The Justice Center: Opportunity Missed

A Report on Survey Findings: The NYS Justice Center's Impact on the Disability Sector

October 2016

"To build a culture of individual responsibility, people must trust in the reliability and reasonableness of justice. . .The worse government fails, the more our instinct is to put legal shackles on it. . . .Instead of holding people accountable when something goes wrong, we demand law to guarantee something like that will never happen again. . ."

The Death of Common Sense: How Law is Suffocating America,
by Philip K. Howard, 1994

The NYS Justice Center for the Protection of People with Special Needs (the Justice Center) began operation on July 1, 2013.

Justice Center Vision

People with special needs shall be protected from abuse, neglect, and mistreatment. This will be accomplished by assuring that the state maintains the nation's highest standards of health, safety, and dignity; and by supporting the dedicated men and women who provide services.

Justice Center Mission

The Justice Center is committed to supporting and protecting the health, safety, and dignity of all people with special needs and disabilities through advocacy of their civil rights, prevention of mistreatment, and investigation of all allegations of abuse and neglect so that appropriate actions are taken.

Executive Summary

Following multiple **New York Times** articles, Governor Andrew Cuomo commissioned a report that triggered legislation authorizing the creation of the NYS Justice Center for the Protection of People with Special Needs (the Justice Center). The voluntary sector widely supported the goals outlined in the report and generally perceived the stated increased efficiency in the handling of allegations of abuse and neglect across State agencies as what might prove to be an asset to their respective quality assurance/improvement practices that had been in place for years.

Since July 2013, the widespread provider impression of the Justice Center has been less than positive. The Justice Center has not made significant progress toward the original goals identified in the Governor's report of supporting staff in the protection of one of New York's most vulnerable groups. In fact, the Justice Center now stands as an unfunded, administrative burden on providers, and the people we support and the employees who work in our agencies have been negatively affected by the State agency established for opposite purposes. We publish these survey findings in strong hope that the opportunity for significant changes in the Justice Center's operations and approach will get the agency back on track with its original goals.

This report summarizes survey results from a significant majority of voluntary, non-profit providers who fall under the Justice Center's purview. The largest portion of programs that survey respondents operate are certified by the Office for People With Developmental Disabilities (OPWDD). Responses include observations/experiences since July 2013, with any annual information presented representing experiences from 2015.

Our Key Findings:

- There have been $149.1 million in the Governor's budget request for new appropriations to support the Justice Center since it began in July 2013. Voluntary providers have had their funding cut by almost $500 million over the past 4 years.

Executive Summary

- $26 million/year in additional unreimbursed costs for voluntary providers in investigations/aspects of investigations have been created by Justice Center requirements.
- $4.5 million has been incurred by providers in costs for staffing on administrative leave awaiting Justice Center action.
- Less than 10% of agencies surveyed indicated that they have witnessed an improvement in the quality of life for the people they support as a result of the Justice Center's implementation.
- The survey results indicated that almost all (98%) of respondents had in fact fired/removed staff for allegations of abuse/neglect prior to the Justice Center's implementation. Similarly, prior to the Justice Center's implementation, 99% had involved law enforcement when a crime was thought to be committed.
- At a time where many providers are faced with greater than 10% employee vacancy rates, the survey findings show that 57.6% indicate the Justice Center activities have decreased their ability to recruit and retain staff.
- Two thirds (63/94 responding to the question) believe that their incidents were incorrectly classified by the Justice Center.
- 42% report Justice Center delays have been disruptive to their organization.
- 1 in 3 agencies reported that the Justice Center staff used their law enforcement authority in a manner that threatened and intimidated staff.
- 81% report that they have experienced an improvement in the Justice Center's operations since it began operations in July 2013.
- With the Justice Center's reported rate of 45 convictions since it began in 2013, even assuming the unlikely prospect that none of the convictions would have occurred without the Justice Center's existence, the cost/conviction is over $11 million!

Executive Summary

Our Key Recommendations:

- The NYS Comptroller's office needs to conduct an audit of the Justice Center to assess its effectiveness and efficiency and identify opportunities for improvement.
- The Justice Center authorizing statute needs to be rewritten with its overarching goal being to streamline the incident management activities across State agencies and to position the Justice Center as a referral agent for law enforcement activities for the more egregious cases of abuse and neglect.
- The Justice Center's education and family outreach functions in the original statute should be emphasized along with a general focus on quality and best practices.
- State agency coordination with the Justice Center must immediately be corrected and improved – the blurred lines between State agencies and the Justice Center cause confusion, frustration, and waste.
- The Legislature needs to act swiftly to revise the authorizing legislation for the Justice Center, and return funding diverted for this public policy experiment back to the services and supports for the people it was intended to protect.
- The antagonistic approach to staff must stop immediately; the goal of supporting staff and incorporating the concept of restorative justice must be put at the front of the Justice Center's activities.
- The Justice Center must be held accountable for its performance.

Sundram Report Calls for Sweeping Reforms...

"Creating transparency of the investigative process by including independent actors on incident review committees, and requiring an annual systemwide public report on outcomes by the Commission on Quality of Care and Advocacy for Persons with Disabilities.

Restoring the trust and confidence of the residents, staff, families and the public requires (paraphrased) a coordinated, consistent effort to:

- *Create an effective system for thorough investigations of incidents once reported,*
- *Implement differential responses to incidents based on the nature/severity,*
- *Include mechanisms for rehabilitation of employees committing lesser offenses."*

NOTE: The voluntary community agrees and supports all three of these goals. We believe the findings in this report show not only has the Justice Center missed the mark on each, it has worked to achieve diametrically opposed outcomes.

