal Property – Items which belong to a youth including, but not limited to, clothing, money, jewelry, keys, identification, and personal care items. Personal property includes both permissible items and items that are unauthorized for use in the facility and considered contraband.

C. Authorized Person – Any individual authorized to receive a youth's inventoried personal property including, but not limited to, parents/guardians, discharge resources, siblings, half-siblings, potential permanency resources, and/or any other persons of significance to the youth.

III. Facility Handbook or Resident Manual

A. Each provider agency shall develop a listing of permissible items which must be approved by ACS. Variations which depend on the youth's level of care, progress in the program, or other factors must also be provided to ACS.

B. Facility Handbooks or Resident Manuals provided to youth, parents/guardians, or other persons of significance to the youth shall include the following information:

1. A clear statement of the youth's right to personal property;
2. A list of permissible and unauthorized personal property;
3. Information about how personal property is inventoried and stored;
4. The process by which a youth's parent/guardian or other authorized person may retrieve personal property; and
5. A sample Personal Property Inventory Form (Attachment A).

IV. Procedure

A. At intake, a designated provider agency staff person shall meet with each youth to explain which personal property items are permissible at the facility and which are not. The staff person must explain which items are permissible and may be kept in the youth's room, on his or her person, or stored by the facility, and which are considered contraband and must be stored, disposed of, or retrieved by a parent/guardian or other authorized person.

B. The youth shall be informed that property exceeding $75 in value is not allowed in the program without prior approval from the facility director or designee.[1]

C. This staff person shall then review the youth's personal property with the youth and complete a Personal Property Inventory Form (Attachment A) while adhering to the following:

1. The staff person shall list each item separately on the inventory form, provide a brief, but detailed description of each item, and note whether the item is permissible or considered contraband.

2. The staff person shall ask the youth to name the person authorized to retrieve the youth's property and that person's relationship to the youth. The youth may at any time notify staff if he or she would like to update the name of the designated person.

3. If the youth is keeping any permissible personal property items in his or her room or on his or her person, the staff person shall explain that the youth is responsible for the property, but that the youth may request that it be stored in a secure on-site location or retrieved by a parent/guardian or other authorized person at any time during the youth's residential placement. Provider agency staff shall assist in making arrangements for pick up.

4. Any money a youth has at the time of admission shall be receipt recorded and stored in a secure on-site storage space as designated by the individual provider agency. Pursuant to the ACS Policy and Procedure #2016/01, *Allowances and Financial Literacy Training for Youth in Juvenile Justice Placement*, provider agency staff shall not disburse allowances, financial incentives, or other personal monies directly to any youth until the youth is either leaving the facility, being transported

[1] For example, sneakers, clothing, or a personal cell phone exceeding $75 in value may be authorized for storage in the facility if a youth has not identified an authorized person to retrieve the items.

for a home visit, or is actually ready to pay for a non-contraband, facility-approved item.

5. If the youth has no personal property, the staff person shall check the "no" box on the inventory form.

6. The staff person shall ask the youth to sign the inventory form regardless of whether the youth has personal property. If the youth refuses to sign, the staff person shall note this on the form. Upon notification of refusal, the designated staff person and a supervisor must both sign and date the form.

7. The original of the signed inventory form shall be kept in the youth's case file; it may be scanned and saved in an electronic file. The staff person shall make two (2) copies of the signed inventory form: one to be stored in the Facility Personal Property log and one to be given to the youth. The provider shall also document completion of this procedure in the Facility Activity/Communication Log Book and in the youth's electronic case record.

D. Facility Storage of Personal Property

1. The staff person shall secure the youth's personal property in an envelope, bag, or other container which shall be stored in a locked cabinet or locked room accessible only by staff designated by the facility director.

2. The completed Personal Property Inventory Form shall be placed in the Facility Personal Property Log pursuant to the ACS Policy and Procedure, *Required Log Books and Paper Files for Juvenile Justice Placement Facilities.*

3. The facility director or designee shall oversee monthly inventory reviews to confirm that the Facility Personal Property log accurately reflects personal property in storage. Such reviews shall be documented in the Facility Activity/Communication Log Book. In the event a discrepancy is discovered, the facility director or designee shall immediately commence procedures for Claims of Lost or Damaged Property as described in this policy (see section VII. D. below).

4. Provider agencies shall conduct an updated inventory of the youth's personal property upon return from each home visit or other extended absence from the facility.

    a. If the youth returns to the facility from a home visit or other extended absence with no additional items other than personal property that has been previously inventoried, completion of an updated Personal Property Inventory Form is not required. The staff person must document the youth's return and personal

property review in the Facility Activity/Communication Log Book pursuant to ACS Policy and Procedure, *Required Log Books and Paper Files for Juvenile Justice Placement Facilities.*

b. If the youth returns to the facility from a home visit or other extended absence with property that has been not been previously inventoried, the designated staff person on duty at the time of the youth's return to the facility shall review the youth's personal property pursuant to the procedure described in this policy (see section IV. C. above), and complete a new Personal Property Inventory Form (Attachment A).

c. The original of the signed updated inventory form shall be kept in the youth's case file; it may be scanned and saved in an electronic file. The staff person shall make two (2) copies of the signed updated inventory form: one to be stored in the Facility Personal Property log and one to be given to the youth. The provider shall also document completion of this procedure in the Facility Activity/Communication Log Book and in the youth's electronic case record.

5. If any of the youth's personal property is not permissible, the staff person must note this on the inventory form.

   a. The provider must make arrangements for unauthorized property to be retrieved from the facility by the youth's parent/guardian or other authorized person. If exigent circumstances exist and retrieval of these items is not feasible, the provider must make arrangements for the personal property to be delivered to the youth's parent/guardian or other authorized person at an address noted in the youth's case file.

   b. Staff must dispose of items of negligible value which are unauthorized for use in the facility, such as perishable items. If there are any illegal items, including weapons or drugs, staff must turn them over to law enforcement pursuant to the ACS Policy and Procedure #2015/03, *Contraband Policy for Juvenile Justice Placement.*

E. <u>Access to Stored Personal Property</u>

1. Only staff designated by the facility director shall have access to the stored personal property of youth. Youth shall not be given access to personal property that is not authorized for use in the facility.

2. Any youth going home for a visit may pack his or her items and have them stored in a secure on-site location until he or she returns from the visit. For any youth on

absent without leave (AWOL) status, all personal property shall be packed and stored by the provider in a secure on-site location.

V. Authorized Persons and Approved Visitors

A. Authorized Persons

1. In collaboration with the youth, provider staff shall develop a list of persons authorized by the youth to retrieve personal property. This listing, as well as a listing of approved and prohibited visitors, shall be maintained in each youth's case record. Youth may notify provider staff at any time if modifications need to be made to the authorized persons list, and provider staff shall document the modifications in the youth's electronic case record.

2. Provider staff must consult the authorized persons list, along with the documented list of approved and prohibited visitors,[2] prior to making arrangements for pick up and receipt of the youth's personal property.

3. At any time during a youth's residential placement, the youth may authorize release of his or her property to a parent/guardian or other authorized person. Staff shall arrange for the items to be retrieved and shall encourage parents/guardians or other authorized persons to pick up the youth's property as soon as possible.

4. All authorized persons, including attorneys and clergy, shall be allowed to retrieve a youth's personal property, except in instances where the security of the facility may be compromised. No child under 18 may retrieve personal property from a juvenile justice placement facility unaccompanied by an adult unless prior arrangements have been made and approved by the facility director or his or her designee.[3]

B. Approved Visitors

1. Pursuant to ACS Policy and Procedure #2015/08, *Visiting Youth in Juvenile Justice Placement Facilities,* provider agencies must develop visiting plans for youth and their parents/guardians, siblings, half-siblings and other significant family

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[2] See ACS Policy and Procedure #2015/08, *Visiting Youth in Juvenile Justice Placement Facilities*.

[3] See ACS Policy and Procedure #2015/08, *Visiting Youth in Juvenile Justice Placement Facilities*; #2015/05, *Access to Counsel for Youth in Juvenile Justice Placement*; and #2016/04, *Access to Religious Services and Practices for Youth in Non-Secure and Limited Secure Juvenile Justice Placement*.

members, potential permanency resources and/or any other persons of significance to youth.[4]

2. Provider agency staff shall provide clear direction to parents/guardians or other approved visitors about what items youth are permitted to keep in the facility and shall discourage visitors from bringing valuable property to youth. Approved visitors shall be informed that personal property exceeding $75 in value is not allowed in the program without prior approval from the facility director or designee.

VI. Transfer of Personal Property Between Facilities

A. Sending Facility

1. In the event a youth is transferred between juvenile justice placement facilities, a designated staff person from the sending facility must review the youth's most recent Personal Property Inventory Form prior to transfer. The staff person must sign and date the inventory form as confirmation of the youth's personal property being released to the receiving facility and include the form along with the youth's personal property.

2. If there are any discrepancies, the staff person at the sending facility shall note this on the inventory form and alert the facility director who shall resolve such discrepancies.[5]

3. A copy of the form signed as confirmation of the youth's personal property being released to the receiving facility shall be placed in the Facility Personal Property log. The transfer of personal property must also be documented in the Facility Activity/Communication Log Book and the youth's electronic case record.

B. The Receiving Facility

1. Staff from the receiving facility shall take possession of the youth's personal property and the included Personal Property Inventory Form at the time of the youth's transfer.

2. Upon admission to the receiving facility, a designated staff person shall review the inventory form provided by the sending facility with the youth, and conduct an

[4] See 18 NYCRR § 428.6(a)(2)(viii).
[5] The sending facility is responsible for reconciling any discrepancies between the inventory form and the youth's personal property

inventory of the youth's personal property pursuant to the intake procedure described in this policy (see section IV. C. above).

3. The staff person of the receiving facility must note any discrepancies on the inventory form and alert the facility director, who must resolve such discrepancies with the sending facility. All efforts to resolve property discrepancies shall be documented in the youth's electronic case record.

VII. Procedure for Claims of Lost or Damaged Property

A. Provider agencies shall develop policies and a claims process regarding the replacement of any lost or damaged permissible personal property items, and include them in the Facility Handbook or Resident Manual.[6] Pursuant to this policy (see section IV. C above), youth are responsible for safeguarding and maintaining any permissible items that they keep in their rooms or on their person according to facility standards.

B. The youth, parent/guardian, or other person of significance to the youth may file a claim for lost or damaged property as specified in the Facility Handbook or Resident Manual. The youth's assigned Permanency and Placement Specialist (PPS) and/or the ACS Office of Family Engagement and Youth Advocacy shall provide guidance throughout the claims process and assist in completing agency-specific claim forms

C. Provider agencies shall inform the youth's assigned ACS PPS of all inquiries made by youth, parents/guardians, and/or other persons of significance regarding lost or damaged property. All allegations of lost or damaged property must be documented in the Facility Activity/Communication Log Book and in the youth's electronic case record.

D. In the event the provider agency is unable to locate property that has been previously inventoried and stored, and a claim for lost or damaged property has been received, staff shall conduct a search of the facility and document the results of the search in the Searches for Contraband log, the Facility Activity/Communication Log Book, and in the youth's electronic case record.[7]

E. Provider agencies shall provide reimbursement within 2-4 weeks for items that were vouchered and subsequently deemed to be lost or damaged beyond repair. Such

[6] Provider agencies' personal property replacement policies must be approved by ACS and communicated to youth, parents/guardians, and/or other persons of significance in writing. Provider agencies are strongly encouraged to establish reimbursement/replacement cost limits.
[7] See ACS Policy and Procedure, *Searches of Juvenile Justice Placement Facilities*.

reimbursement can exceed $75 if the lost, stolen, or damaged item was approved and allowed in the program by the facility director while the youth was in placement.

F. Note: The provider agency will be responsible for replacement or reimbursement of permissible property items that the youth keeps in his or her room or on his or her person if the items are lost, stolen, or damaged as a result of inadequate supervision of youth and/or staff misconduct. ACS will not be responsible for replacing lost, stolen, or damaged permissible property items that the youth keeps in his or her room or on his or her person.

VIII. Retrieval of Personal Property/Unclaimed Property

A. All personal property shall be returned immediately to youth upon their completion of residential placement. If a youth believes that the amounts or items returned are incorrect, the provider agency must advise the youth of any applicable procedures for claims of lost or damaged property.

B. In the event a youth cannot retrieve all personal property upon release, the provider shall arrange for the youth or other authorized person to pick up the personal property or shall arrange for facility staff to drop off the property at an address noted in the youth's case record.

C. Staff shall ask the youth or other authorized person to sign and date a Receipt for Youth Property Form (Attachment B). If the youth or other authorized person refuses to sign and date the form, the designated staff person shall note this on the form. Upon notification of refusal, the designated staff person and a supervisor must both sign and date the form.

D. If the youth's property is not claimed within one (1) week of release, provider agency staff shall make at least three (3) phone calls and send one (1) letter to contact the youth and/or authorized person about picking up the property before disposing of it. Provider agency staff shall seek the assistance of the assigned PPS to contact the youth and/or authorized person for retrieval of all personal property.

E. Any money left by a youth (e.g., allowance) after the completion of residential placement shall be turned over to the person or agency authorized to act as custodian of such money, or to the youth.

G. If a youth is AWOL, hospitalized, or remanded to detention or the Department of Corrections, the facility must store the youth's personal property until a new case planning agency is assigned. At that time, the facility shall send the new agency the youth's personal property.

H. After 180 calendar days, the facility may donate a youth's unclaimed property to charity or dispose of all other unclaimed property. Staff shall document all efforts to contact the youth and/or authorized person and donations or disposals of youth personal property in the youth's electronic case record.

I. Note: Recognizing that some youth may not have adequate family resources, provider agencies shall develop alternative policies to address the needs of such youth rather than donate or dispose of youth's personal property. Provider agencies shall be mindful of each youth's individual circumstances, especially those youth for whom a 180 calendar day timeframe may not be practical, and continue storing personal property until a new case planning agency is assigned.

DIVISION OF YOUTH AND FAMILY JUSTICE
CLOSE TO HOME YOUTH PERSONAL PROPERTY FORM

Instructions: Fill out this form at Intake and any time a youth returns following a home visit or other extended absence (if the youth returns with property that has not been previously inventoried). Provide a brief and detailed description of all items, including permissible property and unauthorized items. For clothing items, please include the quantity, type of clothing item, color, and any other features.

Upon Completion: Sign the form, have the youth sign the form, and make three (3) copies: one for the youth, one for the case file, and one to be placed in the Facility Personal Property File. Use additional sheets as needed. If the youth refuses to sign, note the refusal on the form on the line for "youth signature," and sign and date in the presence of a supervisor. A supervisor must also sign the form.

For Any Items Over $75: Please note that the facility director or designee, the youth, and the parent/guardian or other authorized person must agree on the value of the item and note the value in the "Type" column of the form.

Youth Name: ____ **Date of Birth:** _______________________

Date of Admission: _____________________ **Date of Inventory:** ___________________

Agency Name: ____

Facility Name: ____

Name of Person Authorized to Retrieve Items: ____

Relationship to Youth: ____

Does the youth have personal property? ☐ Yes ☐ No

DIVISION OF YOUTH AND FAMILY JUSTICE
CLOSE TO HOME YOUTH PERSONAL PROPERTY FORM

#	ITEM	QUANTITY	DESCRIPTION	TYPE	STATUS	DATE RETRIEVED/DATE TRANSFERRED
1	Socks	3 pairs	Calvin Klein brand, blue, ankle length	✕ PERMISSABLE ☐ UNAUTHORIZED ☐ ILLEGAL ☐ VALUE $75 + __________	☐ YOUTH IS KEEPING ✕ STORED BY FACILITY ☐ RETURN TO AUTHORIZED PERSON ☐ VOUCHERED/DISPOSED	
				☐ PERMISSABLE ☐ UNAUTHORIZED ☐ ILLEGAL ☐ VALUE $75 + __________	☐ YOUTH IS KEEPING ☐ STORED BY FACILITY ☐ RETURN TO AUTHORIZED PERSON ☐ VOUCHERED/DISPOSED	
				☐ PERMISSABLE ☐ UNAUTHORIZED ☐ ILLEGAL ☐ VALUE $75 + __________	☐ YOUTH IS KEEPING ☐ STORED BY FACILITY ☐ RETURN TO AUTHORIZED PERSON ☐ VOUCHERED/DISPOSED	

I have reviewed this inventory form and it is accurate. I am aware that my property must be claimed within 180 calendar days of my release.

____ **Youth Signature**

________________ **Date**

FOR TRANSFERS ONLY:

____ **Staff Signature**

________________ **Date**

____________________________ **Sending Staff Signature**

_______________ **Date**

____ **Supervisor Signature**

________________ **Date**

DIVISION OF YOUTH AND FAMILY JUSTICE

RECEIPT FOR YOUTH PROPERTY RECEIVED BY AUTHORIZED PERSON

I, ______________________________, AM AUTHORIZED BY __________________________ TO RECEIVE HIS OR HER
AUTHORIZED PERSON YOUTH NAME

PROPERTY FROM _______________________________. THE PERSONAL PROPERTY THAT I AM PICKING UP IS AS FOLLOWS:
FACILITY NAME

#	ITEM	QUANTITY	DESCRIPTION	TYPE	DATE ITEMS RETRIEVED
1	Jewelry	1	14k Gold necklace w/ nameplate	☐ PERMISSABLE ☐ UNAUTHORIZED ☒ VALUE $75 + __________	
				☐ PERMISSABLE ☐ UNAUTHORIZED ☐ VALUE $75 + ___________	
				☐ PERMISSABLE ☐ UNAUTHORIZED ☐ VALUE $75 + ___________	

BY SIGNING THIS FORM, I EXPRESSLY ACKNOWLEDGE RECEIPT OF THE ITEMS LISTED ABOVE.

Youth/Authorized Person's Signature **Date**

Designated Staff Member Signature **Date**

Supervisor Signature **Date**

Physical Restraint Form

Complete this form for each youth that was restrained and attach it to the accompanying incident report form. *[Staff only need to complete the Physical Restraint Form for each youth the staff restrained.]*

Name of Youth:____**Incident Number:** __________________________

Name of Staff(s) who administered the restraint: ____

____

[MCCU will need to know the specific ESPIs administered by each staff]

A. Was an escape technique used? [ ] Yes [ ] No If yes, check the technique(s) used:

[ ] Pivot and Parry [ ] Deflecting a Swing (TCI) [ ] Forearm Choke Escape [ ] Scribe a Circle [ ] Bite Release

[ ] Front Choke Escape [ ] Rear Choke Escape [ ] Little Finger Roll [ ] Two Handed Wrist Grab [ ] Hair Pull Assist (front and rear)

[ ] One Arm Grab Escape (TCI) [ ] Two Arm Grab Escape (TCI) [ ] One Arm Two Hands Grab Escape (TCI) [ ] Forearm Twist [ ] Bar Arm Choke Escape (TCI)

B. Was an escort technique used? [ ] Yes [ ] No If yes, check the technique(s) used:

[ ] Extended Arm Assist (Single Person) [ ] Multiple Person Extended Arm Assist **[ ]** Multiple Person Bicep Assist

C. Was an Emergency Safety Physical Intervention Used (ESPI)? [ ] Yes [ ] No (If yes, check the technique(s) used below:

Lower Level ESPIs:

[ ] Upper Torso Assist **Minutes in ESPI**____ [ ] Multiple Person Upper Torso Assist **Minutes in ESPI** ____

[ ] Cradle Assist (Single Person) **Minutes in ESPI**____ [ ] Cradle Assist to Seated/Kneeling Position **Minutes in ESPI** ____

[ ] Hook Transport and Assist to Seated /Kneeling Position **Minutes in ESPI**____ [ ] Standing Hold (TCI) **Minutes in ESP** ____

[ ] Breaking up a Fight (TCI) **Minutes in ESPI** ____ [ ] Standing Hold (TCI) **Minutes in ESPI** ____

Higher Level ESPIs:

[ ] Upper Torso Assist to Seated/Kneeling Position **Minutes in ESPI**____[ ] Side Assist **Minutes in ESPI** _____

[ ] Multiple – Person Seated/Kneeling Upper Torso Assist and Bicep Assist **Minutes in ESPI** ____

[ ] Multiple Person Supine Torso Assist **Minutes in ESPI**____ [ ] Sitting up from a Supine Position **Minutes in ESPI** ____

[ ] Supine – Seated Hold (TCI) **Minutes in ESPI**____[ ] Small Child (TCI) **Minutes in ESPI** _____

Other Intervention Used – Provide Explanation:

____

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____

Time Restraints Started:_____________________________**Time Restraints Concluded:**________________________**Duration of Restraints:** __________

Reason for Restraint:

[ ] Youth presents a risk of physical injury to self or to others

[ ] Youth clearly indicates that the youth physical attempting to AWOL and represents a danger to self or others

If only one staff participated in the ESPI/TCI Intervention, describe the specific emergency circumstances in which this occurred:

____

____

Describe an additional details of the ESPI/TCI Intervention(s): ____

____

____

Was the parent notified about the ESPI/TCI Intervention(s)? [ ] Yes [ ] No If not, discuss why and document all efforts taken to notify the parent.

____

Staff Signature/Title:____**Date Submitted:**________/______/________

Supervisor Initials:_________________**Date Reviewed by Supervisor:**________/______/________

Attachment C

NYC - ACS DIVISION OF YOUTH AND FAMILY JUSTICE
LIMITED SECURE PLACEMENT INCIDENT REPORT

Print or Type all Information ***(Complete entire form, including a Physical Restraint Form or a Mechanical Restraint Form for each youth restrained.)***

All ORIGINAL Incident Reports are to be forwarded to the LSP Facility Director or designee. All immediately reportable incidents must be called into MCCU within one (1) hour of occurrence. All reportable incidents must be called into MCCU by the end of the shift the incident occurred.

Full Name of Report Writer:____**Title:** _____________________________________

Incident Date:___/___/____**Time:**________**(AM/PM) MCCU Incident Report #:**________________**Time Reported to MCCU:** _______

LSP Provider Agency and Facility Name: ____

Location:_________________________**Sub-location:**_______________________________**Location Detail:** _______________________

Staff involved **(use full names, titles, and role):** ____

____

Witnesses (use full names, titles, and indicate if youth, staff, or other): ____

____

Youth's Name: ______________________________ **Role in Incident: [ ] Victim [ ] Aggressor [ ] Subject**

Mental Health Referral [ ] Yes [ ] No Medical Referral [ ] Yes [ ] No Was youth restrained? [ ] Yes [ ] No If yes, complete Physical Restraint Form

Was a Youth Debriefing completed? [ ] Yes [ ] No Date:_____/_____/_____**Time:**__________**AM/PM Staff Name:** _______________________

If injury, indicate type: [ ] Type A [ ] Type B Indicate cause of injury: [ ] Incident [ ] Restraint [ ] Escape/Escort
If additional injury, indicate type: [ ] Type A [ ] Type B Indicate cause of injury: [ ] Incident [ ] Restraint [ ] Escape/Escort
If additional injury, indicate type: [ ] Type A [ ] Type B Indicate cause of injury: [ ] Incident [ ] Restraint [ ] Escape/Escort

Youth's Name: ______________________________ **Role in Incident: [ ] Victim [ ] Aggressor [ ] Subject**

Mental Health Referral [ ] Yes [ ] No Medical Referral [ ] Yes [ ] No Was youth restrained? [ ] Yes [ ]No If yes, complete Physical Restraint Form

Was a Youth Debriefing completed? [ ] Yes [ ] No Date:_____/_____/_____**Time:**__________**AM/PM Staff Name:** _______________________

If injury, indicate type: [ ] Type A [ ] Type B Indicate cause of injury: [ ] Incident [ ] Restraint [ ]Escape/Escort
If additional injury, indicate type: [ ] Type A [ ] Type B Indicate cause of injury: [ ] Incident [ ] Restraint [ ] Escape/Escort
If additional injury, indicate type: [ ] Type A [ ] Type B Indicate cause of injury: [ ] Incident [ ] Restraint [ ] Escape/Escort

Youth's Name: ______________________________ **Role in Incident: [ ] Victim [ ] Aggressor [ ] Subject**

Mental Health Referral [ ] Yes [ ] No Medical Referral [ ] Yes [ ] No Was youth restrained? [ ] Yes [ ] No If yes, complete Physical Restraint Form

Was a Youth Debriefing completed? [ ] Yes [ ] No Date:_____/_____/_____**Time:**__________**AM/PM Staff Name:** _______________________

If injury, indicate type: [ ] Type A [ ] Type B Indicate cause of injury: [ ] Incident [ ] Restraint [ ]Escape/Escort
If additional injury, indicate type: [ ] Type A [ ] Type B Indicate cause of injury: [ ] Incident [ ] Restraint [ ] Escape/Escort
If additional injury, indicate type: [ ] Type A [ ] Type B Indicate cause of injury: [ ] Incident [ ] Restraint [ ] Escape/Escort

[Attach additional documentation if identifying more than 3 youth participants]

AWOL [ ] Reported to Police Department: [ ] Yes [ ] No Precinct:_______**Reported to Parent/Guardian: [ ] Yes [ ] No**

Reported to Family Court: [ ] Yes [ ] No Reported to OCFS: [ ] Yes [ ] No

CONTRABAND [ ] Search Type:_____________________**List Contraband Found in Incident Narrative**

MANAGER REQUESTED EVENT [ ] Reason: ____

Incident Narrative: Provide a detailed chronological description of the incident. If an ESPI or TCI physical restraint was used, describe exactly youth and staff positioning. Provide an observation of youth and situation prior to the incident. Steps taken to de-escalate the situation must be included in the incident narrative.

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Incident Narrative (continued):

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Staff Signature/Title:____Date Submitted:_______/_____/_______

Supervisor's Follow-up Narrative: This must include any medical and/or mental health follow-up information if medical and/or mental health referrals were made.

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Supervisor reviewed/ initialed all the accompanying Physical Restraint or Mechanical Restraint Forms for each youth involved in a restraint: [ ] Yes [ ] No

Were facility activities canceled due to this incident? [ ] Yes [ ] No

Was a Staff Debriefing completed? [ ] Yes [ ] No Date:_____/_____/_______ Time:________________AM/PM
[If all staff involved in the incident did not participate in a staff debriefing – must explain in Supervisor's Follow-Up Narrative]

Was a Group Debriefing completed? [ ] Yes [ ] No Date:_____/_____/_______Time:_________________AM/PM

Debriefing By: [ ] Non-ACS Staff [ ] ACS Staff NAME:__________________________

Did the incident result in a child abuse allegation? [ ] Yes [ ] No
If Yes: Date Reported to SCR/VPCR:______________Accepted: [ ] Yes [ ] No
Indicate SCR/VPCR Number:______________________Party Accepting the Complaint: _______________________

Supervisor Signature/Title:____**Date:**______/_____/_______

Physical Restraint Form

Complete this form for each youth that was restrained and attach it to the accompanying incident report form. ***[Staff only need to complete the Physical Restraint Form for each youth the staff restrained.]***

Name of Youth:_______________________________________**Incident Number:** _________________________

Name(s) of Staff who administered the restraint: ____

____

[MCCU will need to know the specific ESPIs administered by each staff]

A. Was an escape technique used? [ ] Yes [ ] No If yes, check the technique(s) used:

[ ] Pivot and Parry	[ ] Deflecting a Swing (TCI)	[ ] Forearm Choke Escape	[ ] Scribe a Circle	[ ] Bite Release
[ ] Front Choke Escape	[ ] Rear Choke Escape	[ ] Little Finger Roll	[ ] Two Handed Wrist Grab	[ ] Hair Pull Assist (front and rear)
[ ] One Arm Grab Escape (TCI)	[ ] Two Arm Grab Escape (TCI)	[ ] One Arm Two Hands Grab Escape (TCI)	[ ] Forearm Twist	[ ] Bar Arm Choke Escape (TCI)

B. Was an escort technique used? [ ] Yes [ ] No If yes, check the technique(s) used:

[ ] Extended Arm Assist (Single Person) [ ] Multiple Person Extended Arm Assist **[ ]** Multiple Person Bicep Assist

C. Was an Emergency Safety Physical Intervention Used (ESPI)? [ ] Yes [ ] No (If yes, check the technique(s) used below:

Lower Level ESPIs:

[ ] Upper Torso Assist **Minutes in ESPI**____ [ ] Multiple Person Upper Torso Assist **Minutes in ESPI** ____

[ ] Cradle Assist (Single Person) **Minutes in ESPI**____ [ ] Cradle Assist to Seated/Kneeling Position **Minutes in ESPI** ____

[ ] Hook Transport and Assist to Seated /Kneeling Position **Minutes in ESPI**____ [ ] Standing Hold (TCI) **Minutes in ESP** ____

[ ] Breaking up a Fight (TCI) **Minutes in ESPI** ____ [ ] Standing Hold (TCI) **Minutes in ESPI** ____

Higher Level ESPIs:

[ ] Upper Torso Assist to Seated/Kneeling Position **Minutes in ESPI**____[ ] Side Assist **Minutes in ESPI** _____

[ ] Multiple – Person Seated/Kneeling Upper Torso Assist and Bicep Assist **Minutes in ESPI** ____

[ ] Multiple Person Supine Torso Assist **Minutes in ESPI**____ [ ] Sitting up from a Supine Position **Minutes in ESPI** ____

[ ] Supine – Seated Hold (TCI) **Minutes in ESPI**____[ ] Small Child (TCI) **Minutes in ESPI** _____

Other Intervention Used – Provide Explanation:

____

____

____

Time Restraints Started:___________________________**Time Restraints Concluded:**_______________________**Duration of Restraints:** __________

Reason for Restraint:

[ ] Youth presents a risk of physical injury to self or to others

[ ] Youth clearly indicates that the youth physical attempting to AWOL

If only one staff participated in the ESPI/TCI Intervention, describe the specific emergency circumstances in which this occurred:

____

____

Describe an additional details of the ESPI/TCI Intervention(s): ____

____

____

Was the parent notified about the ESPI/TCI Intervention(s)? [ ] Yes [ ] No If not, discuss why and document all efforts taken to notify the parent.

____

Staff Signature/Title:____**Date Submitted:**________/______/________

Supervisor Initials:_________________**Date Reviewed by Supervisor:**________/______/________

Mechanical Restraint Form

Complete this form for each youth that was mechanically restrained and attach it to the accompanying incident report form. ***[Staff only need to complete the Mechanical Restraint Form for each youth the staff restrained.]***

Name of Youth:____Incident Number: ___________________________

Name(s) of Staff who applied the mechanical restraints: ____

____

Mechanical Restraints used: [ ] Handcuffs [ ] Foot Cuffs [ ] Flex-Cuffs

Time Mechanical Restraints Applied:_____________________________Time Mechanical Restraints Removed: ______________________

Duration Mechanical Restraints Used: __________

Reason for Mechanical Restraints:

[ ] Youth presented a risk of physical injury to self or to others

[ ] Youth was attempting to AWOL

[ ] Transport ***(Parental notification not required)***

Describe any additional details of the Intervention(s):

____

____

____

Was the parent notified about the mechanical restraint? [ ] Yes [ ] No If not, discuss why and document all efforts taken to notify the parent.

____

____

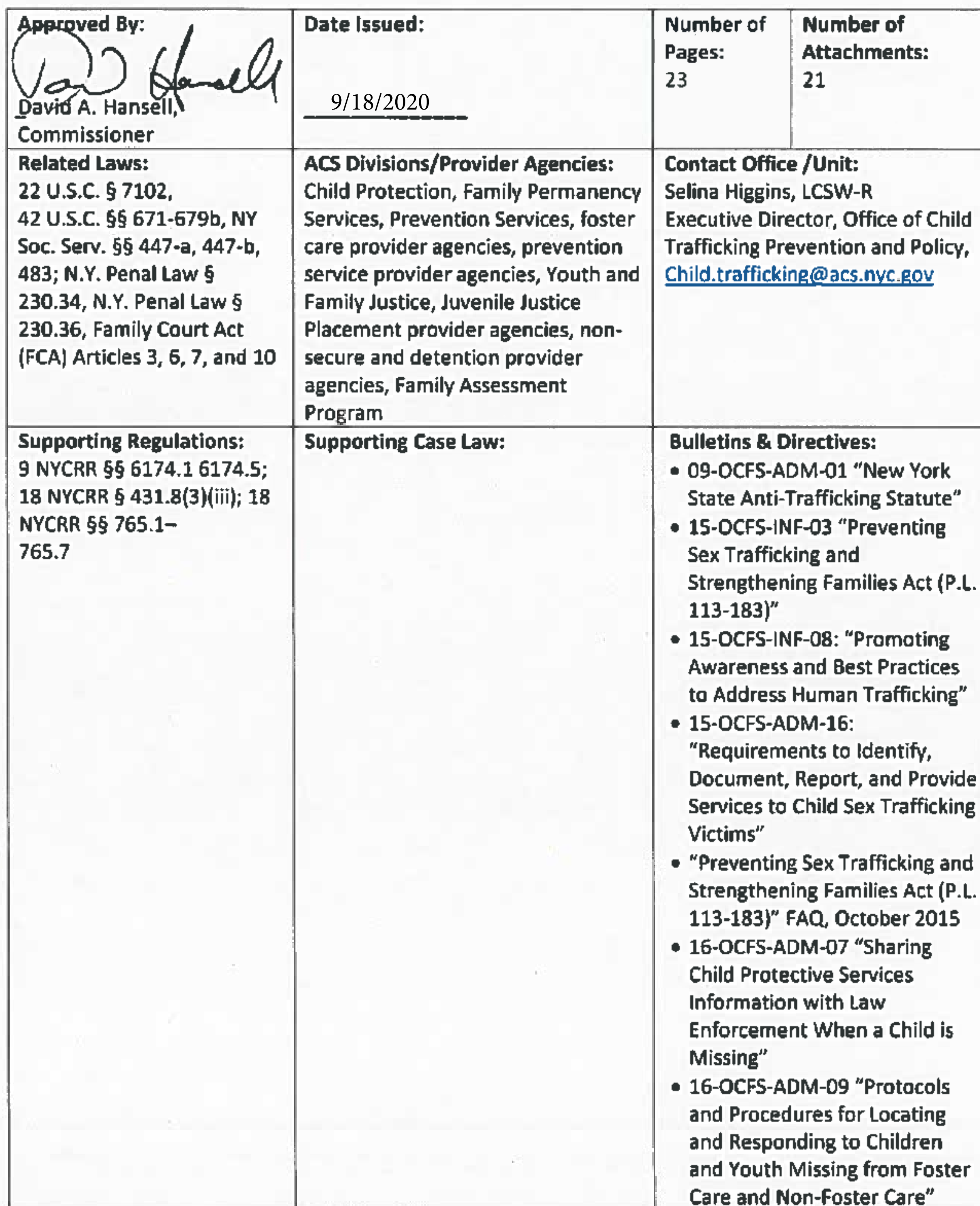
Staff Signature/Title:____Date Submitted:_________/______/_________

Supervisor Initials:_________________Date Reviewed by Supervisor:________/______/______

City of New York
Administration for Children's Services

Policy and Procedure
2020/05

Identifying, Assessing, and Safety Planning with Child Sex and Labor Trafficking Victims



Approved By: David A. Hansell, Commissioner	**Date Issued:** 9/18/2020	**Number of Pages:** 23	**Number of Attachments:** 21
Related Laws: 22 U.S.C. § 7102, 42 U.S.C. §§ 671-679b, NY Soc. Serv. §§ 447-a, 447-b, 483; N.Y. Penal Law § 230.34, N.Y. Penal Law § 230.36, Family Court Act (FCA) Articles 3, 6, 7, and 10	**ACS Divisions/Provider Agencies:** Child Protection, Family Permanency Services, Prevention Services, foster care provider agencies, prevention service provider agencies, Youth and Family Justice, Juvenile Justice Placement provider agencies, non-secure and detention provider agencies, Family Assessment Program	**Contact Office /Unit:** Selina Higgins, LCSW-R Executive Director, Office of Child Trafficking Prevention and Policy, Child.trafficking@acs.nyc.gov	
Supporting Regulations: 9 NYCRR §§ 6174.1 6174.5; 18 NYCRR § 431.8(3)(iii); 18 NYCRR §§ 765.1–765.7	**Supporting Case Law:**	**Bulletins & Directives:** • 09-OCFS-ADM-01 "New York State Anti-Trafficking Statute" • 15-OCFS-INF-03 "Preventing Sex Trafficking and Strengthening Families Act (P.L. 113-183)" • 15-OCFS-INF-08: "Promoting Awareness and Best Practices to Address Human Trafficking" • 15-OCFS-ADM-16: "Requirements to Identify, Document, Report, and Provide Services to Child Sex Trafficking Victims" • "Preventing Sex Trafficking and Strengthening Families Act (P.L. 113-183)" FAQ, October 2015 • 16-OCFS-ADM-07 "Sharing Child Protective Services Information with Law Enforcement When a Child is Missing" • 16-OCFS-ADM-09 "Protocols and Procedures for Locating and Responding to Children and Youth Missing from Foster Care and Non-Foster Care"	

		• 17-OCFS-INF-03 “New York State Processes Related to Notifications of Victims of Human Trafficking” • 19-OCFS-ADM-11, “Sex Trafficking Allegation”
Supersedes: • Assessment and Safety Planning with Commercially Sexually Exploited (Sex Trafficked) Children Policy, Division of Child Protection, issued on June 11, 2012	**Related Policies:** • Policy #2012/01 “Promoting a Safe and Respectful Environment for Lesbian, Gay, Bisexual, Transgender and Questioning (LGBTQ) Youth and their Families Involved in the Child Welfare, Detention, and Juvenile Justice System *issued* on November 21, 2012	**Key Words:** OCTPP, trafficking, sex trafficking, labor trafficking, human trafficking, child sex trafficking, victim, survivor, at risk, at-risk children, youth, identification, documentation, report, reporting, victim services, trauma focused services, trauma-informed services, commercial sexual exploitation of children, law enforcement, quick screening, rapid indicator tool, comprehensive screening, child sex trafficking indicators tool, ongoing screening, Native American, Lesbian, Gay, Bi-Sexual, Transgender, Questioning, LGBTQ, assessment, casework contacts

Related Forms:
OCFS- 3921, Rapid Indicator Tool to Identify Children Who May Be Sex Trafficking Victims or Are at Risk of Being a Sex Trafficking Victim (Attachment E)
OCFS-3920, Child Sex Trafficking Indicators Tool (Attachment F)
OCFS-3922, Law Enforcement Report of a Child Sex Trafficking Victim (Attachment G)

SUMMARY: This policy articulates guidelines and procedures for ACS and provider agency staff in identifying children and youth, who are in the care, custody, care and custody, maintenance, or supervision of the Administration for Children’s Services (ACS), who are survivors of, or at risk of, sex and/or labor trafficking. Additionally, this policy provides guidance and procedures for ACS and provider agency staff in working towards keeping these trafficked children and youth or at-risk children and youth safe and supported by safety planning, coordinating with law enforcement, and making referrals for appropriate services.

SCOPE: This policy applies to all ACS and provider agency staff involved in the care, custody, care and custody, maintenance, or supervision of children, youth and young adults of any age who remain in care.

Table of Contents

I. Purpose....................5
II. Definitions....................6
III. Identifying Victims or At-Risk Victims of Child Sex Trafficking....................8
IV. Screening for Sex Trafficking....................9
A. General Requirements and Guidelines....................9
B. Initial Screening for Sex Trafficking with the Rapid Indicator Tool....................13
C. Comprehensive Screening for Sex Trafficking....................14
D. Reporting Child or Youth Identified as a Sex Trafficking Victim to Law Enforcement....................15
E. Refer Sex Trafficking Victim for the State Confirmation Process....................16
F. Safety Planning....................17
G. Document Service Referrals and Plan and Service Plan in the FASP....................19
H. Ongoing Screenings for Sex Trafficking....................20
V. Labor Trafficking....................21
A. Indicators....................21
B. Procedure for Suspected Labor Trafficking Cases....................22
V. Organ Trafficking....................22
A. Procedure for Suspected Organ Trafficking Cases....................23
VII. Attachments
A. ACS' Office of Child Trafficking Prevention and Policy (OCTPP)
B. ACS's Child Trafficking Database (CTDB) Summary
C. Red Flags for Sex and Labor Trafficking and Who to Contact
D. Language Associated with the Commercial Sex Industry
E. Rapid Indicator Tool to Identify Children Who May Be Sex Trafficking Victims or At Risk of Being A Sex Trafficking Victim (OCFS 3921)
F. Child Sex Trafficking Indicators Tool (OCFS 3920)
G. Law Enforcement Report of a Child Sex Trafficking Victim (OCFS 3922)
H. NYS Referral of Human Trafficking Victim Form
H2. 17-OCFS-INF-03
I. Who to Notify of a Trafficking Victim
J. "Understanding Child Trafficking and What You Can Do To Help" Brochure
K. NYC Services for Trafficked and At-Risk Youth
L. NYC Child Tattoo Eradication Project Referral Protocol
M. OCFS Debriefing Tool for Children and Youth Who Have Returned After Being Absent Without Consent, Missing, or Abducted (Attachment 'B' from 16-OCFS-ADM-09)
N. Office of Child Trafficking Prevention and Policy Safety Planning Tips
O. Awareness and Red Flags for Emergency Room Visits and Medical Professionals

P. Trafficking Red Flags for School Professionals and Staff
Q. Division of Child Protection (DCP) Business Processes for Determining and Documenting Child Sex Trafficking

Q2. Child Trafficking Database and Sex Trafficking Screening Tips for DYFJ Provider Agencies

R. Division of Prevention Services (DPS) and Provider Agencies Business Processes for Determining and Documenting Child Sex Trafficking
S. Division of Youth and Family Justice (DYFJ) and Provider Agencies Business Processes for Determining and Documenting Child Sex Trafficking
T. Family Assessment Program Business Process for Screening for and Documenting Child Sex Trafficking
U. Division of Family Permanency Services (FPS) and Provider Agencies Business Processes for Determining and Documenting Child Sex Trafficking

Additional resources available via the following links:

ACS' Trafficked Youth web pages:
http://www1.nyc.gov/site/acs/youth/traffickedyouth.page;

Movin' On: The NYC Child Tattoo Eradication Project
https://www.youtube.com/watch?v=NGUMtzpIo48

I. Purpose

The New York City Administration for Children's Services (ACS) is committed to keeping children and youth who are in its care and/or custody, maintenance, or under its investigation or supervision, safe from sex trafficking/commercial sexual exploitation and labor trafficking. Statistics and studies have shown that children and youth involved in the child welfare system and in the juvenile justice system are particularly vulnerable to sex trafficking/commercial sexual exploitation.[1]

In September 2014, the federal government passed the Preventing Sex Trafficking and Strengthening Families Act[2] to help address sex trafficking and the commercial sexual exploitation of children involved in the child welfare and juvenile justice systems. Based upon this legislation, in September 2015, the New York State Office of Children and Family Services (OCFS) issued the Administrative Directive 15-OCFS-ADM-16 (Revised March 30, 2016), *Requirements to Identify, Document, Report and Provide Services to Child Sex Trafficking Victims,* to notify local departments of social service (LDSS), including ACS, of new procedural requirements. In August 2019, the New York State Office of Children and Family Services (OCFS) issued the Administrative Directive 19-OCFS-ADM-11, *Sex Trafficking Allegation*, to notify local departments of social service (LDSS), including ACS, of the addition of sex trafficking as a new allegation related to child abuse and maltreatment and selection in Connections.

ACS is issuing this policy in accordance with the law and OCFS directives to provide a practice outline for the identification, documentation, safety planning, and provision of appropriate services to children who are sex trafficking victims or at risk of becoming sex trafficking victims. This policy will additionally provide guidance and procedures to follow for children who are identified as labor trafficked or organ trafficked. Finally, this policy will outline practice requirements and provide guidance and additional resources for ACS staff and provider agency staff who, in collaboration with law enforcement, refer children and youth who are identified as victims of sex trafficking for the state confirmation process, coordinate with trauma-focused service providers,[3] and help keep children and youth safe and supported. While this policy outlines required screening and reporting requirements, **staff must immediately call 911 if they suspect a child is in immediate danger**.

Sex trafficking is not the only form of human trafficking. Staff must also be alert for indicators and red flags that children and their family members are victims of labor trafficking. Some victims may be both sex and labor trafficked. Staff who identify suspected

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[1] Polaris Project (2014)) www.polarisproject.org; Human Rights Project for Girls (2015)) http://rights4girls.org/wp-content/uploads/r4g/2015/03/DCST-and-JJ-System.pdf; SPARC "Child Sex Trafficking and the Child Welfare System" (2014) http://childwelfaresparc.org/wp-content/uploads/2014/07/Sex-Trafficking-and-the-Child-Welfare-System.pdf. See also Coughlin, C., Miller, R.R., Higgins, S., Martinez, K.L., DiPaolo, C., & Greenbaum, J. (2020). Human trafficking in the foster care system. In: Titchen, K. E. & Miller, E. (eds.), pp. 137-149. Medical Perspectives on Human Trafficking in Adolescents: A Case Based Guide. Switzerland: Springer Nature.

[2] 113 P.L. 183 (2014)

[3] N.Y. Soc. Serv. Law § 447-b.

sex and/or labor trafficking are required to document and report their suspicions immediately to the ACS Office of Child Trafficking Prevention and Policy (OCTPP) at child.trafficking@acs.nyc.gov for additional guidance. See 17-OCFS-INF-03, *New York State Processes Related to Notifications of Victims of Human Trafficking* for additional information.[4]

ACS Office of Child Trafficking Prevention and Policy offers several trainings and resources to learn more about child sex trafficking. For more information about these programs, trainings, and resources, please reach out to traffickingtraining@acs.nyc.gov.

II. Definitions

A. The Child Trafficking Database (CTDB) is a system that allows assigned staff to complete the mandated sex trafficking screening tools in an electronic web-based format, which permits every screening to be recorded and saved for future access by other staff assigned to a child, thereby complying with mandated state and federal screening requirements. The Child Trafficking Database (CTDB) Summary (Attachment B) describes the application. The CTDB Reference Guide for Screeners and Supervisors provides detailed guidance for staff on accessing and using the CTDB to complete the screenings in this system.[5]

B. Child Sex Trafficking Victim/Survivor – Any child under age 18 who is induced to perform a commercial sex act is considered a sex trafficking victim regardless of whether force, fraud, or coercion is present.[6] [7]

C. Commercial Sex Act – Where something of value – money, food, clothing, drugs, shelter, protection, or other consideration – is provided in exchange for a sex act. This can also include a child being prostituted, child pornography (photos or videos), exotic dancing, private sex parties and other sexual exploitation.[8]

D. Commercial Sexual Exploitation of Children (CSEC) – Comprises sexual abuse and remuneration in money, goods, or services - or the promise of money, goods, or services – to the child or a third person or persons for the sexual abuse of a child, who is treated as a commercial sex object. A form of child sexual abuse where a person under the age of 18 has exchanged a sexual act or performance in exchange for something of value.[9] Actions which constitute CSEC under the New York Safe Harbour law include but are not

[4] 17-OCFS-INF-03: New York State Processes Related to Notifications of Victims of Human Trafficking.
[5] See Child Trafficking Database Summary (Attachment B)
[6] 15-OCFS-ADM-16: Requirements to Identify, Document, Report and Provide Services to Child Sex Trafficking Victims, page 5.
[7] Victims of Trafficking and Violence Prevention Act of 2000 (TVPA), Public Law 106-386, H.R. 3244.
[8] 15-OCFS-ADM-16 pp. 5-6
[9] NY State Safe Harbour Act; See also, OCFS Safe Harbour NY Fast Facts: CSEC and Minor Trafficking. 15-OCFS-ADM-16

limited to: stripping, exotic dancing or performance, sexually explicit photography or video, and minor sex trafficking.[10]

1. Commercial Sexual Exploitation of Children (CSEC) is - Referred to as a "severe form of trafficking in persons" in federal law and is defined as "sex trafficking in which a commercial sex act is induced by force, fraud, or coercion, **or** in which the person induced to perform such act has **not attained 18 years of age**." [11]

E. CONNECTIONS (CNNX) – The New York State automated system designed to create a single integrated statewide system for collecting and recording child protective, prevention, foster care, adoption, and Close to Home information. The system does not have the ability in which to complete a sex trafficking screening. It does include a window ("Sex Trafficking Screening Window") where staff assigned to the case must record the results of a completed sex trafficking screening.

F. Indicator(s) – For purposes of this policy, "indicator" refers to a sign or warning of a problem requiring attention, and/or factors associated with increased vulnerability. Also known as "trigger(s)" or "red flag."[12]

G. Labor Trafficking – Refers to a crime where a person compels or induces another person to engage in labor, or recruits, entices, harbors, or transports such other person by means of intentionally: (1) providing the victim with certain drugs;[13] (2) requiring servicing of a debt that is caused by a course of conduct, with intent to defraud such a person; (3) withholding or destroying government identification documents; (4) using force or engaging in any scheme, plan, or pattern to compel or induce such person to engage in labor activity by making that person fearful.[14]

H. ACS Office of Child Trafficking Prevention and Policy (OCTPP) – Established in 2015 to provide guidance for ACS and provider agency staff in their work with trafficked and at-risk youth and their families, OCTPP responds to all inquiries, provides consultation, guidance and technical assistance, assists in identifying appropriate services, develops and provides training and awareness events, administrates the CTDB, and works to develop policies and procedures for best practice work with trafficked and at-risk youth. OCTPP also developed and administrates "Movin On': The NYC Child Tattoo Eradication Project", and provides direct preventive and therapeutic groupwork services for vulnerable youth. Please see Attachment A for details.

I. Organ Trafficking – The recruitment, transport, transfer, harboring or receipt of living or deceased persons or their organs by means of the threat or use of force or other forms

[10] N.Y.S.S. Title 8-A § 447A.
[11] 22 U.S. Code § 7102 (11a).
[12] See Section III of 15-OCFS-ADM-16.
[13] New York Penal Law § 135.37.
[14] NY Penal Law § 135.35

of coercion, of abduction, of fraud, of deception, of the abuse of power or of a position of vulnerability, or of the giving to, or the receiving by, a third party of payments or benefits to achieve the transfer of control over the potential donor, for the purpose of exploitation by the removal of organs for transplantation.[15]

J. Safety Planning – For purposes of this policy, "safety planning" refers to an ongoing process of prioritizing the child or youth's physical, psychological and emotional safety to, or in the process of breaking away or following having broken away from the trafficker at various points of case management, including initial and all subsequent contacts with the child or youth, during standard case planning meetings, and prior to discharge.

K. Sex Trafficking – The recruitment, harboring, transportation, provision, obtaining, patronizing, or soliciting of a person for the purpose of a commercial sex act.[16]

L. Trauma-Focused Services – Also known as "trauma-specific interventions" or "trauma-informed services." Services or treatments that are specifically developed for children and youth exposed to violence and trauma.[17]

III. Identifying Children and Youth Who Are Victims of, or At-Risk for Sex Trafficking[18]

Case planners and other child-serving staff are encouraged to seek additional guidance and consultation from ACS' Office of Child Trafficking Prevention and Policy (OCTPP),[19] Investigative Consultants (ICs), and clinical consultants from the ACS Clinical Consultation Program (CCP), as appropriate.[20] All staff are expected to familiarize themselves with indicators of, and vulnerabilities to sex trafficking.[21] The following are some (but not all) indicators to help identify victims and youth at-risk of sex trafficking:

A. History of sex abuse and/or a reason to believe that the child is currently being sexually abused or exploited.

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[15] Declaration of Istanbul on Organ Trafficking and Transplant Tourism (2008), http://www.declarationofistanbul.org/**;** http://hottproject.com/about-the-crime/other-crimes/trafficking-in-organs.html.

[16] 22 USC § 7102

[17] "Reducing the Trauma of Investigation, Removal, & Initial Out-of-Home Placement in Child Abuse Cases." Center for Improvement of Child and Family Services, Portland State University School of Social Work, page 16. http://ocfs.ny.gov/main/cfsr/Reducing%20the%20trauma%20of%20investigation%20removal%20%20initial%20out-of-home%20plcaement%20in%20child%20abuse%20cases.pdf

[18] Please note that when working with Native American youth, there is significant guidance from OCFS in reference to the Indian Child Welfare Act (ICWA). More information can be found at http://ocfs.ny.gov/main/nas/

[19] Contact at Child.trafficking@acs.nyc.gov

[20] Attachments T and U for business processes for Prevention and Foster Care case planners, respectively.

[21] Please see the OCFS resource Responding to Commercially Sexually Exploited and Trafficked Youth (pp. 8); Questions about indicators may be sent to Child.trafficking@acs.nyc.gov. Training requests may be sent by the program director to Traffickingtraining@acs.nyc.gov.

B. A reason to believe there are photographs, social media posts, or other recordings of child posed or dressed provocatively and/or instance(s) of sexual acts with or abuse of a child, particularly if such images or recordings are publicly available (i.e., not limited to "private" settings or on sites that the child does not manage).

C. The child has a history of running away and/or absences without consent (AWOCs) or episodes of homelessness/couch-surfing in the past (except family homelessness), including frequent short absences or lengthy absences.

D. The child has tattoos that show, imply, or suggest ownership and/or that he or she does not have an explanation for (e.g. daddy's girl, property of someone's name, or other symbols indicative of sex trafficking).[22]

E. Unaccounted-for money or goods that do not fit the youth's financial situation, including mobile phones, drugs and alcohol, or an unaccounted for person who supplies these goods/money to child/youth. Examples may include frequent manicures or hair styling, hotel stays, and/or designer clothing or shoes or electronics the youth is not known to be able to reasonably afford.