Introduction

Since the implementation of the NYS Justice Center for the Protection of People with Special Needs (the Justice Center) in July 2013, disability providers have worked diligently to comply with the new agency's rules, in part because they have been working for years toward its stated goals. Moreover, providers had strongly endorsed the concept of streamlined and uniform application of investigation and oversight across State agencies that had initially been proffered in a special report to the Governor as an outcome of the Justice Center's creation.

That report, "The Measure of A Society: Protection of Vulnerable Persons in Residential Facilities Against Abuse & Neglect," was prepared by Clarence Sundram, the Governor's Special Advisor on Vulnerable Persons, in response to a series of **New York Times** articles highlighting numerous problems the State had in the reporting/identification of abuse and neglect and the concomitant proper treatment of the abusers in homes/programs supporting people with developmental disabilities. The articles for the most part highlighted incidents in State-operated facilities and the difficulties the State had experienced in removing the abusers and/or appropriately addressing the incidents and the staff responsible.

In New York State, the majority of residential supports and services are provided by independent, voluntary, non-profit providers whose Board members often include family members and community leaders driven by their collective mission, which might be summarized as supporting people with disabilities and their families to lead full lives in their communities. A clear distinction must be made between this group of voluntary providers and State-operated facilities which are not able to move as swiftly and appropriately on personnel matters regarding potential abuse/neglect within their programs.

We recognize the huge undertaking the implementation of the Justice Center has been. Many strides have been made and some processes have shown improvement. Unfortunately, the collective impression to date of the Justice Center initiative has not been wholly favorable and there remain

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Our goal is for this report to prompt a collaborative discussion to this end and seize the opportunities missed by the Justice Center's processes to date.

many opportunities for improvement in focus and function. To that end, many providers thought it time to quantify for policymakers various aspects of the provider community's Justice Center experience, highlighting the provider perspective on the impact of the agency on our staff, operations, and the people we support.

The significance of the undertaking is noteworthy in that the non-profit, voluntary disability service providers in New York State have a long tradition of advancing the rights of people with disabilities and working toward the goals of the Justice Center. Many of the organizations responding to the survey were founded by families of people with disabilities and family members today remain integral parts of these valuable community organizations. These voluntary agencies have responded over the years with high quality, innovative programs to meet the identified community needs. This perspective is one of the reasons Clarence Sundram's report appealed to voluntary providers; it was presented as a balance between consistency in reporting abuse and neglect as well as the training and employee support afforded to the people providing the services. The report offered a distinction in the characterization/definitions of abuse while suggesting an improved quality of life would result by its streamlined approach.

In fact, the Sundram report's statistics verified the high level of incident reporting already taking place in OPWDD programs. What has occurred since the Justice Center was started in July 2013 has been a major disruption in the already robust incident management systems in voluntary providers, with uninformed Justice Center staff delaying background screening of candidates, failing to perform timely investigations, losing records, inappropriately interviewing staff and program participants, failing to support our dedicated workforce, and draining the resources of our quality assurance/improvement programs.

We report our survey findings with high hopes that policymakers in the State will take swift action to effect meaningful change in the Justice Center's scope and the administrative processes the Justice Center has implemented. The Justice Center should be "supporting the dedicated men and

women who provide services" rather than examining all untoward incidents as if staff were guilty of crimes. How can it be argued that people are experiencing (or steps are being made toward) an improved quality of life when the Justice Center has decreased agencies' ability to recruit capable staff as stories appear frequently of mistakes being prosecuted as crimes? How is the quality of life for the people supported by these programs improved when staff members they know and are comfortable with are removed for extended periods of time because of delays in the Justice Center's processing of investigations on baseless allegations?

Survey results confirm the widespread impression that the disproportionately large expense assumed by providers to comply with the Justice Center rules and regulations has yielded little to no improvement in the people's lives it was intended to protect and support. In fact, the unfunded mandate of the Justice Center poses a threat to the ability of providers to support the number of people they had in the past. How is this in the best interest of the people the Justice Center was intended to protect?

The public policy goals of ensuring protections and offering consistency/uniformity across New York State agencies have great merit. Unfortunately, survey results suggest neither goal has been realized and that costs have been added to the system, little to no improvement in protections/quality of life has occurred, and there has been a negative impact of the ability of providers to recruit and retain staff as well as to perform quality assurance/improvement processes as they had in the past as a direct result of the Justice Center's implementation.

It is time for the Justice Center to be thoughtfully examined and evaluated with an eye on its impact on the human service provider community. **We seek broad fundamental changes to occur in Justice Center mission and functions with a focus on quality assurance activities, development of best practices, and education. Our goal is for this report to prompt a collaborative discussion to this end, and seize the opportunities missed by the Justice Center's processes to date.**

Survey Respondents:

Below is a brief profile of the respondents to the survey; information was collected for most questions across all respondents. A subgroup of respondents representing a cross-section of those surveyed participated in a follow-up survey to extract more detailed financial information on costs.

- 119 Voluntary, Non-Profit Agencies, operating OPWDD, OMH, DOH, SED, OCFS, and other State licensed programs
- Those who completed the survey were largely administrative staff, ranging from Executive Directors to QA/Corporate Compliance Directors
- Agencies represent almost $5 billion in total operating revenues
- Agency Employees – Approximately 100,000 employees, with over 76,000 of them subject to Justice Center oversight
- Allegations Abuse/Neglect Calls to the Justice Center – 20,500, of which 940 were investigated by the Justice Center and the agencies surveyed investigated the balance (19,560)

Our provider organizations have worked closely with the Office for People With Developmental Disabilities (OPWDD), the Department of Health (DOH), the Office of Mental Health (OMH), and the State Education Department (SED) to improve the programs and services offered as well as to ensure that our organizations comply with all State and Federal statutes and regulations governing our programs. We have a strong history of cooperation and the mutual goal of ensuring the safety and well-being of those we support, and have been proactive in identifying and removing people and situations that put the people we support at risk. Our survey respondents represent only a segment of the entire disability provider community, but we believe the sample is significant enough to represent the field as a whole.