F. Having an older boyfriend/girlfriend/best friend, especially if he or she appears controlling; youth appearing fearful of boyfriend/girlfriend/best friend at times.

G. Associating with adults or other children/youth, who are being trafficked or are known to be involved with trafficking and/or exploitation.

H. Use of slang trafficking terms (e.g. calling the romantic partner "Daddy" or "Mommy," talking about "the life," "the game," "bottom," "out of pocket" (to look at or talk to another pimp) or "track" (a street location for commercial sex). See the OCFS handbook, *Responding to Commercially Sexually Exploited and Trafficked Youth*[23] for a longer list of terms.

I. A child or youth who identifies as lesbian, gay, bi-sexual, transgender, or questioning (LGBTQ) and lacks social supports or is estranged from their family.[24]

J. A child or youth who significantly reduces contact with family, friends or other support networks and/or who significantly withdraws from previous activities.

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[22] Attachment L and Section IV(F) provide additional information on tattoo removal regarding trafficked and former gang-involved youth.

[23] This handbook can be found here: https://ocfs.ny.gov/main/humantrafficking/resources/OCFS-Handbook-for-Office-print.pdf.

[24] Dank et. al, Surviving the Streets of New York, Experiences of LGBTQ Youth, YMSM, and YWSW Engaged in Survival Sex, available at https://www.urban.org/research/publication/surviving-streets-new-york-experiences-lgbtq-youth-ymsm-and-ywsw-engaged-survival-sex; *see also* Polaris Project, Sex Trafficking and LGBTQ Youth, available at https://polarisproject.org/wp-content/uploads/2019/09/LGBTQ-Sex-Trafficking.pdf.

K. A child or youth who has had multiple sexually transmitted infections (STIs), pregnancies and/or multiple miscarriages or abortions.

L. A child who reports that he/she has been trafficked or is engaging in commercial sex act(s).

IV. Screening for Sex Trafficking

A. General Requirements and Guidelines

1. If a child is in immediate danger the staff member must call 911.

2. For the purposes of this policy, the outlined requirements and guidelines apply to all ACS staff with a primary role in an investigation or case management role in a case and contracted provider agency case planners or their agency's designee[25] (hereinafter "staff") who are involved in the investigation of, or the care, custody, care and custody, maintenance, or supervision of any child or youth under the age of 18 and any youth 18 or over in care.[26] For individuals who remain in the care and custody of ACS, all screening procedures are exactly the same as for children ages birth through 18 to ensure the same quality of services and protections. Although persons over age 18 are not legally defined as children, these individuals in the care and custody of ACS are receiving services from a child welfare agency, and therefore, all child relevant policies apply fully to them.

3. **Staff must conduct all sex trafficking screenings in the Child Trafficking Database (CTDB).** Staff must review and follow the CTDB Reference Guide for instructions while conducting the Sex Trafficking screening (hereinafter "screening") for a child or youth in the CTDB. The only exception to CTDB usage is for Advocates Prevention-Only cases (ADVPO cases), as documented in section IV5a.[27]

4. The tools and protocols must be completed by staff as listed in the order below, as required. The OCFS 3921 (*Rapid Indicator Tool to Identify Children Who May Be Sex Trafficking Victims or At Risk of Being a Sex Trafficking Victim) and OCFS 3920 (The Child Sex Trafficking Indicator Tool)* are available for completion electronically within the CTDB for all children in the care and/or custody, maintenance, investigation or

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[25] See Attachments Q-U for additional information on which staff in specific divisions and/or program areas are responsible for the screening, documenting and reporting process.

[26] The CSEC screenings are for all youth ages birth through 18, and also for youth over the age of 18 who are receiving any level of ACS or provider agency services. For example, the CSEC screening applies if the youth re-entered foster care from ages 18 to 21 years old and plans to attend college or if the youth is 21+ years old and remains in care.

[27] ADVPO cases include families who are voluntarily receiving prevention services, but whose parent/guardian is not being investigated for abuse or neglect.

supervision of ACS.. More information regarding the specific tools and/or actions is detailed below, starting with Section IV B:

a. OCFS-3921: *Rapid Indicator Tool to Identify Children Who May Be Sex Trafficking Victims or At Risk of Being a Sex Trafficking Victim* (also known as the Rapid Indicator Tool or Quick Screening)

b. OCFS-3920: *The Child Sex Trafficking Indicator Tool* (also known as the Comprehensive Tool), must be completed in the CTDB if any indicator was selected on the Rapid Indicator Tool screening.

c. *Law Enforcement Report of a Child Sex Trafficking Victim* (also known as the LER), must be completed if the Comprehensive Tool indicates that the child's experiences meet the Federal Definition Level of a child sex trafficking victim;

d. Safety planning with a focus on harm reduction and referral to appropriate services with providers experienced in working with trafficked youth must occur for all children/youth who meet the Federal Definition level of sex trafficking. Consult with the Office of Child trafficking prevention and Policy for resource suggestions.

e. NYS Notification of Victims of Human Trafficking referral for child/youth meeting the Federal Definition Level of child sex trafficking[28]; and/or

f. Safety planning with a trafficking prevention focus and referral to appropriate services must occur for all children who screen at the High Risk or Medium Risk levels for sex trafficking. [29]

5. The Child Trafficking Database (CTDB)
   a. The CTDB must be used to complete all sex trafficking screenings for all children in the care and/or custody, maintenance, or investigation or supervision of ACS at the time of initial case assignment, and/or when a Family Assessment and Service Plan (FASP) is due, and/or every time a youth returns from AWOC, and/or when any occurrence of significance occurs in a youth's life that may reflect trafficking.

   b. Staff must complete the child or youth's initial screening and any subsequent screenings, where required by the division or program (see Attachments Q-U), in the CTDB as soon as possible, but not more than 30 days from the date of its initiation. Screenings shall be completed in the CTDB as soon as possible. If the

[28] 17-OCFS-INF-03: New York State Processes Related to Notifications of Victims of Human Trafficking.
[29] Per form OCFS-3920 (Attachment F): For High Risk Level: Close monitoring and intensive case management services to address current, or prevent future trafficking. For Medium Risk Level: Child should be more closely monitored and provided services that may address current, or prevent future trafficking.

screening is not completed within 30 days, the CTDB will finalize the screening which will be considered an incomplete screening.

c. The person with case planning responsibility for the child is responsible for the screening, documentation and reporting requirements outlined in this policy. For cases with multiple assigned workers, it is **the worker with child planning responsibility** that is required to timely conduct the sex trafficking screening in the CTDB and document the results in CNNX[30].

d. Finalized screenings in the CTDB can only be re-activated for two weeks after completion, and only by the supervisor of a unit to insert the Law Enforcement referral (LER) information resultant of the OCFS-3922: *Law Enforcement Report of a Child Sex Trafficking Victim* form if the Law Enforcement information for a child meeting the Federal Definition Level of trafficking was incomplete at the time of screening finalization in the CTDB.

e. An incomplete screening that becomes finalized in the CTDB does not fulfill the screening mandate. Staff must manually generate a new screening in the CTDB and complete the screening to fulfill the screening mandate.

f. **When a child or youth discloses sex trafficking** during the course of an assessment, custody, investigation, placement, program enrollment, or supervision, staff must complete the screening in the CTDB, indicating that the child or youth meets the Federal Definition of a child sex trafficking victim, completing all of the required information as prompted in the CTDB and any other designated record or file.[31]

g. For screeners encountering challenges with accessing or using the CTDB:
   i. ACS staff should submit a Help Desk ticket
   ii. Provider agency staff should email CTDB@acs.nyc.gov

6. Advocates Preventive-Only Cases
The CTDB must be used to complete all sex trafficking screenings with the exception of Advocates Prevention-Only cases (ADVPO cases). Staff assigned to ADVPO cases must continue to use the paper version of the tools within the same time frames as the CTDB (see below) when conducting the screening for a child or youth, and

[30] As per 19-OCFS-ADM-11, there is now a separate distinction to differentiate sex trafficking from sexual abuse in CNNX. Based on the screening, the worker with the child planning responsibility must indicate the potential presence of "sex trafficking" in CNNX. The allegation will be noted as such in the SCR report. Any sex trafficking allegations require that the worker with the child planning responsibility must additionally refer the allegation to a local multidisciplinary team (MDT) / Child Advocacy Center (CAC) **and constitute a law enforcement report**.

[31] For ADVPO cases, staff must indicate whether the child or youth meets the federal definition of a child sex trafficking victim in the paper forms.

adhere to the same deadlines. These paper tools are stored in the youth's case record. If an Advocates Preventive-Only youth screens at the Federal Definition level for sex trafficking, the screener is to notify the Office of Child Trafficking Prevention and Policy (OCTPP) at Child.trafficking@acs.nyc.gov with only the youth's age, gender and borough. In addition to the notification requirements to OCTPP, staff must call in reports of abuse or maltreatment to the Statewide Central Register or to 911, as appropriate.

7. CNNX Sex Trafficking Screening Window
    a. In addition to completing the sex trafficking screening in the CTDB, staff must enter all screening results from the CTDB (or from the paper form for ADVPO cases) in the CNNX *Sex Trafficking Screening* window.[32]

8. In addition to the reporting requirements described in this policy, staff must immediately call in a report of abuse or maltreatment to the Statewide Central Register (SCR)[33] if there is a concern or suspicion that the parent or person legally responsible is involved in the sex trafficking of the child or youth. Although the parent/person legally responsible may not be the trafficker per se, they have a duty to protect the child, which may reflect an allegation(s) of Lack of Supervision, Inadequate Guardianship and/or Lack of Food, Clothing and Shelter.

B. Initial Screening for Sex Trafficking With the Rapid Indicator Tool[34]

1. Staff must complete the **Rapid Indicator Tool** (OCFS-3921, Attachment E) **within the CTDB** as soon as possible to determine whether the child or youth is a survivor of child sex trafficking or is at risk of becoming a victim.[35] Staff assigned to ADVPO cases must complete and file the paper format of the Rapid Indicator Tool within 30 days. The Rapid Indicator Tool must be completed prior to the completion of the initial Family Assessment and Service Plan (FASP, which is similarly required to be completed within 30 days for applicable children and families) and/or prior to the conclusion of a child protective or Family Assessment Response (FAR) case.

2. The **Rapid Indicator Tool** is not designed to be used as an interview tool for children and youth. It may never be revealed in the presence of a child or family member. Instead, staff are expected to be familiar with the tool indicators, and observe and ask related questions to obtain relevant information and complete the **Rapid**

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[32] For additional information, see the 2016 OCFS Job Aid, "Changes to the CONNECTIONS Family Services Stage (FSS) – Phase 4."
[33] As per 19-OCFS-ADM-11, the SCR will select "sex trafficking" as a specific allegation if the basis of the report expresses concern or suspicion that a parent or person legally responsible (PLR) is involved in sex trafficking of the child or youth. Such allegations should also be selected in documentation completed within CNNX.
[34] 15-OCFS-ADM-16
[35] See Attachments Q-U for requirements and guidelines for specific divisions and/or program areas, for the circumstances where this screening and subsequent screenings must be completed, as well as further details on the screening, documenting, and reporting process.

Indicator Tool as indicated and in the timeframe specified by each division/program (see Attachments Q-U). Staff shall continue to be alert for indicators during ongoing interactions with the child, and shall complete another screening as needed when indicators are newly observed or reported.

3. If the **Rapid Indicator Tool** finds that the child or youth does not have any indicators that give cause to believe the child or youth is a child sex trafficking survivor, or is at risk of becoming a victim, no further screening is needed and the screening is complete until otherwise specified in this policy. However, staff must monitor the child or youth on an ongoing basis.

4. The Rapid Indicator Tool must be used to screen children and youth prior to each comprehensive FASP due date and/or prior to the closure of a child protective investigation or FAR case, regardless of the outcome of the case (see part H within this section for additional ongoing screening expectations).

5. If any indicator(s) is selected on the **Rapid Indicator Tool portion of the screening within the CTDB** (or with the paper tool for ADVPO cases) that gives cause to believe the child or youth is a child sex trafficking victim, or is at risk of becoming a victim, staff must proceed to the **Comprehensive Tool portion within the CTDB** to determine the level of risk for the child or youth. Staff shall select all applicable indicators and enter the identified indicators into the CTDB.

C. <u>Comprehensive Screening for Sex Trafficking</u>

1. Staff must complete the **Comprehensive Tool** (OCFS-3920, Attachment F) **within the CTDB** as soon as possible for all children and youth for whom one or more indicator was selected from the **Rapid Indicator Tool,** and enter the results from the CTDB into the CNNX Sex Trafficking Window as soon as possible, but within no more than 30 days of completing the **Rapid Indicator Tool**. Staff assigned to ADVPO cases must complete the paper format of the **Comprehensive Tool** within the same required timeframe. Staff must note the following points while completing the **Comprehensive Tool**:

    a. Staff must not use the **Comprehensive Tool** as a questionnaire. Instead, staff are expected to use their knowledge of the tool's listed indicators in observations and interactions with the child, as well as when reviewing the child's case history and other documentation, and when discussing the child's needs and strengths with others in the child's life. The **Comprehensive Tool** shall reflect the information gathered based on the staff's ongoing casework contacts, and/or during the course of a child protective investigation, and/or during the youth's program enrollment, and/or during the youth's custody or detention.

b. If, at any time, the child or youth discloses that he or she is a survivor of child sex trafficking, staff must immediately check the applicable indicators in the "Federal Level" tab of the **Comprehensive Tool** screen in the CTDB indicating that the child or youth is a child sex trafficking victim.[36] Staff must proceed with law enforcement notification, safety planning, NYS confirmation process, and service referral protocols pursuant to this policy (see Section IV. D-F.). Consult with OCTPP as needed for guidance.

2. If the **Comprehensive Tool** reflects that the child or youth meets the Federal Definition Level of a sex trafficking victim,[37] staff must report this to law enforcement immediately, but no later than 24 hours[38] after identification of the child or youth as a victim (see Section IV. D. below for the notification process). Staff must notify the Office of Child Trafficking Prevention and Policy,[39] seek immediate consultation from the Investigative Consultation Team (if applicable to the division), and proceed to subsequent steps as per this policy.

3. If the **Comprehensive Tool** indicates that the child or youth is at "high risk," or "medium risk" of becoming a child sex trafficking victim, staff must document the screening results in CONNECTIONS (CNNX) or the designated record or file, continue to monitor the case for as long as it is open, based on the indicator level (see Section IV. F.), and provide service referral(s) (see Section IV. E.) to address any indicators present.

    a. If the child or youth is in foster care, staff must indicate in the CTDB, CNNX, and in the designated record/file whether the victimization occurred prior to or while the child or youth was in foster care.

D. Reporting Child or Youth Identified as a Sex Trafficking Victim to Law Enforcement

Staff must report any child or youth who is identified as a victim of child sex trafficking to law enforcement immediately, and no later than 24 hours[40] after identification of the child or youth as a victim. **If a child is in immediate danger or at risk of harm for trafficking, the staff member must immediately call 911.**

1. Staff must notify law enforcement in the following ways:

    a. Staff must complete the OCFS 3922: **Law Enforcement Report (LER) of A Sex Trafficking Victim form** (Attachment G):

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[36] For Advocate cases, staff must check off the applicable box in the "Federal Level Indicator" section in the paper format (Comprehensive Tool).
[37] See federal definition of "child sex trafficking victim" in Section II of this policy
[38] 15-OCFS-ADM-16
[39] Child.trafficking@acs.nyc.gov
[40] 15-OCFS-ADM-16

i. As of October 2019, NYPD requests that all LERs are to be emailed to the Vice Enforcement Division. Scan the form and email to: VED@nypd.org, copied to Child.trafficking@acs.nyc.gov . **Do not fax the form.**

ii. Call the Vice Enforcement Division at 212-694-3013 to confirm receipt of the **Law Enforcement Report Form** and obtain a log number and the name of the detective taking the staff member's call; [41]

iii. Document the log number and the detective's name who took the staff member's call, as soon as possible, but not more than 30 days after screening initiation in the CTDB, the CNNX sex trafficking screen, CNNX progress note, and any other designated record/file.

2. Staff must notify child.trafficking@acs.nyc.gov with the assigned log number and the name of the detective who took the staff member's calls, along with the ACS case number, and first name of the child or youth.

3. If, due to law enforcement's delay, staff is unable to obtain the log number and/or the name of the detective taking the staff member's call, the supervisor of the unit under which the screening was conducted has two weeks in which to re-activate the screening in the CTDB to insert the information when law enforcement provides the necessary information.[42]

E. Refer Sex Trafficking Victim for the State Confirmation Process[43]

1. Staff must notify the New York State Office of Temporary and Disability Assistance (OTDA) and the New York State Division of Criminal Justice Services (DCJS) immediately of any child or youth who meets the federal definition of child sex trafficking victim or reasonably appears to be a sex trafficking victim.[44] Staff must notify OTDA and DCJS by taking the following actions:

a. Complete the hard copy version of the **NYS Referral Form** (Attachment H) as soon as practicable after encountering a child or youth who meets the Federal Definition Level of sex trafficking;[45]

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[41] Note - a separate detective will get assigned to the case/child or youth after the "Law Enforcement Report Form" is submitted and processed.

[42] The NYPD treats youth who are sex trafficking victims as "rescues," although they may charge the youth. Staff working with a youth and with the NYPD should not discourage the youth from talking with law enforcement, but must also be sure not to coerce youth to talk.

[43] 17-OCFS-INF-03: "New York State Processes Related to Notifications of Victims of Human Trafficking"

[44] NY Penal Law § 230.34; 17-OCFS-INF-03

[45] NY Penal Law § 230.34; 17-OCFS-INF-03

b. Fax the **NYS Referral Form** to the number on the form.

2. Within three business days of a referral, OTDA shall notify ACS/provider agency and the child or youth regarding whether the child or youth is a State-confirmed trafficking victim[46] and if so, is eligible for benefits and services from a case management provider or any other available source.[47]

3. Staff must immediately assist the child or youth in obtaining the eligible benefits and services, if any.

4. Staff must document OTDA's response, communications with the child or youth regarding ODTA's response, and communications with the referred service provider(s), if any, in CNNX[48], in an email to Child.trafficking@acs.nyc.gov, the case file or record, and any other designated database.

F. Safety Planning

Safety planning is always necessary when working with an identified or possibly sex-trafficked child or youth. CPS teams and case planning teams are responsible for developing safety plans that are flexible, individualized for the youth, and reviewed and updated regularly. Additionally, safety plans must provide for physical, psychological and emotional safety, which includes referring youth to trauma informed service providers who are knowledgeable about sex trafficking.

1. Safety planning with an identified sex trafficked child or youth:

   a. Staff must develop a safety plan with any identified sex trafficked child or youth to increase the likelihood of the plan succeeding. The safety plan shall reflect that the following steps were reviewed:

      i. Assess current and potential risks and safety concerns;

      ii. If applicable, refer the child or youth to the NYC Child Tattoo Eradication Project. The mission of the project is to assist trafficking survivors and former gang members in positively moving forward with their lives through the removal of exploiter brandings and gang-related tattoos, along with relevant, trauma informed support. Based upon the widespread recognition that exploiter and/or gang related brandings inhibit the emotional healing progress, OCTPP has developed a comprehensive network of providers to

[46] 18 NYCRR § 765.4; 9 NYCRR § 6174.3

[47] 9 NYCRR § 6174.3; A child or youth meeting the criteria for certification as a victim of a severe form of trafficking may be eligible for federal, state, or local benefits and services, as determined by OTDA; see 18 NYCRR 765.6.

[48] As per 19-OCFS-ADM-11, there is an option to specify and select "sex trafficking" from "sexual abuse" as a potential allegation in CNNX.

meet the needs of identified youth who want to progress positively with their lives. A youth will need to discuss the specific request with the medical provider before making an informed decision. Parental consent is necessary, unless the youth is over age eighteen, is married or is a parent. Referrals should be sent to: Child.tattoo.removal@acs.nyc.gov[49]

iii. Consider whether the parent or person legally responsible is involved in the child or youth's trafficking, or did not protect the youth from trafficking;[50]

iv. Create strategies to avoid or reduce the threat of harm (e.g. avoiding routes where the trafficker is known to frequent). It may take a child multiple attempts to leave a trafficker;

v. Conduct a debriefing with the child or youth when a child or youth returns to the facility, placement, or program after being absent without consent, missing, or abducted.[51] Staff must use the debriefing tool[52] as a guide to assess safety concerns and address harm reduction with the child or youth. Staff should never use a paper copy of the tool in the child's presence. Staff should achieve familiarity with the questions on the tool and approach the child conversationally; and

vi. Outline actionable steps for the child or youth to take to stay safe in potentially dangerous situations, such as:

a) Planning an escape route or exit strategy, and rehearsing it, if possible;

b) Discussing various options and/or back-up plans if one should fail and ensure the child has resource information for a safe place

c) Obtaining any important documents/items and a change of clothes in preparation for an immediate departure;

d) Considering a change of phone numbers to a number unknown by the trafficker;

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[49] Attachment L: NYC Child Tattoo Eradication Project - Referral Protocol

[50] As a reminder, if a parent/guardian or other person legally responsible is known or reasonably suspected to be involved in the trafficking, staff are mandated to report to the SCR. A parent/guardian or other person legally responsible may also have contributed to trafficking vulnerability through Inadequate Guardianship, Lack of Supervision and/or Lack of Food, Clothing and Shelter.

[51] 16-OCFS-ADM-09: Protocols and Procedures for Locating and Responding to Children and Youth Missing From Foster Care and Non-Foster Care, issued on May 5, 2016.

[52] Attachment M: Debriefing Tool for Children and Youth Who Have Returned After Being Absent Without Consent, Missing, or Abducted, issued on May 5, 2016.

e) Having the child or youth identify trusted friends or relatives who can help support the safety and service plan; and/or

f) Providing the child with contact numbers for service providers[53] or the National Human Trafficking Resource Center (NHTRC) hotline (888-373-7888 or text to 233733) to obtain further assistance (see below for information about service referrals and providers).

b. Staff must document the safety plan in CNNX, and any other designated database, file, form, or record.

1. Safety planning with a child or youth at-risk of becoming a sex trafficked victim

a. Staff must engage in safety planning with any child or youth found at risk of becoming a sex trafficking victim by focusing on the importance of harm reduction. Staff must:

i. Assess potential risks and safety concerns with the child or youth;

ii. Conduct a debriefing with the child or youth when a child or youth returns to the facility, placement, or program after being absent without consent, missing, or abducted.[54] Staff must use the debriefing tool[55] as a guide to assess safety concerns and address harm reduction with the child or youth; and

iii. Provide contact numbers for service providers[56] and information about resources to the child or youth such as:

a) The National Human Trafficking Resource Center (NHTRC) hotline (888-373-7888 or text to 233733)[57];

b) Drop-in centers; or

c) LGBTQ Affirming support services, Immigrant services, or legal assistance[58]

b. Staff must document the safety plan in CNNX progress notes and any other designated database, file, form, or record.

G. Document Service Referrals and Plan and Service Plan in the FASP

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[53] See Attachment K for list of LGBTQ-affirming and anti-trafficking hotlines and service providers.
[54] 16-OCFS-ADM-09.
[55] Attachment M: Debriefing Tool for Children and Youth Who Have Returned After Being Absent Without Consent, Missing, or Abducted, issued on May 5, 2016.
[56] See Attachment K for NYC Services for Trafficked and At-Risk Youth.
[57] See Attachment I for a complete list of Hotlines.
[58] See Attachment I for a complete list of Hotlines.

As always, the child's service needs and the referrals and services connected to those identified needs, which includes referrals to services related to the child's safety plan, must be documented in the child's FASP.

1. CTDB screening results must inform the child's FASP, and thus must be completed by the FASP due date.

2. Staff shall consider whether the following needs of identified sex trafficked victims, or at-risk children and youth, are being met in their homes, placements, or facilities in order to effectively assess for appropriate services.

3. Appropriate services for victims of sex trafficking include but are not limited to: trauma-focused services and supports, services offered by providers who specialize in working with children at risk or with a history of sex trafficking, and any service identified as part of the child's safety plan.

4. Staff must document the assessment for appropriate services and any service referrals made in CNNX, and any other designated database, file, form, or record, including the child's FASP.

H. Ongoing Screenings for Sex Trafficking

1. Staff are expected to remain alert to indicators throughout ongoing contacts with the child and the child's placement and supports, and must complete subsequent sex trafficking screenings throughout the life of a case, especially when the following occur:

   a. A child or youth discloses new information about sex trafficking victimization or risk, or a significant life change related to a trafficking indicator;

   b. Staff observe indicators that give cause to believe the child or youth is a victim or is at risk of being a sex trafficking victim;

   c. A child or youth returns from runaway status or after having been AWOC from foster care;[59] and

   d. Prior to the due date of every comprehensive Family Assessment Service Plan (FASP).

2. Staff must document the following in the CTDB (see Attachment B), CNNX[60], and any other designated database, file, form, or record:

[59] 16-OCFS-ADM-09.
[60] 19-OCFS-ADM-11.

a. Complete any currently active screenings in the CTDB, or if there is no active screening to complete;

b. Manually create a new screening in the CTDB.

c. Note any changes to the level of indicators from the prior screening (for example, if a child had previously been reported at medium-level risk for sex trafficking is now observed to have new indicators at the high-risk level);

d. Completion of law enforcement notification for children and youth identified as child sex trafficking victims;

e. Safety planning and related service referrals made for children and youth identified, or at risk of becoming sex trafficking victims conducted;

f. Notify the Office of Child Trafficking Prevention and Policy at **Child.trafficking@acs.nyc.gov**

g. Referral to state confirmation process for trafficking victims, if applicable.

V. Labor trafficking

In addition to screening and documenting indicators of sex trafficking, staff must also be alert to signs that a person with whom they interact is a survivor of labor trafficking, and must document and report labor trafficking as outlined in this section. Safety planning with a focus on harm reduction must occur with all identified labor trafficking survivors, and staff shall make referrals to appropriate services with providers experienced in working with labor trafficked youth.

A. Indicators

1. The presence of one indicator does not mean a child or youth is a trafficking victim; rather a pattern of red flags and vulnerabilities is a more accurate prediction of labor trafficking. Many youth are both sex and labor trafficked, so. indicators may apply to both sex and labor trafficked youth.

2. Indicators of labor trafficking include, but are not limited to:[61]

   a. Lack of control of income, finances or identification documents;

   b. Unpaid, underpaid, or paid only through tips;

[61] 15-OCFS-INF-08: Promoting Awareness and Best Practices to Address Human Trafficking, issued on August 26, 2015.

c. Works excessively long/unusual hours;

d. Limited freedom to leave working/living conditions;

e. Lives and works in the same place;

f. Signs of trauma, fatigue, injuries, or abuse;

g. Controlled/restricted communications;

h. Excessive/inappropriate security features;

i. Excessive fearfulness of law enforcement;

j. Non-cooperativeness;

k. Unexplained absences from school for a period of time; and/or

l. Running away chronically.

B. Procedure for Suspected Labor Trafficking Cases

1. Staff must immediately notify the ACS Office of Child Trafficking Prevention and Policy (OCTPP) at Child.trafficking@acs.nyc.gov for all suspected labor trafficking cases for notification and guidance.

    a. If applicable, staff must contact an IC for suspected labor trafficking for further consultation and guidance.

    b. If applicable, staff may contact the ACS Office of Immigrant Services at 917-551-7961 or the New York State Department of Labor Division of Immigrant Policies and Affairs, via phone at 877-466-9757, or email at trafficking@labor.ny.gov for further guidance and information.

2. Staff must immediately call in a report of abuse or maltreatment to the SCR if there is a suspicion or concern that the parent or person legally responsible is involved in the child or youth's labor trafficking.

3. Staff must document his or her contact with the ACS Office of Child Trafficking Prevention and Policy, the IC, and the SCR in CNNX and any other designated database, file, form, or record.

VI. Organ Trafficking

In addition to screening and documenting indicators of sex and labor trafficking, staff must also be alert to signs that a person with whom they interact is a survivor of organ trafficking and must document and report organ trafficking as outlined in this section. Safety planning with a focus on harm reduction must occur with all identified organ trafficking survivors, and staff shall make referrals to appropriate services with providers experienced in working with organ trafficked youth.

Organ trafficking is: "the recruitment, transport, transfer, harboring or receipt of living or deceased persons or their organs by means of the threat or use of force or other forms of coercion, of abduction, of fraud, of deception, of the abuse of power or of a position of vulnerability, or of the giving to, or the receiving by, a third party of payments or benefits to achieve the transfer of control over the potential donor, for the purpose of exploitation by the removal of organs for transplantation."[62]

A. Procedure for Suspected Organ Trafficking Cases

1. Staff must immediately notify the ACS Office of Child Trafficking Prevention and Policy (OCTPP) at Child.trafficking@acs.nyc.gov for all suspected organ trafficking cases for notification and guidance. OCTPP will notify the Agency Medical Director.
    a. If applicable, staff must contact an IC for suspected organ trafficking for further consultation and guidance.
    b. If applicable, staff may contact the ACS Office of Immigrant Services at 917-551-7961.

2. Staff must immediately call in a report of abuse or maltreatment to the SCR if there is a suspicion or concern that the parent or person legally responsible is involved in the child or youth's organ trafficking.

3. Staff must document his or her contact with the ACS Office of Child Trafficking Prevention and Policy, the IC, and the SCR in CNNX and any other designated database, file, form, or record.

[62] Declaration of Istanbul on Organ Trafficking and Transplant Tourism (2008), http://www.declarationofistanbul.org/**;** http://hottproject.com/about-the-crime/other-crimes/trafficking-in-organs.html.

We are here to help ACS, contract and provider agency staff with:

- Guidance in work with trafficked and at-risk children/youth and their families:
  - Case Consultations
  - Safety Planning Suggestions
  - Technical Assistance
  - Resource Identification
- The NYC Safe Harbour Program
- Development of Policies and Procedures
- "Movin On': The New York City Child Tattoo Eradication Project & Network": Helping youth to positively move forward with their lives through the provision of trauma informed tattoo removal & relevant support
- "Children are NOT for $ale" Awareness Campaign: brochures and posters in 12 languages!
- Group Work Services for Vulnerable Youth:
  - Dialectical Behavioral Therapy
  - Love146 #Not a Number
  - I am Little Red
  - Power Me Up!
  - Creative Arts Therapy
- Events, trainings, conferences:
  - Trained over 3,600 professionals, youth and community members in 2019!
  - Produces the annual Human Trafficking Exposition and Resource Fair and a host of other events specifically for "January is National Slavery and Human Trafficking Prevention Month"
  - Provides expert workshops and panel presentations at agencies, schools, hospitals, other venues, and at national and local conferences
- The Child Trafficking Database (CTDB): Mandated electronic sex trafficking screenings and longitudinal data aggregation
- The Female Genital Mutilation/Cutting Awareness (FGM/C) Initiative

Contact us at:

- **Child Trafficking Mailbox** for case identification, guidance and Law Enforcement Referrals: Child.trafficking@acs.nyc.gov
- **Child Trafficking Database (CTDB)** Issue Mailbox: CTDB@acs.nyc.gov
- **OCTPP Training Request Mailbox**: Traffickingtraining@acs.nyc.gov
- **Child Tattoo Removal Mailbox** for inquiries/referrals: Child.tattoo.removal@acs.nyc.gov
- **FGM/C Mailbox** for Female Genital Mutilation/Cutting: FGM@acs.nyc.gov

The Child Trafficking Database (CTDB)

Administrated by ACS' Office of Child Trafficking Prevention and Policy (OCTPP), and platformed in Microsoft Dynamics, the Child Trafficking Database (CTDB) allows assigned staff to electronically complete the mandated OCFS sex trafficking screening tools, thereby alleviating the use of paper tools. All children under investigation, in the care of ACS contracted foster care agencies, and receiving services from preventive service agencies and juvenile detention providers are expected to be screened using the CTDB. The only exception to use of the CTDB for sex trafficking screening is for Advocates Preventive-Only (ADVPO) cases, which require the use of paper screening tools to maintain the confidentiality required by the Advocate's Agreement.

The CTDB allows staff to view child trafficking screening histories of children on their caseload, input screenings and view caseload demographics relevant to screenings assigned. The CTDB permits every screening to be recorded and saved in the system for future access by a worker assigned to a child (and only when a worker is assigned to a child), and for administrative research and reporting needs, as required by Federal and State legislation.

The development of the CTDB had been divided into two phases: Phase 1: Child Trafficking Screening Tool and Phase 2: Demographic and Service Data and Reports. Phase I, launched on February 15, 2017, provided a mechanism for data input in relation to NYS child sex trafficking screening mandates. CTDB Phase II, scheduled for release in early 2020, will encompass expanded abilities, including a new window which permits the viewing and recording of services, and auto-generated report capability:

- The ability for authorized users to record information related to referring, receiving and/or providing services for every child identified as trafficked or at-risk for trafficking in a comprehensive screening
- The ability to run a 'Child Screening History' report which shall include Child Services History to view information on every screening ever done on a child, and any services provided
- The ability to run a CTDB Area Compliance report that shall display all completed screenings for all children based on a specific ACS Division, Provider Name (program area), and shall display all Active/Inactive screenings.
- The ability to run a CTDB Indicator Trend report – to view how many times a particular indicator had been selected for a specified timeframe
- The ability for users with "Screener" and "Supervisor" assigned roles to deactivate a screening for a specifically provided reason

Questions about the CTDB should be emailed to CTDB@acs.nyc.gov

Child.trafficking@acs.nyc.gov

Red Flags for Sex and Labor Trafficking and Who To Contact:

Sex Trafficking:

- Exploited by a trafficker/exploiter/pimp
- Engages in survival sex
- Uses sex to obtain goods
- Lives in a brothel or trap house
- Works in a strip club, massage parlor, adult book/video stores
- Works as an exotic dancer or escort
- Child Pornography (photo, video)
- Suspicious tattoos, especially of a man's name: "daddy", bar code, paw prints
- Has a cell phone that the parent did not provide
- Expensive new clothing and jewelry, hairstyles and nails
- Gang involvement
- References to frequent travel to other cities
- Abusive relationship(s)
- Significantly older partner or spends a lot of time with a controlling person or older adult
- Indications or reports of domestic violence/intimate partner violence
- Runs away from home frequently and/or for significant periods of time
- Shows signs of mental, physical, or sexual abuse
- Has large amounts of money or costly items that s/he cannot reasonably afford
- Involvement in systems such as social services, PINS, courts, etc.
- Exhibits overt sexualized behavior
- Exhibits evidence of sexual abuse
- Is unwilling or unable to identify as a victim

Labor and/or Sex Trafficking:

(Many children are **both** sex and labor trafficked)

- Reluctant to discuss how they make money, where they live, how or when they came to the U.S.
- Lacks control over schedule and/or money
- Is unwilling to disclose whereabouts or information about parents or caregivers
- Is scared of consequences to a degree greater than a situation (for example being late) merits
- Is not in control of their own identification or travel documents
- Works excessive hours
- Unpaid for work, or paid very little
- Lives with their employer, or with multiple people in a cramped space
- Does not manage own money

- Appears to have little privacy or is rarely alone
- Appears to be under someone else's control or under surveillance, needs to answer phone promptly
- Contacts with family, friends, professionals are monitored
- Exhibits submissive or fearful behavior
- Coached or rehearsed responses to questions
- Lies about age or carries a fake form of identification
- Housing is provided by employer
- Youth retells the same story in the same way many times, giving the appearance that the story has been coached

Medical Issues Relevant to Trafficking:

- STD, HIV/AIDS, pelvic pain, inflammation, rectal trauma, urinary difficulties, abdominal or genital trauma
- Multiple STDs and/or abortions
- Evidence of sexual abuse
- Mental Health Issues: emotional distress, depression, anxiety, panic attacks, confusion, phobias, disorientation, self-mutilation, suicidality, helplessness, shame, humiliation, fearfulness, trauma symptoms
- Visible or untreated injuries, scars, cuts, bruises, burns
- Untreated illness or infection (including STDs)
- Explanation inconsistent with, or contradictory to injury
- General poor health and diseases associated with unsanitary conditions
- Suicidal ideation and/or depression

Who To Contact:

If you believe the person is in immediate danger, call 9-1-1. Otherwise, please contact:

- The National Human Trafficking Hotline at 888-373-7888 or Text to 233733
- NYPD Human Trafficking Hotline: 646-610-7272
- If a child is trafficked and missing from home or a program: The National Center for Missing and Exploited Children (NCMEC) at 1-800-THE-LOST (800-843-5678), or use their Cyber Tipline at www.missingkids.com
- If the suspected trafficker is a parent or person legally responsible for the child: The NY Statewide Central Register of Child Abuse and Maltreatment at: 1-800-342-3720
- If you have reason to believe that a youth is being abused or neglected while placed in residential care, call the New York State Justice Center at 1-855-373-2122

If you are from ACS, Foster Care, Preventive Services or Detention Services, please ALSO notify:

- The ACS Child Trafficking Mailbox at: Child.trafficking@acs.nyc.gov
- NYPD, using the OCFS-3922 form may also be required as per 15-OCFS-ADM-16. See handout on how to send the form to NYPD.
- The NYS Office of Temporary and Disability Assistance (OTDA) to commence the victim confirmation process for a child meeting the Federal Definition of Sex Trafficking. Fax the *New York State Referral of Human Trafficking Victim* to 518-485-9611

NYC Children | Office of Child Trafficking Prevention and Policy

Child.trafficking@acs.nyc.gov

Language Associated with the Commercial Sex Industry*:

- **12:** Notifying others that Law Enforcement is in the area.
- **Automatic:** The victim's "automatic" routine when the exploiter is not physically present.
- **Beef:** Argument that can escalate to physical fighting.
- **Bottom or Bottom Bitch**: the #1 woman who acts as an enforcer.
- **Branding**: A tattoo or carving on a victim that indicates ownership by a trafficker/pimp/gang.
- **Brothel (Cathouse, Whorehouse):** Guarded locations to keep exploited in and criminals and law enforcement. Victims are often locked in until they are rotated to other locations.
- **Caught a Case:** When exploited or exploiter has been arrested and charged.
- **Catch a Fade**: Invitation to fight.
- **Choosing Up:** If a victim makes eye contact with a pimp, the pimp takes ownership.
- **Circuit**: A series of cities among which victims are moved.
- **Cousins In Law:** Victims of pimp partners working together
- **Curb (Kerb) Crawling:** Driving down the street, looking for a "date".
- **Daddy:** Pimp/exploiter/trafficker (male or female).
- **Dates**: Interaction with Johns, Tricks (buyers of sex).
- **Escort:** Dates arranged by telephone or Internet. Can be outcall (victim travels), or in-call (buyer travels).
- **Exit Fee:** An outrageously large amount of money demanded by the exploiter for the victim to leave the life. (Most exploiters do not let their victims leave.)
- **Family or Folks:** The other members of the stable.
- **Fleek:** Looking good.
- **Flexing:** Lying.
- **Head Cut:** Victim beat down by the pimp.
- **Hurt:** Unattractive.
- **In Pocket:** Not speaking to other pimps, or paying other pimps (controlled).
- **Gorilla Pimp:** Controls through force and humiliation and pain.
- **John (Buyer, Trick):** Trades something of value for sex.

- **Kiddie Stroll:** Area that has younger victims.
- **Lit:** Excited or intoxicated.
- **Loose Bitch:** Keeps choosing different pimps.
- **Lot Lizard:** Exploited at truck stops.
- **Madam:** Manages a brothel, escort service or other trafficking house.
- **Out of Pocket:** when an exploited breaks the rules and makes eye contact with another pimp, or when an unaffiliated trafficked individual is harassed to force him/her to select a pimp.
- **Pimp Circle:** humiliation and intimidation by pimps swarming and hissing insults around the exploited, forcing choose up.
- **PI:** Someone else's pimp.
- **Pipeline:** a chain of states through which victims are moved through a series of locations to markets.
- **Reckless Eyeballing:** Looking around instead of looking down.
- **Renegade:** Without a pimp.
- **Salty:** Upset or angry.
- **Seasoning:** Actions to break resistance and maintain compliance. Can include psychological manipulation, physical violence, rape, sleep or food deprivation, threatening a victim' family.
- **Quota:** The amount an exploited must make before returning home.
- **Romeo Pimp (aka Finesse Pimp):** Controls through psychological manipulation.
- **Square/Squaring Up:** trying to get out of "the life" or "the game"
- **Stable:** The group controlled by the pimp
- **Stroll or Track or Blade:** where sex work occurs regularly.
- **Survival Sex:** Exchanging sex for basic needs to survive.
- **The Game or The Life:** The culture of exploitation.
- **Trade Up/Trade Down:** Exchanging victims like objects.
- **Trap House:** Originally used to describe a place where drugs were sold, it has been extended to exploitation, meaning a location where there is only one exit which is heavily guarded. Victims are trapped inside and sex is exchanged for drugs.
- **Turning a trick:** Act of exploitation.
- **Turn out:** Newly involved, or to be forced into exploitation.
- **Wifeys/Wife in Law:** the other "family" or "folks" of the stable.
- **Wire:** A pimp phone tree to share information, or a victim sending money to a pimp long distance.

NEW YORK STATE
OFFICE OF CHILDREN AND FAMILY SERVICES

RAPID INDICATOR TOOL

To Identify Children Who May Be Sex Trafficking Victims or Are At Risk of Being a Sex Trafficking Victim [1]

The indicators listed on page two help to determine whether a child may be a victim of sex trafficking, or is at risk of being a victim of sex trafficking. These factors are to be considered as a means to determine whether there is reasonable cause to believe the child is a victim or at risk of being a victim, in which case a more comprehensive assessment of the child's experiences and service needs is required. [2]

Do not directly ask the child or family the questions. This is not a questionnaire.

Populations

This tool is to be applied in **all** instances, regardless of age, where a child is in the care, supervision or custody of a local department of social services (LDSS) or the Office of Children and Family Services (OCFS). For more information on the population this tool pertains to, please see *Requirements to Identify, Document, Report, and Provide Services to Child Sex Trafficking Victims* (LDSS/VAs) or *Child Sex Trafficking/Commercially Sexually Exploited Children (CSEC)* (OCFS DJJOY).

When to Complete the Tool

The tool MUST be completed and documented:

- If the child returns from being missing, abducted, or absent without consent.
- If a new CPS investigation is opened for the child.

For Cases in CONNECTIONS

- By the due date of the initial Family Assessment and Service Plan (FASP).
- Prior to the investigative or FAR case being closed (whether the case is completed and closed or transferred to receive foster care or preventive services).

For Cases in Juvenile Justice Information System (JJIS)

- During the intake/reception process.

If the child's circumstances change or new information is learned, the tool may be used in addition to the above requirements.

Completion of the Tool

The information about the indicators below is to be collected through the routine process of investigation or case work. The tool should be completed based on the information already gathered as part of the investigation for CPS cases or in the case record.

If the child has already disclosed sex trafficking this tool does **not** need to be completed. The comprehensive screening tool should be completed instead. All children identified as victims must receive services to address the needs identified.

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[1] *Referenced as the quick screening tool in the sex trafficking requirements policies.*
[2] *Child Sex Trafficking Indicators Tool.*

Name of Child: ______________________ **DOB:** ____________

Name of Person Completing Form: ______________________ **Date:** ____________

Agency: ______________________

The following is a list of some red flags that indicate a child may be a sex trafficking victim or is at risk of being a victim of sex trafficking.

- **Do not directly ask the child or family the questions. This is not a questionnaire.**
- **The child may be a victim or is at risk if the answer is "Yes" to any of the indicators below:**

	Yes
Are there signs of child abuse of a sexual nature and reason to believe that the child, or parent/guardian of the child or other person(s) facilitating the abuse, was given or promised anything in return for the sexual abuse?	☐
Is there reason to believe there are photographs, social media posts, or other recordings of instance(s) of sexual abuse of the child?	☐
Has the parent/guardian been a victim of trafficking or is there concern that the parent/guardian has been a victim?	☐
Does the child have a history of multiple runaways/AWOLS or episodes of homelessness/couch surfing in the past? (Family homelessness should not be counted)	☐
Does the child have tattoos that show, imply, or suggest ownership and/or that he or she does not have an explanation for? (e.g., daddy's girl, property of someone's name, symbols, etc.)	☐
Does the child have or has he or she previously had a significantly older boyfriend or girlfriend who is controlling and/or whom the child appears to be afraid of?	☐
Does the child have a history of multiple or chronic sexually transmitted infections, or pregnancies/abortions, or report multiple anonymous sexual partners?	☐
Does the child have money, a cell phone, hotel keys, or other items that he or she does not have the resources to obtain and cannot account for?	☐
Has a gang affiliation been disclosed, reported, or suspected?	☐
Is someone else other than the child's parent or guardian in control of his or her identification or passport?	☐
Do you have any other reason to believe the child may be a sex trafficking victim?	☐

The Results: Documentation and Required Actions

The worker must document the results of this tool in CONNECTIONS or JJIS.

☐ No indicators have been marked "yes". The worker enters "No Risk Indicators" into CONNECTIONS/JJIS and no further screening is needed, unless new information is learned, the child's circumstances change, the child returns from being missing, abducted, or absent without consent or a new CPS investigative case is opened for the child.

☐ There **are** one or more indicators marked "**Yes**" or the child has already been determined to be a victim. The worker enters "**At Risk**" into CONNECTIONS/JJIS and must complete the comprehensive screening tool(s) as outlined in the policies *Requirements to Identify, Document, Report, and Provide Services to Child Sex Trafficking Victims* (LDSS/VAs) or *Child Sex Trafficking/Commercially Sexually Exploited Children (CSEC)* (OCFS DJJOY)

Place a copy of this form in the child's case record for documentation of completion and decision.

NEW YORK STATE
OFFICE OF CHILDREN AND FAMILY SERVICES

CHILD SEX TRAFFICKING INDICATORS TOOL

To be used for the comprehensive screening

This tool is based on the work done by Westchester County and Monroe County through the Safe Harbour: NY program (formerly known as ChildRight: New York). Safe Harbour: NY is a New York State Office of Children and Family Services (OCFS)-coordinated program that aims to improve the ability of local departments of social services (LDSSs) and child welfare-serving agencies to efficiently and effectively use their resources to respond to and care for children and youth who are victims of commercial sexual exploitation or child trafficking.

This tool is to be used with children who the LDSS, VA, or juvenile justice staff believe may be a victim, believe may be a victim, or are at risk of being a victim, of sex trafficking. The tool assists workers with looking at possible indicators of sex trafficking, or at risk of sex trafficking, that the child may exhibit. Other than those that are disclosures or proof of trafficking or commercial sex acts, exhibiting one of these indicators does not automatically mean that a child was a victim of trafficking.

The indicators are grouped into “meets child trafficking definition”, “high” and “medium” levels, indicating that a child may have been trafficked or is at risk of being trafficked. Some items included in medium level may be of high concern in general, but may fall on the medium scale for sex trafficking indicators (for example, while a child under 13 who is engaging in sexual activity is of general high concern, it may not correlate with a higher level indicator for sex trafficking, depending on the specific circumstances). Youth with higher numbers of indicators or who have indicators in a higher level are more likely to have been trafficked or engage in behaviors that may increase the risk of being trafficked. The child’s indicator level should be used when developing the child’s case plan and referral for services for him/her. In addition, when completing the indicator level tool, workers should carefully consider when youth who have certain vulnerabilities, such as chronic homelessness, multiple runaway episodes, are LGBTQ, immigration status issues, developmental delays, and/or history of sex abuse, also have indicators present, as they may hold more weight due to the increased vulnerability of the youth.

If an indicator is checked off under the section titled, “Child meets federal definition as child sex trafficking victim,” the child must be documented as a sex trafficking victim and the response protocol must be followed. This includes documenting the notification to law enforcement within 24 hours. See the policy *Requirements to Identify, Document, Report, and Provide Services to Child Sex Trafficking Victims* (for LDSSs and VAs) or *Child Sex Trafficking Commercially Sexually Exploited Children (CSEC)* (for OCFS DJJOY) for more information.

If a child is determined to be a trafficking victim, the worker is not required to complete the rest of the indicators on the checklist during the initial screening, but it is recommended that the worker revisit the tool and check off all applicable indicators when developing the child’s case plan and referring the child for services. This is also the case for the other levels of indicators. If a child has high or medium level indicators, there is no need to complete the rest of the checklist during the first screening, but it should be done prior to the development of the plan of services for the child.

These levels are meant to be fluid; a child’s indicator level may go up or down based on information learned during the life of the case. The tool should be used any time the worker learns new information about the child that may be an indicator of trafficking involvement. Workers should mark the indicators the child exhibits and follow the instructions for each section.

Name of Youth: ______________________ DOB: / /

Name of Person Completing Form: ______________________ Date: / /

Agency: ______________________

Child Meets Federal Definition of a Child Sex Trafficking Victim - ONE or more of these indicators: Child needs to be documented as a trafficking victim in CONNECTIONS or JJIS (for DJJOY) and trafficking response protocol followed (see policy or desk aid[1]).	Yes	No
Child reports engaging in commercial sex act(s) (a sex act where something of value is received).	☐	☐
Child reports he/she has been prostituted or trafficked.	☐	☐
There are photos or videos of the child being victimized and/or being used to advertise the child for sexual purposes (Backpage, Craigslist, etc).	☐	☐
Law enforcement refers child instead of arresting for prostitution, or does arrest for prostitution.	☐	☐
Child reports trading sex for a place to stay, food, drugs, or anything of value.	☐	☐
Child reports being involved in the sex industry (working in strip clubs, private sex parties, etc.).	☐	☐
Someone witnesses the child engaged in a commercial sex act.	☐	☐
Youth over 18 is engaging in prostitution or commercial sex acts due to force, fraud or coercion.	☐	☐
High-Level Indicators - ONE or more of these indicators Child exhibits indicators that are commonly associated with sex trafficking, which causes serious concerns. Document high-level Indicators in CONNECTIONS or JJIS (for DJJOY). Child needs to be closely monitored and needs intensive case management services to address current or prevent future trafficking.	Yes	No
Associating with adults or other children/youth who are being prostituted, or are known to be involved with trafficking and/or exploitation.	☐	☐
Being seen in exploitation hotspots, i.e., known houses or recruiting grounds.	☐	☐
Pattern of street homelessness and staying with someone believed to be sexually exploiting the youth.	☐	☐
Multiple AWOLS, runaway or being kicked out (4+).	☐	☐
Being taken to clubs and hotels by adults or older peers.	☐	☐
Disclosure of serious sexual assault and then withdrawal of statement.	☐	☐
Abduction and/or forced imprisonment; not allowed to freely move about.	☐	☐
Child discloses or someone reports the child being moved around for sexual activity.	☐	☐
Disappearing from the “child welfare system” with no contact or support.	☐	☐
Use of slang trafficking terms (e.g., calling romantic partner “Daddy” or “Mommy,” talking about “the life,” “the game”).	☐	☐
Recruiting peers into exploitation.	☐	☐
Tattoos that he/she is reluctant to explain, especially if they show ownership (names, dollar signs, symbols, acronyms) or other types of branding, like cutting or burning.	☐	☐
Does not have any identification or reports someone holding his/her identification.	☐	☐
Unexplained hotel keys.	☐	☐
Child discloses or someone reports that child offered to have sex for money or other payment and then ran before sex took place.	☐	☐
Being groomed and/or sexualized on the Internet; contact with strangers on the Internet and/or sexual risk taking on social media, such as Facebook, Backpage, Zoosk, Craigslist.	☐	☐

[1] *Requirements to Identify, Report, and Provide Services to Child Sex Trafficking Victims* (for LDSSs and VAs) or *Child Sex Trafficking/Commercially Sexually Exploited Children (CSEC)* (for DJJOY).

Medium-Level Indicators - ONE or more of these indicators Child exhibits significant indicators that may indicate sex trafficking. Document medium level of Indicators in CONNECTIONS or JJIS (for DJJOY). Child should be more closely monitored and provided services that may address current or prevent future trafficking.	Yes	No
Getting into cars with unknown adults.	☐	☐
Child under 13 engaging in sexual activity.	☐	☐
Known history of prior sexual abuse or sexual acting out.	☐	☐
Having an older boyfriend/girlfriend, especially if he or she appears controlling; youth appears fearful of boyfriend/girlfriend at times.	☐	☐
Not attending school; concerns regarding school attendance.	☐	☐
Staying out overnight with no explanation multiple times and/or regularly coming home late or going missing.	☐	☐
Unaccounted money or goods, including mobile phones, drugs and alcohol, or other person supplies these goods/money to child/youth.	☐	☐
Multiple sexually transmitted infections, pregnancies and/or multiple miscarriages or abortions.	☐	☐
Gang member or association with gangs or neighborhood groups.	☐	☐
Someone else other than the child's parent or guardian was in control of immigration to U.S.	☐	☐
Overt sexual dress.	☐	☐
Does not know his/her address and/or has moved multiple times.	☐	☐
Chronic alcohol and/or drug use by youth.	☐	☐
Youth's story does not make sense - inconsistencies, the narrative doesn't fit together.	☐	☐

Contact for non-emergency questions on child trafficking: ocfs.sm.sppd.child.trafficking.questions@ocfs.ny.gov

NEW YORK STATE
OFFICE OF CHILDREN AND FAMILY SERVICES

LAW ENFORCEMENT REPORT OF A CHILD SEX TRAFFICKING VICTIM

Directions: If the youth is in immediate danger, do not complete this form, call 9-1-1. Otherwise, complete the following questions:

1. Is the youth under 21 years old and in the care, custody, or supervision of the New York State Office of Children and Family Services (OCFS), Local Department of Social Services (LDSS), or a Voluntary Authorized Agency (VA)?

   ☐ Yes – **CONTINUE** ☐ No – **STOP** do not complete this form

2. Are you submitting this form to notify law enforcement of a missing child or a youth who is absent from care?

   ☐ Yes – **STOP** do not complete this form; refer to 16-OCFS-ADM-09 ☐ No – **CONTINUE**

3. Does the youth meet one or more of the criteria below (check all that apply)

Child Meets Federal Definition of a Child Sex Trafficking Victim - ONE or more of these indicators: Child needs to be documented as a trafficking victim in CONNECTIONS or JJIS (for DJJOY) and trafficking response protocol followed (see policy or desk aid[1]).	
Child reports engaging in commercial sex act(s) (a sex act where something of value is received).	☐
Child reports he/she has been prostituted or trafficked.	☐
There are photos or videos of the child being victimized and/or being used to advertise the child for sexual purposes (Backpage, Craigslist, etc.).	☐
Law enforcement refers child to services instead of arresting for prostitution, or does arrest for prostitution.	☐
Child reports trading sex for a place to stay, food, drugs, or anything of value.	☐
Child reports being involved in the sex industry (working in strip clubs, private sex parties, etc.).	☐
Someone witnesses the child engaged in a commercial sex act.	☐
Youth over 18 is engaging in prostitution or commercial sex acts due to force, fraud or coercion.	☐

   ☐ Yes – **CONTINUE** ☐ No – **STOP** do not complete this form

4. Are there any federal, state, county, or municipal law enforcement agencies already involved in the youth's case relevant to his or her trafficking victimization? (This includes law enforcement involved in Multi-Disciplinary Teams (MDT) or Child Advocacy Centers (CAC), as well as Department of Labor investigators. This **does not** include Probation Officers nor instances where a youth has been accused of a crime, including loitering or prostitution.)

   ☐ Yes – **STOP do not complete this form** ☐ No - **CONTINUE**

If all four conditions are met, continue completing this form. If not, stop here.

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[1] The terms "child" and "youth" are used interchangeably throughout this form.

[2] *Requirements to Identify, Report, and Provide Services to Child Sex Trafficking Victims* (for LDSSs and VAs) or *Child Sex Trafficking/Commercially Sexually Exploited Children (CSEC)* (for DJJOY).

Youth Information

Youth's name: ______________________ Today's Date: / /

Youth's DOB: / /

Youth's Gender: ☐ Male ☐ Female ☐ Trans-male ☐ Trans-female ☐ Gender Non-conforming

Youth's current address:

Legal Permanent Address (if different than current address)

Youth's phone number: Cell: ( ) - Secondary: ( ) -

Youth's social media handles (Email address, Instagram, Snapchat, Twitter, Facebook, Kik, WhatsApp etc.):

Describe any visible physical marks (branding, tattoos, etc.) on the youth's body:

Addresses/locations where youth often spends time or sleeps:

Trafficking Situation

Describe what is known about the trafficking situation:

Do you believe the youth is currently being trafficked? ☐ Yes ☐ No

Date of most recent victimization, if known: / /

County/city/borough(s) where trafficking act(s) occurred, if known:

Any information about the alleged perpetrator(s), including names and nicknames, if known:

*If the alleged perpetrator is the youth's parent, guardian, or a person legally responsible for his or her well-being, a report **must also be made** to the NYS Central Register of Child Abuse and Maltreatment (SCR) by calling **1-800-342-3720**.*

If an SCR report was made check "Yes" box: ☐ Yes

Person Completing This Form

Name: ______________________ Phone number: ( ) -

Agency/District: ______________________________

Name of your supervisor: ______________________ Supervisor's phone number: (   )   -

Evening contact name and phone number for person familiar with this report:

Next Steps

1. Fax only the completed form (no other documentation), **immediately or within 24 hours to**:
   - **New York City**: New York Police Department (NYPD) at **212-694-3149**
   - **Rest of State**: New York State Intelligence Center (NYSIC) at **518-786-9398**
2. Place a copy of this form and the fax confirmation in the youth's case file.

The notification process is complete once the documentation is filed. After faxing this form, do not make additional law enforcement referrals (except calling 9-1-1 relevant to immediate danger).

For questions, refer to the FAQ attached to 15-OCFS-ADM-16, contact your OCFS Regional Office, or email humantrafficking@ocfs.ny.gov.

For law enforcement use only:

Case/Complaint Number: ______________________________

New York State Referral of Human Trafficking Victim

FAX TO 518-485-9611

Social Services Law §483-cc requires that this form be completed and sent to the Division of Criminal Justice Services and the Office of Temporary and Disability Assistance as soon as practicable after a first encounter with a person who reasonably appears to be a human trafficking victim.

Date Form Faxed: ____/_____/_____ Time Form Faxed: _____ : ____ a.m. / p.m. (circle one)

Victim's Name: ____Victim's DOB: ____/____/_____

Victim's Gender:____

Was victim trafficked from another country? YES__ NO__ DON'T KNOW__

Penal Law crime committed against victim: Sex Trafficking/Penal Law §230.34 __ Labor Trafficking/Penal Law §135.35 __

Incident number: ____

Date & Jurisdiction where Penal Law crime occurred:____

Is victim willing to assist in investigation/prosecution of trafficker(s)? YES___ NO___

Was victim arrested? YES__ NO__ Court case is pending in:_____________________________________

Statutory Referral Source:

____

Contact person:____

Telephone (______) __________________________ E-mail ____

Address ____

If a service provider or local social services department is involved or has been contacted, please provide name or any other contact information. ____

____

Please indicate the facts and circumstances regarding Penal Law crime committed against victim and the victimization upon which this referral is based. Describe any force, fraud, or coercion used and be as specific as possible. Use additional sheets if necessary.

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Office of Children and Family Services

Andrew M. Cuomo
Governor

52 WASHINGTON STREET
RENSSELAER, NY 12144

Sheila J. Poole
Acting Commissioner

Informational Letter

Transmittal:	17-OCFS-INF-03
To:	Commissioners of Social Services Executive Directors of Voluntary Authorized Agencies Temporary Assistance Directors
Issuing Division/Office:	Child Welfare and Community Services
Date:	March 17, 2017
Subject:	**New York State Processes Related to Notifications of Victims of Human Trafficking**
Suggested Distribution:	OCFS Regional Directors Directors of Social Services Child Protective and Preventive Services Supervisors Child Welfare Supervisors Foster Care and Adoption Supervisors Staff Development Coordinators Temporary Assistance Directors LDSS Human Trafficking Liaisons
Contact Person(s):	humantrafficking@ocfs.ny.gov InfoDCJS@dcjs.ny.gov bria.contact@otda.ny.gov
Attachments:	*New York State Referral of Human Trafficking Victim Form* The following attachments can be accessed by clicking on their titles or by using the OCFS website links below: • OCFS-3920: *Child Sex Trafficking Indicators Tool* • OCFS-3921: *Rapid Indicator Tool* • OCFS-3922: *Law Enforcement Report of a Child Sex Trafficking Victim Form* • *Sample Sex Trafficking and CSEC Referral Flow Chart: For youth in the care, custody or supervision of an LDSS, Voluntary Agency, or OCFS* • *DSS Quick Reference Guide for compliance* with 15-OCFS-ADM-16 • OCFS intranet: http://ocfs.state.nyenet/admin/forms/Foster_Care/ • OCFS internet: http://ocfs.ny.gov/main/documents/forms.asp

Filing References

Previous ADMs/INFs	Releases Cancelled	NYS Regs.	Soc. Serv. Law & Other Legal Ref.	Manual Ref.	Misc. Ref.
09-OCFS-ADM-01 / OTDA 09-ADM-01 16-OCFS-ADM-09 15-OCFS-ADM-16 15-OCFS-INF-08 15-OCFS-INF-03		18 NYCRR 431.8(b)(3)(iii)	22 U.S.C. §7102; 42 U.S.C. §§671- 679b; Social Services Law §483-aa, bb, cc Chapter 74 of the Laws of 2007; Chapter 368 of the Laws of 2015		Preventing Sex Trafficking and Strengthening Families Act (P.L. 113-183); ACYF-CB-IM-14-03; ACYF-CB-PI-14-06

I. Purpose

The purpose of this Informational Letter (INF) is to explain differences between certain requirements (detailed in 15-OCFS-ADM-16) to identify, document, and report child victims of trafficking, and the process of confirming human trafficking victimhood; a process managed by the New York State Division of Criminal Justice Services (DCJS) and New York State Office of Temporary and Disability Assistance (OTDA).

II. Background

On September 29, 2014, President Obama signed the *Preventing Sex Trafficking and Strengthening Families Act* (P.L. 113-183) [hereinafter referred to as the "Act"] into law, which amended various provisions of Title IV - E of the *Social Security Act* (SSA). The Act has two primary purposes - to protect and prevent at-risk children and youth from becoming victims of sex trafficking, and to improve the safety, permanency, and well-being outcomes of children and youth involved with the child welfare system. Among other provisions, the Act requires that policies, procedures, and tools for identification, documentation, and response to child victims of sex trafficking, or those at risk of becoming victims, be developed. In response to the Act, the New York State Office of Children and Family Services (OCFS) issued the *Requirements to Identify, Document, Report, and Provide Services to Child Sex Trafficking Victims* Administrative Directive (ADM).[1] For more information on the basic provisions of the Act, please see 15-OCFS-INF-03.[2]

[1] 15-OCFS-ADM-16 *Requirements to Identify, Document, Report, and Provide Services to Child Sex Trafficking Victims.*
[2] 15-OCFS-INF-03 *Preventing Sex Trafficking and Strengthening Families Act.*

On November 1, 2007, the *New York State Anti-Trafficking Law*[3] took effect, establishing human trafficking as a state crime, and establishing a process to "confirm" victims of human trafficking under the state law. This process was established as a means of providing assistance to confirmed victims, including those who would not be otherwise eligible for assistance due to their immigration status. Confirmed victims, if otherwise eligible, are eligible for benefits and services in accordance with their citizenship or immigration status. On January 7, 2009, OCFS and OTDA issued 09-OCFS-ADM-01 / OTDA 09-ADM-01 to provide local districts with information about this law and its effects, including details about the confirmation process and benefits available to victims.

The *New York State Anti-Trafficking Law* requires DCJS and OTDA to accept referrals of potential victims from local law enforcement agencies or local district attorneys' offices. In 2015, the ability to refer potential victims of human trafficking expanded to include established legal and social services providers.[4]

Based on the requirements of the two laws, the three agencies (OCFS, OTDA, and DCJS) have roles in the identification and the provision of services to victims. Per the *New York State Anti-Trafficking Law,* OTDA and DCJS are charged with confirming or denying referrals of victims made to their agencies to allow access to services. Additionally, OTDA manages the New York State Response to Human Trafficking Program (RHTP), which provides case management and referral services to adult foreign-born, New York State confirmed trafficked persons who by virtue of the lack of an eligible immigration status are therefore not otherwise eligible for any mainstream benefits and/or services. This referral process is open to any potential victim of human trafficking, including minors in the care, custody, or supervision of OCFS, local departments of social services (LDSSs), and voluntary agencies (VAs). Additionally, per the federal *Preventing Sex Trafficking and Strengthening Families Act*, OCFS provides oversight to its facilities, LDSSs, and VAs to screen, identify, and provide services to identified victims of human trafficking and youth identified as at risk of becoming a victim.

DCJS, in consultation with OTDA, must determine whether to confirm the referred person as a human trafficking victim (HTV) under statutory and regulatory guidelines. Once confirmed, victims are directed to either the LDSS or the RHTP service provider network. For more information on the *New York State Anti-Trafficking Law* or the RHTP, please refer to OTDA 09-ADM-01.[5]

III. Program Implications

The specific purposes, affected populations, and procedures of the separate and distinct screening, notification, and referral processes of the child sex trafficking and confirmation of victimhood policies described above are summarized in the following table and diagrams:

	Child Welfare Screening and Law Enforcement Notification	**Confirmation of Victimhood**

[3] Chapter 74 of the Laws of 2007.
[4] Chapter 368 of the Laws of 2015.
[5] OTDA 09-ADM-01 *New York State Anti-Trafficking Statute.*

Lead Agency and Contact	**OCFS:** 518-474-8536; humantrafficking@ocfs.ny.gov; http://ocfs.ny.gov/main/humantrafficic/	**OTDA:** (518) 402-3096; bria.contact@otda.ny.gov; https://otda.ny.gov/programs/bria/trafficking.asp **DCJS:** (518) 457-5837, InfoDCJS@dcjs.ny.gov; http://www.criminaljustice.ny.gov/pio/humantrafficking/humantrafficking.htm **Shared OTDA/DCJS fax:** (518) 485-9611
Relevant Policy	*Requirements to Identify, Document, Report, and Provide Services to Child Sex Trafficking Victims* (15-OCFS-ADM-16)	*New York State Anti-Trafficking Law* (OTDA 09-ADM-01)
Purpose of Process	To identify, document, and provide services to child sex trafficking victims in the child welfare system	To identify and document adult and minor victims of human trafficking, and refer to the appropriate service provider based on age and eligibility status
Applicable Definition of Victims of Sex Trafficking	OCFS's policies refer to the federal definition of sex trafficking, namely that any person under 18 years old who has engaged in transactional or commercial sex is a victim of "severe form of trafficking in persons."[6] **For the purposes of OCFS policies, any child under age 18 who has engaged in transactional sex or a commercial sex act is considered a sex trafficking victim, regardless of whether force, fraud, or coercion is present.**	OTDA and DCJS may confirm an individual under the New York State confirmation process using any definition of "trafficking in persons," either state[7] or federal.[8] The trafficking must have a nexus to New York State and must have occurred after the *New York State Anti-Trafficking Law* went into effect in 2007.
Applicable Definition of Victims of Labor Trafficking	The *Requirements to Identify, Document, Report, and Provide Services to Child Sex Trafficking Victims* policy only applies to child victims of sex trafficking; however, children and youth are also able to access services	Referrals for confirmation and associated services are available to potential victims of both sex and labor trafficking under New York State and federal definitions.

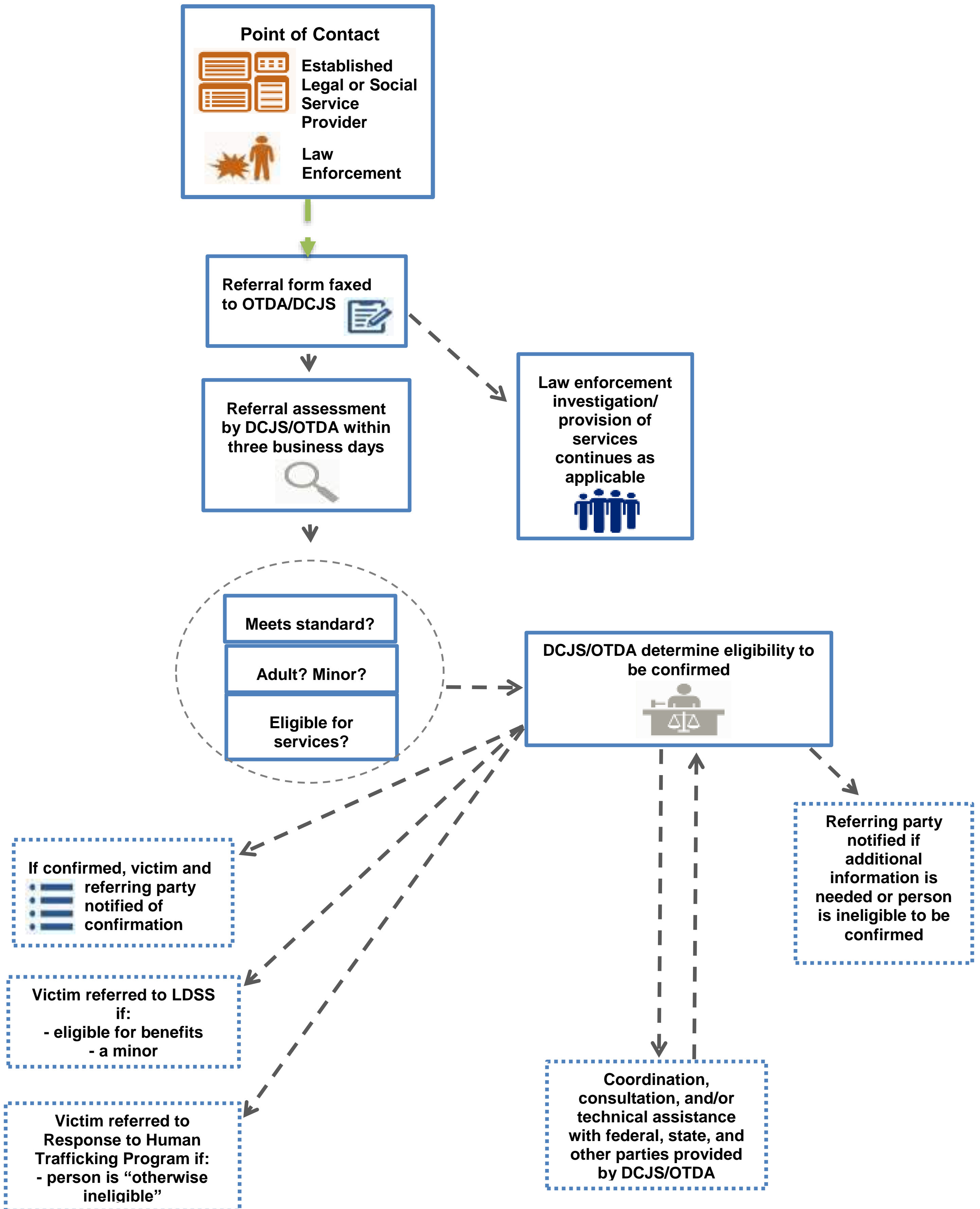
[6] *Trafficking Victim Protection Act of 2000*, P. L. 106-386 (TVPA).
[7] Chapter 74 of the Laws of 2007 (New York State Anti-Trafficking Statute).
[8] TVPA.

	related to potential labor trafficking experiences.	
Client Population Affected	All children and youth, regardless of age, in the care, custody, or supervision of an LDSS or OCFS, including children in foster care, child protective services (including family assessment response [FAR] cases), and open preventive cases, receiving Chafee services, or on runaway status from foster care up until the age of 21	All persons (children and adults) whom a designated entity reasonably believes to be a victim of human trafficking
Professionals Affected	All applicable personnel of OCFS, LDSSs, Voluntary Authorized Agencies, and relevant contractors	All representatives of established social and legal services agencies; all members of law enforcement, including district attorneys' office personnel, probation, and Department of Labor personnel
Required Actions	Defined in *Requirements to Identify, Document, Report, and Provide Services to Child Sex Trafficking Victims* (15-OCFS-ADM-16)	Defined in Chapter 74 of the Laws of 2007, Chapter 368 of the Laws of 2015, and *New York State Anti-Trafficking Statute* (OTDA 09-ADM-01)
Is client consent required to take defined action(s)?	No – Process is mandatory without consent of parent/guardian and/or youth. In instances where a report to law enforcement is made, youth are not required to cooperate with law enforcement. For more information, please refer to "Is cooperation with law enforcement required?" below. Although consent is not required, workers are encouraged to discuss the reporting process with parents/guardians and youth to maintain engagement.	Yes – For referral to be made by established social or legal services provider, regardless of victim's age No – For referral to be made by law enforcement, regardless of victim's age
Is there an impact on eligibility for youth to access services?	No – Youth who are entitled to services through LDSSs and community-based services may access those services as needed, even if the youth is not identified	No – For youth under 18 years old

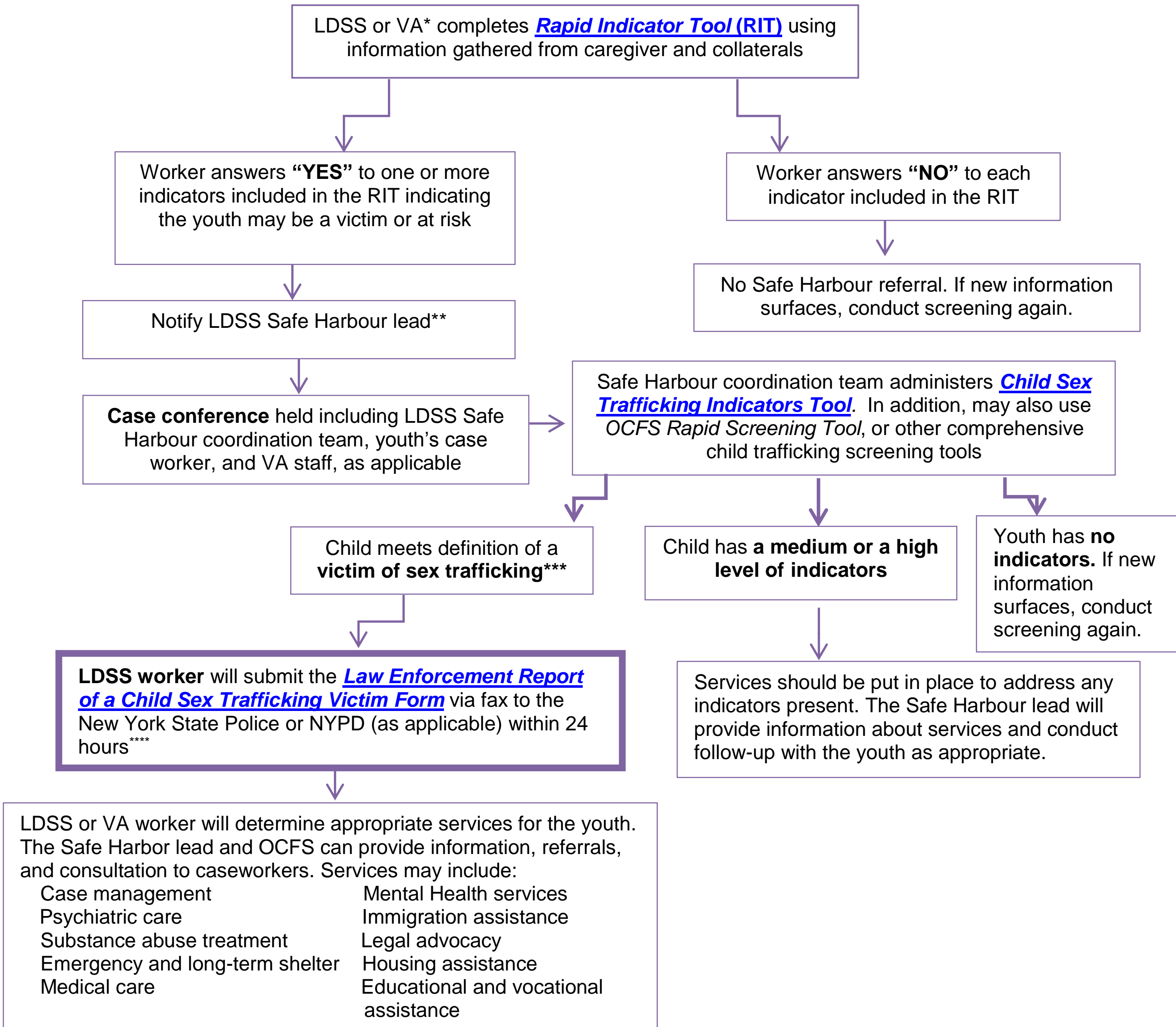
	as trafficked or at risk according to screening tools	Potentially – For persons over 18 years old[9]
Does the result of one process affect the other?	No – The process defined in 15-OCFS-ADM-16 is not impacted by a client's confirmation or lack thereof. There may be instances where a youth is determined to be a sex trafficking victim by the OCFS screening process, but would not qualify for confirmation by OTDA and DCJS. For more information, please refer to "Applicable Definition of Victims of Sex Trafficking" above.	Yes – If through the course of screening, using the tools attached to 15-OCFS-ADM-16, a child-serving professional reasonably suspects a youth has been trafficked, the worker must submit the *New York State Referral of Human Trafficking Victim* form to OTDA and DCJS, *if consent is obtained*. (Note: A worker may reasonably suspect a youth has been trafficked even if the results of the screening do not indicate the youth has been trafficked.)
Is cooperation with law enforcement required?	Requirements for cooperating with law enforcement differ based on whether the individual is a professional or identified youth victim: Yes – *Professionals* who notify law enforcement of an identified victim of sex trafficking are required to cooperate following the notification. No – *Identified youth victims* of human trafficking are not required to cooperate with law enforcement, but should be encouraged to do so by professionals as appropriate.	No – The confirmation process is established as a referral for services. It is not an investigative tool for law enforcement.

Referral process for confirmation of victimhood as established by the *New York State Anti-Trafficking Law*:

[9] For more information about the New York State Response to Human Trafficking Program, please contact bria.contact@otda.ny.gov.


Point of Contact
Established Legal or Social Service Provider
Law Enforcement
Referral form faxed to OTDA/DCJS
Law enforcement investigation/ provision of services continues as applicable
Referral assessment by DCJS/OTDA within three business days
Meets standard?
Adult? Minor?
Eligible for services?
DCJS/OTDA determine eligibility to be confirmed
If confirmed, victim and referring party notified of confirmation
Referring party notified if additional information is needed or person is ineligible to be confirmed
Victim referred to LDSS if:
- eligible for benefits
- a minor
Coordination, consultation, and/or technical assistance with federal, state, and other parties provided by DCJS/OTDA
Victim referred to Response to Human Trafficking Program if:
- person is "otherwise ineligible"

***Sample Sex Trafficking and CSEC Referral Flow Chart* for youth in the care, custody or supervision of an LDSS, Voluntary Agency (VA), or OCFS:**



Note: Mandated reporters are **required** to call the New York Statewide Central Register of Child Abuse and Maltreatment if, at any time, it is suspected that a youth's parent, guardian, or a person legally responsible for the youth is abusive or neglectful of the youth, including by trafficking or exploiting the youth.

***The LDSS and VA should determine in advance** which agency is responsible for the sex trafficking screening, reporting, and determining services requirements.

****To find your local Safe Harbour lead, contact your OCFS regional office.**

*****It must be documented in the case record that the child is a victim of sex trafficking**; if the youth is in foster care, the documentation must indicate whether the victimization occurred prior to or while the youth was in foster care.

******Form OCFS-3922 must be faxed to the New York State Police** or **the New York City Police Department.** Though LDSSs and VAs are required to report to law enforcement when a child is identified as a sex trafficking victim, the child is **not** required to cooperate with a law enforcement investigation, should one occur as a result of this report. However, children and youth should be given an opportunity to discuss with law enforcement if they wish. For more information on the required protocol when a youth is suspected to be at risk of sex trafficking refer to 15-OCFS-ADM-16. For more information on how to support youth and provide services to youth who may be at risk of experiencing trafficking, refer to *Responding to Commercially Sexually Exploited and Trafficked Youth: A Handbook for Child Serving Professionals*.

/s/ Laura Velez

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Issued By:
Name: Laura Velez
Title: Deputy Commissioner
Division/Office: Child Welfare and Community Services

Child.trafficking@acs.nyc.gov

Updated NYPD Law Enforcement Contact Information for Notification of a Sex Trafficked Youth

Effective October 18, 2019

This information applies to all ACS, Foster Care, Preventive Services, Juvenile Justice, Family Assessment Program, and any other child welfare staff who screen children and youth for sex trafficking, using the ACS Child Trafficking Database (CTDB), or for Advocacy cases only, the paper version of the two OCFS screening tools (OCFS 2321 and OCFS 2920).

To provide NYPD with the OCFS 3922 Law Enforcement Referral (LER) for children who meet the Federal Definition Level of Sex Trafficking:

1. **Scan and email the OCFS 3922 to VED@NYPD.Org (NYPD's Vice Enforcement Division), copied to Child.trafficking@acs.nyc.gov**
   Do NOT fax the OCFS 3922. The fax numbers on the form are obsolete.

2. After emailing, the screener should **call the Vice Division Office at (212) 694-3013.** The office is available Monday through Friday, 10 am to 6 pm.
   a. Explain you just E-MAILED a sex trafficked child LER for review
   b. Ask for the NYPD LER number and the name of the detective to whom you are speaking for documentation in Connections and in the Child Trafficking Database (CTDB).
   c. If you e-mail the LER after business hours, please ensure the follow up phone call occurs immediately on the next business day.
3. Staff from the Vice Division Coordinator's office will review / vet the LER, then send it out to the appropriate unit within the Vice Enforcement Division for assignment. VED will call the screener to gather additional information.

4. Notify ACS' Office of Child Trafficking Prevention and Policy (OCTPP) of all sex and labor trafficked children at Child.trafficking@acs.nyc.gov OCTPP will respond to your email and can assist with assessment, safety planning and resource suggestions.

If there are any issues with, or questions about this process, please notify ACS' Office of Child Trafficking Prevention and Policy at Child.trafficking@acs.nyc.gov

Office of Child Trafficking Prevention and Policy (OCTPP)

Division of Family Permanency / Office of Older Youth Services

David A. Hansell, Commissioner

Julie Farber, Deputy Commissioner

Sabine Chery, Assistant Commissioner

Selina Higgins, LCSW-R, Executive Director, Office of Child Trafficking Prevention and Policy

About the Office of Child Trafficking Prevention and Policy

The ACS Office of Child Trafficking Prevention and Policy (OCTPP) works to raise awareness of trafficking and assists in identifying appropriate services available to help trafficked and at-risk youth and their families.

OCTPP responds to inquiries, provides consultation and technical assistance, develops and provides training, maintains the Child Trafficking Database (CTDB) and works with stakeholders to develop policies and procedures for best practice work with trafficked and at-risk youth.

OCTPP also leads **"Movin' On": The NYC Child Tattoo Eradication Project and Network,** which focuses on referrals for tattoo consultations with medical providers for exploited and gang involved youth.

WHO TO CALL IF YOU HAVE A REASONABLE SUSPICION THAT A CHILD HAS BEEN TRAFFICKED:

If you believe the person is in immediate danger, **call 9-1-1.**

Everyone:

- The National Human Trafficking Hotline at **888-373-7888** or Text to **233733**
- NYPD Human Trafficking Hotline: **646-610-7272**
- If a child is trafficked and missing from home or a program: please report the missing child to local law enforcement and notify the National Center for Missing and Exploited Children (NCMEC) at **1-800-THE-LOST (800-843-5678)**, or use their Cyber Tipline at **www.missingkids.com**
- If the suspected trafficker is a parent or person legally responsible for the child: The NY Statewide Central Register of Child Abuse and Maltreatment at: **1-800-342-3720**
- If you have reason to believe that a youth is being abused or neglected while placed in residential care, call the New York State Justice Center at **1-855-373-2122**

If you are from ACS, Foster Care, Preventive Services or Juvenile Justice, please ALSO notify:

- The ACS Child Trafficking Mailbox at: **Child.trafficking@acs.nyc.gov**
- NYPD, using the OCFS-3922 form as per 15-OCFS-ADM-16, for a child meeting the Federal Definition of Sex Trafficking. After completing the form, fax to NYPD at: **212-694-3149** or **212-694-0264**, and follow up with a phone call to **212-694-3013**, which is the Vice Division Office, available Monday through Friday, 10 am to 6 pm. After 6 pm or on weekends, call **646-610-7272**
- The NYS Office of Temporary and Disability Assistance (OTDA) to commence the victim confirmation process for a child meeting the Federal Definition of Sex Trafficking. Fax the New York State Referral of Human Trafficking Victim to **518-485-9611**

To learn more, please visit:
www1.nyc.gov/site/acs/youth/traffickedyouth.page

- **To report trafficked child cases/case inquiries:** Child.trafficking@acs.nyc.gov
- **For information on upcoming trainings:** Traffickingtraining@acs.nyc.gov
- **For Child Trafficking Database (CTDB) concerns:** CTDB@acs.nyc.gov
- **For inquiries about removal of exploiter and gang tattoos:** Child.tattoo.removal@acs.nyc.gov

Understanding Child Trafficking and What YOU Can Do

CHILDREN ARE NOT FOR $ALE

NAVY BLUE is the official color for Human Trafficking Awareness and Prevention. By wearing a navy blue ribbon we help raise awareness of human trafficking and child sexual exploitation.

What is Human Trafficking?

Human Trafficking is **MODERN DAY SLAVERY.** Human Trafficking occurs whenever a person engages in sexual and/or labor services for the benefit of someone else due to force, fraud or coercion, OR whenever a young person under the age of 18 is involved in a commercial sex act.

Types of Human Trafficking:

- Labor Trafficking
- Sex Trafficking
- Commercial Sexual Exploitation of Children
- Organ Trafficking

NYC Administration for Children's Services

Child Labor Trafficking:

When a child under the age of 18 is included to perform labor or services through force, fraud or coercion.

- **Force: When a person controls another person through violence** Assault, rape, food/sleep deprivation, forced drug use, kidnapping
- **Fraud: Tricking people into something they wouldn't otherwise do** Fraudulent employment contracts, promise of love/marriage, bait and switch
- **Coercion: Using threats against the survivor or their loved ones** Threat of deportation or blackmail, debt bondage, left threats, withholding wages or legal documents, psychological manipulation

Sex Trafficking (Federal Definition):

As per the Trafficking Victims Protection Act (TVPA): "the recruitment, harboring, transportation, provision, or obtaining of a person for the purpose of a commercial sex act"

Child Sex Trafficking:

Any instance where a person under the age of 18 has exchanged a sexual act or performance in exchange for something of value. This is known as Commercial Sexual Exploitation of Children (CSEC).

Child Sex Trafficking: The Commercial Sexual Exploitation of Children (CSEC)

CSEC occurs whenever a person under the age of 18 has exchanged a sexual act or performance for something of value. CSEC can consist of:

- Engaging or agreeing or offering to engage in sex in return for a fee, or for any item of value
- Child Pornography (sexually explicit photographs, videos)
- Exotic Dancing or Performance
- Stripping
- Escort Services
- Trading sex for food, clothing , a place to stay, or other basic needs

CSEC is a crime! It should be reported, and appropriate services provided to survivors!

Youth Who Are Especially Vulnerable to Trafficking Include:

- Runaway or homeless Youth
- Children involved in the Foster Care system and/or Juvenile Justice System(s)
- Children with a history of abuse (especially sex abuse), maltreatment or neglect
- Children with a history of substance abuse
- Children with disabilities (mental illness, developmental, physical)
- LGBTQ Youth
- Refugees, Immigrants or Non-English Speaking Youth

Warning Signs (Red Flags) for Child Sex and Labor Trafficking:

- Runs away from home frequently and/or for significant periods of time;
- Shows signs of mental, physical, or sexual abuse;
- Has a significantly older partner or spends a lot of time with a controlling person or older adult;
- Indications or reports of domestic violence/intimate partner violence;
- Lies about age or carries a fake form of identification;
- Housing is provided by employer;
- Significantly reduces contact with family, friends, or other support networks;
- Displays a pattern of staying in the homes of friends or a non-legally responsible adult;
- Reluctant to discuss how they make money, where they live, how or when they came to the U.S.;
- Lacks control over schedule and/or money;
- Has large amounts of money or costly items that s/he cannot reasonably afford;
- Involvement in systems such as social services, PINS, courts, etc.;
- Works more than he or she is in school or does not often attend school;
- Experiences suicidal ideations and/or depression.
- Explanations for injuries are inconsistent with their severity;
- Has had multiple sexually transmitted infections and/or abortions;
- Has suspicious tattoos or burn marks (branding);
- Exhibits overt sexualized behavior;
- Exhibits evidence of sexual abuse;
- Is unwilling to disclose whereabouts or information about parents or caregivers;
- Is restricted in communication and/or displays anxious, fearful, depressed, submissive, tense and nervous behavior;
- Is unwilling or unable to identify as a victim;
- Youth retells the same story in the same way many times, giving the appearance that the story has been coached;
- Is scared of consequences to a degree greater than a situation (for example being late) merits.

NYC Children | Office of Child Trafficking Prevention and Policy

New York City Services for Sex and/or Labor Trafficked Youth

For copies, email: Traffickingtraining@acs.nyc.gov

- **NYC Children's Office of Child Trafficking Prevention and Policy (OCTPP):**
  OCTPP leads all aspects of ACS' policy, practice, training and technical assistance concerning trafficked and commercially sexually exploited children. Trafficked Child Notifications & Inquiries: **Child.trafficking@acs.nyc.gov** CTDB Issues: **CTDB@acs.nyc.gov**
  Tattoo Removal Referrals: **Child.tattoo.removal@acs.nyc.gov** Training Requests:**Traffickingtraining@acs.nyc.gov**
- **NYC Children's Immigrant Services and Language Affairs:** Training and technical assistance, information about legal services and resources. **917-551-7968**
- **NYC Mayor's Office to End Domestic and Gender Based Violence (END GBV)'s Family Justice Centers:** Free and confidential assistance for victims and survivors of sexual violence, human trafficking, stalking, and intimate partner violence. No appointment needed **311 or 1-800-621-HOPE (4673)** **https://www1.nyc.gov/site/ocdv/programs/family-justice-centers.page**
  Healthy Relationship Academy: Training and prevention education for teens, parents or professionals. **212-788-2516**
  https://www1.nyc.gov/site/ocdv/programs/nyc-healthy-relationship-training-academy.page
- **Ali Forney Center:** Housing and supportive services for male and female LGBTQ youth: **212-222-3427** **www.aliforneycenter.org**
- **Arab-American Family Support Center, Anti-Violence Program.** Available all 5 boroughs**.** **https://www.aafscny.org/**
- **Bellevue/NYU: Program for Survivors of Torture.** Medical, mental health, social services, legal, training, advocacy. Email: **info@survivorsoftorture.org**
- **Center for Court Innovation/Queens Youth Justice Ctr. Anti-Trafficking Program 718-233-4014** **info@courtinnovation.org**
- **City Bar Justice Center's Immigrant Justice Project:** Free assistance for asylum seekers fleeing persecution in their home countries, survivors of violent crimes & trafficking, and seekers of humanitarian protection and other forms of relief **212- 382-6710**
- **Covenant House.** Crisis Counseling and emergency housing for youth 16 to 21. (2120 613-0300 **www.covenanthouse.org**
- **Day One:** Individual services for exploited and trafficked males & females, and intimate dating violence, training: **212-566-8120, Ext. 5692 or** **socialworker@dayoneny.org**
- **The Door:** Multi-service center for all teens (male, female, LGBTQ) ages 12 to 21: **212-941-9090 or** **www.door.org**
- **DYCD's Runaway and Homeless Youth Programs, including 24 Hour Drop In Centers in all boroughs:** Call DYCD Youth Connect at:1-800-246-4646 or 1-646-343-6800. **https://www1.nyc.gov/site/dycd/services/runaway-homeless-youth.page**
- **ECPAT-USA** Youth and community education **718-935-9192** **kwooden@ecpatusa.org**
- **EMPOWER Center for Survivors of Sex Trafficking.** Care for women who have experienced sexual trauma. For an appointment, email: **empowergyn@gmail.com** Website: **http://empowergyn.org/**
- **Freedom Youth Project** Youth prevention program **https://www.freedomyouthproject.org/**

Version 2-3-20

Office of Child Trafficking Prevention and Policy
NYC Children

New York City Services for Sex and/or Labor Trafficked Youth

For copies, email: Traffickingtraining@acs.nyc.gov

- **Garden of Hope** Chinese communities: Crisis intervention, counseling, shelter, legal advocacy, support groups, case management, youth programs. Hope House (Chinese speaking shelter). 877-980-8595 **https://gohny.org/**
- **GEMS:** Individual and group work services for exploited and trafficked females, housing, mentoring, training: **www.gems-girls.org**
- **Hetrick Martin Institute:** Services and referrals for male and female LGBTQ youth ages 13 to 24: **212-674-2400** or **www.hmi.org**
- **JCCA's Gateways Program (JCCA):** Residential Foster Care for trafficked females (active ACS cases must be referred through the Office of Placement): **gateways@jccany.org**
- **JCCA's Center for Healing:** Evidence based, clinical services for children and families involved with JCCA who have experienced sexual abuse and/or exploitation. **914-769-0164**
- **Jewish Board's "Bridging the Gap" Program** Confidential one-on-one support, job training, skills building, and social activities, staffed by mentors. **bridgingthegap@jbfcs.org**
- **Jewish Board's Sally & Anthony Mann Center. Residential Treatment Facility with a specialized unit for trafficked girls.** (active ACS cases must be referred to the NYS Office of Mental Health PACC the through the ACS Office of Placement)
- **Lifeway Network.** Housing, education, advocacy and mentorship program for trafficked youth. **718-779-8075** **contact@lifewaynetwork.org**
- **Mayor's Office to End Domestic and Gender Based Violence (END GBV). Family Justice Centers:** Free and confidential assistance for victims and survivors of sexual violence, human trafficking, stalking, and intimate partner violence. No appointment needed. **311 or 1-800-621-HOPE (4673). https://www1.nyc.gov/site/ocdv/programs/family-justice-centers.page** **Healthy Relationship Academy:** Training and prevention education for teens, parents or professionals. **212-788-2516. https://www1.nyc.gov/site/ocdv/programs/nyc-healthy-relationship-training-academy.page**
- **Mt. Sinai Adolescent Health Center:** FREE Medical, Dental, Optometry, Mental Health, Counseling, Mentoring and Transitioning Services for males and females up to age 24 (must register by age 22): **212-423-3000** for appointment
- **NYS Department of Labor, Division of Immigrant Policies and Affairs** helps individuals in filing claims for back wages, provides referrals, providing victim certifications for visas **877-466-9757** **trafficking@labor.ny.gov** **https://www.labor.ny.gov/immigrants/**
- **NYS Office of Temporary and Disability Assistance (OTDA)** For submission of the New York State Referral of Human Trafficking Victim form. Reference: 17-OCFS-INF-03 Email: **child.trafficking@acs.nyc.gov** for form and procedure.
- **Restore** Services for foreign-national survivors of sex trafficking **https://restorenyc.org/referral**
- **Safe Horizon's Anti-Trafficking Program:** Counseling, basic needs, legal services, linkage to services, training **718-943-8631**
- **Safe Horizon's Streetwork Project:** Hotline for homeless youth under age 25: **800-708-6600.** Drop In Centers in all 5 boroughs: **https://www.safehorizon.org/tour-homeless-youth-drop-center/**

Office of Child Trafficking Prevention and Policy
NYC Children

New York City Services for Sex and/or Labor Trafficked Youth

For copies, email: Traffickingtraining@acs.nyc.gov

- **Sanctuary for Families' Anti-Trafficking Initiative** Legal, counseling, case management, advocacy. **(212) 349–6009** **info@sffny.org**
- **Sanctuary for Families' Immigration Intervention Project:** Services in over 30 languages, locations in 4 boroughs, but serves Citywide. **718-250-4240 or** **www.sanctuaryforfamilies.org**
- **Sanctuary for Families' Justice and Empowerment for Teens (JET) Initiative:** Training, advocacy and clinical services for all exploited or risk of exploitation youth. **Email:** **amathieson@sffny** for the referral form
- **STAND Clinic**: Sex Trafficking, Abuse, Neglect, Domestic Violence at Staten Island University Hospital/Northwell Health. FREE outpatient child assessment clinic serving up to age 21. Call Dr. Kaplan at: **(718) 226-3224**
- **Urban Justice Center Sex Workers Project.** Female, male, transgender and immigrant survivors of sex and labor trafficking. 646-602-5617 **www.sexworkersproject.org**
- **U.S. Department of Labor, Wage and Hour Division**: Community education/training, referrals, investigates employers, computes and recovers back wages for immigrants or labor trafficked, minors, wage loss and wage theft victims

  212-264-8185 **www.wagehour.dol.gov**

Hotlines

- National Human Trafficking Hotline: **888-373-7888 or text 233733** **https://polarisproject.org/get-assistance/national-human-trafficking-hotline**
- National Center for Missing and Exploited Children: **800-THE-LOST (843-5678) Cyber Tip-line:** **www.missingkids.com**
- NYPD Special Victims/Human Trafficking Hotline: **646-610-7272**
- NYC 24-hour Domestic Violence Hotline: **1-800-621-HOPE (4673)** for immediate safety planning, shelter assistance, and other resources. **TTY: 1-800-810-7444**
- NY Statewide Central Register of Child Abuse and Maltreatment (parent or person legally responsible): **800-342-3720**
- NYS Justice Center (abuse/neglect in residential care) **855-373-2122**
- Lifenet: Free and confidential mental health and substance abuse information, referral, and crisis hotline services for New York City residents 24 hours a day / 7 days a week **212-995-5824**
- National Suicide Prevention Lifeline: Available 24/7/365 **800-273-8255**
- Safe Horizon's Streetwork Project: Hotline for homeless youth under age 25: **800-708-6600**
- Samaritans 24 Hour Suicide Prevention Hotline: **212-673-3000**

"Movin' On": The NYC Child Tattoo Eradication Project and Network

Mission: To assist trafficking victims and former gang members in positively moving forward with their lives through the provision of trauma informed tattoo removal and the provision of relevant support.

Goals:

- To ensure that all youth have the opportunity to have an exploiter or gang branding safely removed.
- To link together medical and social work professionals willing to contribute time and expertise towards removing tattoos from child trafficking victims and youth leaving street gangs.
- To reduce trauma by connecting medical providers with case planners and youth to provide an opportunity for shared discussion and situational understanding.
- To provide tattoo removal in a trauma informed, and physically and emotionally safe environment.
- To provide training to medical providers on trafficking and gang dynamics to enhance their knowledge of, and empathy for branded youth.

Why this happened:

Based upon the recognition that exploiter brands inhibit the emotional healing progress, ACS' Office of Child Trafficking Prevention and Policy (OCTPP) has linked together multiple NYC medical providers and social workers who demonstrated an interest in helping tattooed youth eradicate exploiter tattoos and gang markings. In affiliation with FPS' Office of Older Youth Services and ACS' Agency Medical Director, OCTPP is developing a comprehensive network towards meeting the needs of identified youth who want to progress positively with their lives.

What We Will Provide:

What we will provide is a referral for consultation with a medical provider. Tattoo removal can take many sessions and can be very painful. It's a very individualized situation based upon the number of tattoos, the size and placement, skin tone and other factors. A youth will need to discuss the specific request with the medical provider before making an informed decision. Additionally, parental consent is necessary (even when a youth is in care), unless the youth is married or is a parent.

Minimizing Trauma:

There are a lot of youth with brandings and not a lot of pro bono services currently available, so please be prudent in sharing this information with youth. At this time we would like to concentrate on youth who have voluntarily indicated they would like to have the tattoos removed, which often happens when they want to seek employment out of the life or away from the gang, rather than advertise generally to all youth. We want to reduce trauma, not heighten it, so we do not want to make any promises that are delayed due to a long waiting list. Additionally, a youth really needs to be ready, both emotionally and physically, so please choose those who meet this criteria.

Therefore, due to a currently finite ability to obtain free services, please do not solicit youth about having their tattoos removed if they have not yet mentioned it, or if you have not observed signs of self-removal. (It is very important to be observant of self-harm for any reason, but self-harm also extends to youth who try to remove their tattoos themselves.) As we develop extended capacity within the medical community, we will start advertising widely.

Additionally, the experience involved with exploitation or gang affiliation is traumatic, and the permanent inking of a youth's body and psyche compounds the trauma experienced. The tattoo removal process may result in emotional disturbance and stress. **All youth who decide to have their tattoos removed MUST receive continual supportive counseling from staff of an agency with expertise in working with youth who have experienced trafficking or gang affiliation.** If the case planner requires assistance in locating an agency with this expertise, please email OCTPP at Child.tattoo.removal@acs.nyc.gov

Communication:

To facilitate communication, OCTPP has established a dedicated electronic mailbox available at: Child.tattoo.removal@acs.nyc.gov Access to the mailbox is limited to three persons with the expertise and experience to conference requests: The Director of OCTPP, The Assistant Commissioner of the Office of Older Youth Services, and the Agency Medical Director), in order to maintain confidentiality.

All requests to the mailbox will be assessed for sufficiency of information, then scheduled for initial discussion as to whether the youth meets the criteria for referral.

Referral Criteria:

1. **ACS Affiliation:** Youth must be affiliated with ACS at the time of the request.

2. **Priority:** Priority will be given to youth with tattoos that impact upon safety and well-being and minimize the potential for progress:

a. Highest priority: Exploiter- and gang-related tattoos in highly visible places (face, hands, neck) that impact upon the physical safety and psychological well-being of youth
b. Secondary Priority: Exploiter- and gang-related tattoos in not highly visible places (other body parts) that impact upon the psychological well-being of youth.
c. Non Priority: A youth who wants to have a decorative tattoo removed that is not exploiter- or gang-affiliated, does qualify for the program, but will not take priority over a safety and/or psychological well-being need.

3. Who Can Consent:

a. Parental consent is required for all youth under the age of 18, except as noted below:
b. Parental consent is not required when:
    i. A youth is age 18 or over; or
    ii. A youth under the age of 18 is either currently married or is a parent.

4. Consent Form:

a. A consent form must be signed by either the parent of a youth under the age of 18, or by a youth age 18 or over (or a youth under the age of 18 and is either married or a parent). The form will be signed after the medical consultation, but prior to the commencement of treatment.
b. The form must be scanned and emailed to OCTPP at: Child.Tattoo.Removal.@acs.nyc.gov
c. Only after the waiver is received by OCTPP, will the medical provider be authorized to proceed with treatment.

5. Required Information for Consideration:

1. Youth's full name
2. Date of birth and age
3. Tattoo description and location (including ink color)
4. Reason for request (please explain the safety or psychological well-being need)
    a. Tattoo is an exploiter branding
    b. Tattoo represents gang affiliation
    c. Youth is attempting to obtain employment and cannot due to tattoo
    d. Other reason impacting safety or psychological wellbeing
    e. Youth wishes to remove decorative tattoo he/she/they regret (tattoo not exploiter or gang affiliated)

6. Referral Process:

Attachment L

Upon approval:

1. The case planner will receive (1) a consent form and (2) a list of medical providers.
2. The case planner will call the medical providers on the list and discuss the needs of the youth, and based upon discussion, select a provider and schedule the appointment.
3. Youth under the age of 18 (unless married or is a parent) should be accompanied by their parent.
4. After the consultation with the medical provider, if the decision is to proceed with the tattoo removal, the parent for youth under the age of 18, or a youth age 18 or over (or is married or a parent under the age of 18) will sign the waiver form.
5. The case planner will scan and email the signed waiver form to OCTPP at: Child.tattoo.removal@acs.nyc.gov The process cannot commence without signed waiver receipt by OCTPP.
6. OCTPP will contact the medical provider after receipt of the waiver, and authorize commencement of treatment.
7. The case planner should keep OCTPP updated on the status and results of the process by emailing Child.tattoo.removal@acs.nyc.gov

Debriefing Tool for Children and Youth Who Have Returned After Being Absent Without Consent, Missing, or Abducted

Federal law and OCFS regulations require that the reason(s) the youth left care and the experiences he or she had while absent be identified and addressed, both in the current foster care placement and in any future placement.

The following questions are provided as a **guide** to assist in obtaining this information:

Youth's Name: ___________________________________ **Date of Birth**: __________

Placement Name/Address: ____

Date of Absence: ________ **Date Returned**: _________ **Time Returned**: _______________

How did the youth return? (circle one) Self Family Friend Police Staff Other

<u>Determining the Reason(s) for the Absence and the Youth's Experiences During the Absence:</u>

Reasons for Absence:

1) Why did you leave or choose to be out of contact? _____________________________

____

2) Did you plan in advance to leave, or was it a spur-of-the-moment decision?

____

3) Did anyone ask or encourage you to leave?

____

4) Did anyone force you to leave, or did anyone threaten either you or someone you care about to coerce you into leaving?

____

____

5) Did you go with anyone else or have a plan to meet someone?

____

If yes, please identify these individuals:

Name: _______________________ Relationship to the youth: _________________

Name: _______________________ Relationship to the youth: _________________

Name: _______________________ Relationship to the youth: _________________

6) Was this the first time you ever left your placement? If you left another time, when was that? Why did you leave? Were you alone or with someone?

____

7) What made you decide to come back? (*applies only if the youth returned voluntarily*)

____

8) How do you feel about returning to this placement?

____

9) Do you think you might leave again in the future? If so, how can we work together to prevent your leaving again?

____

Experiences While Absent:

1) What was the best and worst thing about being away?

____

____

2) What was the first thing you did after you left?

____

____

3) Where did you go? If you were planning to go a specific place, did you go there?

____

____

4) With whom and where did you stay while you were gone?

____

____

5) Did you contact or stay with a family member or family friend?

____

____

6) How did you meet your daily needs for food, shelter, and money?

____

____

7) People do many different things like have sex, drink, smoke, or use illegal substances or drugs when they are away from home.

   a. Did you have sex or sexual contact with someone while you were away?

      Yes No

      If yes, did you agree to the activity?

      Yes No

      Were you able to use protection against pregnancy or STIs?

      Yes No

      Do you have reason to believe you might be pregnant (*if relevant*) or have an infection?

      Yes No

   Notes: ____

   ____

   b. Did you drink alcohol while you were away?

      Yes No

      Did you use any drugs while you were away?