Effects on Provider Costs/Budgets/Time

While the Sundram report suggests efficiencies on "how the state manages the vast resources" devoted to its efforts, survey results suggest the opposite effect. Increased costs to providers, increased administrative burden, and a bloated Justice Center staff have been the result of the new state agency's creation.

- There have been $149.1 million in the Governor's budget request for new appropriations since the Justice Center began in July 2013. At the same time, voluntary providers have had their funding cut by almost $500 million over the past 4 years.

- The Justice Center statutes have added almost $1 million in unreimbursed costs for pre-employment screening.

- On average, agencies annually spend 70 hours of administrative time per abuse and neglect allegation that has been investigated by the Justice Center; the Justice Center investigation does not remove administrative responsibility from providers.

- Just within the respondents to this survey, a total of 1.85 million hours were spent in one year on investigations, with 65,800 hours spent on Justice Center investigations, and 1,783,500 hours spent on incident investigations.

Sundram Report:

"The findings in this report should prompt a broader re-examination of how the state manages the vast resources that it devotes to the support of these multiple systems of human services, and the consistency of its policies and practices in doing so."

NOTE: We agree with this comment in the Governor's report and hope that our report on survey findings will refocus a similar look at managing state resources.

The number of lives reported as positively being affected by the Justice Center's activities is less than 200 . . .the cost across NYS is minimally $181 million.

- Providers incur a total cost/per incident of $2,057 when the Justice Center investigates an incident.
- The average annual total cost of compliance for each agency for a Justice Center investigation is $12,937.
- The Justice Center has 450 staff authorized in this year's State budget; it began in 2013 by creating 288 new staff outside of the FTE's transferring from other agencies.
- Survey respondents indicated that the Justice Center has added $677 per investigation for incidents that the agencies have responsibility for investigating. This means that the Justice Center has added $13.8 million in unreimbursed costs for investigations that the agencies perform. In addition, agencies are incurring costs of $12.2 million for investigations performed by the Justice Center. That's $26 million/year in additional unreimbursed costs for voluntary providers in investigations/aspects of investigations that were created by the Justice Center.
- $4.5 million have been incurred by providers in costs for staffing on administrative leave awaiting Justice Center action; this number continues to grow.

Sundram Report:

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

NOTE: Providers agree wholeheartedly and would very much like to see the Justice Center's work focus on creating one set of administrative rules and processes.

Effects on Quality Assurance / Improvement Programs

We agree with the Sundram report's message that "in the absence of comprehensive incident management systems, we miss opportunities to identify and address abuse . . . " However, providers – particularly those operating OPWDD programs and the large majority of those surveyed – already had extensive incident management systems in place. Previous to the Justice Center's existence, almost 100% of agencies worked with law enforcement, removed staff in criminal and other situations, and collectively offered years of professional quality improvement/incident management experience to the programs supporting people with disabilities. Survey results suggest that the Justice Center has been a deterrent in the progress and efficiency of these internal programs and has, in fact, negatively impacted the incident management process for survey respondents.

Since the implementation of the Justice Center . . . 70% of respondents now spend more than half their time on incident management.

Consider these findings:

96% of respondents have a QA/QI program in place, with these programs in place for an average of 15 years, with an average of 5 FTEs staffing the QA/QI department. All perform QA/QI oversight with over 80% of the departments also fulfilling incident management and corporate compliance functions for their organizations. More than half these departments also are responsible for training or some other internal functions.

Since July 2013, 45% of survey respondents report they have added FTE's to the department to:

"handle paperwork and added investigations"
"meet the onerous reporting requirements"
"handle the increased workload related to Justice Center and incident management"

Interestingly, among the 55% who have not added FTE's since 2013, a majority indicated that they "would like to" add staff but "cannot afford to" . . .

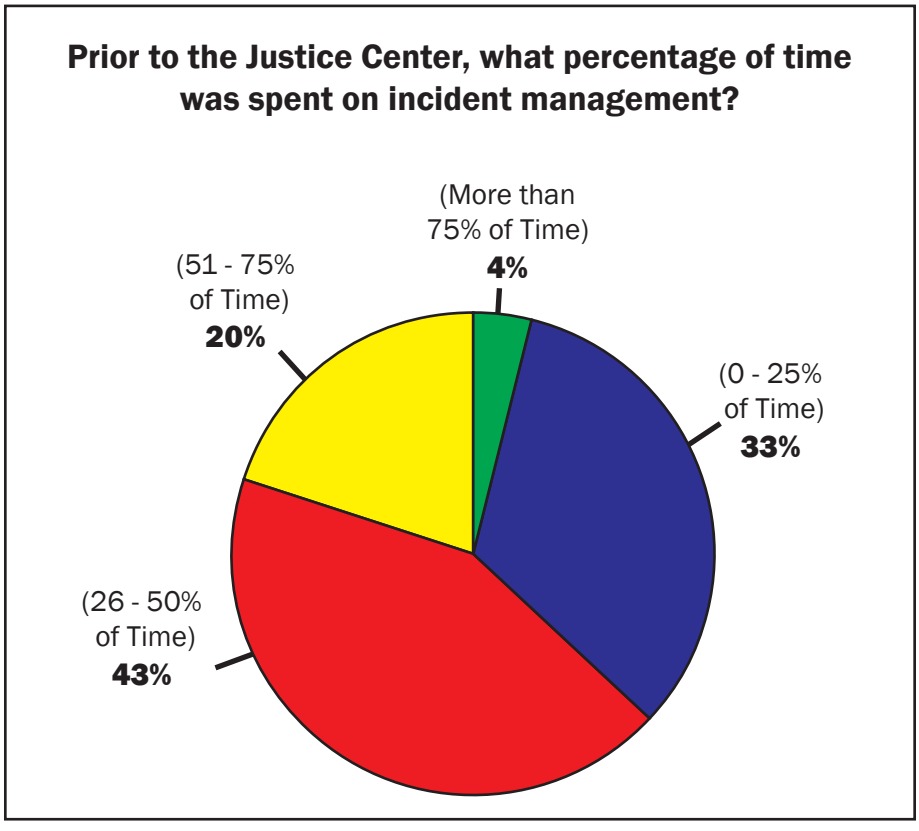
Sundram Report:

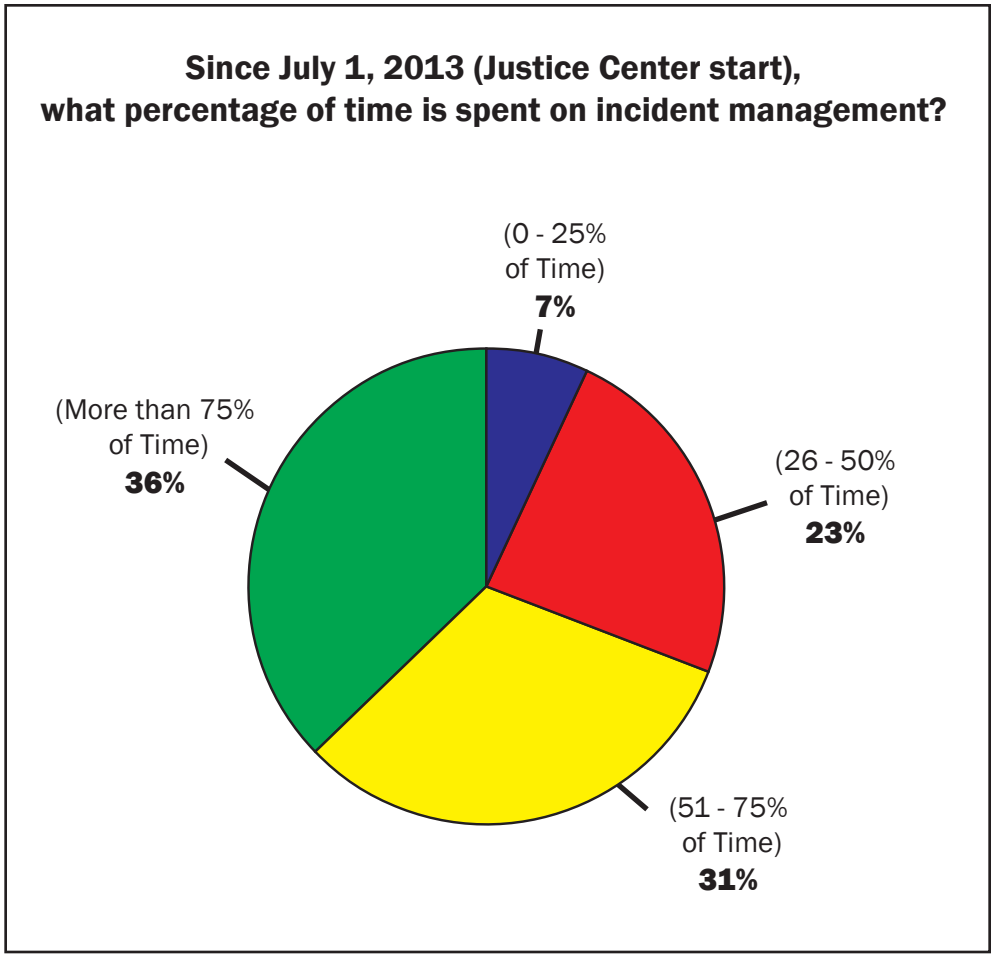
"It is notable that some state agencies do not keep track of and could not provide information regarding the volume or rates of reported incidents of abuse and neglect."

FACT: OPWDD agencies had far and away the highest rate of tracking, reporting and managing incidents.

Since the implementation of the Justice Center, the percentage of time spent on incident management in these departments increased dramatically, with 75% of respondents indicating that they spent less than half their time on incident management with the converse now true: 70% of respondents now spend more than half their time on incident management.

Further, respondents report than since July 1, 2013 their QA/QI activities have been impacted so that they are spending less time on regulatory compliance, mandated trainings, and risk assessments.





The Justice Center requires that numerous incidents that would have been handled administratively now require the additional administrative burden of Justice Center reporting, with almost 80% of respondents indicating they have reported incidents that were previously "administrative events." Examples of these incidents that are being accepted by the Justice Center are:

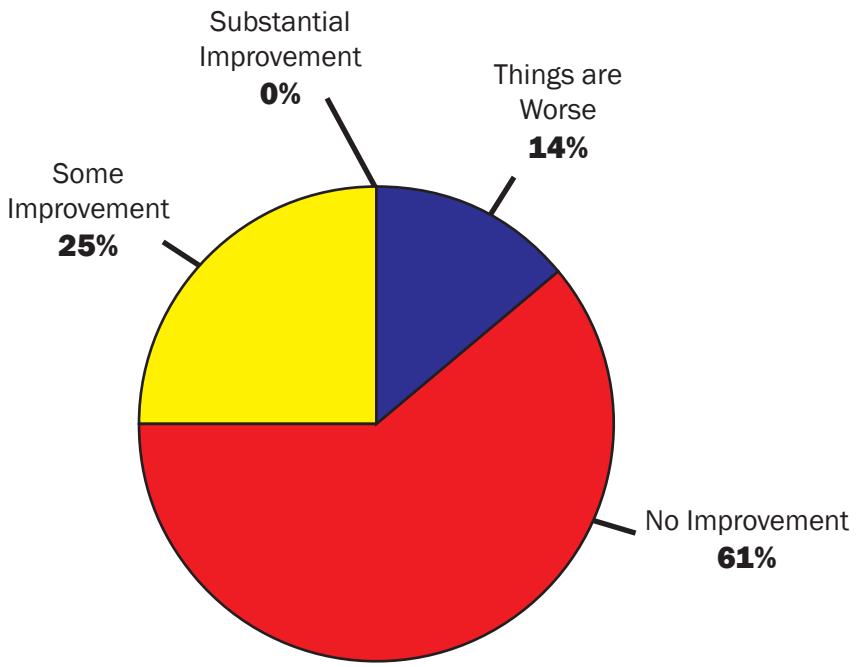
> "individuals hitting a staff member"
>
> "conduct between persons receiving services that would constitute abuse" – individuals that we serve are often supported by a team of individuals who work with that person to work on their disabilities. There are plans put in place, overseen by a certified clinician, and taught to the staff to follow and implement. There is no distinction that the plan was or wasn't followed at onset; often not intentional or reckless. The Justice Center has failed to provide guidance on this category in over three years despite pleas from the field for such guidance.

Incidents that are disciplinary from an HR perspective but fail to rise to the level of a Justice Center incident.

Self-Abusive Behaviors – again this is addressed through a therapeutic or behavior support plan. The individuals we serve are receiving services from these organizations to assist them with decreasing this behavior.

"levels of supervision while individual is in the hospital" – while it is most agencies' practice to individually determine the level of support an individual should have when hospitalized, there is clear delineation of roles and responsibilities shifting from the certified program to the hospital staff when this occurs and such should never be considered an incident for investigation through the Justice Center, yet it has been.

How would you characterize the safety, well being, and protections in place for people with disabilities as a result of the Justice Center's activities?



The voluntary sector has high-quality, experienced staff in incident management . . .

The experience and trainings of the staff in the voluntary sector responding to this survey varies, both in the number of people who work in each agency as well as in the years they have been at their profession. The point to take away, however, is that consistently across providers, the people performing investigations and quality assurance tasks are experienced and well trained. Our survey indicates that agencies on average (there are some with large numbers of investigators and some with just one or two people), have three to four staff dedicated to investigations and QA. These same agencies have staff who bring up to 300 years' experience to their agency's investigations, with the lowest number of years reported as five years and on average they have at least 40 years' experience conducting investigations.

- Almost 100% of the voluntary agency investigative staff have program experience, with 90% coming from agency residences and other programs and a small percentage with police experience.

- All staff performing investigations/QA activities hold a bachelor's degree, a few hold doctorate level degrees, and almost 50% hold master levels or additional training beyond their bachelor's.

- All investigators in the voluntary sector responding to this survey have received OPWDD-approved investigator training. All this training was completed well before the Justice Center began in 2013.

Sundram Report:

"In the absence of comprehensive incident management systems, programs miss opportunities to identify and address abuse and other significant events which may endanger residents."

NOTE: OPWDD providers have had comprehensive incident management systems for many years.

Effects on People's Quality of Life

Almost 90% of agencies surveyed questioned whether a positive impact has been observed in the quality of life of those we support as a result of the Justice Center's implementation.

One of the main goals in establishing the Justice Center was, rightly so, to help improve the quality of life for people with disabilities. Survey results indicate that in few instances have providers witnessed any significant improvements, while resources that might have been spent on people and programs have been diverted to meet Justice Center requirements.

In response to the fundamental question – "have the Justice Center activities improved the quality of life for any individuals/families you support?" – almost 90% of agencies surveyed questioned whether a positive impact has been observed in the quality of life of those we support as a result of the Justice Center's implementation.

Of those who found a positive impact on someone's quality of life, the number of people affected was minimal, with most respondents seeing a positive change in less than 5 people's lives and the total number of lives reported as positively being affected by the Justice Center's activities are less than 200, while there are almost 100,000 people supported by these agencies.

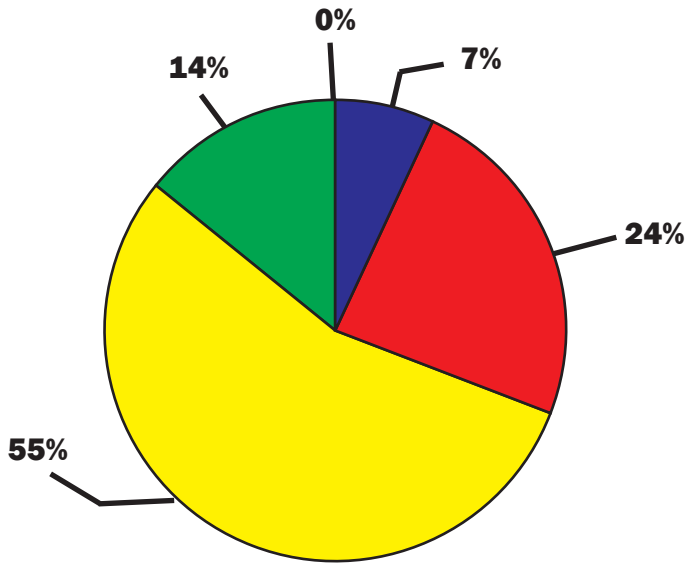
With little evidence of quality of life increasing, there is considerable cost, with over 90% reporting that Justice Center requirements have increased agency expenses and none have received any additional funds to cover those costs. Only 25% reported "some improvement" in the safety, well-being, and protections for people with disabilities as a result of the Justice Center activities, and not one would characterize the Justice Center initiative as "substantial" improvement in this area.