      Yes No

      If yes, do you know what you drank or what you used?

      Yes No

      Do you have any concerns about anything you drank or what you used?

      Yes No

   Notes: ____

   ____

8) Did anyone hurt you, or try to hurt you, while you were away?

   Yes No

   Did anything happen that frightened you or made you upset?

   Yes No

   Do you feel safe now?

   Yes No

   Notes: ____

   ____

Safety Assessment and Sex Trafficking Screening

General description of the youth (appearance, mood, interaction, behavior, attitude, etc.):

____

____

____

____

1. Did the youth appear to be under the influence of drugs or alcohol at the time of his/her return? Yes No

2. Is the youth on routine medication?

Yes No

If yes, did the youth miss one or more doses while absent?

Yes No

If yes, contact the youth's medical professional.

3. Does the youth appear to have any immediate physical or mental health needs that need to be addressed?

Yes No

4. Has the youth been seen by a medical professional since returning?

Yes No

5. If yes, is follow-up indicated?

Yes No

6. Has the mandatory sex trafficking screening been done? *

Yes No

*When the youth has returned, a sex trafficking screening must be completed once he/she has stabilized, but no later than five days after his/her return. Please see 15-OCFS-ADM-16 *Requirements to Identify, Document, Report, and Provide Services to Child Sex Trafficking Victims*[1] for the appropriate procedure for this screening, and instructions on your response if the youth is determined to be a victim or at risk.

[1] 15-OCFS-ADM-16 *Requirements to Identify, Document, Report, and Provide Services to Child Sex Trafficking Victims:* http://ocfs.ny.gov/main/policies/external/ADM.

Child.trafficking@acs.nyc.gov

Safety Planning Tips*

Debrief with the Youth Upon Return From AWOL:

- **WELCOME the youth back and inquire as to their immediate needs.**
- **Debriefing Tool (Attachment B of 16-OCFS-ADM-09)**
  - Do not read the tool to the youth.
  - Become familiar with the questions on the tool and engage youth in conversation relevant to the questions.
  - Rephrase the questions as needed without changing the content for a more comfortable conversation.
  - If you are new to using the tool, keep a copy nearby and refer to it as needed. Explain to the youth that this is guidance for you, not for them.
  - Ensure the youth does not obtain the tool from you.
- **Update the Safety Plan based upon the discussion.**

WHAT NOT TO DO	WHAT YOU CAN DO

• Do Not Make Assumptions:
  ○ How the youth feels about the trafficker
  ○ Whether the youth is ready to leave the life
  ○ Whether the youth thinks of self as a victim (or do you?)
• Do not take the youth's reaction personally
• Do not project your own ideals onto the youth
• Do not ask unnecessary questions or for details
• Do not judge
• Do not display disappointment or disapproval
• Be aware of body language, facial expressions, voice fluctuations
	• Provide encouragement and support
	• Affirm, affirm, affirm!
	• Understand teen development: Cognitive, Social-Emotional, Physical
	• Recognize the impact of trauma on cognitive development/decision making
	• Cultural sensitivity, Gender sensitivity
	• Address the culture shock of the reality of leaving the life
	  ○ Making a lot of money in one night versus making little money in one month
	  ○ Schedule regulation issues
	  ○ Lack of self-efficacy
	• Anticipate stress and plan for stress reduction
	• Recognize the power dynamic
	• Assess your own expectations and biases
	  ○ Do you want to "rescue" the youth?
	  ○ How do you really feel about trafficked youth?

***Extracted from the Safety Planning WITH Trafficked Youth workshop created by Selina Higgins, Ann Marie Pendleton and Jessie Boye-Doe. Copyright 2019. All Rights Reserved.**

To inquire about upcoming sessions, or to book a session of the workshop Safety Planning WITH Trafficked Youth for your program or agency, please email: Traffickingtraining@acs.nyc.gov

NYC Children | Office of Child Trafficking Prevention and Policy

Child.trafficking@acs.nyc.gov

Awareness and Red Flags for Emergency Room Visits and Medical Professionals

- Traffickers send their victims to the hospital as a last resort because they really do not want the victims to be seen by anyone in authority or to question a condition.
- Traffickers tend to "hospital shop", not returning to the same hospital or clinic to avoid detection/identification.
- Victims will lie, or try to hide evidence of bruising, injuries or illness.
- Stories never vary. Responses seem scripted.
- Overdependence on an accompanying person.
- Injuries in places not visibly noticeable: inside mouth, vagina, anus. These injuries can be the result of a violent encounter, or the result of discipline by the exploiter.
- Missing teeth: Dental assistance may be sought for broken teeth, teeth knocked out, or intentionally extracted as a disciplinary measure.
- Signs of physical abuse: Bruising, burns, cuts/wounds, blunt force trauma, fractures, signs of torture.
- Head injuries and neurological symptoms: Traumatic Brain Injury, headaches/migraines, memory loss, vertigo, which could be the result of continual head injuries.
- Reproductive issues: STIs, genitourinary issues, genital trauma, retained foreign bodies. Repeated unwanted pregnancies and forced abortions may be the result of reproductive coercion.
- Dietary Issues: Malnutrition, dehydration, loss of appetite.
- Gastrointestinal issues that can be exacerbated by stress: IBS, continual diarrhea, severe constipation.
- Mental Health: Depression, PTSD, suicidal ideation, self-harming behaviors (cutting), anxiety, nightmares, flashbacks, hyper-vigilance, feeling of guilt and/or shame, fattened affect, hostility. Attachment Disorder indicators, Dissociation Disorder indicators, Eating Disorders, depersonalization or derealization.
- Traffickers or Bottoms may attempt to remain during examinations to monitor all conversations and/or to interject explanations. Note if accompanying person provides all, or most responses while patient remain silent.
- Strategies that can be used to have alone time with the patient (if the accompanying person will not leave): Explain that the patient must to be taken elsewhere for blood work or x-rays, and as per hospital policy, cannot be accompanied.
- Provide the National Human Trafficking Hotline number (888-373-7888) or text to 233733) and have victim memorize the number. Do not provide any information on paper, because if discovered, severe repercussions could occur.

Interviewing Tips:

Victims of trafficking will not often disclose during a first meeting. Therefore, it is critical for medical professionals to not focus upon disclosure, but to provide a safe, non-judgmental environment for conversation that may permit identification of trafficking indicators. Always interview the patient in private, and if the accompanying person will not permit a private interview, provide a strategy that will provide an opportunity to permit a private interview. If the patient refuses to be separated from the accompanying party, do not force them. Maintain an awareness of the red flags for trafficking, and if noted, enact with the patient through trauma informed practice. Provide a space that is safe and conducive to discussing sensitive topics. Develop rapport before bringing up sensitive topics. Always assess safety risks which may result from asking sensitive questions. Despite circumstances which may seem disturbing, especially when a patient is determined to return to an unhealthy situation, your goal is not to rescue, but to best assist the patient.

When a Patient is Under the Age of Eighteen (18) and There is a Reasonable Cause to Suspect Child Abuse or Maltreatment:
Contact the NYS Statewide Register of Child Abuse and Maltreatment (SCR)

All mandated reporters who have a reasonable cause to suspect a child is being trafficked for sex must make a report to the SCR. Physicians and other medical professionals are Mandated Reporters. As per the Summary Guide for Mandated Reporters in NYS: "Mandated reporters are required to report suspected child abuse or maltreatment when they are presented with a reasonable cause to suspect child abuse or maltreatment in a situation where a child, parent, or other person legally responsible for the child is before the mandated reporter when the mandated reporter is acting in his or her official or professional capacity. "Other person legally responsible" refers to a guardian, caretaker, or other person 18 years of age or older who is responsible for the care of the child."

"A reasonable cause to suspect child abuse or maltreatment means that, based on your rational observations, professional training and experience, you have a suspicion that the parent or other person legally responsible for a child is responsible for harming that child or placing that child in imminent danger of harm. Your suspicion can be as simple as distrusting an explanation for an injury."

Contacting the SCR launches a child protective investigation that will assess your suspicions, as well as any other safety and risk factors within the family and provide safety and service plans to work towards strengthening the family. To contact the SCR, call: 1-800-342-3720.

As of August 26, 2018, NYS has a new allegation related to child abuse and maltreatment: Sex Trafficking Allegation. If there is a reasonable cause to suspect a child is being trafficked for sex, contact the SCR in reference to the Sex Trafficking Allegation.

Child.trafficking@acs.nyc.gov

Trafficking Red Flags for School Professionals and Staff

- Unexplained absences from school, or an inability to attend school on a regular basis
- Sudden or gradual adverse change in academic performance
- Uncharacteristically promiscuous behavior, and/or references to sexual situations or use of terminology beyond age-specific norms, or use of language associated with the commercial sex industry
- Change in usual attire and/or grooming habits
- New and/or more expensive material possessions
- Chronic running away from home
- Behavioral changes: Fearful, anxious, depressed, submissive, tense, nervous, aggressive
- New relationship, especially with an older partner
- Deference to another person (other than the parent) to speak for him or her, especially during interactions with school authority figures ("relative", romantic partner)
- Signs of physical and/or sexual abuse, physical restraint, confinement, or other serious pain or suffering?
- Deprivation of food, water, sleep (many trafficked youth continue to attend school), medical care, or other basic needs?
- Hotel keys or key cards?
- Large amounts of money/cash rolls or refillable gift cards?
- Prepaid cell phone, or more than one cell phone?
- Not in possession of own identification documents (including school ID)

Interviewing Tips:

- Be aware of the **power dynamic** between you (authority figure) and the youth.
- Remember **not to take their reaction personally**. Speaking to a stranger isn't easy or comfortable and speaking about personal trauma is never comfortable.
- Be mindful when speaking to survivors of any type of sexual violence that **asking details about their experience can be intrusive** and can evoke resistance due to feelings of embarrassment, shame, self-blame, fear or anger. Only ask for details of the abuse if it is a necessary requirement for your job (filing a report). Otherwise, knowing specific details is not necessary to provide help.

Attachment Q

Division of Child Protection (DCP) Business Processes for Screening for and Documenting Child Sex Trafficking

I. Investigative (INV) and Family Assessment Response (FAR) stages:

The Child Protective Specialist (CPS) in a Protective Diagnostic (PD), Family Assessment Response (FAR) and/or Family Service Unit (FSU) who has primary case planning responsibility in an investigation or FAR assessment stage, must complete the sex trafficking screening process as follows:

A. The CPS who has primary case planning responsibility must complete the **Rapid Indicator Tool** in the Child Trafficking Database (CTDB), for all children, within seven (7) days of the initiation of a child protective investigation or FAR assessment (including subsequent reports).[1]

   The CPS who has primary case planning responsibility must re-administer the **Rapid Indicator Tool** anytime a child returns from being missing **or** when there are indicators that give cause to believe the child is involved in sex trafficking or at risk of becoming involved in sex trafficking.

   1. If a child discloses sex trafficking during an investigation or FAR assessment, the CPS must indicate that the child meets the federal definition of Child Sex Trafficking in the CTDB and fill in the required information as prompted by the CTDB.

   2. If a child discloses sex trafficking and it is suspected that the parent or person legally responsible (PLR) for the child, trafficked the child or allowed the child to be trafficked, the CPS must call in a new report to the Statewide Central Register of Child Abuse and Maltreatment (SCR) alleging sex trafficking, *if* there is no current allegation of sex trafficking under investigation.

   3. If no indicators have been selected on the **Rapid Indicator Tool**, the screening results from the CTDB must be entered in the Connections (CNNX) Sex Trafficking window prior to the closure of an investigation or FAR assessment.

B. If any indicator has been selected on the **Rapid Indicator Tool** or the child or youth has disclosed current involvement or history of sex trafficking, the CPS must complete the **Comprehensive Tool** in the CTDB within 30 days of completing the **Rapid Indicator Tool** screening.

   1. The **Comprehensive Tool** screening results from the CTDB must be entered in the Connections (CNNX) Sex Trafficking window prior to the closure of an investigation of FAR assessment, regardless of the outcome of the investigation or assessment.

[1] Please note that DCP has established shorter timeframes than those referenced in the agency-wide policy.

2. If the **Comprehensive Tool** indicates that the child meets a "medium level" or a "high-level" risk of trafficking, the CPS must meet with the IC and any other applicable Clinical Consultant(s), as soon as possible, for further investigative and clinical guidance. If the CPS has not been able to locate the child or youth they must inform the IC and request an assist to locate.

3. If the **Comprehensive Tool** indicates that the child meets the "federal definition" of sex trafficking, the CPS must meet with the IC and applicable Clinical Consultant(s), as soon as possible **and**, these specific actions must occur immediately:

   a. The CPS must *immediately, but no later than 24 hours after identification of the child as being involved in sex trafficking*, complete the **Law Enforcement Report Form** and submit the form to the IRTC.

   b. The IRTC must *immediately, but no later than 24 hours after identification of the child as involved in sex trafficking*, scan and email the **Law Enforcement Report Form** to the NYC Police Department (NYPD) at VED@NYPD.org **and** to the ACS Office of Child Trafficking Prevention and Policy (OCTPP) at Child.Trafficking@acs.nyc.gov . After emailing the form, the IRTC must call NYPD to confirm receipt, obtain the log number and the name of the detective taking the IRTC's call. The IRTC must also provide the log number and the detective's name to the CPS and document in CNNX progress notes.

   c. The CPS must document the date of law enforcement notification and the log number into the CTDB **and** the CNNX sex trafficking screen within five business days of obtaining the information[2], in accordance with the timeframes for CNNX entries policy.

4. If applicable, the CPS must proceed to the next steps detailed in the General Policy Section IV(E), starting with the New York State confirmation process.

II. Family Service Stage (FSS)

The Child Protective Specialist (CPS) in a Protective Diagnostic (PD), Family Assessment Response (FAR) and/or Family Service Unit (FSU) who has case planning responsibility in a family service stage, must complete the sex trafficking screening process as follows:

A. The CPS who has case planning responsibility, must complete the **Rapid Indicator Tool** in the CTDB by each FASP deadline, **and** re-administer the **Rapid Indicator Tool** anytime a child returns from being missing **or** when there are indicators that give cause to believe the child is involved in sex trafficking victim or at risk of becoming involved in sex trafficking.

---

[2] The CPS with primary and/or case planning responsibility is responsible for entering the Law Enforcement Report (LER) information into the CTDB and the CNNX sex trafficking screen even in situations where ECS has initiated the LER notification.

1. If a child discloses sex trafficking during a service case, the CPS must indicate that the child meets the federal definition of Child Sex Trafficking in the CTDB and fill in the required information as prompted by the CTDB.

2. If a child discloses sex trafficking and it is suspected that the parent or person legally responsible (PLR) for the child, trafficked the child or allowed the child to be trafficked, the CPS must call in a new report to the SCR alleging sex trafficking, *if* there is no current allegation of sex trafficking under investigation.

3. If no indicators have been selected on the **Rapid Indicator Tool**, the screening results from the CTDB must be entered in the Connections (CNNX) Sex Trafficking window prior to the closure of an investigation or FAR assessment.

B. The FSU CPS must also follow the same requirements and guidelines as the PD or FAR CPS noted in section I.B. above and as detailed in Section VI(B)(1) of the policy.

III. Emergency Children's Services (ECS)

A. Any Child Protective Specialist (CPS) in ECS who is assigned to an investigation or case and learns that a child meets the "federal definition" of sex trafficking, must complete the hard copy version of the **Law Enforcement Report Form** *if* the form has not already been completed by a CPS with primary or case planning responsibility.

1. The ECS CPS must *immediately, but no later than 24 hours after identification of the child as involved in sex trafficking*, submit the **Law Enforcement Report Form** to the ECS IRTC.

2. The ECS IRTC must *immediately, but no later than 24 hours after identification of the child as involved in sex trafficking*, scan and email the **Law Enforcement Report Form** to NYPD at VED@NYPD.org **and** to the ACS Office of Child Trafficking Prevention and Policy (OCTPP) at Child.Trafficking@acs.nyc.gov. After emailing the form, the ECS IRTC must call NYPD to confirm receipt, obtain the log number and the name of the detective taking the IRTC's call. The IRTC must also provide the log number and the detective's name to the CPS and document in CNNX progress notes.

3. The CPS must document the date of law enforcement notification and the log number into the CTDB **and** the CNNX sex trafficking screen within five business days of obtaining the information, in accordance with the timeframes for CNNX entries policy.

B. If during ECS involvement, a child discloses sex trafficking and it is suspected that the parent or person legally responsible (PLR) for the child, trafficked the child or allowed the child to be trafficked, the ECS CPS must call in a new report to the SCR alleging sex trafficking, *if* there is no current allegation of sex trafficking under investigation.

NYC Children | Office of Child Trafficking Prevention and Policy
Child.trafficking@acs.nyc.gov
CTDB@acs.nyc.gov

Child Trafficking Database (CTDB) and Sex Trafficking Screening Tips for DYFJ Provider Agencies

1. Accessing the CTDB:

To access the ACS Child Trafficking Database (CTDB), each screener and supervisor must have an individual Contract Agency Remote Access (CARA) account and a Microsoft Dynamics license.

- The agency's Systems Administration will apply for the CARA account.
- The email attached to the CARA account should match the email that is regularly used by the employee, so the emails from the CTDB do not go to the CARA default (dfa.state.ny.us) email, unless that is the email the agency uses.
- Once the CARA account is obtained, the CTDB liaison should email **CTDB@acs.nyc.gov** and request a Microsoft Dynamics license for the employee. The Office of Child Trafficking Prevention and Policy (OCTPP) will forward the request to IT Admin, who will secure the license.
- Once the license is activated, the employee (screener or supervisor) can access the Child Trafficking Database through the CTDB link. See the CTDB Reference Guide on how to access the link.

2. Requirements for Creating a Screening within the CTDB:

To create a screening within the CTDB, the screener needs to have the RIN and Admission Number or the PID and the CIN.

- For Pre-Adjudicated Youth: Since pre-adjudicated youth do not have RIN or Admission Numbers, Provider Agencies cannot create a screening in the CTDB. They will need to screen using the paper version of the tools.
    - When a Provider Agency recognizes after screening a youth with the paper tools that the youth meets the Federal Definition of Trafficking (indicators within the Federal Definition level), they must notify the Office of Child Trafficking Prevention and Policy (OCTPP) at Child.trafficking@acs.nyc.gov Provide the youth's name, date of birth, borough of origin, the Federal Definition level indicators, and the NYPD LER (see section 4). OCTPP will respond to the email.
- For Crossover Youth: Crossover Youth have PIDs and CINs, so screenings should occur within the CTDB. DYFJ will regularly update the Crossover Youth

List for the screener to obtain the PID and the CIN to create a screening in the CTDB.

3. Who to Inform When a Youth is Determined to be Trafficked:

- For all youth who meet the Federal Definition of Trafficking level on the screening, the screener must notify NYPD's Vice Enforcement Division, Human Trafficking Unit, by completing OCFS 3922 (Law Enforcement Referral of a Child Sex Trafficking Victim Form). See section 4 for the instructions on how to submit the form and obtain the Law Enforcement Report (LER) number.
- Email the ACS Office of Child Trafficking Prevention and Policy (OCTPP) at Child.trafficking@acs.nyc.gov with the youth's name, date of birth, borough of origin, Federal Definition indicators and the NYPD LER number.
- Notify the National Human Trafficking Hotline at 888-373-7888

4. How to Submit the OCFS 3922 Law Enforcement Report of a Sex Trafficking Victim and Obtain the Law Enforcement Report (LER) Number:

- Only use the June, 2018 (3 page) version of the OCFS 3922 form.
- **Email the form to ved@nypd.org copied to Child.trafficking@acs.nyc.gov with "HT" in the subject line.**
- Follow up with a phone call to (212) 694-3013, which is the Vice Division Office, available Monday through Friday, 10 am to 6 pm, to obtain the LER number.
- Explain you just E-MAILED a sex trafficked child LER for review. Ask for the NYPD LER number and the name of the detective to whom you are speaking for documentation in Connections and in the Child Trafficking Database (CTDB).
- If you e-mail the LER after business hours, please ensure the follow up phone call occurs immediately on the next business day.

5. Contacting the SCR:

All mandated reporters who have a reasonable cause to suspect a child is being trafficked for sex must make a report to the NYS Statewide Register of Child Abuse and Maltreatment (SCR). As of August 26, 2018, NYS has a new allegation related to child abuse and maltreatment: Sex Trafficking Allegation. If there is a reasonable cause to suspect a child is being trafficked for sex, contact the SCR in reference to the Sex Trafficking Allegation. To contact the SCR, call: 1-800-342-3720.

6. Where to Submit Questions:

- For questions about **Microsoft Dynamics licenses, CTDB screenings, CTDB challenges and any paper tools issues**, email: CTDB@acs.nyc.gov

- For questions about **trafficking indicators, assessment, safety planning and service suggestions,** email: Child.trafficking@acs.nyc.gov

Attachment R

Division of Prevention Services (DPS) and Provider Agencies Business Processes for Screening for and Documenting Child Sex Trafficking

I. Child Welfare Service (CWS) Cases

A. Upon case assignment, the case planner or designated staff must first confirm whether the ACS CPS or the transferring provider agency previously completed the **Rapid Indicator Tool** in the Child Trafficking Database (CTDB) for the child(ren). If the previous ACS CPS worker or the transferring provider agency did not complete the tool within the past 30 days, or there is any new information suggesting the potential presence of child trafficking, the case planner or designated staff must complete the **Rapid Indicator Tool** as soon as possible, but no more than 30 days after screening initiation. The Rapid Indicator Tool results must be entered in the CTDB upon completion and by the due date of the initial FASP and each subsequent FASP.

   1. If a youth was administered a **Comprehensive Screening** during a prior assessment within the past 30 days and the findings revealed that the child was involved in sex trafficking, another screening shall not be administered; however, the case planner will research any follow up/actions taken from the findings from the previous screenings, and will follow the required steps as outlined in Section D.

B. The case planner or designated staff must re-administer the **Rapid Indicator Tool** in the CTDB for the child(ren) when there are new or newly-observed indicators that give cause to believe the child is involved in or is at risk of becoming involved in sex trafficking, and/or whenever a child returns after being missing from the home or after having run away from home.[1]

   1. If a child discloses sex trafficking involvement at any point during an open prevention service case, the case planner or designated staff must immediately complete a screening in the CTDB, documenting the applicable federal definition level indicator(s). The case planner or designated staff must also note the disclosure in the case record.

C. If any indicator has been selected on the **Rapid Indicator Tool** or the child or youth has disclosed current involvement in or history of sex trafficking, the case planner or designated staff must progress to the **Comprehensive Tool** section of the CTDB. After progressing to the Comprehensive Tool, the case planner or designated staff must consult with their supervisor to discuss best practice decisions and to determine next steps, which may include arranging for services or referrals to address any present indicators, making a report to the Statewide Central Register for Child Abuse and

[1] For additional indicators that may identify the potential presence of sex trafficking, and which would call for re-administering of the Rapid Indicator Tool, see Section III of the general policy and Attachment C: Red Flags for Sex and Labor Trafficking.

Maltreatment (SCR) and/or requesting and holding an Elevated Risk Conference (ERC). If a parent or person legally responsible is suspected to be involved in the sex trafficking, the case planner must call in a report of abuse or maltreatment to the SCR.

D. If a child meets the federal definition of child sex trafficking, the case planner or designated staff must immediately notify their supervisor, manager, or Program Director and notify ACS' Office of Child Trafficking Prevention and Policy (OCTPP) by emailing child.trafficking@acs.nyc.gov. The designated case planner and supervisor, manager, or Program Director must additionally submit a report to the SCR and complete and submit OCFS-3922, Law Enforcement Report of Child Sex Trafficking, notifying NYPD and ACS OTCPP within 24 hours.[2] Following completion of the Law Enforcement Report, the case planning staff must call the NYPD Vice Enforcement Division/Human Trafficking Unit to verify receipt of the LER and to obtain the NYPD Log Number and the name of the detective providing the confirmation. The designated case planner and supervisor or Program Director must request an ERC to discuss immediate concerns, including safety planning for the child/family.

II. Advocate Cases

A. Upon case assignment, the case planner or designated staff must complete the paper format of the **Rapid Indicator Tool** for the child(ren) within 30 days of screening initiation and by the due date of the initial FASP or by the due date of each subsequent FASP. The completed paper version of the tool must be stored in the family's case record. If the case is received as a transfer case from an alternative prevention agency, the receiving agency case planner must confirm whether the previous agency has completed the tool within the past 30 days. If the tool has not been completed, or if there is any new information that indicates the potential presence of sex trafficking, the case planner or designated staff must complete the paper format of the **Rapid Indicator Tool** for the child(ren) within 30 days of screening initiation and by the due date of the initial FASP or by the due date of each subsequent FASP.

1. If a youth was administered a **Comprehensive Screening** during a prior assessment within the past 30 days and the findings revealed that the child was involved in sex trafficking, another screening shall not be administered; however, case planner will research any follow up/actions taken from the findings from the previous screenings, and will follow the required steps as outlined in Section D.

B. The case planner or designated staff must re-administer the paper version of the **Rapid Indicator Tool** for the child(ren) when there are indicators that give cause to believe the child is involved in or is at risk of becoming involved in sex trafficking, including upon return from AWOL. The completed paper version of the tool must be stored in the family's case record, along with all other prior completed versions.

[2] For information on completing and sharing form OCFS-3922, refer to section D of the general policy.

1. If during the assessment, a child discloses sex trafficking, the designated case planning staff shall skip the **Rapid Indicator Tool** and proceed in conducting the **Comprehensive Tool** as a guide to obtain any relevant information. The case planning staff must note the disclosure in both the hard copy case record and complete the screening within 30 days of screening initiation.

C. If any indicator has been selected on the Rapid Indicator Tool or the child or youth has disclosed any involvement in or history of sex trafficking, the case planner must complete the paper version of the **Comprehensive Tool**. After progressing to the Comprehensive Tool, the case planner or designated staff must consult with their supervisor to discuss best practice decisions and to determine next steps, which may include referrals to address any indicators present, making a report to the SCR and/or requesting and holding an ERC. If a parent or person legally responsible is suspected to be involved in the sex trafficking, the case planner must call in a report of abuse or maltreatment to the SCR.

NOTE: Upon calling the SCR, the case status will change from an advocate case to a CWS case.

D. If the comprehensive screening finds that the youth either does not present a medium or high level of indicators (e.g. risk) of being trafficked, there is no notification required. All screening results must be recorded in the child's case record and the case must continue to be monitored and the tools re-administered as necessary. The case planner must work to arrange for services to address any indicators noted present during the screenings.

E. If a child meets the federal definition of child sex trafficking, the case planner or designated staff must immediately notify their supervisor, manager, or Program Director and notify ACS' Office of Child Trafficking Prevention and Policy (OCTPP) by emailing child.trafficking@acs.nyc.gov. The designated case planner and supervisor, manager, or Program Director must additionally submit a report to the SCR and complete and submit OCFS-3922, Law Enforcement Report of Child Sex Trafficking, notifying NYPD and ACS OCTPP within 24 hours.[3] Following completion of the Law Enforcement Report, the case planning staff must call the NYPD Vice Enforcement Division/Human Trafficking Unit to verify receipt of the LER and to obtain the NYPD Log Number and the name of the detective providing the confirmation. The designated case planner and supervisor or Program Director must request an ERC to discuss immediate concerns, including safety planning for the child/family.

[3] For information on completing and sharing form OCFS-3922, refer to section D of the general policy.

David A. Hansell
Commissioner

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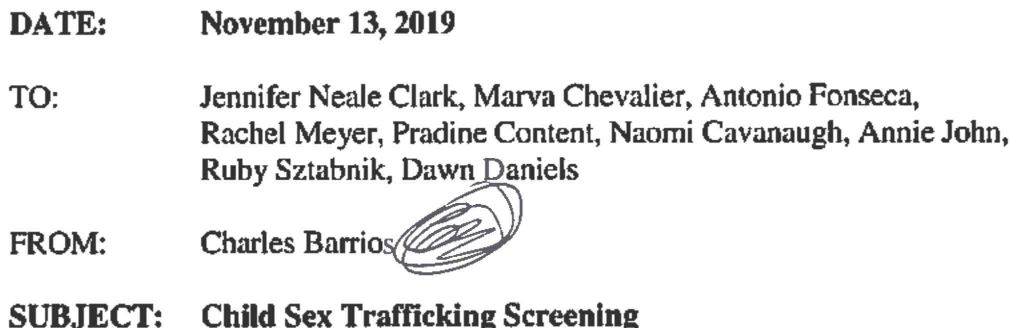
MEMORANDUM



DATE: **November 13, 2019**

TO: Jennifer Neale Clark, Marva Chevalier, Antonio Fonseca, Rachel Meyer, Pradine Content, Naomi Cavanaugh, Annie John, Ruby Sztabnik, Dawn Daniels

FROM: Charles Barrios

SUBJECT: Child Sex Trafficking Screening

As you know, the Division of Youth and Family Justice (DYFJ) and ACS' Office of Child Trafficking Prevention and Policy (OCTPP) have established a process for identifying, documenting, and determining services for sex trafficked children, and children at-risk of sex trafficking. The identification of child trafficking is a multi-phase process that takes place at different points in time over the course of a youth's involvement in juvenile justice. DYFJ is adjusting the screening process in order to identify any youth exposed to trafficking activity in as early a manner as possible. Effective, Monday, November 18, 2019, case management staff will implement the use of the NYS mandated "Rapid Indicator Tool to Identify Children Who May Be Victims or at Risk of Being Sex Trafficking Victims" (aka Rapid Indicator Tool) and the "Child Sex Trafficking Indicator Tool" (aka Comprehensive Tool) for all youth admitted to an ACS specialized secure detention, specialized juvenile detention, and non-secure detention facility.

Scope: This guidance applies to ACS case management staff in the Division of Youth and Family Justice within secure detention and case managers providing services in ACS-contracted non-secure detention facilities.

Policy: The following outlines the steps to be taken when a youth is admitted to detention:

1. Upon Admission
   During the intake process, case management administers the Rapid Indicator Tool and if any of the indicators apply, immediately progresses to the Comprehensive Tool.

2. When There Are No Indicators for Child Sex Trafficking:
   If the youth does not meet any trafficking indicators on the Rapid Tool, the

screener places the results in the youth's file. If the youth AWOLS, the screening will be completed again upon their return. For crossover youth who are also child welfare involved, the screener must transmit the results to the youth's child welfare case planner to input them into the Child Trafficking Database (CTDB) and Connections. If the screener is not sure who the child welfare case planner is, they can contact the Confirm Unit at 212-966-8146.

3. Who to Inform When a Youth is Determined to be Trafficked:
   - For all youth who meet the Federal Definition of Trafficking threshold on the screening, the screener must notify NYPD's Vice Enforcement Division by completing the Law Enforcement Report of a Child Sex Trafficking Victim form (OCFS 3922) and emailing the form to VED@nypd.org, copying the email to ACS' Office of Child Trafficking prevention and Policy (OCTPP) at Child.trafficking@acs.nyc.gov After the email is sent, telephone VED at 212-694-3013 to obtain the Law Enforcement Report (LER) number and the name of the detective to whom you spoke.
   - If the youth is a crossover youth, contact the child welfare case planner to see if this process has been done for the youth previously and provide them with the results to input them into the CTDB and Connections.
   - Notify the National Human Trafficking Hotline at 888-373-7888
   - All mandated reporters who have a reasonable cause to suspect a child is being trafficked for sex must make a report to the NYS Statewide Register of Child Abuse and Maltreatment (SCR). As of August 26, 2018, NYS has a new allegation related to child abuse and maltreatment: Sex Trafficking Allegation. If there is a reasonable cause to suspect a child is being trafficked for sex, contact the SCR in reference to the Sex Trafficking Allegation. To contact the SCR, call: 1-800-342-3720.

Attached are the two child sex trafficking screening tools, the Law Enforcement Report of a Child Sex Trafficking Victim form, and OCTPP's informational handout on how to contact NYPD. For further information or questions regarding this memorandum, please contact Dawn Daniels, Executive Director Juvenile Justice Behavioral Health Services at ACS, at Dawn.Daniels@acs.nyc.gov. For questions about child sex (and labor) trafficking indicators, assessment, safety planning and service suggestions, email: Child.trafficking@acs.nyc.gov

Family Assessment Program (FAP) Business Processes for Screening for and Documenting Child Sex Trafficking

A. Upon case assignment, the case planner or designated staff must complete the paper format of the **Rapid Indicator Tool** for the child(ren) within 30 days of screening initiation and by the due date of the initial FASP or by the due date of each subsequent FASP. The completed paper version of the tool must be stored in the family's case record, as well as the FAP Child Trafficking Tracking Log. If the case is received as a transfer case from an alternative prevention agency, the receiving agency case planner must confirm whether the previous agency has completed the tool within the past 30 days. If the **Rapid Indicator Tool** has not been completed, or if there is any new information that indicates the potential presence of sex trafficking, the case planner or designated staff must complete the paper format of the **Rapid Indicator Tool** for the child(ren) within 30 days of screening initiation and by the due date of the initial FASP and each subsequent FASP.

1. If a youth was administered a **Comprehensive Screening** during a prior assessment by a designated ACS FAP staff within the past 30 days and the findings revealed that the child was a sex trafficking victim, another screening shall not be administered; however, the FAP provider agency staff/case planner will research any follow up/actions taken from the findings from the previous screenings, and will follow the required steps as outlined in Section D.

B. The case planner or designated staff must re-administer the paper version of the **Rapid Indicator Tool** in the for the child(ren) when there are indicators that give cause to believe the child is involved in or is at risk of becoming involved in sex trafficking, including upon return from AWOL. The completed paper version of the tool must be stored in the family's case record and the FAP Child Trafficking Tracking Log, along with all other prior completed versions.

1. If during the assessment, a child discloses sex trafficking, the designated case planning staff shall skip the **Rapid Indicator Tool** and proceed in conducting the **Comprehensive Tool** as a guide to obtain any relevant information. The case planning staff must note the disclosure in both the hard copy case record and the FAP Child Trafficking Tracking Log and complete the screening within 30 days of screening initiation.

C. If any indicator has been selected on the Rapid Indicator Tool or the child or youth has disclosed current victimization or history of sex trafficking, the case planner must complete the paper version of the **Comprehensive Tool**. After progressing to the Comprehensive Tool, the case planner or designated staff must consult with their supervisor to discuss best practice decisions and to determine next steps, which may include referrals to address any indicators present, making a report to the Statewide Central Register of Child Abuse and Maltreatment (SCR), and/or requesting and holding an Elevated Risk Conference (ERC). If a parent or person legally responsible is suspected

to be involved in the sex trafficking, the case planner must call in a report of abuse or maltreatment to the SCR.

> **NOTE:** Upon calling the SCR, the case status will change from an advocate case to a CWS case, and the case must be documented in CNNX.

D. If the comprehensive screening finds that the youth either does not present a medium or high level of indicators (e.g. risk) of being trafficked, there is no notification required. All screening results must be recorded in the child's case record and the FAP Child Trafficking Tracking Log, and the case must continue to be monitored and the tools re-administered as necessary. The case planner must work to arrange for services to address any indicators noted present during the screenings.

E. If a child meets the federal definition of child sex trafficking, the case planner or designated staff must immediately notify their supervisor, manager, or Program Director and notify ACS' Office of Child Trafficking Prevention and Policy (OCTPP) by emailing child.trafficking@acs.nyc.gov. The designated case planner and supervisor, manager, or Program Director must additionally submit a report to the SCR and complete and submit OCFS-3922, Law Enforcement Report of Child Sex Trafficking, notifying NYPD and ACS OCTPP within 24 hours.[1] Following completion of the Law Enforcement Report, the case planning staff must call NYPD Vice Enforcement Division/Human Trafficking Unit to verify receipt of the LER and to obtain the NYPD Log Number and the name of the detective providing the confirmation. The designated case planner and supervisor or Program Director must request an ERC to discuss immediate concerns, including safety planning for the child/family.

> **NOTE:** All providers must submit a quarterly report documenting child sex trafficking to the ACS Family Assessment Program (FAP). The report must indicate the number of **Rapid Indicator Tools** completed and the number of **Comprehensive Screenings** completed. If any children have met the federal definition of trafficking, the report must also document the number of Law Enforcement Reports filed to NYPD, including non-identifying demographics of such reports, such as the sex/gender and age of children meeting the federal definition level.

[1] For information on completing and sharing form OCFS-3922, refer to section D of the general policy.

Attachment U

Division of Family Permanency Services (FPS) and Provider Agencies Business Processes for Screening for and Documenting Child Sex Trafficking

I. ACS FPS – Specialized Care Unit (SCU)

A. The case planner will complete the **Rapid Indicator Tool** for children and youth in the Child Trafficking Database (CTDB) within 30 days of screening initiation **and** when the following triggers occur:

1. Immediately upon the child or youth entering foster care placement in which SCU has oversight and if DCP, the Children's Center (CC), Youth Reception Center (YRC), or provider agency did not previously complete the **Rapid Indicator Tool** in the CTDB;

2. By the next Family Assessment and Service Plan (FASP) due date;

3. Immediately any time a child or youth returns to placement after having been missing or Absent Without Consent (AWOC);

4. Immediately when a child or youth discloses or is suspected of CSEC involvement throughout the life of the case;

5. When a child or youth under 21 years old enters or re-enters foster care and there is suspicion of CSEC involvement by staff;

6. Immediately if a child or youth is psychiatrically hospitalized and discloses CSEC involvement;

7. Immediately when a child or youth is arrested or detained for CSEC involvement and returns to the foster care agency; or

8. Immediately when there is suspicion that the child or youth is CSEC involved during a Family Team Conference (FTC) regarding a goal change, permanency planning, placement change, trial discharge or final discharge.

9. If a child or youth discloses CSEC or sex trafficking during the course of placement, the case planner must document the disclosure in the CTDB and in CONNECTIONS (CNNX), and enter the required information as prompted by the CTDB within 30 days of screening initiation.

B. If any indicator has been selected on the Rapid Indicator Tool or the child or youth has disclosed current victimization or history of sex trafficking, the case planner must proceed to the next steps detailed in the General Policy Section IV(C), the **Comprehensive Tool**.

II. Pre-Placement

A. The Nicholas Scoppetta Children's Center (CC)

1. The Child and Family Specialist (CFS) must confirm, via the CTDB, whether ACS CPS or the designated provider agency staff previously completed the **Rapid Indicator Tool** for the child or youth upon entry into the CC.

    a. If ACS CPS or the designated provider agency did not previously complete the **Rapid Indicator Tool**, the CFS must complete the **Rapid Indicator Tool** within 24 hours of the child or youth's entry into the CC in the CTDB. The CFS must consult with nursing staff on-site[33] and the ACS CPS or case planner, if any, assigned to the child or youth for further information.

        i. Please note that this is a shorter timeframe requirement to complete the Rapid Indicator Tool than referenced throughout the body of the policy.

    b. If ACS CPS or the designated provider agency previously completed the **Rapid Indicator Tool** in the CTDB and an indicator is selected for the child or youth, the CFS must notify the CSEC consultant on-site, if any, and nursing staff.

    c. If ACS CPS or the designated provider agency previously completed the **Rapid Indicator Tool** in the CTDB and no indicator is selected for the child or youth, the CFS must monitor the child or youth and complete a new **Rapid Indicator Tool** in the CTDB when a child or youth returns from AWOC status during the child or youth's stay at the CC, and/or when there are indicators that give cause to believe the child is a victim or is at risk of becoming a victim.

        i. If applicable, the CSEC consultant on-site or designated staff member must complete the hard copy version of the **Comprehensive Tool**. The CFS must complete the **Comprehensive Tool** in the CTDB as soon as possible, but no more than 30 days of electronic screening initiation. Nursing staff must prepare for potential obstetrician and gynecological follow-up and planning.

        ii. If applicable, the CFS must proceed to the next steps detailed in the General Policy Section IV(D), the **Law Enforcement Report Form**.

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[33] Nursing staff on-site will have cleared the child or youth prior to the CFS's initial contact with the child or youth. Similarly, the assigned ACS CPS or provider agency case planner will have had casework contacts with the child or youth prior to entering the Children's Center. In either circumstance, the child or youth may have disclosed statements or exhibited behavior resulting in red flags or indicators of CSEC or trafficking. The CFS can obtain more information for his or her assessment of the child or youth.

iii. If a child or youth discloses CSEC or sex trafficking during the course of pre-placement, the CFS and CSEC consultant on-site must note the disclosure in the CTDB and in CONNECTIONS (CNNX), and enter the required information as prompted by the CTDB.

B. Youth Reception Center (YRC) Provider Agencies or Host Homes
Upon the youth's entry into the YRC or Host Home, the intake/admissions department or designated staff must confirm, via the CTDB, whether ACS CPS or the CC completed the **Rapid Indicator Tool** for the youth.

1. If ACS CPS or the CC did not previously complete the **Rapid Indicator Tool**, the intake/admissions department or designated staff must complete the **Rapid Indicator Tool** within 24 hours of the youth's entry into the YRC or Host Home in the CTDB.

2. If ACS CPS or the CC previously completed the **Rapid Indicator Tool** and an indicator is selected for the youth, the intake/admissions department or designated staff must complete the **Comprehensive Tool** as soon as possible, but not more than 30 days of screening initiation in the CTDB.

3. If ACS CPS or the CC previously completed the **Rapid Indicator Tool** and no indicator is selected for the youth, the intake/admissions department must notify the team and document the required information in the CTDB and in CNNX.
4. If applicable, the intake/admissions department or designated staff must proceed to the next steps detailed in the General Policy Section IV(D), the **Law Enforcement Report Form**.

   a. If a child or youth discloses CSEC or sex trafficking during the course of casework contact, the intake/admissions department or designated staff must note the disclosure in the CTDB and in CNNX, and enter the required information as prompted in the CTDB within 30 days of screening initiation.

5. Upon a FASP reassessment, the treatment team caseworker must re-administer the **Rapid Indicator Tool** and all applicable tools/actions if a child or youth is absent from program (AFP) or AWOC, and/or when there are indicators that give cause to believe the child or youth is a victim or is at risk of becoming a victim.

III. Provider Foster Care Agencies

A. The case planner will complete the **Rapid Indicator Tool** in the CTDB within 30 days of screening initiation for children and youth by the same deadlines detailed above for ACS FPS SCU (Section VI(E)(1)).

1. For cases involving Expectant and Parenting Youth (EPY) where parenting youth are in foster care while their child(ren) are not (also known as "8D cases"), the case planner can only conduct the screenings for the EPY who are in placement, not their child(ren).

2. If a child discloses CSEC or sex trafficking during placement, the case planner must document the disclosure in the CTDB and in CNNX, and enter the required information as prompted in the CTDB within 30 days of screening initiation.

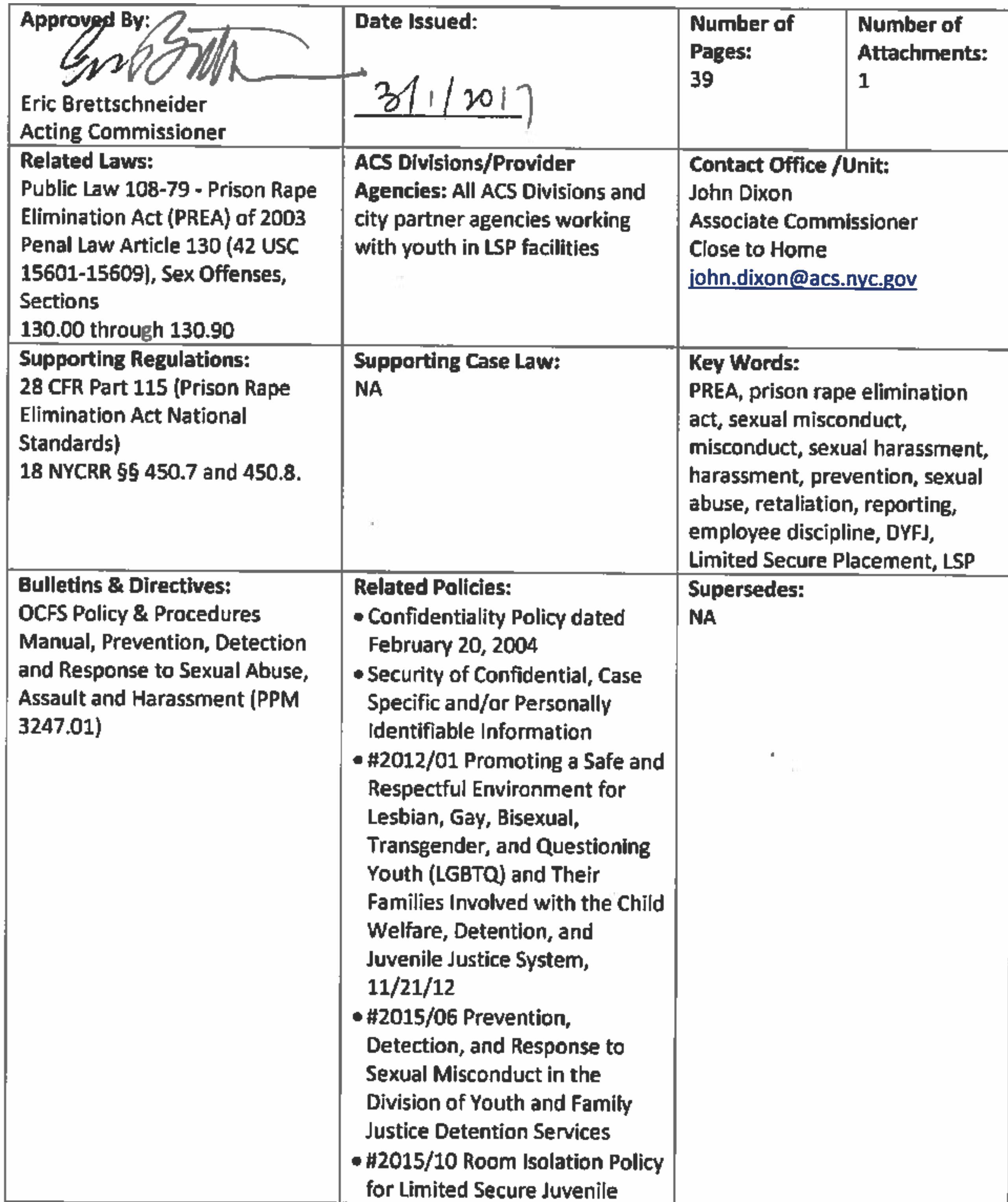
B. If applicable, the case planner must proceed to the next steps detailed in the General Policy Section IV(C), the **Comprehensive Tool.** The case planner must document the required information, including whether the victimization, if any, occurred prior to or while the child or youth was in foster care, as prompted in the CTDB within 30 days of screening initiation and promptly in CNNX.

C. The case planner must send any identified CSEC or sex trafficking findings to the ACS trafficking inbox at: child.trafficking@acs.nyc.gov

City of New York
Administration for Children's Services

Policy and Procedure
#2017/05

Prevention, Detection, and Response to Sexual Misconduct in Limited Secure Juvenile Justice Placement



Approved By: Eric Brettschneider Acting Commissioner	**Date Issued:** 3/1/2017	**Number of Pages:** 39	**Number of Attachments:** 1
Related Laws: Public Law 108-79 - Prison Rape Elimination Act (PREA) of 2003 Penal Law Article 130 (42 USC 15601-15609), Sex Offenses, Sections 130.00 through 130.90	**ACS Divisions/Provider Agencies:** All ACS Divisions and city partner agencies working with youth in LSP facilities	**Contact Office /Unit:** John Dixon Associate Commissioner Close to Home john.dixon@acs.nyc.gov	
Supporting Regulations: 28 CFR Part 115 (Prison Rape Elimination Act National Standards) 18 NYCRR §§ 450.7 and 450.8.	**Supporting Case Law:** NA	**Key Words:** PREA, prison rape elimination act, sexual misconduct, misconduct, sexual harassment, harassment, prevention, sexual abuse, retaliation, reporting, employee discipline, DYFJ, Limited Secure Placement, LSP	
Bulletins & Directives: OCFS Policy & Procedures Manual, Prevention, Detection and Response to Sexual Abuse, Assault and Harassment (PPM 3247.01)	**Related Policies:** • Confidentiality Policy dated February 20, 2004 • Security of Confidential, Case Specific and/or Personally Identifiable Information • #2012/01 Promoting a Safe and Respectful Environment for Lesbian, Gay, Bisexual, Transgender, and Questioning Youth (LGBTQ) and Their Families Involved with the Child Welfare, Detention, and Juvenile Justice System, 11/21/12 • #2015/06 Prevention, Detection, and Response to Sexual Misconduct in the Division of Youth and Family Justice Detention Services • #2015/10 Room Isolation Policy for Limited Secure Juvenile	**Supersedes:** NA	

	Justice Placement • #2015/13 Mechanical Restraints for Limited Secure Placement • #2016/05 Limited Secure Placement Personal Youth Search Policy • #2017/04 Required Log Books and Paper Files for Juvenile Justice Placement Facilities • Transfers in Juvenile Justice Placements • Safe Intervention Policy for Juvenile Justice Placement • Vulnerable Persons Central Register (VPCR) Reportable Incidents and Notification • Incident Reporting for Juvenile Justice Placement and Aftercare • Youth Grievance Policy for Juvenile Justice Placement	

Related Forms: Search Request Form for Transgender and Intersex Youth

SUMMARY:

Employees of the Administration for Children's Services (ACS), Limited Secure Placement (LSP) provider staff, professionals, volunteers, interns, contractors, staff of city partner agencies, and youth may not engage in sexual abuse or sexual harassment of youth in the care and custody of ACS. Individuals covered by this policy must report any such instances and engage in appropriate follow-up with respect to allegations of sexual abuse and sexual harassment of youth. ACS employees and LSP provider staff must employ supervision and search practices that minimize the possibility of harm to youth in their care, and must educate youth and staff about their rights and responsibilities under this policy.

SCOPE:

This policy applies to all youth in the care and custody of ACS in LSP, in court, and during transportation to and from LSP facilities pursuant to Article 3 of the Family Court Act. This policy applies to ACS employees, LSP provider staff, professionals, volunteers, interns, contractors, and staff of city partner agencies in those settings.

Table of Contents

I. PURPOSE 4
II. POLICY 4
III. DEFINITIONS 4
IV. COORDINATION 10
V. HIRING AND PROMOTION 10
VI. STAFFING PLAN AND MONITORING 11
VII. SEARCHES 13
VIII. LIMITS TO CROSS-GENDER VIEWING OF YOUTH 14
IX. COMMUNICATION WITH YOUTH 14
X. TRAINING OF STAFF 16
XI. TRAINING OF VOLUNTEERS 18
XII. TRAINING OF CONTRACTORS, INTERNS, PROFESSIONALS , AND INDIVIDUALS FROM CITY PARTNER AGENCIES 19
XIII. YOUTH EDUCATION 19
XIV. OBTAINING INFORMATION FROM YOUTH AND PLACEMENT OF YOUTH IN HOUSING AND PROGRAMMING ASSIGNMENTS 20
XV. YOUTH REPORTS OF ALLEGED SEXUAL MISCONDUCT 23
XVI. COORDINATED RESPONSE TO ALLEGED SEXUAL ABUSE AND SEXUAL HARASSMENT 24
XVII. YOUTH ACCESS TO OUTSIDE SUPPORT SERVICES AND LEGAL REPRESENTATION 28
XVIII. NOTIFICATION OF YOUTH'S PARENT, GUARDIAN, ATTORNEY, AND/OR CASEWORKER 28
XIX. EMERGENCY AND ONGOING MEDICAL, MENTAL HEALTH, AND CRISIS INTERVENTION SERVICES FOLLOWING AN ACTUAL OR ALLEGED INCIDENT OF SEXUAL ABUSE 29
XX. PROTECTION FROM RETALIATION 32
XXI. BEHAVIOR MANAGEMENT GUIDELINES 33
XXII. REPORTING TO YOUTH 33
XXIII. CRIMINAL AND ADMINISTRATIVE AGENCY INVESTIGATIONS 34
XXIV. ACS AND LSP STAFF DISCIPLINE 35
XXV. DISCIPLINE OF CONTRACTORS, VOLUNTEERS, AND INTERNS 35
XXVI. SEXUAL ABUSE INCIDENT REVIEWS 36
XXVII. DATA COLLECTION AND REPORTING 38
XXVIII. DATA REVIEW FOR CORRECTIVE ACTION 38
XXIX. AUDITS 39
XXX. ATTACHMENTS

A. Search Request Form for Transgender and Intersex Youth

I. PURPOSE

The purpose of this policy is to outline the approach of the Administration for Children's Services (ACS) to zero tolerance for sexual misconduct for youth in limited secure placement (LSP). This policy applies to all youth in the care and custody of ACS, in court, and during transportation to and from LSP facilities pursuant to Article 3 of the Family Court Act. This policy applies to ACS employees, LSP provider staff, professionals, volunteers, interns, contractors, and city partner agency staff in those settings. The policy sets forth ACS' approach to sexual misconduct prevention, detection, and response for youth in LSP and the adults who work with them.

II. POLICY

ACS employees, LSP provider staff, professionals, volunteers, interns, contractors, staff of city partner agencies, and youth may not engage in sexual abuse or sexual harassment of youth in LSP. Individuals covered by this policy must report allegations of sexual abuse and sexual harassment of youth as required by this policy. Those personnel responsible for the provision of services for youth in LSP must engage in appropriate follow-up with respect to allegations of sexual abuse and sexual harassment of youth, and must provide alleged victims and youth perpetrators with needed services and supports. ACS employees and LSP provider staff must use supervision and search practices that are consistent with state law, regulation, and policy and must minimize the possibility of harm to youth in their care.[1] ACS employees and LSP provider staff must also educate youth and staff about their rights and responsibilities under this policy.