> "The lack of timely action on the Justice Center's part force staff suspensions and vacancies which forces us to use staff unfamiliar to the people and families we support, causing anxiety for the service recipients and inconsistency in service provision and care."

The impact on QA/QI activities has been significant with almost 70% of agencies reporting that their attention to quality assurance and improvement activities has been diverted by the Justice Center requirements. Not one agency said that their QA/QI activities were "much improved," and less than 10% found any improvement at all.

How has the implementation of the Justice Center impacted your QA/QI activities?

- **MUCH IMPROVED (0%)** – The Justice Center has not only increased protections for the people we support, but our QA activities have improved with the Justice Center activity.
- **THINGS ARE BETTER (7%)** – The Justice Center has added to the quality of services and supports available.
- **NO CHANGE (24%)** – We are doing all we did prior to the Justice Center, it has had no impact on our QA activities.
- **THINGS ARE SLIGHTLY WORSE (55%)** – We are not able to focus on QA activities as we had in the past since some of our resources have been redirected to meeting Justice Center activities.
- **THINGS ARE MUCH WORSE (14%)** – We spend all our time working on Justice Center-related investigations/activities and are no longer able to focus on QA/QI.



Effects on Employees

Sundram Report acknowledges:

"One might summarize the job description of the direct support worker as requiring the wisdom of Solomon, the patience of Job and the caring of Florence Nightingale."

Employees are central to any human service organization's success in fulfilling its mission. The Justice Center has failed to deliver on its goal of supporting our dedicated workforce. On the contrary, the inefficiency of the Justice Center has negatively impacted employees and the tone and tenor of Justice Center staff have been threatening, with the most frequent threat being that of "obstruction" for any staff member not immediately complying with a Justice Center request. There has been little emphasis on best practice, staff training, and incorporating any concept of restorative justice.

A key concern of those supporting the expansion of the Justice Center had been the ability of disability service providers to handle incidents related to staff. The survey results indicate that almost all (98%) of respondents had in fact fired/removed staff for allegations of abuse/neglect prior to the Justice Center's implementation. Similarly, prior to the Justice Center's implementation, 99% had involved law enforcement when a crime was thought to be committed. Most of the respondents provide services in more than 1 county and work with multiple law enforcement agencies, with agencies working with as many as 35 different law enforcement entities.

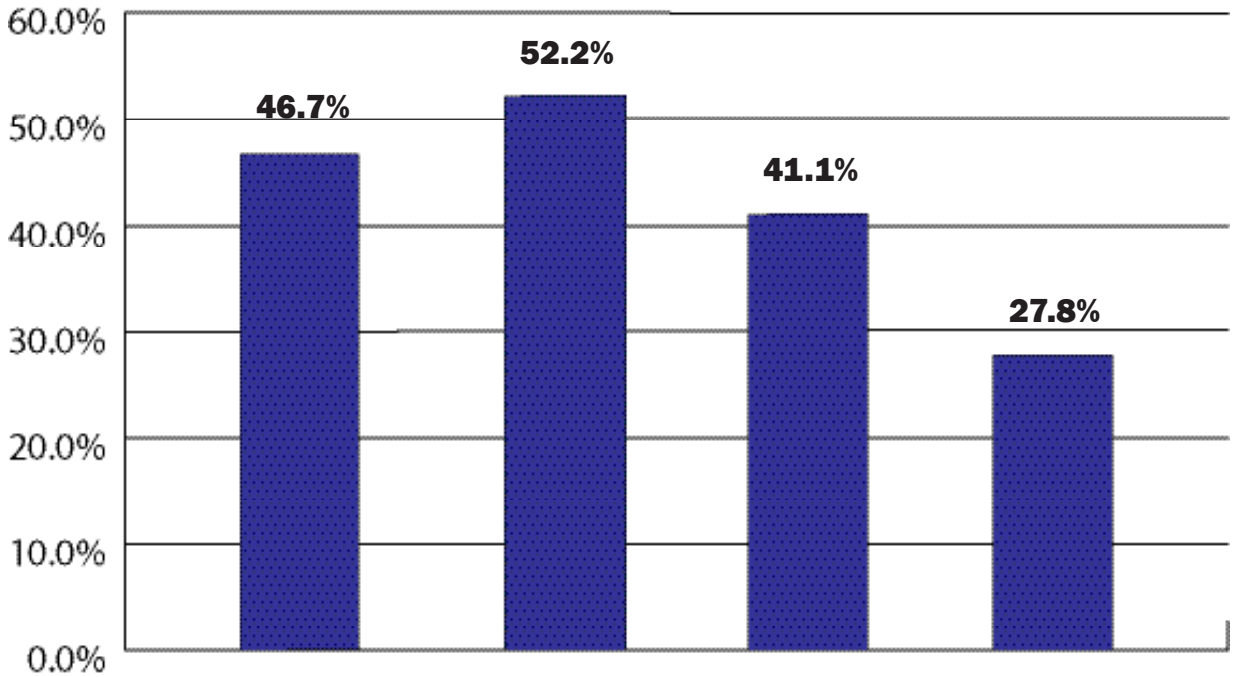
In repeated incidents, Justice Center staff have performed in a way that appear to deny the legal rights of employees through refusal to allow representation at hearings/interrogation by the law authority – the Justice Center. Further, the lack of coordination and education of local law enforcement has created tremendous confusion when agencies have tried to work with law enforcement since the Justice Center's development. Prior to the Justice Center's existence, agency staff contacted local law enforcement agencies when it appeared a crime had been committed. With the advent of the Justice Center, many legal offices would concur that the confusion

has created tremendous work on inconsequential issues that do not raise to the level of a crime. Questions surrounding who is supposed to assume what role with the creation of the Justice Center have created a chaotic series of miscommunications in every part of the State.