III. DEFINITIONS

A. Body Cavity Search – A visual, manual, and/or instrument inspection of a youth's anal or vaginal cavity opening. **Body cavity searches are prohibited.**

B. Contact with Youth – Verbal or physical interactions with LSP youth that are expected to occur based on an individual's role in LSP facilities. For example, a maintenance worker or food delivery person generally would not have contact with youth, even though he or she may pass by youth in part of the facility, because interacting with youth is not part of his or her responsibilities.

C. Contractor – A person or agency that provides services on a recurring basis pursuant to a contractual agreement with ACS, LSP providers, and/or city partner agencies.

[1] See ACS Policy and Procedure, *Vulnerable Persons Central Register (VPCR) Reportable Incidents and Notification*.

D. Exigent Circumstances – Any set of temporary and unforeseeable circumstances that require immediate action in order to combat a serious threat to the security of a facility.

E. Gender Expression – The manner in which a person expresses his or her gender through clothing, appearance, behavior, speech, and other expression. A person's gender expression may vary from the gender norms traditionally associated with that person's biological sex.

F. Gender Identity – Individuals' internal view of their gender; individuals' innermost sense of being male, female, or a different gender. This may include name and pronoun preferences for an individual.

G. Gender Non-Conforming – Having or perceived to have gender characteristics and/or behaviors that do not conform to traditional societal gender expectations.

H. Interns – Students who assist LSP provider agencies and/or ACS pursuant to an agreement with the student's school.

I. Intersex – A person born with sexual anatomy, reproductive organs, or chromosomal pattern that does not seem to fit typical definitions of male or female. Intersex medical conditions are sometimes referred to as disorders of sex development.

J. Limited Secure Placement (LSP) Facility – A limited secure residential setting where youth are placed close to home, in the care and custody of the Commissioner of ACS, by the Family Court on juvenile delinquency cases, pursuant to Article 3 of the Family Court Act.

K. Limited Secure Placement (LSP) Providers – ACS-contracted agencies responsible for the care and custody of youth placed with ACS by the Family Court in the limited secure placement setting pursuant to Article 3 of the Family Court Act.

L. Limited Secure Placement (LSP) Staff – Staff of the LSP facility, including medical and mental health professionals, employed by LSP Providers.

M. Pat-Frisk Search – A visual and manual inspection of a youth's clothed body that consists of physically patting down his or her clothing.[2]

N. Prison Rape Elimination Act (PREA) - A federal law passed by the United States Congress in 2003 to promote the prevention, detection, investigation, and appropriate response to sexual misconduct in certain custodial settings, including juvenile facilities.

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[2] See ACS Policy and Procedure #2015/09, *Limited Secure Placement Personal Youth Search Policy*.

O. Residential Care Advocate – An advocate for youth in LSP facilities overseen by the ACS Office of Advocacy. The Residential Care Advocate is part of the Resident Care Advocacy Program, which advocates for the rights of placed youth by monitoring the overall living conditions within LSP facilities and advocating for improvements in the quality of care in accordance with ACS' policies and procedures.

P. Room Isolation – In an LSP setting, the isolation of a youth for a time-limited period, in a bedroom or other designated room, in order to calm and control the acute physical behavior of a youth.[3]

Q. Security Search – An inspection to check for contraband, conducted to maintain the safety and security of staff and youth, that requires the youth to wear a medical gown or robe after removing his or her upper garments, and then subsequently to remove the rest of his or her garments.[4]

R. Sexual Abuse – The definition of sexual abuse for purposes of this policy includes sexual abuse of a youth by another youth and sexual abuse of a youth by an ACS employee, LSP provider staff member, professionals, volunteer, intern, contractor, or staff of city partner agencies.

1. **Sexual abuse of a youth by another youth:**

    a. The victim does not expressly or impliedly acquiesce in the alleged perpetrator's conduct; and/or

    b. The victim is unable to consent or refuse because of being mentally disabled, mentally incapacitated, or physically helpless; and/or

    c. The victim is coerced into such act by overt or implied threats of or actual use of force or violence; and/or

    d. Any of the following acts occur:

        i. Contact between the penis and the vulva or the penis and the anus, including penetration, however slight;

        ii. Contact between the mouth and the penis, vulva, or anus;

[3] See ACS Policy and Procedure #2015/10, *Room Isolation in Limited Secure Juvenile Justice Placement*.
[4] See ACS Policy and Procedure #2015/09, *Limited Secure Placement Personal Youth Search Policy*.

iii. Penetration of the vagina, urethra, penis, rectum or anus of another person, however slight, by a hand, finger, object, or other instrument; or

iv. Any other intentional touching, either directly or through the clothing, of the genitalia, anus, groin, breast, inner thigh, or the buttocks of any person. Sexual abuse does not include contact incidental to non-sexual horseplay or a physical altercation such as a kick in the groin or the accidental touching of someone's breasts while pushing her away.

2. **Sexual abuse of a youth by ACS employees, LSP provider staff, professionals, volunteers, interns, contractors, or staff of city partner agencies** includes any of the following acts conducted by these parties, with or without the consent of the youth:

   a. Sexual touching, including any of the following:

      i. Contact between the penis and the vulva or the penis and the anus, including penetration, however slight; and/or

      ii. Penetration of the vagina, urethra, penis, rectum or anus of another person, however slight, by a hand, finger, object, or other instrument, except when conducted by a medical professional as part of a medical examination or medical treatment; and/or

      iii. Contact between the mouth and the penis, vulva, or anus; and/or

      iv. The emission or ejaculation upon any part of a youth, clothed or unclothed;

      v. Any other intentional touching not required by official duties, either directly or through the clothing, of the genitalia, anus, groin, breast, inner thigh, or the buttocks of any person. Sexual abuse does not include conduct required by or incidental to official duties (e.g., it would not be sexual misconduct for a staff member to touch a youth's body as required in order to conduct a proper pat-frisk search, or if a staff member's hand slips unavoidably while he or she is breaking up a fight); and/or

      vi. Any other contact where the individual has the intent to degrade or abuse the youth or to arouse or gratify a sexual desire.

   b. Any attempt, threat, or request to engage in sexual touching.

   c. Indecent exposure, which means the display of his or her uncovered genitalia, buttocks, or breast in the presence of a youth.

d. Voyeurism, which means an invasion of a youth's privacy for reasons that do not involve the performance of official duties. Voyeurism may include peering at a youth who is using a toilet, changing in his or her room, or bathing, except when staff are required to maintain constant visual supervision of a youth pursuant to ACS Policy and Procedure #2015/10, *Room Isolation in Limited Secure Juvenile Justice Placement*; requiring a youth to expose his or her buttocks, genitals, or breasts for reasons other than a properly administered strip search or medical examination; or taking images of all or part of a youth's naked body or of a youth performing bodily functions, except in circumstances where images of a youth are captured by the LSP facility's Closed Circuit Television (CCTV) video monitoring system.

e. Any conduct or communication that advances, profits from, uses, patronizes, or encourages a youth's engagement in any act of sexual exploitation, sex trafficking, or prostitution as defined in Article 230 of the Penal Law.

f. Any conduct or communication that allows, permits, promotes, produces, uses, or encourages a youth's engagement in any sexual performance as defined in Article 263 of the Penal Law; having such material involving a youth in his or her possession or control; or having accessed such material with the intent to view it.

g. Any conduct that subjects a youth to incest as defined by Article 255 of the Penal Law.

h. Commission of any other sex offense as defined by Article 130 of the Penal Law.

S. Sexual Harassment – The definition of sexual harassment includes:

1. Repeated and unwelcome sexual advances, requests for sexual favors, or verbal comments, gestures, or actions of a derogatory or offensive sexual nature by one youth in ACS custody toward another youth in ACS custody; and

2. Any verbal or written (e.g., text, email, social media writings) comments or gestures of a sexual nature to a youth by ACS employees, LSP provider staff, professionals, contractors, volunteers, staff of city partner agencies, or interns, including demeaning references to gender, sexual orientation, sexually suggestive or derogatory comments about body or clothing, or obscene language or gestures directed at a youth.

T. Sexual Misconduct – Actions constituting either sexual harassment or sexual abuse.

U. Strip Search – An inspection to check for contraband believed capable of inflicting harm on the youth, staff, or others, conducted to maintain the safety and security of youth and staff. A strip search requires individualized reasonable suspicion that the youth is in possession of potentially dangerous contraband and may only occur after a security search has been conducted.[5]

V. Substantiated* – An allegation that was investigated and determined to have occurred.

W. Transgender – A person whose gender identity (i.e., internal sense of feeling male or female) is different from the person's assigned sex at birth.

X. Unfounded* – An allegation that was investigated and determined not to have occurred.

Y. Unsubstantiated* – An allegation that was investigated and the investigation produced insufficient evidence to make a final determination as to whether or not the event occurred.

Z. Volunteer – An individual who donates time and effort on a recurring basis to enhance the activities and programs of LSP facilities.

AA. Vulnerable Persons Central Register (VPCR) – An office within the New York State Justice Center for the Protection of People with Special Needs (Justice Center) that is designated to receive reports of abuse, neglect, and other significant incidents involving youth in residential settings.

BB. Youth – Any child in LSP, under ACS supervision, who is in the custody of ACS pursuant to Article 3 of the Family Court Act.

Note: Definitions denoted with an asterisk (*) are derived from the regulations (28 CFR Part 115) implementing PREA as it applies to Juvenile Facilities. The definitions only apply to this policy. They are not interchangeable with the definitions of the same words as used in New York Social Services Law.

Note: Youth in facilities are unable to consent regardless of age. Youth are prohibited from engaging in sexual activity with other youth, staff, volunteers, or contractors. However, for such activity to constitute sexual abuse between youth, it must be determined that the activity was coerced.

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[5] See ACS Policy and Procedure #2015/09, *Limited Secure Placement Personal Youth Search Policy*.

IV. COORDINATION

A. The Deputy Commissioner of the Division of Youth and Family Justice (DYFJ) must designate a DYFJ staff member as **PREA Coordinator** to coordinate the development, implementation, and oversight of measures to prevent, detect, and respond to incidents and allegations of sexual misconduct in ACS LSP facilities.

B. Each facility must designate an existing staff member to be the **PREA Compliance Manager** to oversee each facility's implementation of PREA and compliance with ACS policies on preventing, detecting, and responding to sexual misconduct.

C. The Court Services, Admissions, and Movement and Control Communications Unit (CAM) and Field Operations Unit must manage compliance with ACS' policies on preventing, detecting, and responding to sexual misconduct in situations involving ACS and LSP provider staff who interact with youth in court and during transportation to and from LSP facilities.

V. HIRING AND PROMOTION

A. ACS and LSP providers shall not hire or promote any employees who may have contact with youth, and shall not hire any contractor who may have contact with youth, if the prospective employee or contractor:

1. Has engaged in sexual abuse in a prison, jail, lockup, community confinement facility, juvenile facility, or other institution as defined in 42 U.S.C. 1997.

2. Has been convicted of engaging in or attempting to engage in sexual activity in the community facilitated by force, overt or implied threats of force, or coercion, or if the victim did not consent or was unable to consent or refuse; or

3. Has been civilly or administratively adjudicated to have engaged in the activity described above.

B. ACS and LSP providers must consider any incidents of sexual harassment in determining whether to hire or promote any employee or to hire any contractor who may have contact with youth.

C. Before hiring new employees who may have contact with youth in LSP, ACS and LSP providers must:

1. Perform a criminal background check in accordance with Executive Law section 845-b;

2. Consult the State Central Register and the New York State Justice Center for the Protection of People with Special Needs (Justice Center) Staff Exclusion List (SEL); and

3. Make best efforts to contact all prior institutional employers for information on substantiated allegations of sexual abuse or any resignation during a pending investigation of an allegation of sexual abuse.

D. ACS and LSP providers must also perform a criminal background records check and consult the State Central Register and the Justice Center SEL before enlisting the services of any contractor who may have contact with youth.

E. ACS and LSP providers must either conduct a criminal background records check at least every five (5) years of current employees and contractors who may have contact with youth, or have in place a system for otherwise capturing such information for current employees.

F. The LSP provider must ask all applicants and employees who have contact with youth about previous misconduct described in Section A. above in written applications or interviews for hiring or promotions, and in any interviews or written self-evaluations conducted as part of reviews of current employees. Employees must have a continuing affirmative duty to disclose any such misconduct to LSP providers.

G. Material omissions regarding such misconduct or the provision of materially false information shall be grounds for termination.

H. Unless prohibited by law, the LSP provider must provide information on substantiated allegations of sexual abuse or sexual harassment involving a former employee upon receiving a request from an institutional employer for whom such employee has applied to work.

VI. STAFFING PLAN AND MONITORING

A. Each LSP provider facility must develop, implement upon ACS approval, and document a staffing plan that provides for adequate levels of staffing and video monitoring to protect youth against sexual abuse. LSP provider facilities must comply with the staffing plan, except during limited and discrete exigent circumstances, and document any deviation from the plan.

B. In consultation with the PREA Coordinator, LSP provider facilities must review the current staffing plan on an annual basis and update accordingly, where applicable. This review shall be conducted with consideration to the following factors:

1. Any minimum staffing levels required by law, regulation, or policy;
2. Generally accepted juvenile residential practices;
3. Any judicial findings of inadequacy;
4. Any findings of inadequacy from federal investigative agencies;
5. Any findings of inadequacy from internal or external oversight bodies;
6. All components of the facility's physical plant including "blind spots" or areas where staff or youth may be isolated;
7. The composition of the youth population in LSP facilities operated or overseen by ACS;
8. The number, assignment, and coverage of supervisory staff;
9. The use, maintenance, and clarity of video monitoring;
10. Programs occurring during a particular shift;
11. The prevalence of substantiated and unsubstantiated incidents of sexual abuse;
12. Whether additional resources or adjustments to video monitoring or staffing patterns are needed;
13. Any applicable state or local laws; and
14. Any other relevant factors.

C. The Office of Planning, Policy, & Performance (OPPP) must require an increase or adjustment in staffing levels and video monitoring as necessary to fill gaps identified through the review described above in Section B. LSP provider facilities must comply with any such requirements.

D. OPPP must consider whether any of the following will have an impact on ACS and the LSP provider's ability to protect youth from sexual misconduct when ACS or an LSP provider plans the following:

    1. Any new building;
    2. Any building modification or conversion of existing spaces; or
    3. Any new or changed video monitoring capabilities for LSP facilities.

E. At each LSP facility, the facility director must designate staff who must conduct and document regular unannounced rounds on all shifts to identify and deter staff sexual abuse and sexual harassment. Staff may not alert other staff members that these supervisory rounds are occurring, unless such announcement is related to the legitimate operational functions of the facility.

VII. SEARCHES[6]

A. No youth shall be subject to a body cavity search by LSP staff, ACS employees, or contractors.

B. No youth shall be subject to a strip search by non-medical staff of the opposite gender under any circumstances.[7]

C. Youth shall be subject to a pat-frisk or security search by LSP staff of the opposite gender only in exigent circumstances and with approval by the LSP program director or designee.

D. All cross-gender pat-frisk or security searches of youth must be approved by the program director or designee, and the justification for those searches, must be documented in the appropriate unit log book or paper file according to ACS policy.[8]

E. No transgender or intersex youth shall be searched for the purpose of determining genital status.

F. Upon admission,[9] LSP provider intake staff must offer transgender or intersex youth the opportunity to request that staff of a particular gender conduct any pat-frisk, security search, or necessary strip search of the youth.

   1. LSP provider staff must offer youth the opportunity to complete Attachment A: Search Request Form for Transgender and Intersex Youth. LSP staff must comply with that request, absent exigent circumstances, and document any deviation from the youth's documented preference.

   2. If a youth does not indicate a preference, the staff member of the youth's self-identified gender must perform the search.

   3. Any ACS or LSP staff to whom youth disclose that they are transgender or intersex must thereafter arrange for the youth to be offered the opportunity to complete the form if the youth has not already done so.

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[6] See ACS Policy and Procedure #2016/05, *Limited Secure Placement Personal Youth Search Policy*.

[7] In the case of transgender or intersex youth, they must be strip searched only by staff of the requested gender; transgender and intersex youth may make this decision at any time, including at the time of the search.

[8] See ACS Policy and Procedure #2017/04, *Required Log Books and Paper Files for Juvenile Justice Placement Facilities*.

[9] Transgender and intersex youth may make this request at any point during their juvenile delinquency case, including while in Detention and throughout placement in an LSP facility.

4. ACS and LSP staff must also offer the youth the opportunity to complete a new form if he or she indicates that his or her preference has changed.

G. LSP provider facilities must establish procedures for review and approval by ACS that outline who will receive copies of the Search Request Form for Transgender and Intersex Youth, where such forms will be stored, how a youth's preferences shall be communicated to staff, and how LSP provider facilities will assist a youth in changing his or her preference.

H. LSP staff must also follow search requirements contained in ACS Policy and Procedure #2016/05, *Limited Secure Placement Personal Youth Search Policy*.

VIII. LIMITS TO CROSS-GENDER VIEWING OF YOUTH

A. LSP staff must help youth understand and abide by the expectation that youth must be clothed or cover themselves when they may be viewed by others, except as appropriate for medical care.

B. The LSP provider facility must submit policies and procedures for ACS approval that enable youth to shower, perform bodily functions, and change clothing without nonmedical staff of the opposite gender viewing their breasts, buttocks, or genitalia, except in exigent circumstances or when such viewing is incidental to routine bed checks. LSP providers must establish procedures, submitted for approval by ACS, so that Sections B. and C. of this section are implemented based on the individual layout of each LSP facility.

C. LSP staff must maintain an environment in which youth are not viewed in a state of undress, except as required for security or medical reasons outlined in this and other relevant policies. All LSP staff must announce their presence in areas and during times when youth may be performing bodily functions, showering, or changing clothing, and must allow sufficient time for youth to cover themselves before entering those areas, except in exigent circumstances.

IX. COMMUNICATION WITH YOUTH

A. ACS employees and LSP staff who come into contact with youth who may have disabilities or limited English proficiency (LEP) must inform supervisors so that supervisors may make appropriate referrals for assessment and services.[10]

B. ACS employees and LSP staff shall provide youth with disabilities and LEP youth an equal opportunity to participate in and receive the benefits of the programs and

[10] See ACS Policy and Procedure, *Language Access Policy*.

services available in ACS facilities, including efforts to prevent, detect, and respond to sexual misconduct.

C. In order to make appropriate accommodations for youth with disabilities and LEP youth, LSP providers must do the following:

1. Identify youth with disabilities and LEP youth upon admission to an ACS LSP facility and work with each youth's family and medical, mental health, psychiatric, and other staff as necessary;

2. Provide access to professional interpreters who can interpret effectively, accurately, and impartially, using any necessary specialized vocabulary;

3. Provide written materials in formats or through methods that achieve effective communication with youth with disabilities, including youth who have intellectual disabilities, limited reading skills, or who are blind or have low vision;

4. Document the youth's special needs in the youth's case notes and, in consultation with the PREA Coordinator, develop a PREA-compliant case plan in accordance with the youth's needs. The case plan must include arrangements for providing youth with disabilities and LEP youth with explanations in a manner and form that the youth can understand. Among others, such explanations must include how to report if they are feeling unsafe, how to access medical and mental health care, and strategies for effective communication; and

5. Implement the case plan described above, consulting with the Case Manager Supervisor, medical staff, mental health staff, psychiatric staff, family members of the youth, and others, as necessary.

D. Each LSP facility must post and make readily available information for telephone interpretation and translation services for all individuals who work with youth. ACS employees and LSP staff must be trained on how to use available resources to communicate with LEP youth and their families, and must arrange for staff to provide such youth with meaningful access to programs and services.

E. ACS employees, LSP provider staff, professionals, volunteers, interns, contractors, and city partner agency staff must use interpretation resources to communicate with LEP youth at all stages of a youth's stay at an LSP facility unless the staff, volunteer, intern, or contractor speaks the youth's native language and the youth has been advised that he or she is entitled to free interpretation services and has refused such services.

F. ACS employees, LSP provider staff, professionals, volunteers, interns, contractors and city partner agency staff must not rely on youth, family, friends or neighbors to

provide translation or interpretation, except in limited circumstances where an extended delay in obtaining an interpreter could compromise the following:

1. The youth's safety;
2. The performance of first responder duties following an allegation that a youth was sexually abused; or
3. The investigation of the youth's allegations.

G. The PREA Coordinator or designee must communicate with the contractor(s) and agency contracting entity to confirm that interpreters can interpret effectively, accurately, and impartially, both receptively and expressively, using any necessary specialized vocabulary pertaining to placement.

X. TRAINING OF STAFF

A. ACS employees and LSP provider staff who may have contact with youth at an LSP facility must receive initial and biennial (every two years) refresher training on the following:

1. ACS' zero tolerance for sexual misconduct and retaliation;

2. How to fulfill responsibilities regarding prevention, detection, reporting and response to sexual misconduct;

3. A youth's right to be free from sexual abuse and sexual harassment;

4. The right of youth and employees to be free from retaliation for reporting sexual misconduct;

5. The dynamics of sexual abuse and sexual harassment in juvenile facilities;

6. The factors that make youth vulnerable to sexual abuse and sexual harassment;

7. Adolescent development for girls and boys that includes developmentally normative sexual behavior for adolescents, how to distinguish between developmentally normative adolescent behavior and sexually aggressive and dangerous behaviors, and the ways in which sexual victimization can affect healthy development. The training must be informed by the extent to which cultural, social, and family influences interfere with a youth's functioning;

8. The prevalence of trauma and abuse histories among youth in juvenile justice facilities, possible behaviors of youth with trauma and abuse histories, and appropriate gender-specific ways of responding to those behaviors;

9. The common reactions of youth victims of sexual abuse and sexual harassment;

10. How to detect and respond to signs of threatened and actual sexual abuse and sexual harassment, and how to distinguish between consensual sexual contact and sexual abuse between youth;

11. How to communicate effectively and professionally with youth, including lesbian, gay, bisexual, transgender, intersex, and gender non-conforming youth;

12. How to handle disclosures of victimization by youth in a sensitive manner;

13. How to preserve evidence associated with instances of sexual abuse;

14. How to avoid inappropriate relationships with youth, and how to maintain professional relationships and boundaries with youth;[11]

15. Relevant laws and policies related to age of consent, with a clear directive that no youth in ACS care can consent to sexual conduct with any adult, and mandatory reporting of sexual abuse to outside authorities; and

16. How to conduct professional, respectful, and minimally intrusive cross-gender pat-frisk searches and searches of transgender and intersex youth.

B. ACS employees and LSP provider staff must receive additional gender-responsive training if the employee or staff member is reassigned from a facility that houses only male youth to a facility that houses only female youth, or vice versa.

C. During the years in which ACS employees or LSP staff do not receive the refresher trainings outlined above in Section A., ACS must provide information on the agency's current sexual misconduct policies to its employees, and LSP provider facilities must provide this information to LSP provider staff. ACS and LSP provider facilities may provide this information in person, in writing, or through some other means.

D. All full- and part-time medical, mental health, and psychiatric employees and contractors who work with youth in LSP facilities must be trained on these topics:

1. How to detect and assess signs of sexual abuse;
2. How to determine when youth require protection from sexual abuse;
3. How to preserve physical evidence of sexual abuse;

[11] See the ACS Code of Conduct for further information about professional relationships and boundaries.

4. How to respond effectively and professionally to youth victims and alleged perpetrators of sexual abuse, both in terms of the procedures to follow and the treatment to administer; and
5. How and to whom to report allegations or suspicions of sexual abuse.

E. LSP providers must submit their facility's staff training materials, adapted to their facilities, for ACS approval.

F. The LSP provider must develop a method of determining that LSP staff understand and exhibit competence in the information and skills provided in the trainings required by this policy. The LSP provider facilities must retain records of the trainings described above, including documentation that individuals understood the training they received. LSP providers must provide an acknowledgment form upon completion of training which the employee or contractor must sign, including electronically, indicating that they received and understood the training information.

G. Administrative staff or contractors who will not have contact with youth must receive the training for volunteers described below in Section XI.

H. The Facility Director must require that intake staff in LSP facilities be trained to provide the information provided below on Youth Education in Section XIII. A. in an age-appropriate, trauma-informed, and sensitive manner.

I. LSP providers must require that, as new contracts for medical, mental health, psychiatric, and other services are developed, they include requirements that contractors whose jobs will include contact with youth receive the training required under this policy and the United State Department of Justice PREA regulations in their most current form.

XI. TRAINING OF VOLUNTEERS

A. Each volunteer working with youth in an LSP facility must receive a written document providing information about the agency's sexual misconduct prevention policy including how to report suspected sexual abuse and sexual harassment, the facility's zero tolerance for sexual abuse and sexual harassment, and rules about confidentiality. Volunteers must sign a document acknowledging receipt and understanding of this information.

B. Any volunteer working with youth at the facility must have brief verbal contact with an LSP staff member to introduce the document described above, and each volunteer must sign it prior to contact with youth at the facility.

C. Each LSP facility must require that volunteer groups that collaborate with the agency on an ongoing basis receive an in-person orientation to the facility and annual training

about sexual misconduct prevention and reporting. It is not required that every member of the volunteer group receive the annual, in-person training prior to having contact with youth, as long as they sign the document, receive the brief verbal introduction described above, and attend the first available volunteer training.

D. Individuals who volunteer once, rather than on a recurring basis, must sign the document and receive the brief verbal introduction described above. However, such volunteers must be supervised by LSP provider staff at all times.

XII. TRAINING OF CONTRACTORS, INTERNS, PROFESSIONALS, AND INDIVIDUALS FROM CITY PARTNER AGENCIES

A. Contractors, interns, professionals, and individuals from city partner agencies who will have unsupervised interactions with youth must receive a training, prior to beginning work with ACS or a provider agency, that includes information about the agency's policy on preventing, detecting, and responding to sexual misconduct, including the agency's zero-tolerance policy for sexual abuse and sexual harassment and how to report such incidents**.**

B. Contractors, interns, professionals, and individuals from city partner agencies who will only have supervised interactions with youth must receive the training for volunteers described above in Section XI. prior to beginning work with ACS or a provider agency.

C. ACS and LSP providers must retain records of the trainings conducted according to this section, including documentation that individuals understood the training they received.

XIII. YOUTH EDUCATION

A. Upon admission, intake staff in LSP facilities must provide age-appropriate information to youth explaining the facility's zero tolerance policy regarding sexual abuse and sexual harassment, a youth's right to be free from any form of sexual abuse and sexual harassment, and how to report incidents or suspicions of sexual abuse and sexual harassment or situations where a youth does not feel safe. In the event that a youth is moved from an LSP facility before receiving this information, the Facility Director of the receiving LSP facility must provide youth with this information.

B. As part of the intake process in LSP facilities, LSP provider staff must require that youth sign a form confirming receipt and understanding of the information described in Section A. above. In the event a youth refuses to sign, staff must note the youth's refusal on the form, and initial and date the note.

C. Within seven (7) days of a youth's arrival at an LSP facility, LSP provider staff must present more in-depth information about a youth's rights to be free from sexual abuse and sexual harassment and misconduct and free from retaliation for reporting

incidents, the importance of and avenues for reporting, ACS policies for responding to incidents including the youth's right to medical, mental health, and psychiatric care regardless of the status of an investigation, and where to go if he or she has questions.

1. LSP providers must determine who will deliver the youth education and must communicate this to ACS.

2. The PREA Coordinator must arrange for youth already housed in the facilities to receive the same information within 60 days of the promulgation of this policy.

3. LSP provider facilities must document a youth's receipt and understanding of this information.

D. The PREA Compliance Manager, in consultation with the PREA Coordinator, must oversee development and posting of informational posters regarding the sexual abuse and sexual harassment prevention and response policies. Such posters will include key information and be continuously and readily visible to youth.

E. LSP provider facilities must develop and implement the youth education materials described above, submitting such materials for review and approval by the PREA Coordinator. The PREA Compliance manager must verify that youth education materials are updated to reflect any changes to policies and practices.

F. LSP providers must work with the agency's PREA Coordinator to provide youth with disabilities, youth with low reading skills, and LEP youth with the information outlined in Section XIII. in formats that they can understand.

XIV. OBTAINING INFORMATION FROM YOUTH AND PLACEMENT OF YOUTH IN HOUSING AND PROGRAMMING ASSIGNMENTS

A. ACS employees and LSP facility provider staff must attempt to obtain and use the following information to make housing and programming decisions that will reduce the risk of sexual abuse and sexual harassment by or upon youth in LSP:[12]

1. Prior sexual victimization or abusiveness;
2. Any gender non-conforming appearance, manner, or identification as lesbian, gay, bisexual, transgender, or intersex, and whether the youth may therefore be vulnerable to sexual abuse;
3. Current charges and offense history;
4. Age;
5. Level of emotional and cognitive development;

[12] See PREA Standard 115.342.

6. Physical size and stature;
7. Mental illness or mental disabilities;
8. Intellectual or developmental disabilities;
9. Physical disabilities;
10. The youth's own perception of vulnerability; and
11. Any other specific information that may indicate a heightened need for supervision, additional safety precautions, or separation from certain other youth.

B. When youth in LSP are housed in detention awaiting placement in an LSP provider facility, detention staff must attempt to obtain and consider the information outlined above in Section A. 1-11., following the requirements outlined in Policy #2015/06, *Prevention, Detection, and Response to Sexual Misconduct in the Division of Youth and Family Justice Detention Services*.

C. When ACS staff are deciding where youth in LSP must be placed, ACS staff must attempt to obtain and consider the information outlined above in Section A. 1-11. when choosing a particular LSP provider facility.

D. When youth are admitted to an LSP provider facility, LSP provider staff must attempt to obtain the information outlined above in Section A. 1-11. Within 72 hours, LSP provider staff must use this information and an objective screening instrument to make housing, programming, education, and other supervision arrangements with the goal of keeping all youth safe and free from sexual abuse and sexual harassment.

E. ACS and LSP provider staff must review a youth's housing and programming assignments periodically, and at a minimum of twice annually, and work to adjust them, as necessary, based on information that becomes available that affects ACS and LSP provider staff's ability to keep all youth safe and free from sexual abuse and sexual harassment.

F. ACS and LSP providers shall not place lesbian, gay, bisexual, transgender, gender non-conforming, or intersex youth in particular housing or other programming assignments solely on the basis of such identification or status.

    1. ACS and LSP staff shall not consider lesbian, gay, bisexual, transgender, gender non-conforming, or intersex identification or status as an indicator or likelihood of being sexually abusive.

    2. ACS and LSP staff must follow the provisions outlined in Policy #2012/01 *Promoting a Safe and Respectful Environment for Lesbian, Gay, Bisexual, Transgender, and Questioning Youth (LGBTQ) and Their Families Involved with the Child Welfare, Detention, and Juvenile Justice System*.

G. ACS and LSP providers shall not automatically house transgender and intersex youth according to the sex they were assigned at birth.

   1. ACS and LSP providers must make housing decisions for transgender and intersex youth based on each youth's individualized needs and must prioritize the youth's emotional and physical safety.

   2. ACS and LSP staff must give serious consideration to the youth's own views with respect to his or her own safety**,** as well as any recommendations provided by the youth's medical, mental health, or psychiatric care provider.

   3. The presumed default housing for transgender and intersex youth will be according to their gender identity, unless there is a compelling reason that this would be inappropriate or unsafe.

   4. For transgender or intersex youth admitted to LSP, ACS and LSP intake staff must determine appropriate housing and programming placements in consultation with the facility Executive Director.

   5. When a youth is not housed according to his or her identified gender, the Facility Director or designee must consult with and receive authorization from the Associate Commissioner or designee of OPPP within DYFJ in order to receive authorization for the housing decision. ACS and LSP provider staff must document the housing decision for each transgender and intersex youth in the youth's record.

H. All youth must shower individually.

I. If a youth is experiencing trouble with his or her housing or programming assignment, LSP provider staff must assess the youth's current assignments and explore supports and alternatives. LSP provider staff must review housing and programming assignments for transgender and intersex youth at least every six (6) months even if they are not experiencing trouble with those assignments, or sooner if requested by the youth or if the safety of the youth becomes a concern.

J. The Facility Director in each LSP facility must implement appropriate controls on the internal and external dissemination within the facility of the information described in Section XIV. in order to prevent sensitive information from being exploited to the youth's detriment by staff or other youth, and confirm that the LSP provider upholds its responsibilities to safeguard confidential information.

XV. YOUTH REPORTS OF ALLEGED SEXUAL MISCONDUCT[13]

A. LSP staff must provide youth with multiple ways to report[14] sexual abuse and sexual harassment, retaliation, and staff neglect or violation of responsibilities that may have led to such incidents.

   1. Youth may report concerns, either anonymously or by name, verbally and/or in writing.

   2. Youth may also speak to a third party, such as a family member, ACS staff member, or any other adult, and indicate that they have a complaint or otherwise want to report an incident. LSP staff must document any report received from a third party and take action just as they would document a report received from a youth.

   3. LSP staff must provide youth with at least one method to report sexual abuse and sexual harassment, retaliation, and staff neglect that may have led to such incidents to an entity that is operationally autonomous of ACS or the LSP provider. Youth may do so by contacting the Justice Center VPCR, the Office of the OCFS Ombudsman, or by asking an LSP staff member for access to a telephone to call the Justice Center VPCR. Youth do not need to explain why they wish to call the Justice Center VPCR.

B. <u>Requirements for LSP Reporting Mechanisms</u>

   1. The LSP provider must not put a time limit on when a youth may submit a report regarding an allegation of sexual abuse or sexual harassment.

   2. The LSP provider must explain to youth how they can file an emergency report of sexual misconduct if they are subject to substantial risk of imminent sexual abuse, whereby the PREA Coordinator will provide an initial response no later than 48 hours after the emergency filing by the youth. The PREA Coordinator must secure approval for this process from ACS.

   3. The PREA Coordinator must not require youth to use any informal grievance process or to attempt to resolve with staff an alleged incident of sexual abuse.

   4. The PREA Coordinator must make sure that:

[13] See PREA Standard 115.352.
[14] See ACS Policy and Procedure, *Youth Grievance Policy for Juvenile Justice Placement*.

a. A youth who alleges sexual abuse or sexual harassment may submit a report of sexual misconduct without submitting it to a staff member who is the subject of the complaint; and

b. Such a report is not referred to a staff member who is the subject of the complaint.

XVI. COORDINATED RESPONSE TO ALLEGED SEXUAL ABUSE AND SEXUAL HARASSMENT

A. ACS employees and LSP provider staff must take immediate action to protect a youth when informed by any means that the youth is subject to a substantial risk of imminent sexual abuse or that a youth has been sexually abused. This includes the following:

1. Separating the youth from the alleged perpetrator;

2. Preserving and protecting any crime scene until appropriate steps can be taken to collect any evidence by law enforcement;

3. Requesting that the alleged victim not take any actions that could destroy physical evidence if the alleged incident occurred in the last five (5) days, including, as appropriate, washing, brushing teeth, changing clothes, urinating, defecating, drinking, or eating;

4. Requesting that the alleged perpetrator not take any actions that could destroy physical evidence if the alleged incident occurred in the last five (5) days, including, as appropriate, washing, brushing teeth, changing clothes, urinating, defecating, drinking, or eating;

5. Reporting the incident to his or her immediate supervisor and documenting the incident as required; and

6. Contacting the medical department.

B. If the first responder to an allegation of sexual abuse is not an ACS employee or LSP staff member but is subject to this policy, the responder must request that the alleged victim not take any actions that could destroy physical evidence and then notify the Facility Director, an ACS employee, or an LSP staff member.

C. LSP provider staff must take immediate and appropriate action to house any youth who is alleged to have suffered sexual abuse in a safe environment. Appropriate actions may include transferring the youth to a different housing area within the same

facility or transferring the youth to another facility.[15] All actions must be communicated to ACS and reviewed by the Placement and Permanency Specialist (PPS).

D. LSP staff must offer youth who have reported sexual abuse or are believed to have been sexually abused appropriate access to a sexual assault advocate and emergency and ongoing medical, mental health, counseling, and crisis intervention services, free of charge, and regardless of whether the youth names the alleged abuser or cooperates with any investigation.

    1. Such services must be made available both to youth who report victimization that occurred while in ACS custody and to youth who report victimization that occurred prior to the youth's entrance into ACS custody.

    2. LSP staff must also offer youth who are actual or alleged perpetrators of sexual abuse a mental health evaluation and appropriate treatment, so long as such services do not conflict with ongoing investigations or jeopardize a youth's Fifth Amendment right against self-incrimination.

E. <u>Reporting Responsibilities for ACS Employees, LSP Provider Staff, Professionals, Contractors, Volunteers, Staff of City Partner Agencies, and Interns</u>

    1. The individual making the report must follow ACS policies *Incident Reporting for Juvenile Justice Placement and Aftercare* and *Vulnerable Persons Central Register (VPCR) Reportable Incidents and Notification*.

    2. Any ACS employee, LSP staff member, professional, contractor, volunteer, staff of city partner agencies, or intern who has any knowledge of, suspicion of, or information about any of the following must make a report to the Justice Center VPCR:

        a. Sexual abuse of a youth in ACS custody by an ACS employee, LSP staff member, professional, contractor, volunteer, staff of city partner agencies, or intern;

        b. Sexual harassment of a youth in ACS custody by an ACS employee, LSP staff member, professional, contractor, volunteer, staff of city partner agencies, or intern;

        c. Retaliation against youth or staff who reported abuse by an ACS employee, LSP staff member, professional, contractor, volunteer, staff of city partner agencies, or intern; or

[15] See ACS Policy and Procedure, *Transfers in Juvenile Justice Placements*.

d. Neglect or violation of responsibilities by an ACS employee, LSP staff member, professional, contractor, volunteer, staff of city partner agencies, or intern that may have contributed to an incident of sexual abuse or retaliation.

3. If any of the following involve alleged conduct by ACS employees, the individual must also immediately notify the ACS Employment Law Unit (ELU).

4. In cases involving sexual misconduct or sexual harassment among youth in ACS custody, the individual making the report must follow the policies *Incident Reporting for Juvenile Justice Placement and Aftercare* and *Vulnerable Persons Central Register (VPCR) Reportable Incidents and Notification* when reporting the incident.

5. ACS employees, LSP staff members, professionals, contractors, volunteers, staff of city partner agencies, and interns must report incidents involving sexual misconduct to the Justice Center VPCR when required to do so by OCFS, the ACS reporting policy, and/or applicable New York State statutes and regulations.

6. LSP staff must contact the New York City Police Department (NYPD) or other appropriate law enforcement agency as follows:

   a. Any time an incident of sexual abuse is discovered in progress or a report is made soon after an incident, the LSP staff member observing the incident or receiving the report must immediately call the Director of the facility or designee.

      i. The Facility Director or designee must immediately contact the Special Victims Division of the NYPD through that unit's hotline at 646-610-7272, or the designated contact at the law enforcement agency with jurisdiction over the facility.

      ii. However, if LSP staff encounter a situation where there is an immediate need to protect life and/or prevent a crime from occurring, staff must call 911 to report the incident prior to calling the Facility Director or designee.

   b. Any time a report is received of prior sexual abuse, the Facility Director or designee must contact the Special Victims Division of the NYPD through that unit's hotline at 646-610-7272, or the designated contact at the law enforcement agency with jurisdiction over the facility.

7. Designated ACS employees and LSP staff members must be trained in techniques for interviewing youth so that they can determine whether sexual activity with

another youth is alleged to have been consensual. These interviews will be solely for the purpose of deciding whether or not a referral must be made to law enforcement.

8. Upon receiving an allegation that a youth in ACS custody was sexually abused or sexually harassed in ACS custody or while in another facility, the director of the facility currently housing the youth must, immediately upon discovery:

    a. Report the alleged misconduct to the Justice Center VPCR pursuant to OCFS guidance, ACS policies *Incident Reporting for Juvenile Justice Placement and Aftercare* and *Vulnerable Persons Central Register (VPCR) Reportable Incidents and Notification*, and any applicable New York State statutes and regulations;

    b. Report the alleged misconduct to the Facility Director where the alleged abuse occurred and, if the abuse occurred outside of New York State, to the appropriate investigating agency for that facility;

    c. Document that these notifications were made in an incident report; and

    d. Notify ACS of all steps taken.

F. Upon receipt of information about or an allegation of sexual abuse by an ACS employee, LSP staff member, professional, contractor, volunteer, staff of city partner agencies, or intern, the Facility Director or designee must prohibit the individual alleged to have engaged in the conduct from having contact with any youth in ACS custody pending any investigation by OCFS Internal Abuse staff, the Justice Center, or the Department of Investigation (DOI).

G. During the pendency of any investigation by OCFS, the Justice Center, or DOI of alleged sexual harassment by an ACS employee, LSP staff member, professional, contractor, volunteer, staff of city partner agencies, or intern, the Facility Director or designee must determine whether the individual alleged to have engaged in the conduct should be suspended or reassigned until completion of the investigation, depending on the nature of the allegation, in consultation with the PREA Coordinator.

H. Beyond reporting to designated supervisors or officials and ACS, ACS and LSP staff must be prohibited from revealing any information related to a sexual abuse report to anyone other than to the extent necessary as specified in this policy to make treatment, investigation, and other security and management decisions. Medical and mental health practitioners must be required to inform youth at the beginning of services of their duty to report and the limitations of confidentiality.

XVII. YOUTH ACCESS TO OUTSIDE SUPPORT SERVICES AND LEGAL REPRESENTATION

A. The LSP provider must provide youth with access to outside victim advocates for emotional support services related to sexual abuse by providing, posting, or otherwise making accessible mailing addresses and telephone numbers, including toll-free hotline numbers, where available, of local, state, or national victim advocacy or rape crisis organizations. The LSP provider must enable reasonable communication between youth and these organizations and agencies in as confidential a manner as possible.

B. The LSP provider must inform youth, prior to giving them access, of the extent to which such communications described above in Section A. must be monitored, and the extent to which reports of abuse will be forwarded to authorities in accordance with mandatory reporting laws.

C. The LSP provider must maintain or attempt to enter in a Memorandum of Understanding (MOU) or other agreements with community service providers that are able to provide youth with confidential emotional support services related to sexual abuse. The LSP provider must maintain copies of agreements or documentation showing attempts to enter into such agreements.

D. The LSP provider must also provide youth with reasonable and confidential access to their attorneys or other legal representation, and reasonable access to parents/legal guardians.

XVIII. NOTIFICATION OF YOUTH'S PARENT, GUARDIAN, ATTORNEY, AND/OR CASEWORKER

A. Within 24 hours of receipt of information of an allegation of sexual abuse against a youth in ACS custody, the LSP staff member designated in Section B. below must attempt to notify the parties listed below by telephone that a child abuse allegation was made to the Justice Center VPCR. The LSP staff member must make this notification regardless of whether the Justice Center VPCR accepts the allegation, must document in the youth's case file the date and time of each call to the following parties, and must notify ACS that such notifications have been made or attempted:

1. The youth's parent/guardian, unless the case manager has documentation indicating that the parent/guardian should not be notified;

2. The youth's attorney of record; and

3. The youth's child welfare caseworker, if the youth is involved with the child welfare system.

B. The LSP staff members listed below must make the notifications in Section A. above under the following circumstances:

   1. If the allegation involves sexual abuse in an LSP facility, the Facility Director of the facility where the alleged abuse occurred or designee must make the required notifications.

   2. If the allegation involves sexual abuse during transportation to or from the LSP facility or during court, the Executive Director of CAM must make the required notifications.

C. If the LSP staff member is not successful in speaking with the parties listed above during the initial telephone call, that staff member must make two (2) additional attempts to contact the party, by telephone, within one (1) week of the allegation, documenting the date and time of each attempt in the youth's case file. After three (3) unsuccessful attempts to contact the party by telephone, the staff member must mail a letter, return receipt requested, to the person's last known address. The staff member must include a copy of the letter in the youth's case file, as well as the return receipt if and when it is received.

D. Aside from fulfilling reporting responsibilities and cooperating with investigations and supervisory reviews, LSP staff must keep confidential any information they learn regarding an allegation of sexual misconduct, consistent with Policy #2010/07, *Security of Confidential, Case Specific and/or Personally Identifiable Information* and *Confidentiality Policy* dated February 20, 2004.

XIX. EMERGENCY AND ONGOING MEDICAL, MENTAL HEALTH, AND CRISIS INTERVENTION SERVICES FOLLOWING AN ACTUAL OR ALLEGED INCIDENT OF SEXUAL ABUSE

ACS employees and LSP provider staff must follow the procedures below depending on the nature of the alleged sexual abuse:

A. For youth who are actual or alleged victims of sexual abuse 1) while housed in a DYFJ LSP facility or 2) that occurred within 96 hours prior to the youth's admission to a DYFJ LSP facility:

   1. After following the procedures outlined in Section XVI, LSP staff must provide the youth with an opportunity to meet with a sexual assault advocate. If the youth wants to meet with an advocate, the advocate will be allowed to meet with the youth in as confidential a setting as possible.

   2. LSP staff must immediately make arrangements to transport the youth to the hospital to be offered a forensic medical examination and emergency medical

services if the youth agrees to such an examination.

3. Youth must be transported in the least restrictive means possible to a designated hospital, depending on where the youth is currently housed.[16] If there are multiple youth to transport at the same time, staff must transport each youth in separate vans and keep youth apart at the hospital. In the event LSP staff are unable to provide required minimum staff coverage due to the transportation of multiple youth at the same time, staff from the DYFJ CAM and/or Field Operations Units shall assist with transportation to a designated hospital.

4. At the time of a youth's transport to the hospital, LSP staff must provide the youth with the opportunity to have her or his sexual assault advocate go to the hospital as well or to meet only with a social worker or volunteer community sexual assault advocate, when one is available, at the hospital. At the hospital, LSP staff shall make every effort to provide the youth with an opportunity to speak with her or his advocate or social worker in a manner that is as confidential as possible.

5. LSP staff shall also give the youth the opportunity to place a phone call to his or her parent/guardian and attorney of record.

6. Upon the youth's return from the hospital, LSP providers' medical and mental health staff must offer the youth all follow-up medical and mental health care determined necessary by them or by hospital staff. This may include the following:

   a. Information about and timely access to emergency contraception and sexually transmitted infections prophylaxis;
   b. Pregnancy tests;
   c. Information about and timely access to all lawful pregnancy-related medical services;
   d. Treatment plans;
   e. Other follow-up medical and mental health services;
   f. Referrals to rape crisis centers or other organizations that can provide emotional support services; and
   g. Referrals for continued care following the youth's release or transfer to another facility.

7. LSP provider medical, mental health, and psychiatric staff must also offer youth any services that they deem necessary during follow-up consultations with youth.

[16] See ACS Policy and Procedure #2015/13, *Mechanical Restraints for Limited Secure Placement*.

8. Prior to the youth's release from LSP, case managers must provide youth with referrals to a rape crisis center or similar organization that is located in the area where the youth will live upon discharge from the facility.

B. For youth who are or alleged to be victims of sexual abuse that occurred more than 96 hours prior to the youth's admission to an ACS detention facility:

1. After following the procedures outlined in Section XVI of this policy, LSP staff must provide the youth with an opportunity to meet with a sexual assault advocate. If the youth wants to meet with an advocate, the advocate will be allowed to meet with the youth in as confidential a setting as possible.

2. LSP staff must immediately telephone the Sexual Assault Response Team hotline at a designated hospital, depending on where the youth is currently housed, to determine whether the youth should be transported to the hospital to receive services. If the Sexual Assault Response Team indicates that the youth can benefit from services at the hospital, staff must transport the youth to the hospital, following the procedures outlined in Section A., above.

3. LSP provider staff must also offer the youth a referral to the LSP provider's medical, mental health, and psychiatric staff within 24 hours of receipt of the information.

4. If the youth accepts the referral, the LSP provider's medical, mental health, and psychiatric staff must meet with the youth within two (2) business days of receipt of this information to offer the youth immediate, unimpeded access to emergency medical treatment and crisis intervention services, the nature and scope of which must be determined by medical, mental health, and psychiatry practitioners according to their professional judgment. This may include the following:

   a. Information about and immediate access to emergency contraception and sexually transmitted infections prophylaxis;
   b. Pregnancy tests;
   c. Information about and immediate access to all lawful pregnancy-related medical services;
   d. Treatment plans;
   e. Other follow-up medical and mental health services;
   f. Referrals to rape crisis centers or other organizations that can provide emotional support services; and
   g. Referrals for continued care following the youth's release or transfer to another facility.

5. If no qualified facility-based medical, mental health, or psychiatry professional is available at the time that such services are needed, LSP provider staff must within 24 hours transport youth to the appropriate medical facility in the least restrictive means possible.

6. Prior to the youth's release from LSP, case managers must provide youth with referrals to a rape crisis center or similar organization that is located in the area where the youth will live upon discharge from the facility.

C. For youth who are alleged perpetrators of sexual abuse:

1. LSP provider staff must offer the youth a referral to the LSP provider's mental health and psychiatric staff within 24 hours of receipt of the information.

2. If the youth accepts the referral, the LSP provider's mental health and psychiatric staff must meet with the youth within seven (7) days of receipt of this information to offer the youth a mental health evaluation and, as appropriate, mental health treatment. Mental health and psychiatry providers must not offer youth interventions that conflict with ongoing investigations or that jeopardize a youth's Fifth Amendment right against self-incrimination.

XX. PROTECTION FROM RETALIATION

A. The individuals governed by this policy must not retaliate against youth or other individuals who report sexual abuse or sexual harassment or who cooperate with sexual abuse or sexual harassment investigations.

B. The PREA Coordinator and the PREA Compliance Manager must coordinate to protect from retaliation all youth, staff, and others governed by this policy who make such reports or who cooperate in such investigations. The PREA Compliance Manager must designate which LSP staff members must monitor retaliation at LSP provider facilities.

C. LSP staff must protect all youth and staff who report sexual abuse or sexual harassment or who cooperate with sexual abuse or harassment investigations from retaliation by youth or staff. Protection measures must include the following:

1. Housing changes or transfers for youth victims;
2. Removal of alleged staff or youth abusers from contact with victims; and/or
3. Provision of emotional support services.

D. For at least 90 days following a report of sexual abuse, the individuals designated in Section B. above must monitor the conduct and treatment of youth and staff who reported sexual abuse and youth who were reported to have suffered sexual abuse to

see if there are changes that suggest possible retaliation by youth and/or staff. Monitoring must continue beyond 90 days if the initial monitoring indicates an ongoing need. Monitoring must include the following:

1. Periodic in-person status checks with youth, ACS or LSP staff, and individuals governed by this policy;
2. Review of disciplinary incidents involving youth;
3. Review of housing or program changes; and
4. Review of negative performance reviews or reassignments of ACS or LSP staff and individuals governed by this policy.

XXI. BEHAVIOR MANAGEMENT GUIDELINES

A. In addition to following the reporting and response requirements in Part XVI, LSP staff must take the following actions in cases involving youth who engage in sexual abuse or sexual harassment.

    1. LSP staff must refer youth alleged to have engaged in sexual abuse of another youth to NYPD's Special Victims Division or the other appropriate law enforcement agency pursuant to this policy, and the youth shall receive consequences pursuant to the court process.

    2. **For youth who are alleged to have engaged in sexual misconduct other than sexual abuse**, LSP staff must determine whether any action is appropriate as part of the facility's behavior management system. LSP staff must consider whether a youth's mental disabilities or mental illness contributed to his or her behavior when determining whether any action is appropriate.

B. LSP staff must not impose behavior management consequences upon youth for sexual contact with staff unless the agency makes a finding that the staff member did not consent to such contact.

C. LSP staff must not impose behavior management consequences upon youth for making a report of sexual misconduct, even if an investigation does not establish sufficient evidence to substantiate the allegation. If a youth files a false report in bad faith, LSP staff must take appropriate steps to address the underlying reasons for the filing of the false report.

XXII. REPORTING TO YOUTH

A. When an investigating entity completes its investigation into an allegation of sexual abuse or sexual harassment, the ACS PPS or supervisor must notify the youth as to whether the investigating entity has referred an allegation for prosecution or declined

to proceed with the investigation, or whether the investigating entity determined that the allegation was substantiated, unsubstantiated, or unfounded.

B. Unless the investigating entity determines that the allegation of staff sexual abuse or sexual harassment is unfounded, the ACS PPS or the PREA Coordinator must make the following notifications:

    1. Within 24 hours of learning the information, notify the youth when the staff member is no longer posted within the youth's unit or when the staff member is no longer employed at the facility.

    2. Within 48 hours of learning the information, notify the youth when the staff member has been indicted or convicted on a charge related to sexual abuse within the facility.

C. Within 48 hours of learning the information, the ACS PPS or the PREA Coordinator must notify youth of the following:

    1. When the alleged youth abuser has been indicted on a charge related to sexual abuse within the facility; or

    2. When the alleged youth abuser has been convicted on a charge related to sexual abuse within the facility.

D. ACS staff must document the notifications made according to this section.

XXIII. CRIMINAL AND ADMINISTRATIVE AGENCY INVESTIGATIONS

A. The PREA Compliance Manager and the PREA Coordinator must cooperate and coordinate with investigating outside entities and must not impede outside investigations.