Justice Center investigations have left providers in a quandary without swift resolution on how to handle employees who are under investigation for allegations of abuse/neglect.

Related Anecdote
A small agency with less than 150 staff members reports that they have 6 employees out of their current position because of ongoing/unresolved Justice Center investigations. The agency believes that 1 of the 6 MAY prove to be a level three finding but the others will prove not to be substantiated in any way. In the meantime, the positions must be filled and the people they support must get used to new caregivers because of the Justice Center's delays.

What happens to the employees at your organization when the Justice Center is the investigatory? (Check all that apply.)



Sundram Report:

"The System should introduce the concept of restorative justice as a response to category two violations where there is reason to believe in the potential for rehabilitation of the employee."

For employees, even unsubstantiated allegations can have a significant impact, with 42% of responding organizations indicating that they have placed employees on unpaid suspension until the Justice Center has made a final determination. Respondents report that since the Justice Center's implementation, 571 employees have been put on unpaid suspension and another 262 have been placed on paid suspension, 113 have been relocated within the organization, and 226 have been terminated.

Almost all (98%) of respondents had in fact fired/ removed staff for allegations of abuse/neglect prior to the Justice Center's implementation. . . 99% had involved law enforcement when a crime was thought to be committed.

A complicating factor on employees and providers has been the turn-around time of the Justice Center in handling investigations, with respondents reporting that the time it takes to receive a final determination has been in most cases more than 6 months, as well as others reporting:

"a year or more"
"6-9 months"
"an average of 5 months"
"3-11 months"

The voluntary sector is being held to strict 30 day turnaround times, yet the Justice Center itself has failed to keep to the statutory requirement of 60 days to close an investigation. **At a public meeting in March 2016, Justice Center staff indicated that they are following the statute to report reasons for not meeting the 60 day turnaround time, but the reason is put in a file that is not open to the agency where the allegation occurred or the public to see – there is no transparency in that arrangement, nor is there any public review to justify the delays.** The impact of the Justice Center delays not only cost the agencies money, but directly impacts the lives of the accused as well as the continuity of care for the vulnerable people we support. This disregard for employees' rights was raised by numerous survey respondents

as particularly problematic for employee recruitment and retention purposes. It is more than a bit ironic that the Sundram report faults the voluntary sector as one that "generally lacks robust due process protections for employees" when in fact it is the very agency that grew from that report which itself puts employees' due process protections in question.

Only 17% of respondents would characterize the Justice Center as having been "prompt, timely and clear" in their interaction with staff.

Our survey respondents also reported that their decision to remove staff who were subjects of allegations of abuse or neglect has been costly; the cost to the agencies for maintaining employees not allowed to support people with disabilities during Justice Center investigations is reported to be over $4.5 million annually (and that amount is growing).

The Justice Center oversight has impacted employers' ability to recruit and retain staff. At a time where many providers are faced with greater than 10% employee vacancy rates, the survey findings show that 57.6% indicate the Justice Center activities have decreased their ability to recruit and retain staff.

Part of the additional administrative burden the Justice Center brings with it has been the SCR pre-employment checks, with respondents performing over 19,000 such checks which yielded only 385 "hits," of which 157 (0.8%) were related to employment status and prevented the person from being hired. These checks have added approximately $830,000 in unfunded costs for survey respondent agencies alone. On top of the cost of the SCR checks, 1 in 3 agencies have had to add human resources staff to complete the Justice Center pre-employment checks. Finally, almost half (49%) of the agencies report losing viable candidates because the SCR pre-employment checks took too long. [NOTE: The Justice Center is not responsible for timely pre-employment checks; the Justice Center has added to the number of employees who must be screened through this system.]

Justice Center Efficiency and Impact on Providers and People

A new agency in July 2013, the Justice Center has improved since its beginning according to a majority of respondents. However, the Justice Center staff have been inconsistent, have failed to coordinate well with other State agencies, and have negatively impacted the operations of the agencies they oversee at great expense, with little to show for it.

"The Justice Center is the worst thing to happen to people with disabilties since I've been in the field."

Agency CEO with over 30 years supporting people with disabilities

The positive news is that 81% report that they have experienced an improvement in the Justice Center's operations since it began operations.

Approximately two thirds (63/94 responding to the question) indicate that they believe their calls to report incidents were incorrectly classified by the Justice Center – the number of incorrect classifications ranged from a few to many, but there was a significantly high rate of these mistakes. Respondents report that in the first year of operations (2013), the Justice Center incorrectly categorized 185 incidents that were called in, and in 2014, the Justice Center incorrectly categorized 173 incidents.