B. **All incidents of alleged sexual abuse must be referred to law enforcement.**

C. All sexual misconduct allegations must be referred to the Justice Center.

D. Administrative investigations:

    1. Must include an effort to determine whether staff actions or failures to act contributed to the abuse; and

    2. Must be documented in written reports that include a description of the physical and testimonial evidence, the reasoning behind the credibility assessments, and investigative facts and findings.

E. The LSP provider must retain all written reports referenced above for as long as the alleged abuser is incarcerated or employed by the agency, plus five (5) years, unless the abuse was committed by a youth and applicable law requires a shorter period of retention.

F. Administrative investigations must continue even if the alleged abuser or victim leaves the employment or control of the facility or agency.

XXIV. ACS AND LSP STAFF DISCIPLINE

A. ACS employees and LSP provider staff must be subject to disciplinary sanctions up to and including termination for violating ACS sexual abuse or sexual harassment policies.

B. Termination must be the presumptive disciplinary sanction for ACS employees and LSP provider staff who have engaged in sexual abuse.

C. Disciplinary sanctions for violations of ACS policies relating to sexual abuse or sexual harassment, other than actually engaging in sexual abuse, must be commensurate with the nature and circumstances of the acts committed, the employee's disciplinary history, and the sanctions imposed for comparable offenses by other employees with similar histories.

D. For misconduct involving ACS employees, ELU must notify any licensing body responsible for licenses that were required for the employee's position of all terminations for violations of ACS sexual abuse or sexual harassment policies, or resignations by employees who would have been terminated if not for their resignation.

E. For misconduct involving LSP provider staff, the LSP Facility Director or designee must notify any licensing body responsible for licenses that were required for the employee's position of all terminations for violations of ACS sexual abuse or sexual harassment policies, or resignations by employees who would have been terminated if not for their resignation.

XXV. DISCIPLINE OF CONTRACTORS, VOLUNTEERS, AND INTERNS

A. ACS and LSP providers must prohibit any contractor, volunteer, or intern who engages in sexual abuse from any contact with youth; report the individual to law enforcement agencies; and report the individual to any licensing body responsible for licenses that were required as part of the staff member's job description.

B. ACS and LSP providers must take appropriate remedial measures, and must consider whether to prohibit further contact with youth, in the case of sexual misconduct other than sexual abuse perpetrated by any contractor, volunteer, or intern.

C. Termination must be the presumptive disciplinary sanction for interns and contractors who have engaged in sexual abuse. Contractors and interns who have engaged in sexual abuse must also be placed on the Justice Center SEL.

XXVI. SEXUAL ABUSE INCIDENT REVIEWS

A. As soon as possible, but no later than 30 days after the completion of any investigation into sexual abuse,[17] the Sexual Abuse Incident Review Committee must convene to review the incident. The Committee must include the PREA Coordinator, Facility Compliance Manager, and other upper-level management officials from LSP providers with input from line supervisors, investigators, and medical or mental health practitioners. The Committee must:

1. Consider whether the allegation or investigation indicates a need to change policy or practice to better prevent, detect, or respond to sexual abuse;

2. Consider whether the incident or allegation was motivated by race; ethnicity; gender identity; lesbian, gay, bisexual, transgender, or intersex identification, status or perceived status; gender expression; disability; gang affiliation; or was motivated or otherwise caused by other group dynamics at the facility;

3. Examine the area in the facility where the incident allegedly occurred to assess whether physical barriers in the area may enable abuse;

4. Assess the adequacy of staffing levels in that area during different shifts;

5. Assess whether monitoring technology should be deployed or augmented to supplement supervision by staff;

6. Prepare a preliminary report of its findings, including, but not necessarily limited to, determinations made pursuant to the aforementioned factors, and recommendations for improvement within 30 days of the incident; and

7. Submit the final report of findings and recommendations to the Associate Commissioner of OPPP within 60 days of the incident, as well as ELU if the incident

[17] A sexual abuse incident review must follow any investigation into sexual abuse, including where the allegation has not been substantiated unless the allegation has been determined to be unfounded.

involved allegations against an ACS employee.

8. If a Committee was already convened to examine previous investigations of the same incident, the Committee must review its findings to determine whether subsequent investigations have revealed new information or reached different conclusions that would warrant revisiting the Committee's previous findings. The Committee is not required to begin a new full review.

B. The Committee must follow the procedures outlined in Policy and Procedure, *Safe Intervention Policy for Juvenile Justice Placement* when conducting the review outlined in Section A. The Committee's activities must be distinct from any activities of the Justice Center review committees.

C. The Facility Director of the facility where the alleged abuse occurred must review the report and document the steps taken to implement the recommendations, or must document the reasons for not doing so. If the alleged abuse occurred during transportation to or from LSP or during court, the Executive Director of CAM must review the report and document the steps taken to implement the recommendations, or must document the reasons for not doing so.

D. OPPP must review the report prepared by the Committee and the response of the Facility Director of the facility where the alleged abuse occurred, or the response of the Executive Director of CAM if the alleged abuse took place during transportation to or from the LSP facility or during court. The Associate Commissioner or designee must work with other agency officials to implement the recommendations that require coordination with other parts of the agency.

E. To help Sexual Abuse Incident Review Committees begin their review within 30 days of the completion of an investigation:

1. ELU must maintain a docket of open investigations of alleged sexual abuse by ACS employees referred to ELU, and must determine the status of those investigations on a monthly basis, to the extent that this information is available. ELU must notify the Facility Director or the Executive Director of CAM upon completion of each pending investigation. ELU must maintain the records of these investigations.

2. The PREA Coordinator or designee must maintain a docket of open investigations of alleged sexual abuse by all ACS employees not investigated by ELU, as well as investigations of alleged sexual abuse by LSP provider staff, contractors, youth, volunteers, and interns, and any other incident reported under this policy. The PREA Coordinator or designee must determine the status of those investigations on a monthly basis. The PREA Coordinator or designee must notify the Facility Director of the facility where the alleged abuse occurred or the Executive Director of CAM upon completion of each pending investigation. The PREA Coordinator

must maintain the records of these investigations.

XXVII. DATA COLLECTION AND REPORTING

A. The Incident Review Coordinator must collect accurate, uniform data for every allegation of sexual misconduct in LSP facilities operated by ACS and under contract to ACS, using a standardized instrument and set of definitions. The data collection must include, at a minimum, the data necessary to answer all questions from the most recent version of the Survey of Sexual Violence conducted by the Department of Justice. The Incident Review Coordinator must collect and maintain data, as needed, from all available incident-based documents, including reports, investigation files, and sexual abuse incident reviews.[18]

B. The Incident Review Coordinator must securely retain data collected pursuant to Section A. and maintain that data for at least 10 years from the date of its initial collection unless federal, state, or local law requires otherwise.

XXVIII. DATA REVIEW FOR CORRECTIVE ACTION

A. The DYFJ Director of Incident Review must gather and aggregate data collected in Section XXVII. A. in order to help ACS and provider agencies assess and improve the effectiveness of its approach to sexual misconduct prevention, detection, and response. The data shall be reviewed and shared with all PREA stakeholders to help ACS and provider agencies identify problem areas and take corrective action on an ongoing basis.

B. The Director of Incident Review must prepare an annual report of DYFJ's findings and corrective actions for each LSP facility. The report must include a comparison of the current year's data, disaggregated by each LSP provider facility, and corrective actions with those from prior years and must provide an assessment of DYFJ's progress in addressing sexual misconduct. The Director of Incident Review Coordinator must consult with the following individuals when preparing the annual report:

1. OPPP;
2. The PREA Coordinator;
3. Facility Directors of LSP provider facilities; and
4. Any other officials who would be helpful in preparing the report.

C. The Director of Incident Review, in consultation with the ACS Office of Communications and Intergovernmental Affairs, must secure approval of the annual

[18] See ACS Policy #2010/07, *Security of Confidential, Case Specific and/or Personally Identifiable Information*; see *Confidentiality Policy* dated February 20, 2004.

report by the ACS Commissioner and publish the report on the ACS website.

D. LSP provider facilities must make the information outlined in Section C. available on the provider agency's website or otherwise make such information publicly available if the provider agency does not have a website.

XXIX. AUDITS

The Director of Incident Review, in consultation with the PREA Coordinator, must coordinate ACS' response to any audit findings that ACS does not meet a standard in consultation with the Associate Commissioner of OPPP and the LSP Facility Directors.

ATTACHMENT A

SEARCH REQUEST FORM FOR TRANSGENDER AND INTERSEX YOUTH

You can request to be searched by either a male or female staff member while you are here. We will do our best to honor your choice unless there is a security emergency.

Please check the box next to the statement that best matches how you feel.

- ☐ I am most comfortable being searched by a **male** staff member.
- ☐ I am most comfortable being searched by a **female** staff member.
- ☐ I do not care whether a **male or female** staff member searches me.

Youth's Signature: ________________________________

Youth's Printed Name: _____________________________

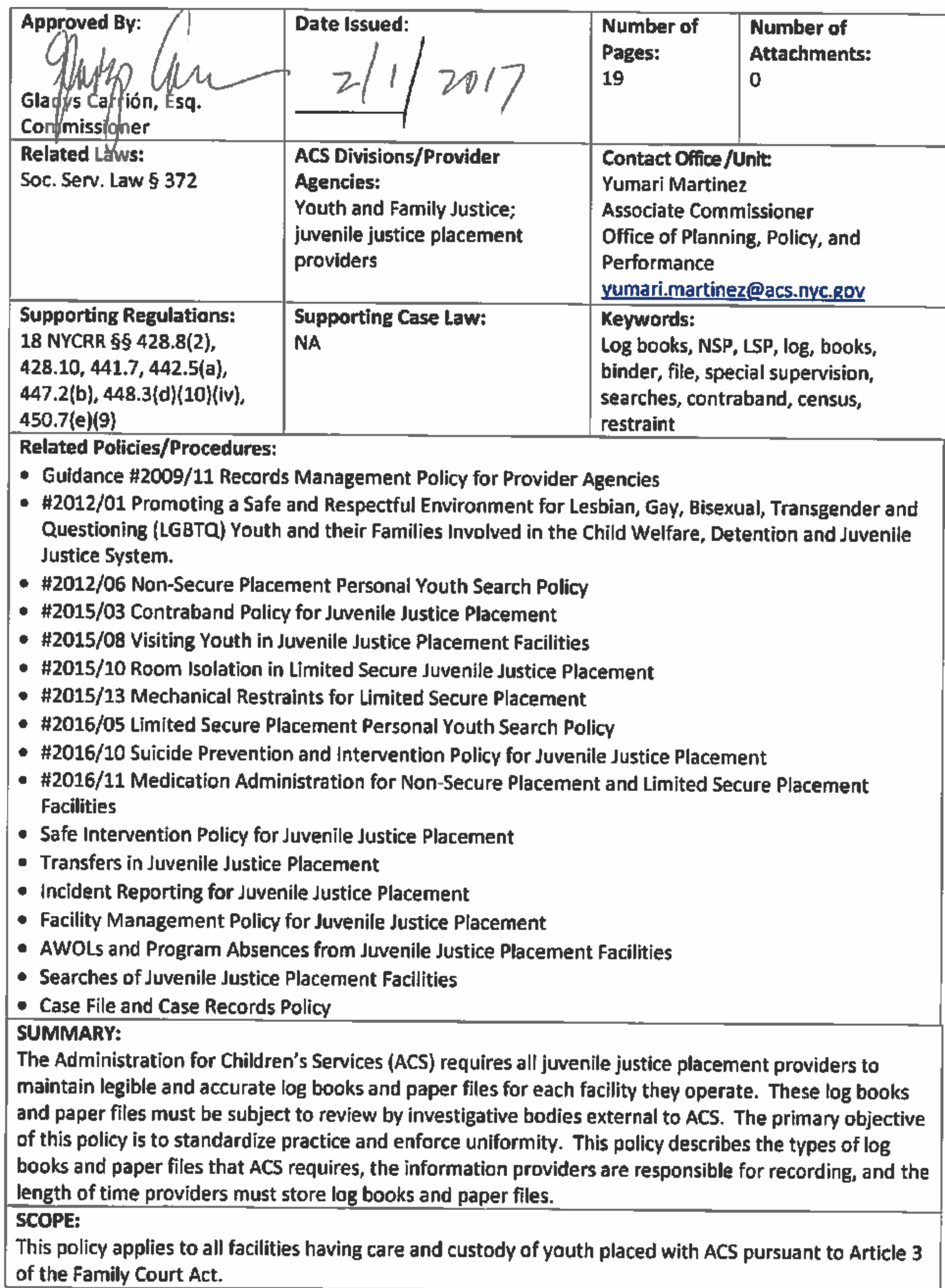
Today's Date: ___________________________________

CC: Youth File

City of New York
Administration for Children's Services

Policy and Procedure
#2017/04

Required Log Books and Paper Files for Juvenile Justice Placement Facilities



Approved By:	Date Issued:	Number of Pages:	Number of Attachments:
Gladys Carrión, Esq. Commissioner	2/1/2017	19	0

Related Laws:	ACS Divisions/Provider Agencies:	Contact Office /Unit:
Soc. Serv. Law § 372	Youth and Family Justice; juvenile justice placement providers	Yumari Martinez Associate Commissioner Office of Planning, Policy, and Performance yumari.martinez@acs.nyc.gov
Supporting Regulations: 18 NYCRR §§ 428.8(2), 428.10, 441.7, 442.5(a), 447.2(b), 448.3(d)(10)(iv), 450.7(e)(9)	**Supporting Case Law:** NA	**Keywords:** Log books, NSP, LSP, log, books, binder, file, special supervision, searches, contraband, census, restraint

Related Policies/Procedures:

- Guidance #2009/11 Records Management Policy for Provider Agencies
- #2012/01 Promoting a Safe and Respectful Environment for Lesbian, Gay, Bisexual, Transgender and Questioning (LGBTQ) Youth and their Families Involved in the Child Welfare, Detention and Juvenile Justice System.
- #2012/06 Non-Secure Placement Personal Youth Search Policy
- #2015/03 Contraband Policy for Juvenile Justice Placement
- #2015/08 Visiting Youth in Juvenile Justice Placement Facilities
- #2015/10 Room Isolation in Limited Secure Juvenile Justice Placement
- #2015/13 Mechanical Restraints for Limited Secure Placement
- #2016/05 Limited Secure Placement Personal Youth Search Policy
- #2016/10 Suicide Prevention and Intervention Policy for Juvenile Justice Placement
- #2016/11 Medication Administration for Non-Secure Placement and Limited Secure Placement Facilities
- Safe Intervention Policy for Juvenile Justice Placement
- Transfers in Juvenile Justice Placement
- Incident Reporting for Juvenile Justice Placement
- Facility Management Policy for Juvenile Justice Placement
- AWOLs and Program Absences from Juvenile Justice Placement Facilities
- Searches of Juvenile Justice Placement Facilities
- Case File and Case Records Policy

SUMMARY:

The Administration for Children's Services (ACS) requires all juvenile justice placement providers to maintain legible and accurate log books and paper files for each facility they operate. These log books and paper files must be subject to review by investigative bodies external to ACS. The primary objective of this policy is to standardize practice and enforce uniformity. This policy describes the types of log books and paper files that ACS requires, the information providers are responsible for recording, and the length of time providers must store log books and paper files.

SCOPE:

This policy applies to all facilities having care and custody of youth placed with ACS pursuant to Article 3 of the Family Court Act.

Table of Contents

I. Introduction 3

II. Policy 3

III. Facility Activity/Communication Log Book 3

IV. Other Required Log Books 14

A. LSP Control Room Activity/Communication Log Book 14

B. Youth Visitor Log Book 15

C. Facility Visitor Log Book 15

V. Required Paper Files 15

A. Fire Drill Log 15

B. Incident Report Log 15

C. Searches for Contraband Log 16

D. Medication Administration Records (MARs) 16

E. Facility Personal Property Log 17

F. Transportation Log 17

VI. Storage of Bound Log Books and Confidential Non-Case File Materials 17

A. Completed Log Books 17

B. Damaged Log Books 18

C. Storage of Closed Log Books 18

D. Storage of Non-Case File Materials 18

I. Introduction

The Administration for Children's Services (ACS) requires all non-secure placement (NSP) and limited secure placement (LSP) providers to maintain log books and paper files for each licensed program that they operate. This policy describes the types of log books and paper files that ACS requires, the information that providers are responsible for recording in log books and paper files, and how and the length of time providers must store them. All log books and paper files are official ACS documents. This policy supplements the record keeping requirements set forth in Social Services Law § 372 and Title 18 NYCRR 441.7, as well as in the ACS Close to Home Quality Assurance Standards and all relevant ACS policies. The primary objective of this policy is to list the log books and paper files required by each facility, to standardize practice, and to verify that uniformity is maintained.

II. Policy

A. NSP and LSP provider log books and paper files provide a chronological account of all events, communication, and activities as they occur in a facility and as they relate to the area for which the log book is maintained.

B. All NSP and LSP provider agencies must maintain legible and accurate log books and paper files. These log books and paper files are official ACS documents and are subject to inspection by the ACS Division of Youth and Family Justice (DYFJ) and external investigators and oversight agencies. All provider agencies must comply with and verify staff compliance with the procedures described in this and other relevant ACS policies.

C. Falsifying, tampering with, or removing pages from log books and paper files is strictly prohibited, and is a violation of ACS policy. Provider agencies must maintain the confidentiality of log books and paper files, must securely store them, and must make every effort to keep them inaccessible to youth.

III. Facility Activity/Communication Log Book

A. The purpose of this log book is for provider staff to keep a running narrative about activities and events as they occur (e.g., incidents,[1] searches for contraband) in a manner that both documents specific actions and captures the overall tone of the facility.

B. The Facility Activity/Communication Log Book serves as a source document for all events that occur in the facility, including but not limited to:

1. Youth counts including any changes as they occur;
2. Overnight bed checks;

[1] Note: Incident entries must match the MCCU incident report including the report number, time of occurrence, youth and staff involved, and a brief description of the event.

3. Youth movement;
4. Admissions and releases;
5. Incidents and other events that are out of the ordinary;[2]
6. All activities (e.g., hygiene, meal periods, visitation, phone calls, general programming);
7. Occurrences such as recreation periods and emergency drills;
8. Equipment failure (e.g., alarm or video system, agency vehicles).
9. Signing in and out by staff assigned to monitor youth or to a post;
10. Tasks accomplished while on duty (e.g., inventories, inspections, searches, rounds);
11. Any changes to a youth's level of observation;[3] and
12. Visitors, including uniformed officers and investigative or oversight agency officials.[4]

C. Facility Activity/Communication Log Book Specifications

1. The log book must be bound with lined and numbered pages. This is to prevent individual pages from being lost or removed without detection.

2. The cover of the log book must be labeled as follows:[5]

    a. "Confidential";
    b. Facility name – Log Book;
    c. Date opened; and
    d. Date closed.

3. Facility Staff Legend

    a. On numbered page one (1) of each log book, the provider agency must write "Facility Staff Legend" in the top margin.

    b. On pages one (1) and two (2) of each log book, each provider agency staff member must provide a writing sample. This sample must be written in blue or black ink on a single line between the left and right margins, and shall be comprised of each staff member's:

        i. Full printed name;
        ii. Signature; and
        iii. Initials.

4. Each newly issued log book must state the following on the opening page (numbered page 3):

[2] See ACS Policy and Procedure, *Incident Reporting for Juvenile Justice Placement and Aftercare*.
[3] See ACS Policy and Procedure #2016/10, *Suicide Prevention and Intervention Policy for Juvenile Justice Placement*.
[4] See ACS Policy and Procedure #2015/08, *Visiting Youth in Juvenile Justice Placement Facilities*.
[5] The cover must be labeled in a manner that cannot be removed.

a. The date the log book was opened;
b. The time the log book was opened; and
c. The entry continued from the previous log book, if applicable.[6]

5. Entries must commence with the first line of each log book page and continue with each consecutive line. Lines must not be skipped.

6. Active Facility Activity/Communication Log Books

   a. The log book must not leave the premises under any circumstances.

   b. Unless the log book is being reviewed or inspected by a supervisor, facility director, DYFJ staff, or external investigators or oversight agencies, the log book must remain within the vicinity of the primary activity and majority of youth at any given moment.

   c. Every effort must be made to safeguard the log book and make sure that it is inaccessible to youth.

D. Facility Activity/Communication Log Book Documentation

1. **All entries must be**:

   a. Recorded in blue or black ink only except as expressly required below in section III. D. 15. d.;

   b. Made without undue delay and recorded legibly, accurately, and concisely in chronological order;

   c. Started on a new line and contain the time of the entry in the left margin;

   d. Started on a new line so that no lines are left blank; and

   e. Initialed by staff to close out the entry. For short entries that do not run the length of the line, staff must draw a horizontal line to the end of the line, followed by their initials or signature.

2. For any new page, the header must include the day of the week and date in the following format: Wednesday, May 10, 2017.

[6] For example, an entry would be continued if a new log book must be opened in the middle of a shift for various reasons such as damage to the log book.

3. To alter an entry, the following procedure must be adhered to:

    a. A single horizontal line must be drawn through the entry, allowing the original entry to be read;

    b. The word "VOID" must be printed within the line above the voided entry;

    c. The reason for the alteration must be noted in the entry (e.g., incorrect census, spelling error, incorrect time), followed by the staff member's initials; and

    d. Entries must never be erased, written or scribbled over, whited out, or marked out, thus making the original entry unreadable.

4. Any entry that is not in chronological order is to be indicated as a "Late Entry." Staff must write "Late Entry" in the left margin, include the time of the event, and proceed with the entry.

5. **Responsibilities of Direct Care Staff**

    a. The logging of all activities in the facility and the safeguarding of the log book are the responsibility of each and every staff member assigned to the facility.

    b. Direct care staff must record all entries in blue or black ink.

    c. Starting with the beginning of each shift and continued through to the end of each shift, the log book must contain the following information in the order below:

        i. The day of the week and date in the following format: Tuesday, May 10, 2016;

        ii. The start time and end time of the shift (e.g., 7:00am-3:00pm);

        iii. The census at the beginning of the shift including any adjustments to the in-count/out-count. The out-count must note the number of youth temporarily out of the area or facility and their known whereabouts;

        iv. The legal or chosen names[7] of all youth identified by first name and last initial and numbered horizontally in two (2) columns. Nicknames or aliases[8] are not permitted in the log book. For day to day activities, youth must be identified by first name only; however, if two (2) or more youth have the same first

[7] See ACS Policy #2012/01, *Promoting a Safe and Respectful Environment for Lesbian, Gay, Bisexual, Transgender and Questioning (LGBTQ) Youth and their Families Involved in the Child Welfare, Detention and Juvenile Justice System*.
[8] Note: Nicknames and aliases are different from chosen names.

name, staff must also use each youth's last initial to distinguish between the youth;

v. The names of all staff on duty identified by first initial and last name;

vi. Confirmation that a dual head count[9] was conducted with the previous shift;

vii. Special watches, alerts, or special instructions left by the previous shift. Youth placed on a special watch or otherwise requiring special instructions should be identified using an asterisk (*). The special instructions pertaining to the identified youth should immediately follow after the in-count/out-count;

viii. Any matters that affect security such as incidents or searches conducted;

ix. All youth activities including but not limited to:

a) Recreation;
b) Special programing;
c) Study periods;
d) Medication administration;
e) Visits;
f) Religious services;
g) Groups, community meetings, and other therapeutic activities; and
h) Academic activities, such as homework or tutoring.

x. The time each activity commenced and concluded, the outcome of the activity and the number of youth participating in each activity;

xi. All youth and staff movement in and out of the housing area; and

xii. The closing census at the end of each shift, including that a dual head count was conducted with the relieving shift.

d. Sample (Shift Change):

3:15pm Staff A. Smith, B. Johnson, and C. Williams arrive at the facility.--------DJ

3:20pm Staff D. Jones briefed incoming staff. During room searches, youth Blue was found to be in possession of a Metrocard and unauthorized clothing. Youth Blue frequently communicates a desire to AWOL and has been placed on AWOL watch. ---EB

3:25pm All six (6) youth were pat frisked by staff F. Davis and are moving from the dining room to the living room. ---EB

[9] See Section D. 7. below.

3:28pm Staff D. Jones, E. Brown, F. Davis, A. Smith, B. Johnson, and C. Williams confirm all six (6) youth are present in the living room. Youth Blue is on AWOL watch. Closing census is six (6) youth. --------------------------------DJ
Tuesday, May 10, 2016 Tour 2 (3:30pm-11:30pm)
A. Smith, B. Johnson, C. Williams
Census: 6

1) Red R.	4) Orange S.
2) Green D.	5) Yellow D.
3) Pink P.	6) *Blue T. (Flight Risk)

In-Count: 6/Out-count: 0

3:30pm Opening census is six (6) youth. Staff D. Jones, E. Brown, F. Davis, A. Smith, B. Johnson, and C. Williams confirm all six (6) youth are present in the facility. Youth Blue is on AWOL watch due to increased flight risk. Site Director G. Miller has entered the living room to provide additional supervision. ---CW

3:35pm Staff D. Jones, E. Brown, and F. Davis exit facility. Staff A. Smith, B. Johnson, and C. Williams posted in living room. All six (6) youth are preparing to move upstairs for group activities. Site Director G. Miller is providing additional coverage for Youth Blue (AWOL watch). --------BJ

6. **Youth Movement**

   a. All youth movement must be documented in the log book. If the majority of youth are present in the facility and participating in the primary activity, only youth and accompanying staff who are not engaged in the primary activity must be identified by name.

   b. For example: Six (6) youth are present in the facility. Four (4) youth are having lunch in the dining room. Youth Red is on the second floor with staff A. Smith using the restroom; youth Green is in the living room with Supervisor H. Wilson discussing an upcoming home pass. --EB

7. **Accounting for Youth**

   a. A dual head count is required at each shift change. During shift change, both shifts are responsible for jointly conducting a youth head count.

   b. The completion of each dual head count must be documented contemporaneously in the Facility Activity/Communication Log Book.

   c. The count of youth must coincide with the running census in the facility.

   d. Inconsistencies in the dual head counts must be resolved before the outgoing shift staff members are relieved from duty.

e. Discrepancies must be reported immediately to supervisory personnel and the facility director or designee, and the ACS Movement Control and Communications Unit (MCCU). Search procedures shall commence and efforts to locate any missing youth shall be documented and reported in the same manner prescribed by this and other relevant ACS policies and procedures [10]

8. **Overnight Bed Checks**

a. During overnight hours, staff must check to be sure that each youth is safe, secure, and that the number of youth in bed is equal to the program census. All overnight bed checks must be documented contemporaneously in the Facility Activity/Communication Log Book.

b. Bed checks shall be conducted repeatedly throughout the overnight shift, in a manner that is least disruptive to youth sleeping patterns.

c. Staff must conduct a physical check of each youth in the facility every 30 minutes, at minimum, and document all observations. Bed checks are to be conducted by adhering to the following procedure:

i. Observing any evidence the youth is in bed (e.g., a portion of the youth's skin or hair, movements indicating the youth is breathing);

ii. Observing that there are no hazardous or otherwise unsafe conditions (e.g., objects in the bed that might obstruct breathing, a sleeping position that may exacerbate pre-existing medical conditions);

iii. In the event an empty bed is observed, documenting whether it is legitimately empty (e.g., no youth is assigned to the bed, the youth has been assigned to another bed/bedroom, the youth is on an authorized home visit); and

iv. When more than one (1) youth is assigned to a bedroom, documenting the number of youth assigned to the room and note the outcome of the bed check for each individual youth. For single bedrooms, staff must indicate the room number or name and the outcome of the bed check; and

v. Documenting any changes in room assignment and the reason for the change.

d. Discrepancies during bed checks must be immediately reported to the facility director or designee and MCCU. Search procedures shall commence and efforts to

[10] See ACS Policy and Procedure, *AWOLs and Program Absences from Juvenile Justice Placement Facilities*.

locate any missing youth shall be documented and reported in the same manner prescribed by this and other relevant ACS policies and procedures.[11]

e. Note: Staff may only enter a bedroom to conduct a bed check if it is clearly safe to enter.

9. **Incidents**

All incidents must be recorded in the log book. The entry must include the following:

a. The time of the incident;

b. The name and number of all youth involved or who witnessed the incident;

c. The name of all staff involved or who witnessed the incident;

d. The time the incident was reported;

e. The MCCU incident report number and the name of the MCCU staff member who received the incident report;

f. The name of the staff member who reported the incident to MCCU; and

g. A brief summary description of the incident. This description shall include the scheduled activity during which the incident occurred, the events or actions of all youth and staff involved or witness to the incident, any physical interventions used, and immediate actions taken by the staff.

10. **Documentation of Searches**[12]

a. All searches must be documented contemporaneously in the log book. Consistent with relevant ACS policies, staff must document all searches in the Facility Activity/Communication Log Book, the Searches for Contraband File, and the youth's case record.

b. Documentation related to all searches should include the following:

i. **Pat Frisk** - All pat frisk searches must be documented in the log book. Entries should include the number of youth searched when the majority is present and searched, or the names of the youth searched when the majority is not

[11] See ACS Policy and Procedure, *AWOLs and Program Absences from Juvenile Justice Placement Facilities*.
[12] See ACS Policy and Procedure #2012/06, *Non-Secure Placement Personal Youth Search Policy* and #2016/05, *Limited Secure Placement Personal Youth Search Policy*.

present. The outcome of the pat frisk must be noted. If contraband[13] is found/identified during a pat frisk the following must be documented:

a) The name of the youth in possession of contraband;
b) The description of the contraband;
c) Who approved the search if not routine;
d) The name of the staff conducting the pat frisk search; and
e) The incident report number and corresponding information.

ii. **Security Searches** - All security searches must be documented as follows:

a) The name of staff conducting the security search;
b) Who approved the search if not routine;
c) The reason for the security search; and
d) The outcome of the security search.

iii. **Strip Searches [LSP only]**[14] - All strip searches must be documented as follows:

a) Who approved the search;
b) The name of staff conducting the strip search;
c) The reason for the strip search [can only occur after a security search]; and
d) The outcome of the strip search.

iv. **Bedroom Searches** - Bedroom searches must be documented as follows:[15]

a) The name of staff conducting the bedroom search;
b) The number of bedrooms searched;
c) The reason for the search, whether the youth was present for the search, and who approved the search if not routine;
d) The name or number of the bedrooms; and
e) The outcome of the bedroom search. For non-routine searches, documentation must include efforts made to obtain the youth's physical presence prior to the search, and when the youth was notified of the search.

v. **Area Searches and Inspections** - Area searches and inspections must be documented as follows:[16]

a) The name of staff conducting the search or inspection;

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[13] See ACS Policy and Procedure #2015/03, *Contraband Policy for Juvenile Justice Placement*.
[14] See ACS Policy and Procedure #2016/05, *Limited Secure Placement Personal Youth Search Policy*.
[15] See ACS Policy and Procedure, *Searches of Juvenile Justice Placement Facilities*.
[16] See ACS Policy and Procedure, *Searches of Juvenile Justice Placement Facilities*.

b) The area or areas of the facility searched or inspected;
c) The reason for the search and who approved the search if not routine; and
d) The outcome of the area search or inspection.

11. **School Day Documentation**

a. For any programs providing educational services on-site, the log book must transition with the youth from the living area to the education area.

b. Note: Facility Activity/Communication Log Books stored at off-site schools must be maintained in the same manner prescribed by this and other relevant ACS policies.

c. For programs providing educational services off-site, staff must document the following:

i. The time of departure;

ii. The names and number of youth attending school; and

iii. The names of all accompanying staff.

d. Upon return to the facility, staff must make an entry indicating the return time, the names and number of youth returning from school, and the names of all returning staff.

e. Staff must write a shift summary indicating the overall tone of the school day and any significant events that occurred.

12. **Off-Premises Activities (e.g., Field Trips, Visits, Recreation)**

a. For any off-premises activities, staff must document the following:

i. The time of departure;

ii. The name and number of youth attending the activity; and

iii. The name of all accompanying staff.

b. Upon return to the facility, staff must make an entry indicating the return time, the names and number of youth returning from the activity, and the names of all returning staff

c. Staff must write a shift summary indicating the overall tone of the activity and any significant events that occurred.

13. **Admission**

Upon receiving a new admission, staff must make an entry in the log book specific to the arrival of the new youth. The entry must be indented toward the middle of the page with the words "New Intake." The entry must include:

a. The youth's name;
b. The youth's date of birth;
c. From where the youth is arriving;
d. Any medications or special instructions;
e. Confirmed inventory of the youth's personal property;[17] and
f. Room assignment.

14. **Release**

When a youth is released to the community on aftercare status, an entry must be made in the log book specific to the youth's departure. The entry must be indented toward the middle of the page with the word "Release." The entry must include the following information, where applicable:

a. The youth's name;
b. The youth's date of birth;
c. To whom and/or to what location the youth was released;
d. Any medications or special instructions;
e. Confirmed receipt of the youth's personal property; and
f. Former room assignment.

15. **Responsibilities of Supervisors/Group Leaders**

Supervisors must make a minimum of one (1) entry whenever a supervisor is on duty to verify that all safety and security features are fully operational, that staff maintain eyes and ears on supervision, and that the facility environment has a therapeutic tone. Supervisory entries must be made in red ink, following the same format prescribed by this policy (see section III. D. 1.).

a. Supervisors must adhere to the following when documenting in the log book:

   i. Review log entries from the previous shift(s);

   ii. Review entries made by staff on duty to verify entries are being made in compliance with prescribed policy; and

[17] See ACS Policy and Procedure, *Personal Property of Youth in Juvenile Justice Placement*.

iii. Enter any special instruction given to the staff on duty.

b. Supervisory entries should include both positive observations as well as areas that need to be improved and any immediate actions steps to be taken.

c. If the supervisor is unavailable to make such entries, his or her designee must follow the above steps in this section.

d. Note: Red ink is reserved for supervisory observations only. If a supervisor is providing coverage for direct care staff, blue or black ink must be used.

16. **Responsibilities of the Facility Director**

The facility director must conduct an inspection of the log book on a weekly basis to verify that entries are being made in compliance with the log book policy. Reviews completed by the facility director must be made in red ink, following the same format prescribed by this policy (see section III. D).

a. The pages or dates reviewed must be noted as well as any observation related to strengths or areas for improvement.

b. The condition of the log book must be reviewed and described.

c. The facility director must maintain the facility staff legend. If a direct care staff member is no longer employed by the program, the facility director must draw a single line through the individual's identifying information, write "Vacated," and initial or sign in the left margin adjacent to the entry along with the date of review.

d. Note: Red ink is reserved for supervisory observations only. If a supervisor is providing coverage for direct care staff, blue or black ink must be used.

IV. Other Required Log Books

A. LSP Control Room Activity/Communication Log Book

Each control room must have a designated log book that is bound with lined and numbered pages for the contemporaneous documentation of observed youth movement, census, staff and visitor entry and exit, pertinent radio and phone communication, and facility rounds. The Control Room Activity/Communication Log Book must be maintained in the same manner as the Facility Activity/Communication Log Book prescribed by this and other relevant ACS policies.[18]

[18] See ACS Policy and Procedure, *Facility Management Policy for Juvenile Justice Placement.*

B. Youth Visitor Log Book (e.g., parents, attorneys)

Providers must keep a Youth Visitor Log Book in the reception area of the residence to note the date and time of the visit, the name of the visitor(s), the name of the youth being visited, and the visitor's relationship to the youth. The log book must include space for visitors to sign in next to the time of arrival and sign out next to the time of departure. This log book must be documented in blue or black ink and bound with lined and numbered pages. This is to prevent individual pages from being lost or removed without detection.[19]

C. Facility Visitor Log Book (e.g., electrician)

Providers must keep a Facility Visitor Log Book in the reception area of the residence to note the date and time of the visit, the name of the visitor(s), and the purpose of the visit. The log book must include space for visitors to sign in next to the time of arrival and sign out next to the time of departure. This log book must be documented in blue or black ink and bound with lined and numbered pages. This is to prevent individual pages from being lost or removed without detection.

V. Required Paper Files

A. Fire Drill Log

Providers must document the date and time of each fire drill in this log, as well as in the Facility Activity/Communication Log Book. Fire drills must be held at different times of the day and night and as often as is needed to familiarize and instruct youth and staff with the routine, but at least once every 30 days.[20] Providers must also document the amount of time it took to evacuate, which staff were present, which youth were present, and the location of any youth who did not participate in the drill. This log must be arranged in a file or binder, and stored in a secure location readily accessible to direct care staff.

B. Incident Report Log

Providers must maintain all incident reports and supporting documentation in this log, arranged chronologically in an unbound binder, and stored in a secure location readily accessible to direct care staff. Consistent with incident reporting policies, staff must document all instances of physical interventions, mechanical restraints, and room isolation in the Facility Activity/Communication Log Book and the youth's case record. Staff must also individually report the circumstances that precipitated the physical

[19] See ACS Policy and Procedure #2015/08, *Visiting Youth in Juvenile Justice Placement Facilities*

[20] See 18 NYCRR 442.5(a), 447.2(b), and 448.3(d)(10)(iv).

intervention in accordance with the incident reporting policy by completing an incident report form.[21] The contents of this log include the following forms (where applicable, as per the circumstances of each unique incident):

1. Close to Home Incident Report Form;
2. Close to Home Physical Restraint Form;
3. LSP Mechanical Restraint Form;
4. LSP Room Isolation Form; and
5. Close to Home Incident Debriefing Form

C. Searches For Contraband Log

Providers must document all searches for contraband, arranged chronologically in an unbound binder, and stored in a secure location readily accessible to direct care staff.[22] Supervisors and the facility director are responsible for reviewing entries made by staff to verify compliance with applicable ACS policy.[23] A supervisor or the facility director must review, sign, and date the log at least once daily while on duty. The facility director must review, sign, and date the log at least once weekly.

D. Medication Administration Records (MARs)

Providers must maintain a log of all active medication administration records (MARs).[24] This log must be arranged in an unbound binder and stored in a secure location readily accessible to direct care staff.

1. Upon admission to the facility, provider agency staff members shall take photographs of each youth that depict the youth's face, head, and shoulders, and may not depict a full body image. One (1) photograph shall be maintained with the youth's health record, and one (1) photograph shall be attached to the youth's MAR.

2. Provider agency staff shall take updated photographs if the youth's appearance changes.

3. At the conclusion of each calendar month, or when a youth is released or transferred, staff must remove the MAR from the active MAR log and place it in the youth's medical record.

[21] See ACS Policy and Procedure, *Safe Intervention Policy for Juvenile Justice Placement*, *Incident Reporting for Juvenile Justice Placement*, #2015/13, *Mechanical Restraints for Limited Secure Placement*, #2015/10, *Room Isolation in Limited Secure Juvenile Justice Placement,* and 18 NYCRR § 450.7(e)(9).
[22] See ACS Policy and Procedure #2015/03, *Contraband Policy for Juvenile Justice Placement*.
[23] See ACS Policy and Procedures: #2012/06, *Non-Secure Placement Personal Youth Search Policy*; #2015/03, *Contraband Policy for Juvenile Justice Placement;* #2016/05, *Limited Secure Placement Personal Youth Search Policy*; *Searches of Juvenile Justice Placement Facilities*.
[24] See ACS policy and procedure #2016/11, *Medication Administration for Non-Secure Placement and Limited Secure Placement Facilities*.

4. At the beginning of each shift, provider staff must review the active MAR log and document any special instructions or alerts related to medication in the Facility Activity/Communication Log Book.

E. Facility Personal Property Log

Each provider must maintain a record of each youth's personal property, arranged in an unbound binder and stored in a secure location readily accessible to direct care staff, including all inventories conducted at admission and upon return from each home visit or other extended absence from the facility. Upon completion of a youth's personal property inventory, a copy of the completed Personal Property Inventory Form must be placed in this log. In addition, the provider shall document completion of the personal property inventory in the Facility Activity/ Communication log book and in the youth's electronic case record. Providers must also individually report the circumstances that precipitated any allegations of lost, stolen, or damaged personal property consistent with ACS policy.[25]

F. Transportation Log

Each provider must maintain a record of all instances during which mechanical restraints are used during transportation, arranged in an unbound binder and stored in a secure location readily accessible to direct care staff. In addition, all instances of mechanical restraints used during transportation shall be documented in the Facility Activity/Communication Log Book.[26] The contents of this log include the following forms (where applicable):

1. Mechanical Restraints During Transport Form; and
2. Mechanical Restraints Special Transport Request Form.

VI. Storage of Bound Log Books and Confidential Non-Case File Materials

A. Completed Log Books

All bound log books must be closed by the facility director as follows after the last entry:

1. Red ink must be used to note the closing of the log;
2. The date the log was opened and the date of the last entry must be noted;
3. The total pages in the log and the pages used must be noted;
4. The condition of the log and verification that pages are not missing must be noted;

[25] See ACS Policy and Procedure, *Personal Property of Youth in Juvenile Justice Placement*.
[26] See ACS Policy and Procedure #2015/13, *Mechanical Restraints for Limited Secure Placement*

5. A supervisory note must be included indicating that the log has been reviewed for tampering and that the log is now closed;
6. The facility director must print his or her name and sign and date the log book; and
7. The facility director must draw two (2) lines forming an "X" through any unused pages.

B. Damaged Log Books

1. All bound log books must remain in good condition. Natural wear and tear is expected, but the log book must be closed immediately and as above, noting irregularities and replaced if any of the following occur:

   a. The log book cover has become detached and cannot be held in place; and
   b. Used pages become separated from the rest of the log book.

2. Any missing pages in the log must be the subject of an incident report.[27]

3. Closing procedures must be followed regardless of how many blank pages remain in the current log book.

C. Storage of Closed Log Books

1. The facility director or designee is responsible for storing closed bound log books.

2. Each log book must be stored on-site for a period of two (2) years after the date of the last entry.

3. After a period of two (2) years after the date of the last entry, the ACS records storage unit may be contacted to arrange for storage of the log books.

4. If an entire agency is closing and cannot maintain the storage of records, the provider must contact the ACS Records Manager to determine an alternate plan for storage of the log books.

D. Storage of Non-Case File Materials

1. See ACS Policy and Procedure, *Case File and Case Records Policy* for information on storing all original non-case file materials including, but not limited to:

   a. Fire drills;
   b. Searches for contraband;
   c. Youth appointment calendars;

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[27] See ACS Policy and Procedure *Incident Reporting for Juvenile Justice Placement*.

d. Financial documents;
e. Administrative records; and
f. Any records with youth and family names, addresses, social security numbers, case information, medical information, or other personal information.

DYFJ CLOSE TO HOME YOUTH LEVEL OF SERVICE/CASE MANAGEMENT INVENTORY AND AFTERCARE SUPERVISION PROTOCOL

CLOSE TO HOME DESCRIPTION

Close to Home is a juvenile justice initiative that allows youth from New York City to receive services and supports in or close to the communities where they live. Close to Home builds on successful New York City and State reforms and best practices from across the country aimed at improving outcomes for young people and their families by strengthening crucial services, resources and opportunities.

The New York City Administration for Children's Services partners with community-based organizations throughout the 5 boroughs to deliver a broad range of services at non-secure and limited secure residential sites and in the community. Close to Home group homes are neighborhood-based, small, supportive, supervised and family like environments where youth learn new skills designed to address their unique needs. Subsequent aftercare supervision enables youth to successfully return home by practicing and enhancing the skills they learned while in placement.

ASSESSMENT

The YLS/CMI is an evidence-based assessment designed to assist professionals in making decisions about a youth's risk for future re-offending and for identifying a youth's need for case planning. The YLS/CMI is a scored, actuarial tool that assesses static risk factors, seven dynamic criminogenic need areas, and how well adjustments are made following reassessment. The YLS/CMI **is not** intended for assessing risk for future sexual offending. It can be used with sex offenders to assess risk of general reoffending but not risk of future sexual offending.

PURPOSE

Close to Home utilizes the YLS/CMI to develop case management strategies and identify individualized service interventions that support progress towards improvement for each youth in care. YLS/CMI results are used to inform the following:

1. Selection of residential placement program, both in program intensity and level of service[1], and case planning and service referrals during residential placement that are responsive to criminogenic needs; and
2. Selection of aftercare supervision intensity and service interventions that appropriately address risk factors and are responsive to criminogenic needs.

If a YLS/CMI cannot be completed at the point in time designated in this protocol, the DYFJ staff member responsible for administration shall document the circumstances surrounding the delay in CNNX and complete the assessment as soon as is practicable.

[1] Applicable only for youth with an "Unspecified" dispositional placement order

RESPONSIBLE PARTIES
Designated staff members from the DYFJ Intake and Assessment (I & A) Unit is responsible for conducting all initial assessments, where applicable. Each youth's assigned Placement and Permanency Specialist (PPS) is the primary party responsible for conducting YLS/CMI reassessments.

TIMING OF ADMINISTRATION: INTAKE AND ASSESSMENT

An initial/pre-dispositional YLS/CMI completed by the New York City Department of Probation (DOP) will be utilized to inform residential placement program selection. Designated staff members from the DYFJ Intake and Assessment (I & A) Unit are responsible for retrieving the most current YLS/CMI for all youth court mandated for supervision, treatment, and confinement and placed in the custody of the Administration for Children's Services (ACS) for Close to Home residential placement services (NSP and LSP, respectively). The following procedures must be adhered to during the Close to Home intake and assessment process:

1. **Expired YLS/CMI**
   In the event the initial/pre-dispositional assessment is more than six (6) months old, the YLS/CMI shall be administered by designated staff from the DYFJ I & A Unit within five (5) business days of the court order. The results of this new assessment will be utilized to inform residential placement program selection.
2. **Current YLS/CMI (less than 6 months old)**
   The results of the initial/pre-dispositional assessment completed by DOP will be utilized to inform residential placement program selection.

Communication of YLS/CMI Results: Intake and Assessment Stage

The intake and assessment specialist will provide the residential placement provider and PPS a copy of the YLS/CMI and the **Intake and Assessment summary form** which summarizes the results of the YLS/CMI by domains. The results will also get communicated at the transitional meeting that is held prior to a youth leaving detention.

TIMING OF ADMINISTRATION: REASSESSMENT

The purpose of the reassessment is to monitor changes in risk, service needs of the youth, and to inform aftercare planning. Appropriate administration of the YLS/CMI is critical to determining how well youth have adjusted to residential placement, changes to service options or service intensity following previous reassessments, and transition to the community.

1. **12-Month Dispositional Placement Order**
   Youth with 12-month dispositional placement orders must be re-assessed with the YLS/CMI in the facility 15 to **30 days** prior to comprehensive team conference, which occurs at approximately at 90-120 days into residential placement. The information will

be incorporated into the Comprehensive Conference and used to inform release date, service plan update, and service referrals for aftercare.

2. **18-Month Dispositional Placement Order**
   Youth with 18-month dispositional placement orders must be re-assessed with the YLS/CMI in the facility **15 to 30 days** prior to the Comprehensive Team Conference, which occurs **at approximately at 120-180 days into residential placemen**t. The information will be incorporated into the Meeting and used to inform release date, service plan update, and service referrals for aftercare.

3. **Aftercare**
   The purpose of the community reassessment is to monitor each youth's adjustment and any changes in risk, service, or supervision needs after they return to the community. Each youth shall be re-assessed with the YLS/CMI in the community within **45 to 60 days** after release into the community. The information will be incorporated into the conference, which occurs within 60 days following release. A discussion and determination should also be made on if an Extension of Supervision (EOP) is needed to further support and monitor youth in the community.
   Exception Clause
   If case circumstances suggest a reassessment of the YLS/CMI may be necessary as an exception to the timeframes, approval must be granted by the Assistant Commissioner of Close to Home Residential Placement or his or her designee. Youths with 6 months or more of Aftercare will have a team conference at the 4 MONTH mark. The purpose of this meeting is to discuss the youth and family response to services, review of current supervision level/plan, discussion on AWOL and any re-arrest. At this meeting it will be determined if an additional YLS administration is needed. If a determination is made to conduct a reassessment, the PPS will administer the YLS tool. Results will be discussed during one of the bi-weekly calls with the providers.

Communication of YLS/CMI Results: Reassessment

The PPS is responsible for conducting reassessments. PPS will collaborate with the provider and family to obtain pertinent information to complete the reassessment. The PPS will inform the provider about the results of the YLS/CMI reassessment, so the residential providers can update the YLS/CMI criminogenic need area risk levels and overall risk levels on the Case Plan. The results and treatment progress within each priority criminogenic need area should be discussed at each Monthly treatment meetings and Family Team Conferences. Providers will be responsible for updating the case plan and sharing this with PPS during placement and aftercare.

SCORING NORMS
All YLS/CMI assessments shall be scored immediately and documented in MHS and CNNX within five (5) business days of completion. To ensure accuracy and appropriateness, the following norm shall be used in scoring:

1. **Community Norms**
   - YLS/CMI conducted by the DYFJ I & A Unit following court ordered placement;
   - In general, consider community norms whenever there is a question of which placement setting is most appropriate for the youth
   - All reassessments of the YLS/CMI in placement or in the community;

PPS is responsible for notifying their director of all completed YLS/CMI Assessment forms. The scoring should be reviewed and signed off by their immediate director. The PPS director will review and approved within a week. The director will ensure that the staff completing the assessment has used all available information to score the tool and monitor for the appropriateness of any override.

If in doubt, Re-scoring of existing YLS/CMI assessments must be approved by the Assistant Commissioner of Close to Home Residential Placement or designee.

SHARING OF INFORMATION

Intake to Placement

Designated staff from the DYFJ I&A unit will complete the "Intake and Assessment Form" based on the YLS/CMI they conducted. If the I&A unit did not need to update the YLS/CMI, they will complete the form based on the existing YLS/CMI information. They will share this form with the residential provider and the PPS. The I&A unit will also share the information in the form at the Transitional Meeting (held prior to a youth leaving detention) with all participants.

Placement and Reassessments

The PPS is responsible for conducting YLS/CMI reassessments and will relay the information to residential providers to update the Case Plan. The case plan will be discussed at all monthly treatment team meetings and at each conference facilitated by the family engagement conference facilitators (FECF).

Aftercare

The PPS will share the results of the YLS with the providers upon completion of the assessment. PPS and providers should use 1 of the bi-weekly phone calls to review the current case plan and make updates a needed. The FECF will also review the case plan at each conference while youth are on aftercare.

At release conference, the residential provider shall share the YLS and Case Plan with the Aftercare Team.

USE OF YLS/CMI IN RELEASE TO AFTERCARE

As part of a structured decision-making process, results from the YLS/CMI reassessment conducted **prior to release** will be used as one factor in the final decision regarding timing of release from placement. The relevant information from the YLS/CMI includes both the youth's

overall risk level for reoffending in the community, and whether the community has the resources necessary to manage the youth's most pressing criminogenic need areas. This does not mean that youth who continue to fall into the high-risk range on the YLS/CMI will not be recommended for release. High risk youth can be managed successfully in the community when evidence-based services are available to address their needs.

AFTERCARE SUPERVISION: INITIAL TRANSITION

Aftercare enables youth to practice and enhance the skills acquired in residential placement into their natural environment—with their families and social networks It is imperative that the assigned PPS, service providers, and other stakeholders support the youth in this crucial transitional period. We are a part of the youth's circle of influence and our role should be very collaborative with all the partners in this family's life. The first month of this transition is critical to ensuring youth stay connected to positive adults, peers, and community supports they were introduced to while in placement. This lays a foundation for maintaining these connections long past their dispositional placement order. Regardless of each youth's level of placement or Aftercare Supervision Level, the assigned PPS must conduct the following activities for the first **thirty (30) days** of aftercare:

1. **Contacts**
   The purpose of contacts is to build a relationship with the family, to work on family and individual youth skills that decrease risk, enhance public safety and help move the youth closer to their current/future goals. Each contact should have a purpose and connection towards each youth's case plan.

   The PPS shall conduct a minimum of **one (1) face-to-face contact per week is this for the first 6 weeks**. These contacts are a means of providing support to the youth and family during the initial transition. While maintaining weekly contact with the youth, the PPS will intensively monitor compliance with the Conditions of Release.

2. **Case Conference**
   Case Conferences assess progress, youth development, service and supervision needs. Decision making facilitation should occur to assess each youths service plan, while having a safety and risk lens. The assigned PPS will work with the family engagement conference facilitator (FECF) to schedule a case conference **45-sixty (60) days** following the youth's return to the community. This conference consists of a thorough review of the youth's adjustment to the community, overall compliance with the Conditions of Release, the YLS/CMI reassessment in the community, and any significant service needs, or risk factors identified during this time.

   *For youths having a shorter aftercare stay use the most current YLS assessment and case plan to evaluate youth's progress and need for continued services. PPS should consult with their director and AC of placement and Permanency.

AFTERCARE SUPERVISION LEVEL – CONDUCTED BY THE AFTERCARE PROVIDER

Number of Contacts –

Following the initial transition period, the YLS/CMI Assessment will be used in the selection of aftercare supervision intensity and service interventions that appropriately address risk factors and are responsive to criminogenic needs. Assignment of Aftercare Supervision Level is based on each youth's risk level as defined by the most recent YLS/CMI Reassessment conducted in the community using community norms. Each supervision level requires the assigned provider make the following number of face-to-face contacts with the youth upon release to the community:

1. **Low**: One (1) Face-to-face contact monthly
2. **Moderate**: One (1) Face-to-face contact bi-weekly
3. **High**: One (1) Face-to-face contact weekly

Level of Supervision Grid

Risk Level	Frequency Of Contact
Low	Monthly
Moderate	Bi-weekly
High	Weekly

Graduated Aftercare Supervision Level Adjustment

Except for very high-risk youth, aftercare Supervision Level may be adjusted either up or down, with built-in incentives for positive progress and consequences for negative progress. After one month at the assigned supervision level, a youth may be bumped down to the next level of supervision if they have been doing well. For example, high risk youth may go down to being seen biweekly if they have met all their requirements and are doing well in their services.

Case Plan Progress Notes/Updates

Case Plan Updates for youths in residential placement will be reviewed and updated as needed in every monthly treatment team meeting and every family team conference. For youths on Aftercare the case plan will be reviewed at all family team conferences. The case plans should be reviewed by individuals who have completed the YLS/CMI case plan training – including the case planner and case plan supervisor for youth in residential placement and the PPS and PPS Directors for youth in aftercare. Case Plan Progress notes should all be documented in CONNECTIONS.

Responsible Party: The case planner is responsible for updating the case plans and case plan progress. The updates should be done in collaboration with the PPS. If a case planner has not been assigned to the youth, the PPS will be responsible for updating the case plans. The FECF will

review the case plans at each conference. All case planners, PPS and FECF are responsible for documenting case plans and progress in CONNECTIONS.

USE OF YLS/CMI IN CASE PLANS & SERVICE MATCHING

The first case plan in residential care will be completed based on the YLS/CMI and other assessments (where applicable) at the initial conference, which takes places within **30 days** of placement in the facility.

The Provider shall prioritize need areas based on the YLS/CMI domains scoring high or moderate for the youth. Need areas shall be prioritized and services shall be assigned that address as many need areas as possible without overloading the youth with services. The youths' level of risk and need in those areas should be considered in the assignment of services. In general, for youth on aftercare:

- high risk youth would be expected to participate in a maximum of 3 services,
- moderate youth would have less services, and
- low risk youth should receive little to no services.

Higher risk youths should receive more intensive services whenever possible.

For some youth, it will be essential to provide services that address any pressing responsivity factors. In these cases, services that treat or assist with responsivity factors may need to be addressed first **but should not be addressed in lieu of criminogenic needs.** In these cases, it is still important to follow the guidelines about number of services listed above. Minimally three goals should be addressed at a time.

Selection of aftercare services will be influenced on the aftercare service matrix developed by CTH according to which services are available in the area. The I&A Unit should review the results of the YLS/CMI and match each youth's high-risk domains to the appropriate residential provider using the Residential Service Matrix.

Training: ACS PPS

Content: The content of training for PPS should include the following components:

1. Risk-need-responsivity,
2. How to administer and rate the YLS/CMI, and
3. Completion of case plans and aligning plans with the YLS/CMI.

<u>Master Trainers</u> – ACS will have a minimum of three (3) master trainers, which will include one individual from senior management. The qualifications and responsibilities of master trainers are outlined in the Training Section of the YLS/CMI administration protocol.

<u>Initial Training for New PPS</u> – New PPS will be expected to complete training on the YLS/CMI and Case Planning, within 30 days of being hired. Training will be conducted by a master trainer and will require at least one full day.

> <u>Interim Plan</u>: Tara Simpson, Executive Director of Conferencing/Coordination and Johan, Assistant Commissioner of Placement and Permanency, or their designees, will train new PPS until ACS has master trainers. New PPS who are hired prior to the YLS/CMI booster training provided by an expert will attend the booster training, which would be extended into a full YLS/CMI training in this case.

<u>Booster trainings for the YLS/CMI and Case Planning</u>– Booster trainings will be required at minimum twice a year (generally every six months) by having all PPS staff and their supervisors (the PPS Directors) complete the <u>YLS/CMI scoring and a case plan</u> for a vignette. The trainings will be facilitated by master trainers and will be designed to hone skills around both YLS/CMI scoring and case planning in a manner that is linked to the YLS/CMI.

Master Trainers will take turns creating the case vignette, to include a YLS and case plan, to be used for the booster training. All the master trainers will score the vignette and have to come to a consensus on the best ratings. The final vignette will be distributed to all PPS and they will be given two weeks to score the YLS/CMI and create a case plan and return it to their supervisors. Master Trainers will provide feedback on each YLS/CMI and case plan to the PPS Directors. The PPS Directors will provide the feedback to their PPS's.

<u>Supervisor training</u> – All supervisors (PPS Directors) will be required to complete both a standard 2-day YLS/CMI workshop and a supervisor training within 30 days of hire. The Supervisor Training will review how to conduct quality assurance on YLS/CMI scores and overrides, how to provide feedback about interviewing and information gathering, risk-need-responsivity and checking that the case plans are appropriately addressing need areas, and what type of data should be reviewed routinely to ensure PPS are rating the YLS/CMI reliably.

In addition to the RNR and case plan training, the relevant agency supervisors (e.g., case plan supervisor) will receive a separate supervisor training (minimum 1-hour) to supervise the case plan process and ensure it is in alignment with the YLS/CMI and the principles of risk-need-responsivity (RNR).

<u>Master Trainers</u> – ACS will have a minimum of three (3) master trainers, which will include at the minimum one intake specialist, one PPS director, one individual from senior management, and ideally, ACS will attempt to have two PPS and two PPS directors trained to be master trainers to account for potential turnover. The qualifications and responsibilities of master trainers are outlined in the Training Section of the YLS/CMI administration protocol.

TRAINING: Providers

Initial Training: All placement and aftercare providers, including the case planners and their supervisors, will complete risk-need-responsivity (RNR) and case plan training in a one-day workshop. New staff will receive one-on-one training on RNR and case planning from a supervisor within the first 60 days of hire. Recommendation of eight hours of training initially and on-going boosters, which will be provided by ACS.

Supervisor Training: In addition to RNR and case plan training, the relevant agency supervisors (e.g. case plan supervisor) will receive training (minimum of one hour) to supervise the case plan process and ensure it is in alignment with the YLS/CMI and the principles of risk-need-responsivity (RNR).

Booster Training: Booster training on case planning will be completed a minimum of twice a year for case planners, their supervisors, and provider staff. This should be consistent across all CTH provider sites. Close to Home master trainers will partner with provider RNR champions to coordinate and provide the booster training to all ACS and CTH provider staff.

Tracking and Performance Improvement

CTH Performance Improvement Unit (PIU) Assess the timeliness of YLS Reassessment Timeliness by PPS to ensure YLS are completed prior to conferences which will provide guidance and direction regarding services for youth in care.

PIU will create a spreadsheet that will track the first YLS reassessment and a second spreadsheet to track the YLS reassessment related to Aftercare. The PIU will generate calculated due dates of YLS and share with PPS and directors 30 days prior.

The PIU will track all of Case Plans completed by providers. Providers will share case plans once completed with assigned PPS and Claudette Thompson, Executive Director of Performance Improvement.

DATA

Data will be shared and discussed during monthly management meetings to celebrate system successes and identify and troubleshoot any process bottlenecks.

Evaluate adherence to protocol the following key areas are suggested:

1. Is the YLS/CMI being conducted/updated on all eligible youth at intake?
    a. Report includes youth ID/name, date of intake, date of incoming YLS/CMI assessment, date of intake's YLS/CMI assessment (when applicable)
    b. How many assessments are completed by intake vs. probation – and how many are initials vs. reassessments

2. Examine frequency of reassessments, and whether reassessments are being completed in a timely fashion –2 reports:
    a. Report date of each YLS/CMI by youth, interviewer, CTH admission date, release into aftercare date, case close date
    b. Aggregate report of reassessments – average length of time between assessments, frequency counts of reasons for reassessments
    - This data would be collected and reported on a quarterly basis.

3. Check number of over-rides/under-rides and rationales for over-rides (a supervisor approval function should be added for over-rides)
    a. Report by YLS rater - includes date-range (report every 3 months or less), youth name, assessment date & type, rationale for over-ride, original risk level and over-ride risk level, total # of over-rides by interviewer

4. Examine YLS/CMI scoring by raters to check for raters who may be outliers
    a. Report by PPS – aggregated risk levels, over-rides, need area scores, and frequency of strengths checked within a specified date range
    b. Report by intake worker - aggregated risk levels, over-rides, and need area scores within a specified date range for YLS/CMI's they completed
    - This data would be collected and reported on a quarterly basis

5. Are case plans being updated in alignment with reassessments
    a. By youth – youth name, date of CTH admission, date of release from placement, date of case close, date of each YLS/CMI, date of each case plan
        - Data to be tracked monthly and shared with providers
    b. Aggregate – calculate average length of time between YLS/CMI assessments and case plans (might be tricky)

Examination of the YLS/CMI's use in decision-making

1. YLS/CMI risk level by aftercare supervision– by youth and in the aggregate
2. YLS/CMI need areas by placement and aftercare provider and type of service received

Descriptive Information for CTH Youth:

1. Examination of initial YLS/CMI risk levels (Low, Mod, High, Very High) and need areas (Low, Mod, High) by…
    a) Community youth are coming from (zip code) (this will inform CTH as to what need areas are the highest in what locations for resource planning purposes)
    b) Provider (what is the risk breakdown for each provider)
    c) Gender and age group
    - This data would be gathered and reported out on a quarterly basis

2. Examination of YLS/CMI reassessment scores within youth to examine

a) Change in risk level and need areas over time – between initial and first reassessment; between release planning YLS/CMI and first aftercare YLS/CMI, between initial YLS/CMI and last YLS/CMI (closing)
b) Risk levels and need area levels by aftercare provider (who is being referred what type of youth)
c) Gender and age differences

- This data would be gathered and reported out on a quarterly basis

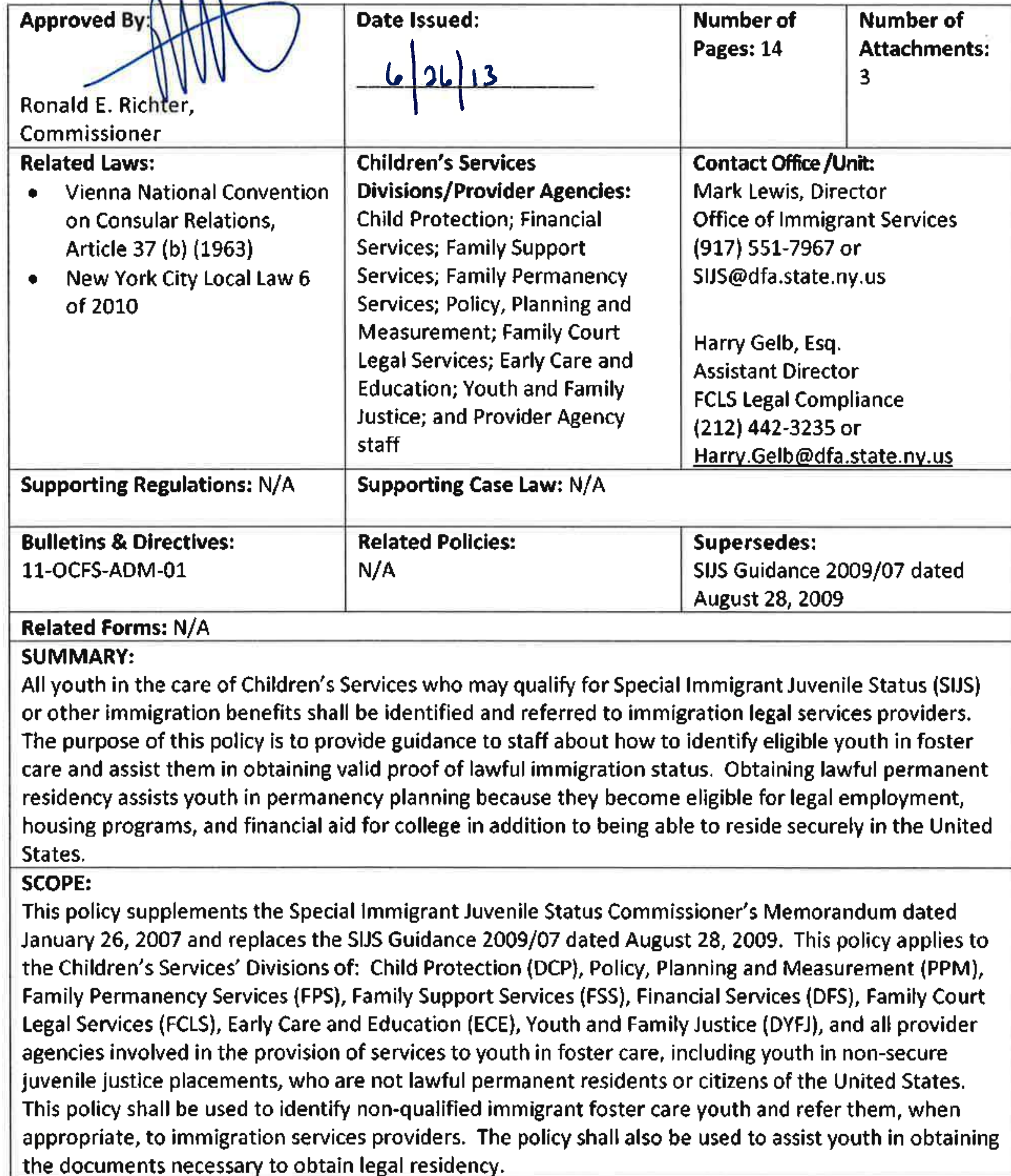
Outcomes:

1. Track % of youth with revocations (revocations tracked by youth rather than by occurrence) over time (e.g., 6-mth increments) – also examine revocations by YLS/CMI risk level
2. Track % of youth with extensions of placement (extensions of placement tracked by youth rather than by occurrence) over time (e.g., 6-mth increments) – also examine by YLS/CMI risk level
3. Track % of youth with AWOL (AWOL tracked by youth rather than by occurrence) over time (e.g., 6-mth increments) – and by YLS/CMI risk level
4. Track % of youth with institutional incidents (incidents tracked by youth rather than by occurrence) over time (e.g., 6-mth increments and from initial to case close) – and by YLS/CMI risk level
5. Track progress (change in YLS scores over time) by provider

City of New York
Administration for Children's Services

Policy and Procedure
2013/05

Special Immigrant Juvenile Status and Immigration Services



Approved By:	Date Issued:	Number of Pages: 14	Number of Attachments: 3
Ronald E. Richter, Commissioner	6/26/13		
Related Laws: • Vienna National Convention on Consular Relations, Article 37 (b) (1963) • New York City Local Law 6 of 2010	**Children's Services Divisions/Provider Agencies:** Child Protection; Financial Services; Family Support Services; Family Permanency Services; Policy, Planning and Measurement; Family Court Legal Services; Early Care and Education; Youth and Family Justice; and Provider Agency staff	**Contact Office /Unit:** Mark Lewis, Director Office of Immigrant Services (917) 551-7967 or SIJS@dfa.state.ny.us Harry Gelb, Esq. Assistant Director FCLS Legal Compliance (212) 442-3235 or Harry.Gelb@dfa.state.ny.us	
Supporting Regulations: N/A	**Supporting Case Law:** N/A		
Bulletins & Directives: 11-OCFS-ADM-01	**Related Policies:** N/A	**Supersedes:** SIJS Guidance 2009/07 dated August 28, 2009	
Related Forms: N/A			

SUMMARY:

All youth in the care of Children's Services who may qualify for Special Immigrant Juvenile Status (SIJS) or other immigration benefits shall be identified and referred to immigration legal services providers. The purpose of this policy is to provide guidance to staff about how to identify eligible youth in foster care and assist them in obtaining valid proof of lawful immigration status. Obtaining lawful permanent residency assists youth in permanency planning because they become eligible for legal employment, housing programs, and financial aid for college in addition to being able to reside securely in the United States.

SCOPE:

This policy supplements the Special Immigrant Juvenile Status Commissioner's Memorandum dated January 26, 2007 and replaces the SIJS Guidance 2009/07 dated August 28, 2009. This policy applies to the Children's Services' Divisions of: Child Protection (DCP), Policy, Planning and Measurement (PPM), Family Permanency Services (FPS), Family Support Services (FSS), Financial Services (DFS), Family Court Legal Services (FCLS), Early Care and Education (ECE), Youth and Family Justice (DYFJ), and all provider agencies involved in the provision of services to youth in foster care, including youth in non-secure juvenile justice placements, who are not lawful permanent residents or citizens of the United States. This policy shall be used to identify non-qualified immigrant foster care youth and refer them, when appropriate, to immigration services providers. The policy shall also be used to assist youth in obtaining the documents necessary to obtain legal residency.

Table of Contents

I. **Introduction** **3**
II. **Identifying Youth Who May Qualify for SIJS Through Child Protective Investigation** **3**
III. **Children Services' Divisional Responsibilities for Immigrant Youth** **4**
- A. Division of Family Court Legal Services (FCLS) 5
- B. Immigrant Services 5
- C. Title IV-E 5
- D. Division of Youth and Family Justice (DYFJ) 5
- E. Immigrant Parents and Non-Foster Care Youth 5

IV. **Identifying Youth Who May Qualify for SJIS Through Provider Agencies** **6**
V. **Referring Youth Who Need Immigration Services to Immigration Legal Services Providers** **7**
VI. **Assisting Youth in Obtaining Necessary Documents for the SIJS Application** **8**
VII. **Criteria for SIJS Eligibility** **9**
VIII. **SIJS Applications** **9**
IX. **SIJS Application Fees and Fee Waivers** **10**
X. **The Adjustment of Status Interview** **10**
XI. **Decision Notification** **11**
XII. **Tracking Youth Who May Qualify for SIJS or Other Immigration Relief** **11**
XIII. **Training** **12**
XIV. **Mechanisms and Indicators for Monitoring Compliance** **13**
- A. Provider Agency Monitoring 13
- B. Indicators 13

XV. **Methods for Collecting Data and Evaluating Outcomes** **14**
XI. **Attachments**
- A. SIJS-Approved Immigration Legal Services Providers
- B. Special Immigrant Juvenile Status (SIJS) Fees
- C. Sample Special Findings Order

I. Introduction

A. Youth in the care of Children's Services, including youth in non-secure juvenile justice placements, who are eligible to obtain lawful permanent residency through Special Immigration Juvenile Status (SIJS) or other immigration applications, must be afforded an opportunity to do so. It is therefore essential that the need for immigration services be identified promptly, and that youth are referred to immigration legal services in a timely manner.

B. If a youth is found eligible for SIJS or other immigration benefits by an immigration legal services provider, Children's Services and provider agency staff, which includes foster care agencies and non-secure juvenile justice placement providers, must secure the documents necessary to submit with the appropriate application and track such youth until the completion of the youth's application or other immigration relief.

C. Additionally, under this policy, all Children's Services' divisions and provider agencies that come into contact with members of families who are not citizens of the United States or who do not have documentation of lawful permanent residence (such as a green card) must provide these families with information on the availability of free immigration services.

D. Under the SIJS plan ("the plan") developed in January 2011, pursuant to New York City Local Law 6 of 2010 (hereinafter "Local Law 6 of 2010"), Children's Services and provider agencies are responsible for the actions described below in this policy.

II. Identifying Youth Who May Qualify for SIJS Through Child Protective Investigation

A. The Child Protective Specialist (CPS) in the Division of Child Protection (DCP) is initially responsible for the identification of youth on a child protective or voluntary placement case who may qualify for SIJS or other immigration benefits.

B. During the investigation stage of a child protective case, in order to determine if a parent or a youth requires assistance with his or her immigration status, the CPS must obtain the following information from the parent or caretaker:

1. Youth's birth certificate;
2. Youth's country of birth;
3. Whether the parent and youth are U.S. citizens; and
4. Whether the parent and youth have documentation of lawful permanent residence.

C. The CPS must also record the information in Section II(B)(1-4) above in the Family Assessment and Service Plan (FASP) and progress notes in CONNECTIONS

(CNNX). The CPS shall include the need for a referral to immigration legal services in the youth's initial FASP in order to notify the agency with case planning responsibility of the youth's immigration needs.

D. The CPS must provide the family with the Children's Services pamphlet "Immigration Assistance for Children and Families" when the family requires immigration services. This pamphlet informs immigrant parents and youth of the availability of free or low-cost immigration services and the benefits of securing legal status.

E. The CPS shall complete the Family Service Intake (FSI) in CNNX, using the following steps, if a youth in the household is identified as not having U.S. citizenship or lawful permanent residence:

1. Check "Immigration Services" under the "**Requested Services**" field in the FSI; and

2. Record in the progress notes the youth's immigration status and type of action taken to assist the youth with his or her immigration issue, e.g., notifying the provider agency and the Family Court Legal Services (FCLS) attorney of his or her finding that the youth is not a lawful permanent resident or citizen of the U.S. The CPS shall do the following when opening the Family Service Stage (FSS) in CNNX:

   a. Document the youth's country of birth and immigration status under the "**Family Background**" section of the FASP;

   b. Select "Immigration Services" " in the "**Service Choice**" section of the FASP if the youth is identified as in need of immigration services.; and

   c. Document in the "**Family Service Plan**" section of the FASP the youth's immigration status and the steps that the case planner and youth must undertake to address the youth's immigration issue.

F. During FCLS Intake (when a child protective petition is being screened or drafted) or at any time during the life of the case, the CPS must promptly notify the FCLS attorney on the case when the CPS identifies a youth who does not have U.S. citizenship or lawful permanent residence and who is or will be placed in foster care.

G. The CPS shall discuss the youth's immigration status with the provider agency case planner during the transition meeting to alert the case planner of the need to continue work on the youth's immigration status.

III. Children's Services' Divisional Responsibilities for Immigrant Youth

A. Division of Family Court Legal Services (FCLS)

1. Upon receiving the information, the FCLS attorney must notify the Children's Services Office of Immigrant Services (hereafter referred to as "Immigrant Services") when youth who are identified as not having U.S. citizenship or lawful permanent residence by DCP or others are placed into foster care. Notification shall occur via email to SIJS@dfa.state.ny.us.

2. The FCLS attorney must inform the Attorney for the Child if a foster care youth does not have lawful permanent residence.

B. Immigrant Services

Immigrant Services must provide notification to the appropriate consulate consistent with the requirements of the Vienna Convention[1] and notify the provider agency once the youth is identified (if a provider agency is the case planner and/or is providing services to the youth).

C. Title IV-E

1. In addition to DCP investigations, Children's Services will identify youth who may qualify for SIJS or other immigration status through the Title IV-E process via the Central Eligibility Unit (CEU) of the Division of Policy, Planning and Measurement (PPM). The CEU will:

   a. Screen all youth who enter foster care, including youth who are placed into non-secure juvenile justice placement, to determine if they have U.S. citizenship or legal immigration status as part of the process to determine Title IV-E eligibility; and,

   b. Issue to Immigrant Services monthly reports of youth entering foster care who are not U.S. citizens or who do not have documentation of lawful permanent residence.

D. Division of Youth and Family Justice (DYFJ)

For youth detained in Division of Youth and Family Justice (DYFJ) detention facilities, DYFJ staff must provide the pamphlet "Immigration Assistance for Children and Families" informing immigrant youth of the availability of free or low-cost immigration services and the benefits of securing legal status.

E. Immigrant Parents and Non-Foster Care Youth

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[1] See Articles 36 and 37 of the Vienna Convention on Consular Relations at http://untreaty.un.org/ilc/texts/instruments/english/conventions/9_2_1963.pdf for additional information about consular notifications.

1. All other immigrant parents and youth who come into contact with Children's Services, including those receiving preventive services, court-ordered supervision, and early care and education services, and those who come into brief contact with Children's Services (e.g., guardianship or custody cases in which Children's Services conducts a court-ordered investigation), shall receive the pamphlet "Immigration Assistance for Children and Families" from Children's Services and provider agencies informing immigrant parents and youth of the availability of free or low-cost immigration services and the benefits of securing legal status.

2. Immigrant parents and youth that have been involved in child protective cases may qualify for special types of immigration relief available for undocumented victims of crimes such as domestic violence. U-Visas, a form of immigration relief that may lead to a green card, may be available to parents and/or their children who do not have lawful permanent residence, are victims of domestic violence or other crimes (such as trafficking or assault), and were cooperative in the Children's Services investigation. Additionally, the Violence Against Women Act (VAWA) (another form of immigration relief that may lead to a green card) may be available to immigrant parents and/or children who are the victims of domestic violence committed by a spouse or parent who is a U.S. citizen or permanent resident. Some of these benefits are time-sensitive, and immigrant youth and parents must be advised to seek the help of an experienced immigration attorney as soon as possible to find out what immigration benefits they may qualify for. A list of free legal services providers who screen clients for possible immigration relief is included in the above referenced pamphlet.

IV. Identifying Youth Who May Qualify for SIJS Through Provider Agencies

Provider agencies are required to identify all immigrant youth in their care who do not have U.S. citizenship or lawful permanent residence. Providers shall:

A. Include in their intake forms questions necessary to determine the youth's country of birth and/or whether a youth has a U.S. birth certificate. These questions shall be asked regardless of the type of foster care placement (e.g., voluntary placement, child protective, juvenile justice placement in a non-secure level of care, or Person In Need of Supervision (PINS)).

B. Designate a SIJS/Immigration Liaison or point person who will be the contact person for Immigrant Services. The provider agency's SIJS/Immigration Liaison will work closely with Immigrant Services so that all identified youth are referred to immigration legal providers and receive appropriate services in a timely manner.

C. For youth entering and/or currently in foster care, document in CNNX each foster care youth's country of birth and whether there is proof of U.S. citizenship or lawful permanent residence in the youth's file. If the youth is not a U.S. citizen or lacks documentation of lawful permanent residence in his or her file, agency staff shall:

1. Select "Immigration Services" in the "**Service Choice**" section of the FASP. This section must be updated in subsequent FASPs to reflect the progress made, if any, to assist the youth with his or her immigration issue; and,

2. Document in the "**Family Service Plan**" section of the FASP the youth's immigration status and the steps that the case planner and youth must undertake to address the youth's immigration issue. See Sections V and VI for additional information about the steps that a case planner must undertake.

D. Promptly notify Immigrant Services when staff identify any immigrant youth in foster care.

E. Record in the CNNX progress notes all immigration related services, contacts and actions. Prior to requesting updated information from provider agencies, Immigrant Services must review the progress notes of identified immigrant youth to determine SIJS case status. Children's Services will only make informational requests to the provider agency if the data has not been entered into the progress notes.

F. **Note: Provider agencies and Children's Services must NEVER contact United States Citizenship and Immigration Service (USCIS) or United States Immigration and Customs Enforcement (ICE) to discuss a family member's or youth's immigration status or any immigration application, including SIJS. All immigration inquiries and applications must be handled through a qualified immigration attorney (see Section V - Referring Youth Who Need Immigration Services to Immigration Legal Services Providers). The attorney will assess the youth's eligibility based on the criteria listed in Section V and provide advice accordingly. For further guidance, provider agencies shall contact Immigrant Services**

V. Referring Youth Who Need Immigration Services to Immigration Legal Services Providers

A. The provider agency must refer all identified youth who do not have U.S. citizenship or proof of lawful permanent residence to immigration legal services providers within four (4) months of entering foster care. A list of immigration legal services providers who accept referrals for immigrant youth in foster care is attached to this policy as Attachment A.

B. In situations in which the youth has been identified as an immigrant after he or she has been in foster care more than four (4) months, provider agencies must refer the youth to immigration service providers as soon as possible, and, at the latest, within sixty (60) days of the identification of the youth's status.

C. Immigration legal services providers will make confidential inquiries regarding the youth's background and history to assess eligibility for SIJS or other immigration benefits. The legal services provider may later ask the provider agency to assist in this process, as well as in matters of obtaining documentation, application fees, and other required items.

D. Prompt referral to an immigration legal services provider is important so that the application process can be commenced expeditiously. If a SIJS-eligible youth is over 16 years of age, the process of referral and document collection must be expedited according to the guidelines listed above in Section V (A-C). This is essential in order to meet the legal filing deadline and to complete other necessary services required to process the SIJS request.

E. **Note**: Agencies must inform Immigrant Services of any referrals made to these providers. Please forward all relevant information to SIJS@dfa.state.ny.us.

VI. Assisting Youth in Obtaining Necessary Documents for the SIJS Application

A. Securing foreign birth certificates can be a long, difficult process and can delay the SIJS process. Once it has been determined that the youth is not a U.S. citizen or lawful permanent resident, and the original birth certificate is not available, the provider agency must immediately begin the process of securing the youth's foreign birth certificate.

B. Before a youth's attorney submits the SIJS application, the provider agency shall assist the attorney in the collection of the necessary documents. These documents include the youth's:

1. Birth certificate;
2. Passport;
3. Court orders and dispositions;
4. Medical examination; and,
5. Other identification papers.

C. To obtain a copy of a foreign birth certificate, provider agencies can either request assistance from the Children's Services Centralized Services Unit (Centralized Services Unit) of the Division of Family Permanency Services (FPS) or directly contact the consulate of the youth's home country. Immigrant Services has completed a guide to securing key documents, such as birth certificates, from the ten consulates that represent the largest number of immigrant families that come into contact with Children's Services. This guide will prove useful in assisting provider agencies and

the Centralized Services Unit. The Consulate Guide is available at http://10.239.3.195:8080/docushare/dsweb/Get/Document-190153/Consulate Guide.doc, on the Children's Services Intranet under Immigrant Services, or by contacting SIJS@dfa.state.ny.us.

VII. Criteria for SIJS Eligibility

A. All youth in foster care who are found to be non-U.S. citizens or do not have documentation of lawful permanent residence must be referred promptly by the provider agency to immigration legal services providers. **All decisions on SIJS eligibility are made by the immigration legal services provider and are not made by Children's Services or the provider agency.** If the youth is not found eligible for SIJS by the immigration legal services provider, that legal provider will also screen the youth for other immigration applications.

B. The immigration legal services provider may use specific criteria including but not limited to the following criteria to make a legal assessment of SIJS eligibility:

1. At the time of application, the youth must be under 21 years of age and not married.

2. SIJS applicants must submit an order from the Family Court in support of a SIJS application making requisite factual findings (often called a Special Findings Order). A sample Special Findings Order is attached to this policy as Attachment C. The Special Findings Order is requested from the Family Court by the Attorney for the Child or the immigration legal services provider.

3. A young person does not need to be the subject of a child protective proceeding in order to obtain a Special Findings Order. The orders can be obtained in other Family Court cases that include voluntary foster care placements, juvenile justice cases, PINS cases, destitute child placements, guardianship cases, and custody cases.

VIII. SIJS Applications

A. Having determined potential SIJS eligibility and acquired the Special Findings Order, the child's immigration attorney will initiate the application for SIJS.

B. It is the provider agency's responsibility to provide the SIJS immigration attorney with necessary documents (e.g., passport, birth certificates, Family Court orders, and other required documentation) needed to supplement the SIJS application, and/or to assist in obtaining those documents. The local consulate of the youth's home country may be able to provide the provider agency with assistance, including obtaining these necessary documents. Once the provider

agency obtains the supplemental documents, the immigration attorney must submit them to the USCIS along with the following forms:

1. Application for SIJS (Form I-360);
2. Application for Legal Permanent Residency (Form I-485); and,
3. Employment Authorization Application (Form I-765), which must be submitted in conjunction with Forms I-485 and I-360.

C. **Note**: If a provider agency has difficulty obtaining assistance from the local consulate of the youth's country, the provider should contact the Centralized Services Unit at (212) 442-1589.

IX. SIJS Application Fees and Fee Waivers

A. There are several fees associated with the SIJS application process, such as application fees, medical examination fees, and birth certificate, passport and legal fees. Attachment B lists all the current applicable fees associated with the SIJS application.

B. Youth in foster care, including youth in non-secure juvenile justice placements, are eligible for fee waivers for certain immigration agency fees associated with the SIJS application (i.e., I-485 and I-765 fees). It is Children's Services policy that immigration legal services providers representing immigrant youth in the custody of Children's Services must apply for fee waivers for immigration application fees unless there are justifiable grounds for not applying for the fee waiver, such as when a youth is 20 and a half years old and older. If an immigration legal services provider decides that there are justifiable grounds for not applying for a fee waiver, the immigration legal services provider shall request approval from Immigrant Services. Immigrant Services must review the request and notify both the immigration legal services provider and provider agency if the request is approved. If approved, the provider agency shall provide the payment to the immigration legal services provider and will be reimbursed by Children's Services, as noted below.

C. For non-waivable fees associated with the immigration application process (i.e., fees charged by consulates for birth certificates and passports, and fees for medical examinations, passport photos, and court orders), the provider agency must issue payment for the fees immediately upon request of the child's immigration attorney. These costs are reimbursable by Children's Services, and should be claimed as a special payment directly from Children's Services Payment Services using the Standard Detail Sheet. Please see Attachment B for a list of current applicable fees.

X. The Adjustment of Status Interview

A. After the immigration attorney submits the SIJS application, USCIS will acknowledge receipt of the application and schedule the applicant for fingerprinting. Subsequently, USCIS will indicate the scheduled date for an "adjustment of status" interview at a district immigration office.

B. The immigration attorney must prepare the youth for the adjustment of status interview and represent the youth during the interview. A provider agency worker may also accompany the youth to provide support, but may not be allowed into the interview. The provider agency is responsible for providing required documents for the interview to the immigration attorney and for arranging for the youth to be produced at the interview. Timely attendance at this interview is extremely important as lateness is excused only in very limited circumstances. Failure to appear at a fingerprinting or adjustment of status interview may result in the denial of the application and initiation of removal proceedings.

XI. Decision Notification

Sometimes the decision of approval is made at the interview, but the notification can also occur at a later date. USCIS may request additional documents or evidence and offer additional time for a response. Once the requested additional documents are submitted, the youth will receive a decision regarding whether the application has been granted or denied. If the adjustment of status application is denied, the notice of denial will inform the applicant of his or her rights to appeal.

XII. Tracking Youth Who May Qualify for SIJS or Other Immigration Relief

Consistent with Local Law 6 of 2010 and the SIJS plan, Immigrant Services is implementing a tracking system, in cooperation with provider agencies and immigration legal services providers, which includes the following items:

A. Youth without U.S. citizenship will be tracked by Children's Services from identification until the youth obtains legal permanent residency and/or the legal process is completed. Youth will be identified by DCP, DYFJ, Title IV-E, provider agencies, and the Attorney for the Child. Immigrant Services will receive this information and will be responsible for tracking youth.

B. Immigrant Services shall notify the provider agency that a youth in its care may be eligible for SIJS or other immigration relief.

C. The provider agency will advise whether the youth's birth certificate is in the case record. If it is not, the provider agency will either obtain the youth's birth certificate on its own, or submit a request to the Children's Services Office of Vital Statistics (212-676-6639) (in FPS) for foreign birth certificates.

D. As noted above, within four (4) months of the youth entering foster care, or within sixty (60) days of determining non-qualified immigrant youth status, if the initial four (4) months has passed, the provider agency shall refer the youth to an immigration attorney. The provider shall then enter the information into the FASP as a service need.

E. Immigrant Services will seek information, subject to confidentiality requirements, on whether or not the case has been accepted by an immigration legal services provider and, subsequently, whether an application for SIJS or other immigration relief has been filed or a green card has been received, or whether there are any delays in obtaining required documents.

F. As noted above, prior to requesting updated information from provider agencies, Immigrant Services must review the progress notes in the case records of the identified immigrant youth in an attempt to determine his or her SIJS case status. Informational requests to the provider agency's SIJS Liaisons will be made only if the data is not found in the progress notes.

XIII. Training

A. Local Law 6 of 2010 requires Children's Services to provide mandatory training programs on immigration benefits, including SIJS, for appropriate Children's Services and provider agency staff.

B. Children's Services has developed a training video/DVD on SIJS and other immigration relief. Training will include but not be limited to best practices for asking youth and families about their country of birth and requesting documentation, such as green cards, visas, etc., in order to determine a youth's immigration status. The video will be posted on the Children's Services Intranet at http://nycacs/immigrant for easy access by ACS staff. Copies may be requested from Immigrant Services by e-mailing SIJS@dfa.state.ny.us. The Children's Services James A. Satterwhite Academy (of PPM) will use the video to train DCP staff as part of their immigration and cultural competency training. Copies of the video, as part of a SIJS training packet, will be given to provider agencies to be used to train new and existing staff on SIJS and other immigration benefits.

C. Immigrant Services will also provide classroom trainings to appropriate Children's Services and provider agency staff. Supervisors will be trained on SIJS and other immigration benefits, and Immigrant Services will work with DCP borough training directors to train DCP front line staff.

D. Provider agency directors will be briefed on the SIJS plan at scheduled quarterly meetings. All provider agencies' SIJS liaisons will be expected to attend mandatory training on SIJS and other immigration benefits. Each agency will then train all supervisors, case planners and staff who work directly with youth and

families on SIJS. Children's Services will provide training material to provider agencies to use in their own training. The material will include the Children's Services SIJS policy, a DVD/PowerPoint presentation on SIJS and immigration benefits, a list of immigration legal services providers to whom they may refer their clients, and a SIJS pamphlet to be provided to youth.

E. Finally, Immigrant Services will combine efforts with non-profit organizations to train provider agencies on SIJS and other immigration benefits.

XIV. Mechanisms and Indicators for Monitoring Compliance

A. Provider Agency Monitoring

As part of the transition planning for youth who are 17 years of age or older, provider agencies must complete a Preparing Youth for Adulthood checklist during the permanency conference every six (6) months. This checklist includes a number of specific questions related to immigrant youth, including whether the youth has a green card, and, if not, whether the youth has been referred for immigration legal services and has received legal status through those efforts. Immigrant Services will monitor the number of youth identified as needing immigration relief and those referred to legal providers for services.

B. Indicators

1. Children's Services will use the following indicators to monitor its own compliance and achievements under the plan:

   a. Number of Children's Services staff trained on SIJS, broken down by title;

   b. Number of foster care SIJS liaisons trained by Children's Services;

   c. Number of immigrant youth identified by DCP and the Title IV-E process; and

   d. Number of immigrant youth successfully identified by Children's Services whose provider agency was notified to follow up.

2. Children's Services will use the following indicators to monitor provider agency compliance and achievements under the plan:

   a. Provider agency's steps to implement the plan, including designating a SIJS liaison, modifying its intake forms to include a section on SIJS and other immigration benefits, and entering immigration service needs into the FASP;

   b. Timeliness of referral of immigrant youth to immigration legal services providers; and

c. Number of SIJS liaison and other provider agency staff receiving training from the provider agency on SIJS and other immigration relief.

XV. Methods for Collecting Data and Evaluating Outcomes

A. Immigrant Services must review case records, and receive information from DCP, FCLS, Title IV-E, provider agencies and immigration legal services providers needed for the tracking system. The tracking system must contain sufficient data to enable the evaluation of three key questions:

1. Are immigrant youth in foster care who are in need of immigration relief, such as SIJS or other immigration benefits, being identified on a timely basis?

2. Are identified immigrant youth being referred for immigration legal services on a timely basis?

3. Are eligible identified immigrant youth receiving SIJS or other immigration benefits on a timely basis?

B. On an annual basis, Immigrant Services will review a sample of cases and prepare an evaluation report answering these three questions. In addition, Immigrant Services will report aggregate data detailing the number of immigrant youth in foster care, number of immigrant youth entering foster care in that year, number of immigrant youth referred to immigration legal services providers, and the number of immigrant youth receiving SIJS or other immigration benefits.

For additional information on SIJS immigration issues, please contact Mark Lewis, Director of the Children's Services Office of Immigrant Services, at SIJS@dfa.state.ny.us or (917) 551-7967.

For additional information on Family Court Legal Services (FCLS)-related SIJS issues, please contact Harry Gelb, Esq., Assistant Director of Legal Compliance, at Harry.Gelb@dfa.state.ny.us or (212) 442-3235.

ATTACHMENT A

SIJS-Approved Immigration Legal Services Providers[1]

Atlas-DIY[2]
SIJS Contact: Lauren A. Burke, Esq.
lauren.orgatlas@gmail.com

Catholic Charities Community Services, Immigration Services Department
SIJS Contact: Mario Russell, Esq.
mario.russell@archny.org

Catholic Migration Services
SIJS Contact: Julia Hernandez, Esq.
1258 65 Street, Brooklyn, NY 11219
Tel: 718-236-3000, Ext. 207
Fax: 718-256-9707
jhernandez@catholicmigration.org

The Door Legal Services
SIJS Contact: Eve Stotland, Esq.; Sara Rosales
Tel: 212-941-9090, Ext. 3288 (Ms. Stotland) or Ext. 3280 (Ms. Rosales)
estotland@door.org; srosales@door.org

Lawyers for Children, Immigrant Rights Project
SIJS Contact: Myra Elgabry, Esq.
Tel: 212-966-6420, Ext. 638
melgabry@lawyersforchildren.org

Legal Aid Society, Immigration Law Unit
SIJS Contact: Maria Navarro, Esq.
Tel: 212-577-3328
mnavarro@legal-aid.org

Lutheran Social Services of New York, Immigration Legal Project
SIJS Contact: Lisa Braff, Esq.
Tel: 212-265-1826, Ext. 3011
lbraff@lssny.org

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[1] Updates or changes to the list of approved immigration legal services providers may be found on the Children's Services Intranet at http://nycacs/immigrant.
[2] Atlas-DIY will only accept referrals for youth who already have Special Findings Orders from Family Court.

New York Law School, Safe Passage Project
SIJS Contacts: Lenni Benson, Esq.; Bethany Ow, Esq.
Tel: 212-431-2336
Lenni.benson@nyls.edu; Bethany.Ow@nyls.edu

Safe Horizon Immigration Law Project
SIJS Contact: Lynn Neugebauer, Esq.
Tel: 718-943-8634
lneugebauer@safehorizon.org

Sanctuary for Families (Manhattan Office)
Immigration Intervention Project
SIJS/Asylum contact: Archi Pyati, Esq.
Tel: 212-349-6009, Ext. 324
apyati@sffny.org

Sanctuary for Families (Brooklyn and Bronx Office)
Immigration Intervention Project
SIJS Contact: Deborah Lee, Esq.
NYC Family Justice Center, Brooklyn
350 Jay Street, 15th Floor
Brooklyn, NY 11201
Tel: 718-250-4402
Fax: 718-624-4240
dlee@sffny.org

Sanctuary for Families (Queens Office)
Immigration Intervention Project
SIJS Contact: Melissa Brennan, Esq.
NYC Family Justice Center, Queens
126-02 82nd Avenue
Kew Gardens, NY 11415
Tel: 718-575-4529
Fax: 718-268-1213
MBrennan@sffny.org

Urban Justice Center
Peter Cicchino Youth Project (Serving lesbian, gay, bisexual, transgender or questioning youth)
SIJS Contact: Megan Stuart, Esq.
Tel: 646-602-5643/877-LBGT-LAW
Fax: 212-533-4598
MStuart@urbanjustice.org

ATTACHMENT B

Special Immigrant Juvenile Status (SIJS) Fees

SIJS fees are subject to change by the United States Citizenship and Immigration Services (USCIS); therefore all SIJS fees must be verified by the immigration attorney before submitting an application with payment. **The current SIJS fees are as follows**:[1]

i. Application for SIJS (Form I-360) Fee- no fee;
ii. Application for Legal Permanent Residency (Form I-485) Fee- $985 (may be waived by immigration agency);
iii. Application for Employment Authorization (Form I-765) Fee - $380 for youth over 14 years old (may be waived by immigration agency);
iv. Biometrics (fingerprinting) Fee- $85 (may be waived by immigration agency);
v. There is a requirement for a medical examination by authorized providers and the costs will vary from as low as $80 if the child or provider agency can document vaccinations, to as high as $300;
vi. Passport photos, approximately $10-$20;
vii. Passports and birth certificates from the native country may also be required, and these costs will vary by consulate;
viii. In some cases, youth may be required to provide certificates of disposition from criminal court matters and/or copies of other court orders, and costs will vary depending on the court;
ix. Additionally, Children's Services will reimburse provider agencies for up to $1000 for legal services associated with assisting youth in foster care through the SIJS process. As indicated above, provider agencies should pay the legal services provider directly and Children's Services will reimburse these costs.

[1] Fees quoted are as of May 2013.

8 U.S.C. §1101

GF-42

(Special Immigrant Juvenile Status Order)

At a Term of the Family Court
of the State of New York, held
in and for the County of ____
at ____________, New York
on______________ , __.

PRESENT: Hon.

---x

Docket No.
Family File No.
ORDER-Special Immigrant
Juvenile Status

---x

This Court, after examining the motion papers and supporting affidavits, all the pleadings and prior proceedings in this matter, and/or hearing testimony, finds, in accordance with 8 U.S.C. § 1101(a)(27)(J), that:

1. The above-named child is under 21 years of age.

2. The above-named child is unmarried.

3. The above-named child is dependent upon the Family Court, or has been committed to or placed in the custody of a state agency or department, or an individual or entity appointed by the state or Family Court.

4. Reunification with one or both of his/her parents is not viable due to [check applicable box(es)]: ☐ abuse; ☐ neglect; ☐ abandonment; and/or ☐ a similar basis under New York law because [specify the basis for the determination]:

____

____

____

5. It is not in the child's best interest to be removed from the United States and returned to [specify country}: ______________, his/her country of nationality or country of last habitual residence of the child or of his/her birth parent or parents.

Dated:

ENTER

____

Judge of the Family Court

PURSUANT TO SECTION 1113 OF THE FAMILY COURT ACT, AN APPEAL FROM THIS ORDER MUST BE TAKEN WITHIN 30 DAYS OF RECEIPT OF THE ORDER BY APPELLANT IN COURT, 35 DAYS FROM THE DATE OF MAILING OF THE ORDER TO APPELLANT BY THE CLERK OF COURT, OR 30 DAYS AFTER SERVICE BY A PARTY OR THE ATTORNEY FOR THE CHILD UPON THE APPELLANT, WHICHEVER IS EARLIEST.

Check applicable box:

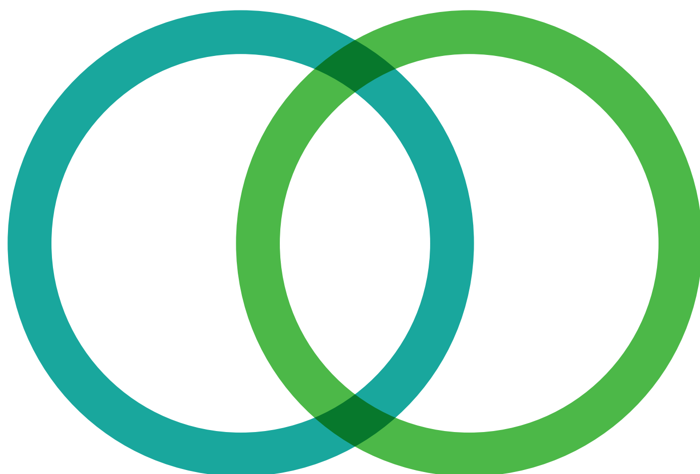
☐ Order mailed on [specify date(s) and to whom mailed]:________________________

☐ Order received in court on [specify date(s) and to whom given]:__________________

ACS
Workforce
Institute

CYPM
The Crossover Youth Practice Model:

A Guide to Working with Youth Involved in Both the **Child Welfare System** & the **Juvenile Justice System**



Administration for Children's Services
June 2016

ACS Workforce Institute

The Crossover Youth Practice Model
A Guide to Working with Youth Involved in Both the Child Welfare System & the Juvenile Justice System

Questions about CYPM?

Speak to the CYPM champion at your agency or call the CONFIRM UNIT at ACS:

1-877-KID-CHEK

For forms and other CYPM resources, visit the CYPM page on the ACS website.

Contents

Section 1: The CYPM Process 7

Introduction to CYPM 9

CYPM Illustrated 11

The Juvenile Justice Flow 13

Section 2: Consent 23

Explaining CYPM and Adjustment 25

Sharing Information 29

The CYPM Consent Form 30

Section 3: CYPM Responsibilities 37

Court-Ordered Supervision 39

Foster Care/Trial Discharge 41

Preventive 43

Appendix: 47

Glossary of Child Welfare and Juvenile Justice Terms 49

Case Planner Checklist 59

Parent Checklist 60

Youth Checklist 61

SECTION 1: THE CYPM PROCESS

Introduction to CYPM

CYPM Illustrated

The Juvenile Justice Flow

Introduction to CYPM

What Is CYPM?

In 2010, the Center for Juvenile Justice Reform at Georgetown University developed the Crossover Youth Practice Model to address the needs of youth known to both the child welfare and juvenile justice systems.

CYPM is a way to help the child welfare and juvenile justice systems work together to achieve better outcomes for crossover youth.

What Is a Crossover Youth?

A *crossover youth* is a young person up to age 21 who is involved in the child welfare system and **crosses over** into the juvenile or criminal justice system by getting arrested. The youth is now involved in both systems.

Such a youth may also be referred to as “dually involved.”

What Is a CYPM Youth?

CYPM youth are a **subset** of crossover youth.

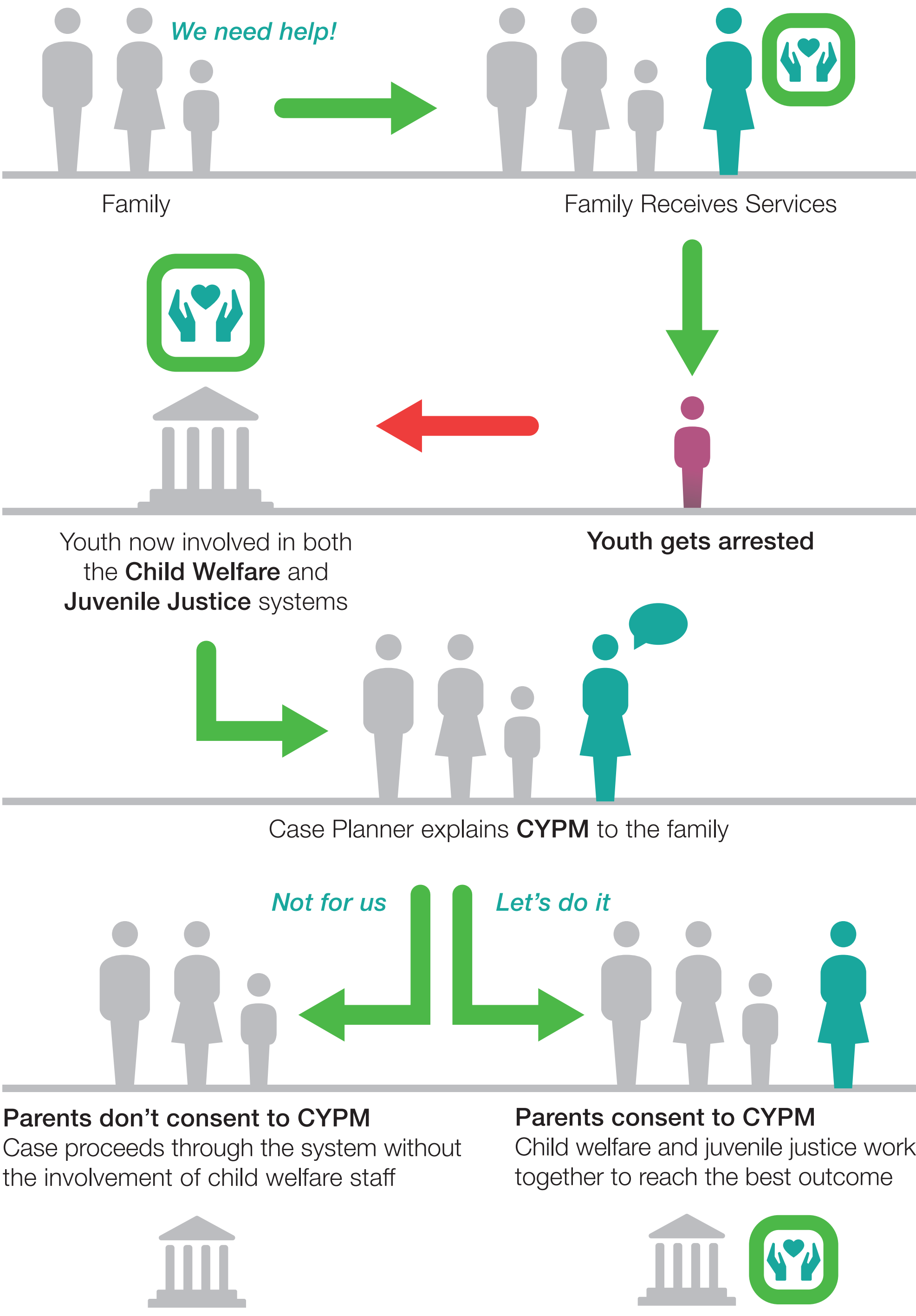
CYPM youth are young people **between 7 and 15** who are involved in an active child welfare case and become involved in the juvenile justice system following an arrest.

What Is the Benefit of CYPM?

CYPM exists because crossover youth have poor short- and long-term outcomes in a number of areas.

- In the juvenile justice system, crossover youth are perceived as riskier and more dangerous than children without child welfare involvement – and thus receive harsher penalties.
- Crossover youth are less likely to complete high school and more likely to experience severe mental health and addiction problems.
- Crossover youth run a greater risk of becoming homeless than their peers without dual involvement.
- Crossover youth tend to penetrate farther into both the child welfare and juvenile justice systems. Their needs are typically not well understood or addressed by the either system.

CYPM Illustrated

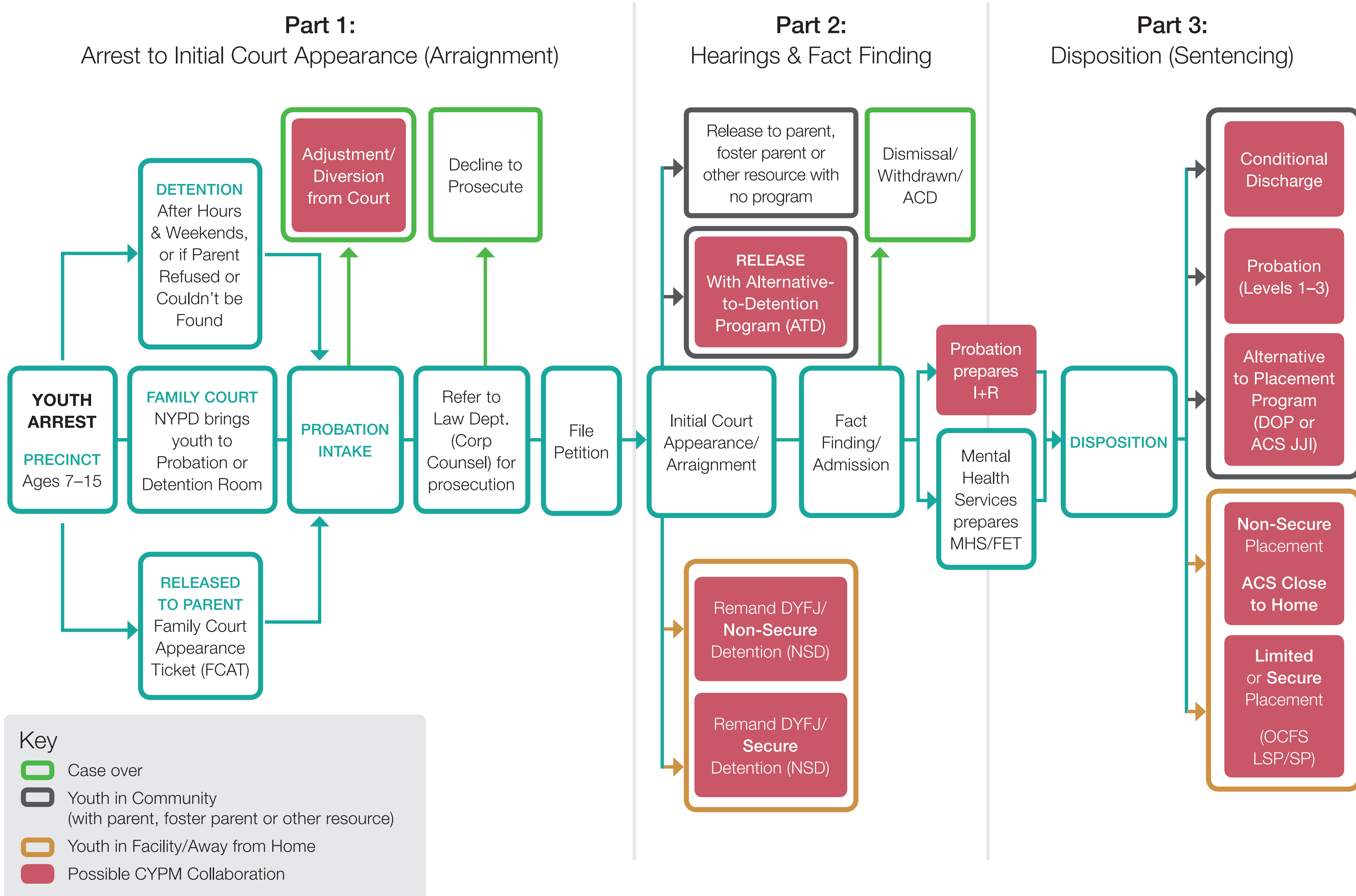


Juvenile Justice Case Flow

Fold out to view diagram

NYC Administration for Children's Services | ACS Workforce Institute | **The Crossover Youth Practice Model** A Guide to Working with Youth Involved in Both the Child Welfare System & the Juvenile Justice System

Juvenile Justice Case Flow



The Juvenile Justice Flow

Overview

As you can see on the flow diagram, the general Juvenile Justice flow with CYPM is not that different from the traditional one: The new aspects are highlighted.

If the family consents to participate in CYPM, the child welfare case planner will participate in the Adjustment Conference, the Investigation and Report Dispositional Planning Conference and any post-dispositional conferences convened by Juvenile Justice staff. Likewise, Juvenile Justice staff will participate in meetings and conferences convened by ACS and child welfare staff.

Arrest

When a youth (age 7 to 15) is arrested, there are **THREE** possibilities:

1. The police release the child to the parent(s) with a Family Court Appearance Ticket (FCAT).
2. The child is brought directly to Family Court and screened by a Probation Officer at **Probation Intake**.
3. The child is held overnight at a detention center because the arrest occurred after court hours and a parent could not be reached, or if the offense is serious.

Probation Intake

The first stop in the juvenile court process is **PROBATION INTAKE**. The child and the parent(s) are interviewed by an intake Probation Officer, who decides if the case is eligible for **ADJUSTMENT**.

In a CYPM case:
Following the arrest, the CONFIRM unit determines whether the youth has child welfare involvement and is eligible for CYPM. If the determination is made before Intake, the Case Planner is notified

and is involved in Probation Intake. In some instances, however, Probation Intake occurs on the day of the arrest, before the Case Planner has knowledge of it. When this happens, the Case Planner will need to get information from the family about what happened.

Adjustment

Adjustment is an alternative to the court process.

Instead of having the case go before a judge, a Probation Officer may decide if it can be settled another way. Many juvenile cases are **adjusted**, meaning they never actually go to court.

If the PO decides the case is eligible for adjustment, he/she schedules an **ADJUSTMENT CONFERENCE**. This is a meeting held at Probation and attended by the youth and family and any supportive adults the family wants to include. The PO will run the meeting. The youth and family are asked to speak about the circumstances of the arrest as well as the overall needs of the youth.

If the case can be adjusted, an ADJUSTMENT CONTRACT is created. This is a list of conditions that the youth must follow for a specified length of time, usually 2 to 4 months. The contract is signed by the PO, the youth and the parent(s)/guardian(s). If the youth follows all the conditions, the adjustment is considered a success and the case is closed. It doesn't go before a judge and doesn't go on the youth's record.

If the case can't be adjusted, or if the adjustment is unsuccessful, the PO will usually refer the case to Corporation Counsel for possible prosecution.

In a CYPM case:

In a CYPM case, there is one **critical difference**: If the youth and parents consent to CYPM, the Case Planner and other child welfare staff may share information with Probation, participate in the Adjustment Conference and collaborate in developing the Adjustment Contract.

This is important because the Case Planner, in most cases, already has an established relationship with the youth and family and has information to share, particularly about the family's strengths, that will shape and inform the adjustment process. The Case Planner may serve as a critical support to the family, guiding them through a process that can be difficult and frightening.

- The Case Planner's main task at this stage is to explain the juvenile justice process and CYPM to the youth and family. (In some cases, CYPM may be explained to the family by the PO at Probation Intake and the PO may also invite the family to sign the CYPM consent forms.)
- If the family and the youth agree to the CYPM process, the Case Planner proceeds to have them sign the CYPM Consent Form – which specifies precisely what information can and cannot be shared with juvenile justice personnel.
- Finally, the Case Planner attends and participates in the Adjustment Conference.

Section 2 addresses in detail how to explain CYPM to the youth and family, the nature of the Consent Form, and guidelines for sharing information.

If Adjustment Is Not Done or Fails…

When a case cannot be adjusted or when adjustment fails, Probation may refer it to **Corporation Counsel** for possible prosecution.

Corporation Counsel is the part of the city's Law Department responsible for, among other things, prosecuting juvenile offenses. [Crimes are called *offenses* in the juvenile system.] After conducting an investigation, Corporation Counsel has four options. It can:

- decline to prosecute
- send the case back to Probation for another try at Adjustment
- refer to one of their own diversion programs
- go forward with prosecution and file a petition with the Court

Petition Is Filed / Arraignment

If a petition is filed, the youth goes before a judge for **arraignment**, where the charges are read and the youth, via his/her attorney, enters a plea (usually "not guilty.") The judge then sets a date to begin fact finding. (A trial is called *fact finding* in the Juvenile system.)

The judge must decide at the arraignment where the youth will be until the next court date. There are five possibilities:

1. Release home.
2. Release home with participation in an Alternative-to-Detention (ATD) program.
3. Remand to non-secure detention (NSD).
4. Remand to secure detention (Horizon or Crossroads).
5. Remand open (facility to be determined by ACS Detention).

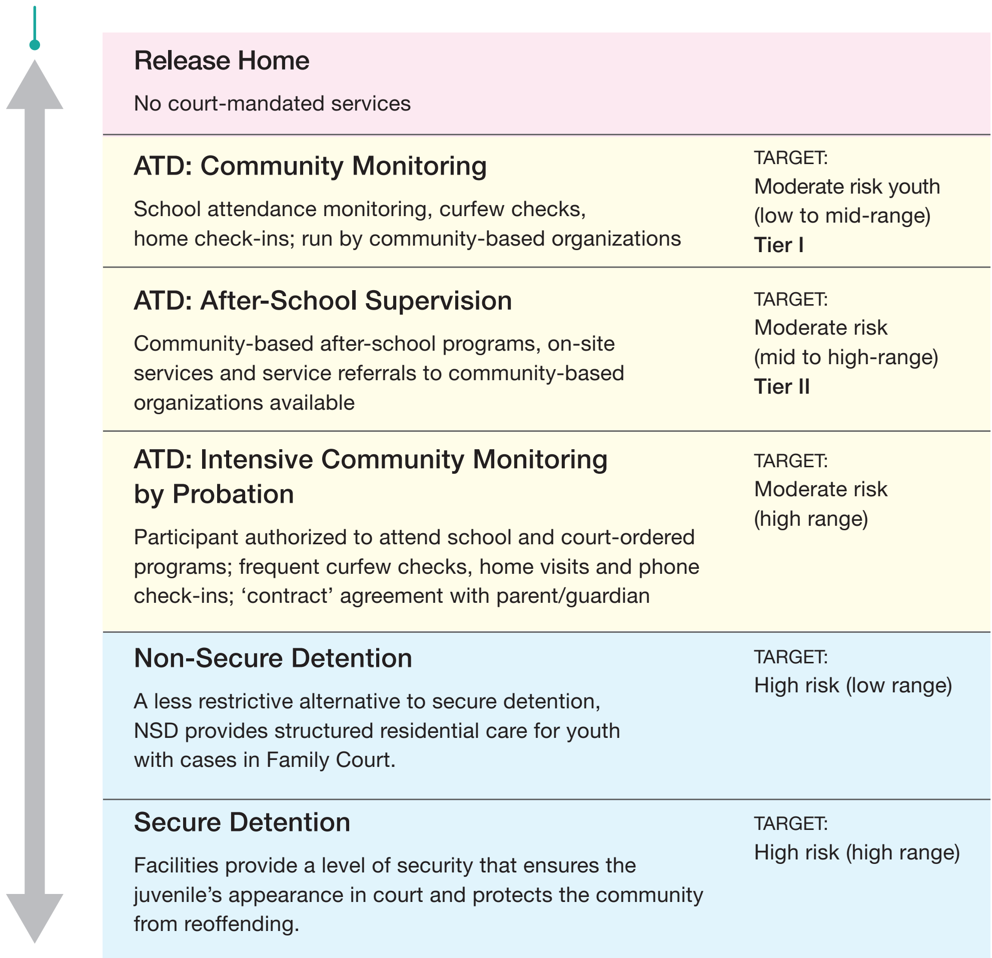
The Juvenile Justice Flow

Post-Arraignment

Detention and Alternative-to-Detention Options for Court-Involved Juveniles in New York City

If a youth is paroled at arraignment, or at any subsequent court appearance, he/she may be ordered by the judge to participate in one of several different Alternative-to-Detention programs during the pendency of the court case. Generally, youth who are evaluated as being 'low risk' are paroled without a court-ordered alternative. Youth deemed to be high risk are often remanded to a secure or non-secure detention facility. For assistance in locating a youth in detention, contact ACS MCCU at 212-442-7100.

Judge can move juveniles up and down the continuum based on performance



Plea

As in the adult system, most juvenile cases are resolved by plea agreement. Typically the youth's attorney discusses the case outside of court with Corporation Counsel and an agreement is reached. The youth makes an admission to one or more counts in the petition, waving his/her right to fact finding. The case is adjourned for disposition.

Fact Finding

When an agreement can't be reached, the case goes to fact finding, during which Corporation Counsel must prove beyond a reasonable doubt that the youth committed the offense(s) described in the petition. Both sides can call witnesses and present evidence. At the end of fact finding, the judge renders a decision.

If the allegations have not been proven, the petition is dismissed and the youth (called the "respondent" in the Juvenile System) is free to go (assuming there are no other cases pending).

If the judge decides that Corporation Counsel has proven one or more of the allegations in the petition, the case is adjourned for *disposition* (roughly equivalent to *sentencing* in the adult system).

Child welfare Meetings and Conferences

In a CYPM case:
ACS and other child welfare staff should proceed as before with regular family conferences and meetings, when necessary. If CYPM consents have been signed, Juvenile Justice staff should be invited to attend. Juvenile Justice staff will vary depending on the stage of the case. If Probation is currently involved in the case, the PO should be invited to attend. Likewise, if the youth is currently receiving Alternative-to-Detention (ATD) services, staff from the program should be invited.

If a child is currently in detention, the case worker from the facility should be invited.

The goals of the meeting/conference are to prepare and support the youth and family for the court process, to collaborate on service plans, and address immediate needs, including safety concerns.

Disposition: I&R and MHS

The judge may consider a variety of factors when arriving at a **disposition**, including the youth's school performance, behavior at home and in the community, past delinquency history, drug and alcohol use, and prior compliance with services. The judge may also consider the parent's ability to adequately supervise the youth. The judge must opt for the least-restrictive alternative that serves the interests of the youth and the community.

To help inform the disposition, the judge will order Probation to prepare an **Investigation and Report (I&R)**. This report will include background information on the youth and family and also contains Probation's dispositional recommendation.

The judge may also order a *Mental Health Study (MHS)*, which is a report by a psychologist on the youth and family. The psychologist also makes a dispositional recommendation.

Dispositional Planning Conference

In a CYPM case:
In CYPM cases, before a case goes to **Disposition**, Probation may convene a **Dispositional Planning Conference.** The Case Planner and other child welfare staff may be asked to contribute to the development of the I&R.

As previously stated, information shared should be strengths-based and relevant to the youth and family's current situation.

If CYPM consents were signed during the Adjustment phase of the case, they remain in effect. If not, the CYPM process and consents will have to be explained to the youth and parent(s), who should be encouraged to discuss CYPM with their attorneys.

Dispositional Options

Conditional discharge: Release without Probation or placement, but with specified conditions for a period of up to 12 months

Probation Supervision: Release with specified conditions and Probation monitoring for a period of 12 to 24 months; there are three levels of Probation supervision.

Alternative-to-Placement (ATP) Program: Mandated community-based services and supervision, occurring while youth is on Probation. Duration of ATP is approximately 6 months, after which the remainder of the Probation term must be completed

Non-secure placement (NSP): Placement outside the home in a small group-home setting in or near NYC. NSP is for up to 24 months on felonies and 12 months on misdemeanors. ACS Close to Home provides NSP via contracts with nonprofit agencies. Close to Home consists of 7 months of residential programming followed by a period of aftercare monitoring and services in the home for the remainder of the placement period.

Limited-Secure Placement (LSP): Medium-secure placement settings run by ACS where youth may be placed for up to 18 months, followed by a period of aftercare monitoring and services for the remainder of the placement period.

Post-Disposition

In a CYPM case:
If CYPM consents have been signed, the Case Planner should continue to work closely with Probation, alternative-to-placement, or placement staff until the dispositional requirements, including aftercare, are completed.

At minimum, collaboration should include monthly phone contact and invitations to meetings and conferences. The focus is on educational planning, coordinating services, re-establishing permanency, and preparing for the youth's return to the home.

In many respects, post-dispositional interventions are the most critical aspect of CYPM. Adjudicated youth, especially those placed away from home, often have difficultly maintaining strong links to family, friends and community resources. They are also likely to experience disruptions and setbacks in education. By attending to these and other areas of concern, including safety, child welfare staff can help ensure a smooth transition back into the community.

ACS Workforce Institute

The Crossover Youth Practice Model
A Guide to Working with Youth Involved in Both the Child Welfare System & the Juvenile Justice System

SECTION 2: CONSENT

Explaining CYPM and Adjustment

The CYPM Consent Form

Sharing Information

Explaining CYPM and Adjustment

Overview

For the CYPM process to proceed, it is important to explain CYPM to the family and the youth. In particular, it is important to use language the family can understand. Below is a “script” you may wish to use.

Script

Your child has been arrested and now you have to make some decisions about what’s going to happen next.

Your child’s case may go before a judge, but first the Department of Probation will decide if it can be settled outside of court. This is called Adjustment. If Probation decides that your child’s case can be adjusted, you and your child and anyone else you wish to invite will go to a meeting at Probation called an Adjustment Conference. You and your child will have a chance to discuss the arrest and also speak about how your child is doing overall.

At the end of the Adjustment Conference, the Probation Officer will set up some conditions that your child must follow for the next 2 to 4 months. This is called an Adjustment Contract. You and your child will be asked to sign the contract. If your child follows the conditions, Probation will close the case. If your child doesn’t follow the conditions, then the case may go before a judge.

It’s possible for me to go with you to the Adjustment Conference and share information with the Probation Officer, but I can’t do that without your permission. Everything I know about you and your child is confidential and I can’t share it unless you sign a consent saying it’s ok.

If you give me permission by signing the consent form, I can tell Probation more about you and your child. I can talk about all the things you and your child do well and ways we can build on those strengths. I can also talk

about some of the difficult experiences your child has gone through and how those experiences might be affecting his behavior now.

It's possible that something I say could be interpreted in a negative way. I don't think this will happen because I'm going to be very careful about what I choose to share. I'm going to focus on your strengths and talk about how we might help your child. Still, whatever is said in the Adjustment Conference cannot be used against your child later if the case goes before a judge.

You should think about this decision carefully and discuss it with your attorney. If you think you would like me to be involved, I'll go over the consent form with you.

Even if you give me permission to participate in this process, you are free to change your mind at any time. You are always free to withdraw your consent.

Do you have any questions about what I have said?

The CYPM Consent Form

Overview

The **CYPM consent form** is a six-page document. It is more complicated than most consent forms you may have used in the past. It requires the parent(s) and child to make decisions about what specific information can be shared and for what purpose.

The language on the consent form may be hard for some families to understand. For this reason, it is very important that youth and parents be encouraged to speak to their attorneys before consenting to participation in CYPM.

Warning!

It is a crime to share child welfare information without parental consent unless ordered to do so by a judge.

A blank consent form appears at the end of this section

Keep in Mind…

The consent form determines how much information, if any, the case planner and other child welfare staff can share with Probation and other stakeholders. There are no such constraints on the family, however. Parents and children are free to share what they wish, even in the absence of consents.

What If Only Some Parties Sign?

When the youth and parent(s) agree to sign the consent form, consent is straightforward. However there are other situations where things become more complicated.

- *If there are two parents, but only one signs the consent form:* Child welfare staff may not share information about the parent who did not sign. During the conference, however, both parents may freely choose to share information as they see fit.

- *If the youth refuses to sign the consent form:*
  If the parent (or parents) sign, but the youth does not, **child welfare staff may still share information**, but there are **limitations**. Information about the youth's mental health treatment, drug treatment, and reproductive health may not be shared without the consent of the child. Although the case should still be considered CYPM by child welfare staff, Probation will not proceed with a CYPM adjustment conference without the child's consent.
- **If neither parent signs the CYPM Consent Form it is not a CYPM case.** No information can be shared and Child Welfare and Juvenile Justice do not attend each other's conferences.
- Remember that in Foster Care/Trial Discharge Cases, the **biological parent(s**) must sign the consent form in order for the CYPM process to proceed unless parent's rights have been terminated.

Sharing Information

Overview

EVEN IF CONSENTS HAVE BEEN SIGNED, YOU MUST **USE CAUTION WHEN SHARING INFORMATION**.

You must balance the **right** to share with the **need** to share!

Guide to Sharing…

- Only share information that is relevant to the issues at hand.
- Maintain a strengths-based perspective at all times. Remember that you are sharing information in order to help the youth and family.
- Carefully consider who is asking for the information and how the information may be used.
- When in doubt about what is appropriate to share, get advice from your supervisor, the FCLS attorney or the CYPM champion in your agency.

CROSSOVER YOUTH CONSENT FORM

CROSSOVER YOUTH CONSENT TO SHARE CONFIDENTIAL INFORMATION:

This form is designed to be used by agencies that collaborate with one another to plan, coordinate and deliver services to crossover youth[1] and their families.

Please read this consent form carefully and, if you have a lawyer, consult with him/her before signing. Your child should also consult with his/her attorney(s) before signing this form.

You are being asked to sign this form because your child was recently arrested and your family has an open child welfare case. To decide the most appropriate services for your child as s/he goes through the court process, child welfare and juvenile justice would like to discuss how the systems can work together to coordinate services.

Information sharing between agencies cannot happen without your consent. If your child consented to certain treatment including mental health, substance abuse or alcohol treatment, only your child can consent to the release of this treatment information. If you (or your child) choose not to sign this form, it will not affect your child's delinquency case. The delinquency case will go forward, but there will not be ongoing communication between providers unless ordered by the court.

PART 1: WHY THE INFORMATION IS BEING SHARED

The sharing of this information is intended to help coordinate between the different agencies serving the child and family and to identify the most appropriate course of action. The goal is to make sure that the services and tasks will meet the child's needs and are not conflicting with referrals that have already been made. The information will be shared to coordinate services for the youth being discussed.

PART 2: WHO CAN RECEIVE THE INFORMATION

I agree that information will be shared and discussed among the NYC Department of Probation (DOP), the NYC Administration for Children's Services (ACS), the foster care and/or preventive services agencies listed here, any Alternative to Detention program, Alternative to Placement Program, or Secure, Limited Secure, and Non Secure Placement provider, DYFJ Detention and any other persons listed here (all individuals, parties, programs and/or agencies, except for DOP and ACS, must be specified here):

PART 3: WHAT INFORMATION CAN BE SHARED

JUVENILE JUSTICE INFORMATION

The following information about my child's delinquency case may be shared with ACS and the agencies and persons named above (*check all that apply*):

☐ Facts surrounding my child's most recent arrest, if relevant

☐ My child's education records (select applicable records)

☐ School enrollment history

[1] "Crossover youth" means a youth who is involved in both the child welfare and juvenile justice systems.

Page **1** of **6**

☐Attendance record

☐Academic record

☐Special education classification, if applicable

☐Other:

☐ Compliance with probation, ATD compliance/attendance, or ATP compliance/attendance

☐ Other information, specified here:

ACS & FOSTER CARE/PREVENTIVE AGENCY INFORMATION

During the juvenile delinquency case, ACS and the foster care/preventive agencies may share the following information about my child with DOP and the agencies and persons specified in Part 2 above (*check all that apply*):

☐ Indicated SCR reports involving this child (except that any information regarding the source of the report shall be redacted)

☐ Foster care information, including:

☐ Service plan

☐ Participation in Services (excluding information relating to parties other than myself and my child)

☐ Permanency and planning goal

☐ Child's current and prior placement history

☐ Court dates and procedural history of child welfare case

☐ Allegations, findings, dispositional orders and other orders

☐ Information about preventive services being provided (excluding information relating to parties other than myself and my child), including (*write in services)*:

☐ My child's education records (*select applicable records)*:

☐ School enrollment history

☐ Attendance record

☐ Academic record

☐ Special education classification, if applicable

☐ Other

☐ My child's mental health information, including diagnosis, current treatment information, medications. (*If the child consented to the mental health treatment, only the child can consent to the release of mental health treatment information.)*

☐ My child's substance abuse or alcohol treatment information, including diagnosis, current treatment information, medications. (*If the child consented to the substance abuse or alcohol*

CROSSOVER YOUTH CONSENT FORM

treatment, only the child can consent to the release of substance abuse or alcohol treatment information.)

OTHER AGENCIES WITH INFORMATION TO SHARE

The other agencies specified in Part 2 above who are involved in the delinquency case may share the following information about my child with DOP, ACS and the foster care/preventive agencies and other meeting participants named above (*check all that apply and specify the agency permitted to share the information*):

☐ Department of Education: Education records, specified here:

☐ Mental health services provider: Mental health information about my child including diagnosis, current treatment information, medications. (*If the child consented to the mental health treatment, only the child can consent to the release of mental health treatment information.)*

☐ Substance abuse or treatment provider: My child's substance abuse or alcohol treatment information including diagnosis, current treatment information, medications. (*If the child consented to the substance abuse or alcohol treatment, only the child can consent to the release of substance abuse or alcohol treatment information.)*

☐ Other information, specified here (include name of agency/organization providing information):

PART 4: HOW THE INFORMATION CAN BE USED

The information to be shared is limited in the following ways:

(*Fill this part in if, for example, the information should be limited to certain time periods or certain services. If no such limitations are needed, indicate "no limitations".*)

PART 5: WHEN DOES CONSENT END

This consent ends when the Delinquency case is dismissed by the Court or upon the completion of dispositional services.

I understand that I can terminate this consent at any time by completing the attached form and mailing it to the address provided. I also understand that records shared before this consent is terminated may not be returned.

PART 6: RE-DISCLOSURE

I agree that my child will participate in the following services and activities:

Page **3** of **6**

CROSSOVER YOUTH CONSENT FORM

To put this plan into place, I agree that information may be shared with the following persons/agencies:

The following information shall not be shared: (*Child welfare personnel cannot guarantee that information shared will remain confidential. ACS cannot limit re-disclosure that may be permitted by law or contract.)*

PART 7: CONSENT

I understand that state and federal law prohibit persons that receive child welfare, mental health, alcohol or drug abuse, and education records from re-disclosing those records without permission. I also understand that information will only be shared as described in this form.

Any information that the child him/herself has the right to keep confidential under Federal and State law and regulations will not be shared without the child's written consent. (Examples are records related to sexual and reproductive health, HIV and AIDS-related information.) The child should consult with his/her attorney before consenting.

***Child welfare personnel cannot guarantee that information shared will remain confidential. ACS cannot limit disclosure that may be required by law or contract.**
Information from this meeting will be documented in the case record, and it may be used for case planning, in subsequent court proceedings, and in the investigation of a new allegation of abuse or maltreatment should such information arise.

Parent/Guardian			
Relationship to child			
Child's name			
Child's date of birth			
Signature of Parent/ Guardian		Date	
Signature of Child *(If your child consented to certain treatment including mental health, substance abuse or alcohol treatment, only your child can consent to the release of this treatment information.)*		Date	

Page **4** of **6**

CROSSOVER YOUTH CONSENT FORM

IMPORTANT CROSSOVER CONTACTS			
Probation Officer		Phone	
Probation Supervisor		Phone	
ACS/Agency Contacts		Phone	
Other Contacts		Phone	

TERMINATION OF CONSENT

Should only be completed when parent or child is withdrawing consent

By signing this form I am saying that I no longer want ACS, any ACS contracted Agency and the Department of Probation to share information with each other regarding my child's criminal case or my child welfare case.

If your child consented to the sharing of certain treatment information, including mental health, substance abuse or alcohol treatment, only your child can terminate consent to share this information.

This information should be mailed to:

Name		Contact Information	
Name		Contact Information	

BY SIGNING THIS FORM I AM TERMINATING MY CONSENT TO SHARE THE FOLLOWING INFORMATION, EXCEPT WHEN DISCLOSURE IS PERMITTED BY LAW:

JUVENILE JUSTICE INFORMATION

☐ Facts surrounding my child's most recent arrest

☐ My child's education records (select applicable records)

- ☐ School enrollment history
- ☐ Attendance record
- ☐ Academic record
- ☐ Special education classification
- ☐ Other:

☐ Compliance with probation, ATD compliance/attendance, or ATP compliance/attendance

☐ Other information, specified here:

ACS & FOSTER CARE/PREVENTIVE AGENCY INFORMATION

Page **5** of **6**

CROSSOVER YOUTH CONSENT FORM

☐	Indicated SCR reports involving this child
☐	Foster care information, including: ☐ Service plan ☐ Service participation (excluding information relating to parties other than myself and my child) ☐ Permanency and planning goal ☐ Child's current and prior placement history ☐ Court dates and procedural history of child welfare case ☐ Petitions, findings, dispositional orders and other orders ☐ All of the above
☐	Information about preventive services being provided to my family that involve my child,:
☐	My child's education records (*select applicable records)*: ☐ School enrollment history ☐Attendance record ☐Academic record ☐Special education classification ☐Other: ☐ All of the above
☐	My child's mental health information, including diagnosis, current treatment information, medications. *(If the child consented to the sharing of mental health treatment information, only the child can terminate consent to share this information.)*
☐	My child's substance abuse or alcohol treatment information, including diagnosis, current treatment information, medications. (*If the child consented to the sharing of substance abuse or alcohol treatment information, only the child can terminate consent to share this information.)*

Parent/Guardian name			
Relationship to child			
Child's name			
Child's date of birth			
Signature of Parent/Guardian		Date	
Signature of Child *(If your child consented to sharing certain treatment information, including mental health, substance abuse or alcohol treatment, only your child can terminate consent to share this treatment information.)*			

Page **6** of **6**

ACS Workforce Institute

The Crossover Youth Practice Model
A Guide to Working with Youth Involved in Both the Child Welfare System & the Juvenile Justice System

SECTION 3: CASE PLANNER RESPONSIBILITIES

Court-Ordered Supervision

Foster Care/Trial Discharge

Preventive

Court-Ordered Supervision

Responsibilities

1. **Notification**: CONFIRM notifies child welfare staff of a youth's arrest and probation intake. Depending on the status of the case, this may include DCP, FSU, and/or DPS and preventive provider. CONFIRM also notifies FCLS, and (if the youth is in detention) ACS MCCU. The FSU Case Manager or preventive case planner notifies the youth's family. FCLS notifies the youth's and parent's attorneys.
2. **Attend all court appearances**: the FSU Case Manager will attend all court appearances on both the delinquency and the neglect matters.
3. **Discussion with the family following arrest**: After CONFIRM notifications, the Case Planner discusses the circumstances of the arrest, the Adjustment process, CYPM, and the signing of consents with the family. The family should also be asked for information about Probation Intake if the Case Planner was not in attendance.
4. **CYPM Adjustment Conference**: Many juvenile cases are diverted from court in the Adjustment process. If the youth's case is eligible for Adjustment, Probation will convene an Adjustment Conference. If CYPM consents have been signed, the Case Planer attends the conference, along with the youth, family, FCLS attorney, other child welfare staff (if involved), and possibly the youth's and parent's attorneys. If CYPM consents have not been signed, child welfare staff will not attend the conference and will not share information.
5. **CYPM Family Meeting**: If a case cannot be adjusted, or adjustment fails, Probation may refer the case for possible prosecution. After a case is filed, but before fact finding has occurred, a CYPM Family Meeting is held to plan for the court process, coordinate service

plans, and assess the youth's needs. If CYPM Consents have been signed, participants include the youth and family, FCLS, and youth's and parent's attorneys, as well as Probation (if the youth is in the Probation ICM program), ATD provider or the detention caseworker (if the youth is in detention). If CYPM consents have not been signed, no juvenile justice staff will be present.

6. **Participation in the creation of the Investigation and Report (I&R)**: If a case is filed and the youth is found to have committed one or more offenses, the judge will order Probation to prepare an I&R before going to disposition. If CYPM consents have been signed, or if the judge orders it, the Case Planner and other child welfare staff may participate in the creation of the I&R.
7. **Post-Dispositional Collaboration and Planning**: Child welfare and juvenile justice staff continue to collaborate on CYPM cases until the requirements under the dispositional order are completed. For youth who receive a disposition of Probation, alternative-to-placement, or placement/aftercare, the Case Manager will work closely with juvenile justice staff to address educational and safety concerns, increase parental capacity, coordinate services and strengthen the youth's ability to regulate his/her behavior.

   At minimum, the Case Manager should make contact with juvenile justice partners on a monthly basis. Formal meetings should be convened prior to court appearances, when there are significant changes in family circumstances, and when the youth transitions from or within from an ATP program, Probation, placement or aftercare.

Foster Care / Trial Discharge

Responsibilities

1. **Notification**: CONFIRM notifies child welfare staff of a youth's arrest. CONFIRM also notifies FPS, FCLS, the Probation Intake Officer, and (if the youth is in detention) ACS MCCU and Corporation Counsel. The foster care agency notifies the youth's family and the foster parent. FCLS notifies the youth's and parent's attorneys.
2. **Attend Probation Intake and all court appearances**: the Case Planner will attend Probation Intake as well all court appearances on both the delinquency and the neglect matters
3. **Discussion with the family following arrest**: After CONFIRM notifies the foster care agency of the youth's arrest and potential CYPM status, the Case Planner discusses the circumstances of the arrest, the Adjustment process, and CYPM and the signing of consents with the family.
4. **CYPM Adjustment Conference**: Many juvenile cases are diverted from court in the Adjustment process. If the youth's case is eligible for Adjustment, Probation convenes an Adjustment Conference. If CYPM consents have been signed, the Foster Care Case Planner attends the conference, along with the youth, family, foster parent, FCLS attorney, other child welfare staff (if involved) and possibly the youth's and parent's attorneys. If CYPM consents have not been signed, child welfare staff will not attend the conference and will not share information.
5. **CYPM Family Team Conference**: If a case cannot be adjusted, or adjustment fails, Probation may refer the case for possible prosecution. After a case is filed, but before fact finding has occurred, the Case Planner should convene a CYPM Family Team Conference to plan for the court process, coordinate service plans,

and assess the youth's needs. For youth who are in detention, the Case Planner will schedule the conference through FPS, and an FPS facilitator will lead the conference.

6. **Participation in the creation of the Investigation and Report (I&R)**: If a case is filed and the youth is found to have committed one or more offenses, the judge will order Probation to prepare an I&R before going to disposition. If CYPM consents have been signed, or if the judge orders it, the Case Planner may participate in the creation of the I&R. When consents have not been signed, Probation may ask the Case Planner for a written summary of the case.

7. **Post-Dispositional Collaboration and Planning**: Child welfare and juvenile justice staff continue to collaborate on CYPM cases until the dispositional order, including aftercare, is completed. For youth who receive a disposition of Probation, alternative-to-placement, or placement, the Foster Care Case Planner works closely with juvenile justice staff to address safety and educational concerns, increase parental capacity, coordinate services and strengthen the youth's ability to regulate his/her behavior.

   At minimum, the case planner should make contact with juvenile justice partners on a monthly basis. Formal meetings should be convened prior to court appearances, when there are significant changes in permanency goals or circumstances, and when the youth transitions from or within an ATP program, from Probation, placement or aftercare.

Preventive

Responsibilities

1. **Notification**: After a youth's arrest, CONFIRM notifies the preventive agency, Child Protective Services (if there is an open investigation), and ACS MCCU if the youth is in detention.
2. **Discussion with the family following arrest**: After CONFIRM notifies the preventive agency of the youth's arrest and potential CYPM status, the Case Planner discusses the circumstances of the arrest, the Adjustment process, and CYPM and the signing of consents with the family. The family should also be asked for information about Probation Intake if the Case Planner was not in attendance.
3. **Elevated Risk Conference (ERC):** The Case Planner determines if an ERC is needed, based on the circumstances of the arrest, assessment of safety issues, and conversations with the family.
4. **24-Hour Report:** Within 24 hours of being notified by CONFIRM, the Case Planner files the CYPM 24-Hour Report with the ACS Division of Preventive Services (DPS).
5. **CYPM Adjustment Conference**: Many juvenile cases are diverted from court in the Adjustment process. Probation convenes the Adjustment Conference to see if this is possible. If CYPM consents have been signed, the Case Planner and other child welfare staff (if involved) attend the Adjustment Conference and collaborate on the Adjustment Contract.

   If the Adjustment Conference was held without the Case Planner's participation, the Case Planner should obtain a copy of the Adjustment Contract, either from the family or from Probation, in order to help the youth successfully complete the conditions of Adjustment.

6. **CYPM 7-Day Report**: Seven days after CONFIRM notification, the Case Planner submits the CYPM 7-Day Report to DPS.
7. **Participation in the creation of the Investigation and Report (I&R)**: If Adjustment is not possible or fails, the case may be referred for prosecution. If a case is filed and the youth is found to have committed one or more offenses, the judge may ask Probation to prepare an I&R before going to disposition. If CYPM consents have been signed, the Case Planner may participate in the creation of the I&R.
8. **Post-Dispositional Collaboration and Planning**: Child welfare and juvenile justice staff continue to collaborate on CYPM cases until all requirements of the dispositional order have been completed. For youth who receive a disposition of Probation, alternative-to-placement, or placement, the Case Planner works closely with Juvenile Justice staff to address safety and educational concerns, increase parental capacity, and strengthen the youth's ability to regulate his/her behavior.

   At minimum, the Case Planner should make contact with Juvenile Justice partners on a monthly basis. Formal meetings should be convened prior to court appearances, when there are significant changes in family circumstances, and when youth transition from or within an ATP program, Probation, placement or aftercare.

Preventive

The Elevated Risk Conference

An Elevated Risk Conference (ERC) may be convened at any stage at which safety is an issue.

In some instances, such as after a very minor arrest (turn-style jumping, for example), an ERC may not be necessary. If, however, the case planner feels that an arrest may raise safety concerns or result in the youth's further involvement in either the child welfare or juvenile justice systems, an ERC should be convened.

If CYPM consents have been signed, the case planner should invite Probation or other Juvenile Justice partners to attend the ERC and participate in the development of a coordinated service plan.

APPENDIX

Glossary of Child Welfare and Juvenile Justice Terms

Case Planner Checklist

Parent Checklist

Youth Checklist

Appendix

Glossary of Child Welfare and Juvenile Justice Terms

18B Panel Attorney

An attorney approved by the Appellate Division of the Supreme Court to represent indigent adults and/or children in certain family court proceedings.

Adjournment

An order to postpone court activity to another date.

Adjournment in Contemplation of Dismissal (ACD)

Upon agreement of the court and all parties, an adjournment of the proceedings with specified conditions before a finding is made. The proceedings are adjourned for a period not to exceed 6 months for a delinquency case and up to one year for a child protective case. The matter is automatically dismissed at the end of the period unless some occurrence during the adjournment necessitates the matter be reconsidered by the court, e.g. violation of the ACD conditions. If the court determines after a hearing that a violation of the ACD has occurred, the original matter is restored to the court's calendar and proceeds to fact-finding.

Adjudication

A case has been adjudicated when the court has made a final decision about the allegations in the petition. The adjudication of a child as a juvenile delinquent or a person in need of supervision (PINS) can only be made if the child is found: 1) to have committed the acts alleged in the petition, and 2) to need supervision, treatment or confinement as a juvenile delinquent or to need supervision or treatment as a PINS.

Adjustment

The process by which Probation may divert cases from court prior to the filing of a petition. The out-of-court resolution may involve referral to community services.

Adjustment Conference

A conference held by Probation, with the participation of the youth and parent/guardian, to decide whether or not to divert the case from court prior to the filing of a petition.

Administration for Children's Services (ACS)

The New York City agency responsible for planning, provision and oversight of child welfare services, including protective services, purchased preventive services, early childhood education and foster care placement. The agency administers juvenile justice programs, including community-based alternatives and confinement.

Aftercare Services

Supervision provided to young people after their release from placement.

Alternative to Detention (ATD)

Mandated community-based services and supervision pending fact finding, issued to respondents by the court in lieu of juvenile detention.

Alternative to Placement (ATP)

Mandated community-based services and supervision issued as a dispositional alternative to juvenile justice placement, youth in ATP programs and also on Probation.

Arraignment (Initial Court Appearance)

The initial court appearance by the respondent; in family court referred to as the intake court hearing.

Attorney for Child

An attorney admitted to practice law in the state of New York and designated under the Family Court Act to represent minors in child welfare and delinquency cases.

Close to Home (CTH)

See Non-Secure Placement (NSP) and Limited-Secure Placement (LSP).

Conditional Discharge

A release without probation or placement but with specified conditions for a period of up to one year.

Confirm

The unit within the Administration of Children's Services responsible for the identification and support of crossover youth.

Appendix

CONNECTIONS (CNNX)

The electronic record-keeping system for child welfare services, including protective, preventive, foster care, adoption, and non-secure placement services in New York State.

Corporation Counsel (Law Department)

The City attorney's office that prosecutes delinquency cases.

Court-Ordered Supervision

An order from the Family Court on a Child Abuse or Neglect Proceeding requiring ACS to monitor the family at home, usually for a period of twelve months.

Crossover Youth

A young person up to age 21 who is involved in the child welfare system and crosses over into the juvenile or criminal justice system by getting arrest. The youth is then involved in both systems. Such a youth may also be referred to as "dually involved."

Child Welfare and Juvenile Justice staff may collaborate and share information if the youth and parent(s) have signed the CYPM consent form or if information sharing is ordered by a judge.

Crossover Youth Practice Model

The protocols developed by Georgetown University's Center for Juvenile Justice Reform in collaboration with Casey Family Programs. CYPM stresses coordination and information sharing between child welfare and juvenile justice systems.

CYPM Youth

Young people, age 7 to 15, who have been arrested on a delinquency charge while they have an active foster care, child protection or preventive case.

Department of Probation (DOP)

The NYC agency responsible for intake, adjustment and supervision of juvenile delinquency cases. Probation also prepares the Investigation and Report (I&R) prior to disposition on a delinquency matter.

Detention
Temporary confinement. Youth charged with delinquent acts may be held pending disposition in secure or non-secure detention facilities operated by ACS or a contracted agency.

Dismissal
Action by the judge that removes a given case from court prior to adjudication.

Disposition
The court decision, once a finding of fact has been made in a case.

Dispositional Hearing
A hearing held after a finding of fact is made by the court that the respondent(s) has committed the act, or acts, alleged in the petition. In a delinquency case, at a dispositional hearing, the judge makes a decision on the required level of supervision, treatment or confinement for the youth. Similar to "sentencing" in an adult criminal case. In a Child Abuse or Neglect case, at a dispositional hearing the judge makes a decision about what is in the best interest of the child and whether placement of the child in foster care is warranted. The court may also order services to address the issues that brought the case to Family Court.

Division of Preventive Services (DPS)
The Division of Preventive Services, formerly known as Family Support Services (FSS) provides Preventive Services and support to families throughout New York City, through a network of community-based, non-profit organizations and family home care services. These services are designed to strengthen and stabilize families, prevent the need for out of home care, expedite permanency and prevent the replacement of children into foster care. In addition, the division provides policy guidance to ACS staff and preventive provider agencies working with children and youth with a variety of educational, medical, mental health and developmental challenges.

Division of Child Protection (DCP)
The division of ACS charged with investigating allegations of child abuse and maltreatment. The division administers investigative units, case management services, and links families to preventive services in their communities.

Appendix

Division of Youth and Family Justice (DYFJ)

The division of the ACS that oversees services and programs at every stage of the juvenile justice process. DYFJ provides therapeutic treatment, custodial care, health care, reentry and educational services to youth involved in the juvenile justice system in New York City.

Elevated Risk Conference (ERC)

Conferences available for all preventive cases that are designed to prevent potential harm to children when a family situation or event poses an increased risk to the safety or stability of the child. These conferences are typically facilitated by specialists from the ACS Division of Preventive Services (DPS), formerly known as Division of Family Support Services (FSS).

Fact Finding (Trial)

A hearing to determine whether the respondent or respondents committed the acts alleged in the petition.

Family Court

The New York State court that deals with the problems of children and families. It has jurisdiction to hear cases including abuse and neglect of children, adoption, custody and visitation, family offenses including abuse of spouses and other family members, youth who may have committed crimes or are in need of supervision, support, and foster care review.

Family Court Legal Services (FCLS)

The legal division at Children's Services comprised of attorneys and other social service and support staff responsible for representing the Administration for Children's Services in Family Court.

Family Permanency Services (FPS)

The Children's Services division that oversees all children in out-of-home care. Office includes: Office of Family Permanency Team Conferencing; Office of Youth Development; Office of Adoption Services; Office of Parent Support and Recruitment, and the FPS Shared Response Team.

Family Service Unit (FSU)

The unit within ACS Division of Child Protection that administers case-management services in cases when a New York State Family Court Judge orders court-ordered supervision for a family.

Family Team Conference (FTC)

Family Team Conferences represent a process for engaging family, community members, foster parents and relative caregivers in critical decisions related to safety, placement (preservation), child well-being and permanence.

Finding

A legal determination made by a judge as to whether the attorney who brought the case to court has proven the allegations based upon the required quantum of evidence and/or admissions.

Foster Care (Child Welfare)

Court-ordered (pursuant to Family Court Act Article 10-C) or voluntary placement (pursuant to Social Services Law Section 384-a) outside of the home with ACS provided in a variety of settings along a continuum of care.

Guardianship

The formal legal arrangement that grants an adult the right to act on behalf of a child.

Intensive Community Monitoring (ICM)

A tier of community monitoring by the NYC Department of Probation that engages parents and guardians.

Investigation & Report (I&R)

For a delinquency case, the report made by DOP after a finding of fact, pursuant to a court order and used to assist the judge at disposition. The report may include such things as previous conduct, family situation, psychological and psychiatric reports, school records and previous social assistance by other agencies. The report indicates DOP's assessment of the respondent and determination of the likelihood of rehabilitation and may include an exploration of treatment plans within the community and/or placement resources.

Appendix

Juvenile Delinquent (JD)

A person at least seven years of age and less than sixteen years of age who commits an act that if done by an adult would constitute a crime. Defined in Article 3 of the Family Court Act.

Law Guardian

See Attorney for Child

Legal Aid Society

A private, not-for-profit, legal services organization that provides representation to New Yorkers. The Legal Aid Society's Juvenile Rights Practice represents 90 percent of children who appear before the Family Court in New York City on child protective, termination of parental rights, PINS (person in need of supervision) and juvenile delinquency petitions.

Limited Secure Placement (LSP)

Medium secure settings where adjudicated delinquents are placed at disposition for up to 18 months. Operated by ACS Close to Home.

Mental Health Study (MHS)

A comprehensive assessment conducted at a Family Court clinic by a psychologist and/or psychiatrist after finding of fact and pursuant to a judicial order; used to assist the judge at disposition. In some orders, an alternate term, FET (Full Evaluation & Testing), is used.

Movement Control and Communications Unit (MCCU)

A unit within the Division of Youth and Family Justice Detention Services, responsible for tracking and monitoring, in real time, the census and movement of youth in the secure and non-secure detention systems.

New York State Office of Children and Family Services (OCFS)

The state agency responsible for regulating and monitoring child welfare and juvenile justice services in New York State. Directly provides Secure placement.

Non-Secure Placement (NSP)

Small group home settings in or near NYC where adjudicated delinquents are placed at disposition for up to 18 months. In NYC, ACS Close to Home provides NSP by contracting with different nonprofit agencies. Close to Home is designed to provide residential programming for up to 7 months and then provide aftercare monitoring and service in the home for the duration of the placement period.

Parole

The release of a respondent to the custody of a parent, legally responsible person or other adult.

Permanency Planning Hearing

A hearing involving a child in child welfare foster care or NSP, court ordered or voluntary, to establish time frames for the return of the child to his/her home or other permanency arrangement, including adoption. A PPH is held at least once every six months and reviews the efforts made by the ACS and foster care agencies to provide a permanent home for children.

Petition

The formal court document or pleading which initiates a proceeding in family court, setting forth the alleged grounds for the court to take jurisdiction of the case.

Placement

In a Delinquency case, transfer of custody to an agency or individual for the purpose of providing out-of-home care for an initial period not to exceed 12 months for misdemeanor findings and not to exceed 18 months for felony findings. In a child protective case, the term placement is often used to refer to foster care placement (see Foster Care- Child Welfare)

Preventive Case

Preventive cases are designed to ensure that children remain in the home and are prevented from entering foster care. An ACS caseworker might recommend preventive services as a result of a child protective investigation.

Appendix

Preventive Services

Community-based, family-oriented supportive and rehabilitative services whose goal is to prevent placement of children or facilitate the reunification of families. Services include counseling, parenting skills training, substance abuse treatment and a continuum of evidence-based treatment options.

Probation

Dispositional order on a JD case that allows for the youth to remain in the community with supervision by the Department of Probation (DOP), which may include specified conditions for an initial period not to exceed two years.

Probation Intake

The probation intake process is triggered by the arrest of a young person under the age of 16. After an arrest, every young person is interviewed by an intake officer from DOP about the circumstances of the arrest, their school attendance, their living situation, etc. The intake officer also interviews the arresting officer, the complainant/victim of the arrest (when available), and the parents or caretakers of the young person. Based on information gathered during this intake process, DOP determines whether the case should be referred for formal court proceedings or held open for adjustment services.

Referral for Prosecution

A recommendation stemming from the Probation Intake process, that a case should be reviewed by the Corporation Counsel for prosecution. Cases that are not adjusted by DOP are forwarded to Corporation Counsel.

Remand

In a delinquency case, a temporary placement order by the judge that a child be kept at a detention facility while awaiting a hearing. Occurs when the judge determines that there is probability that respondent will not appear in court and/or there is serious risk that other delinquent acts may be committed. In a child protective case, a temporary placement order by the judge that a child be kept in ACS custody, i.e. in foster care. Occurs when the judge determines there is a probability that the child would be in imminent risk if left with the parent.

Respondent

The person against whom the petition is brought.

Risk Assessment Instrument (RAI)

A tool used by Probation at the initial court appearance (arraignment) to guide the judge's decision about remand or parole. The tool weighs two factors: the likelihood that the youth will commit another crime and the likelihood that the youth will not come to court for future court appearances.

Trial Discharge

After a time spent in foster care, a youth may be permitted to return home on a trial discharge, a period that typically lasts three months during which the child legally remains in foster care, and case planners monitor the family to ensure that the child is safe and that the conditions of a discharge plan are being followed. The court may intervene and extend the amount of time a youth is on trial discharge. After the completion of a successful trial discharge, a final discharge can occur and the youth is no longer in foster care and the parent is no longer under the supervision of ACS or the foster care agency.

CYPM CHECK LIST
For Case Planner

Review these questions to help you think about what is the best plan and intervention best for this youth.

- ✓ What friends and family members are supportive of the youth? Is the youth visiting or in touch with these family and friends?
- ✓ Where is the youth living? Does the youth feel this setting is a safe an appropriate place? Where or in what type of place would the youth like to live?
- ✓ Is the youth enrolled in school? If not, why not? If yes, is this the right school setting?
- ✓ What things does the youth like to do? Have we signed them up for pro-social activities that they are interested in?
- ✓ Is this the first arrest?
- ✓ Where did the arrest take place? Who were they with? Who did they reach out to for help?
- ✓ If the youth is in detention, where will s/he go if released?
- ✓ If so, what service plan can be put in place so s/he can be released?
- ✓ If not, what services can be put in place to help the youth abide by court orders in the community?

Court Reminders

Next Court Dates: ______________________________ Court Location: ______________
______________________________ Court Location: ______________

FCLS Lawyer ______________________________ Phone: ____________________
Youth's Lawyer ______________________________ Phone: ____________________
Probation Officer ______________________________ Phone: ____________________

What services does the youth have to complete?

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____
____

- ✓ Attend all court appointments and hearing with the youth!
- ✓ Involve any Juvenile Justice partner in all planning meetings

CYPM CHECK LIST
For Parent/Guardian

Review these questions to help you think about what is the best plan and intervention best for your child.

- ✓ Where is your child living? Is that where you want your child to live?
- ✓ Is your child enrolled in school? Do you think your child is getting appropriate support in school?
- ✓ Do you know your child's friends and where they hang out outside of school?
- ✓ What friends and family members are good influences on your child? Does your child have access to those people?
- ✓ What activities does your child like to do and are they signed up to participate in those activities?
- ✓ Are there other services that you think your child might benefit from?

Important Stuff:

Case planner ______________________ Phone: ____________

Lawyer ______________________ Phone: ____________

Probation Officer ______________________ Phone: ____________

Does my child have a court date? _____ When: ________ Where: __________

Does my child have to complete any services? _____ List details below

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Appendix

CHECK LIST
For CYPM Youth

Review these questions to help you think about what is the best plan and intervention best for you.

- ✓ Who are the most supportive people in my life?
- ✓ Who do I go to when I need help?
- ✓ Who is a good influences on me?
- ✓ Who do I like to talk to about what is going on with me? Do I get enough support from the adults in my life?
- ✓ Is there anything I would change about where I live?
- ✓ Am I happy with my school placement?
- ✓ What helps me stay out of trouble?
- ✓ What things do I like to do outside of school?
- ✓ Where do I like to hang out? What do I like about that place?

Important Stuff:

My Case planner ______________________ Phone: ______________

My Lawyer ______________________ Phone: ______________

My Probation Officer ______________________ Phone: ______________

Do I have any court dates? _____

When: __________ Where: __________ For what? ______________

When: __________ Where: __________ For what? ______________

Do I have to complete any services? _____ List details below

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