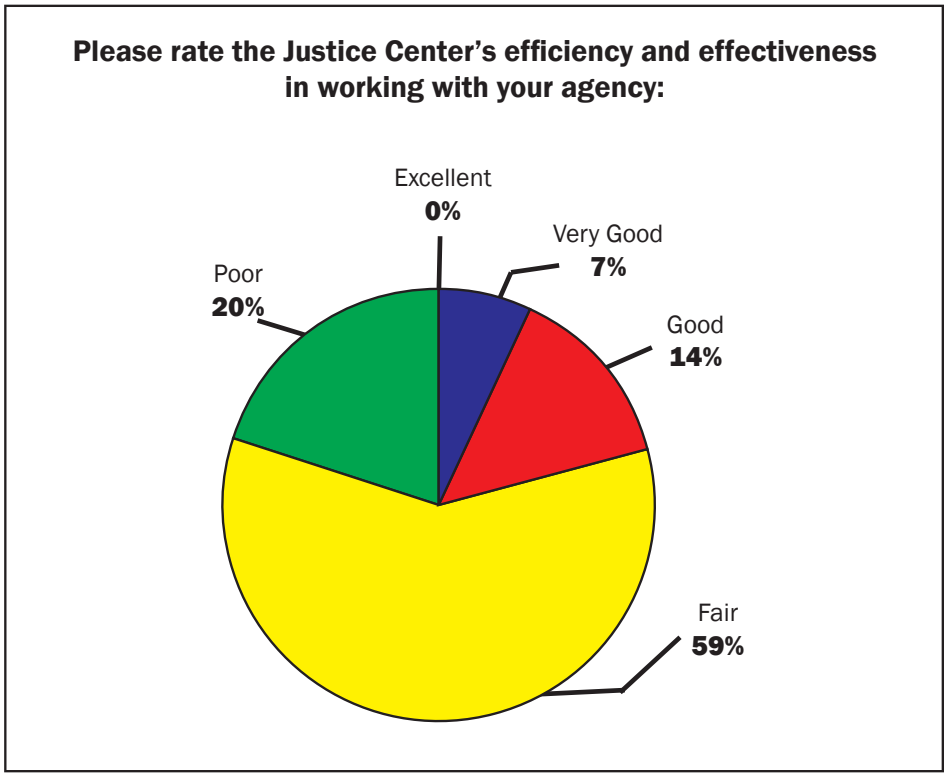
However, only 17% of respondents would characterize the Justice Center as having been "prompt, timely and clear" in their interaction with staff. This has been a problem, not only for its impact on staff members, but in the delays related to communication regarding situations affecting the safety of people we serve (e.g., when the Justice Center gets a report and does not notify the agency in a timely manner, we have a problem).

Among the 83% who disagreed with the positive characterization of the Justice Center's timeliness when interviews have been completed:

42% – report Justice Center delays have been disruptive to our organization,
36% – delays are an inconvenience, with some causing moderate waste of staff time and resources, and
22% – Justice Center has been slow and unclear in instances, but that has had moderate impact on our operations.

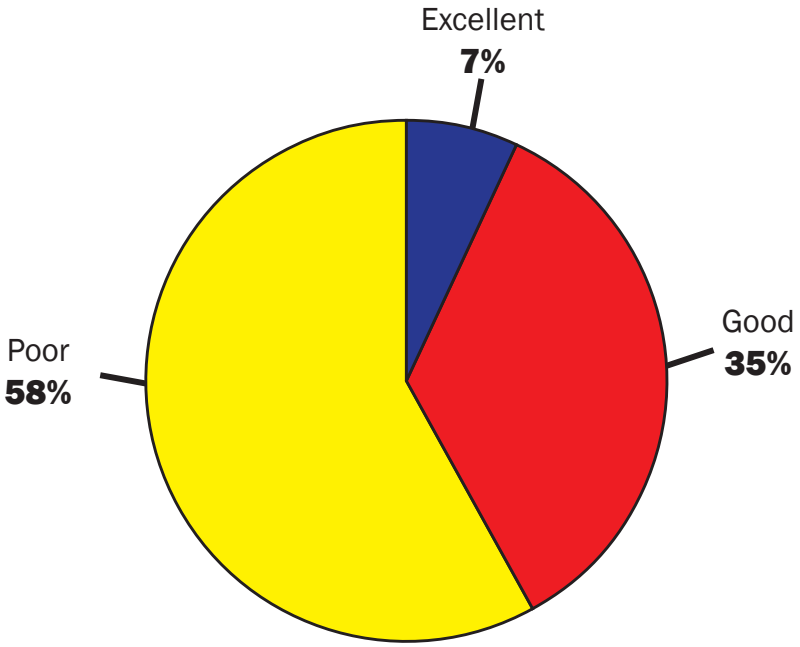
The agencies rate the Justice Center's efficiency and effectiveness in working with their agencies as:

Excellent – 0%
Very Good – 7%
Good – 14%
Fair – 59%
Poor – 20%



Not surprisingly, survey respondents indicate that they did not think the Justice Center worked particularly well with other State agencies – 7% observed excellent interagency cooperation, while almost 60% found their performance "poor" in this category, and not one said they were "very good" at it.

How would you characterize the involvement of OPWDD or other State agencies in your interactions with the Justice Center?



The Justice Center's treatment of employees during an investigation was reported as follows:

Excellent – 3%
Very Good – 20%
Good – 26%
Fair – 28%
Poor – 13%
N/A – 10%

While it is encouraging to see that almost 25% of respondents reported that the Justice Center was either very good or excellent in their treatment of employees during an investigation, the following disturbing facts arose:

- 1 in 3 agencies reported that the Justice Center staff used their law enforcement authority in a manner that threatened and intimidated staff.
- 15% reported their employees were told that they could not have the attorney of their choice represent them when they are being questioned by Justice Center staff.
- 5% reported the Justice Center has threatened to file charges of obstructing a Justice Center investigation against employees who insisted on having legal counsel of their choosing present when they are questioned.
- 30% of respondents indicated the Justice Center has requested voluntary agency resources or information to assist the Justice Center with the appeals process following a Justice Center determination.

1 in 3 agencies reported that the Justice Center staff used their law enforcement authority in a manner that threatened and intimidated staff.

NOTE: Since the data for this report was collected, the Justice Center has updated its policy and now allows all staff to have counsel present in interviews/interrogations.

Related Anecdotes. . .

At least one NYS Trooper office has told agencies to "stop bothering them" with reports of potential cases of abuse and neglect when the agency was following the law. In insisting they were following the NYS statute, the agency representatives were told that they (the NYS troopers) "did not have time for incidents that don't rise to the level of a crime."

Similarly, at least one district attorney's office has indicated that the Justice Center staff have not followed traditional law enforcement agency collaboration/interaction procedures by allowing one agency to take the lead; Justice Center investigators' refusal to cooperate with other law enforcement agencies has interfered with/obstructed investigations in the other law enforcement agencies' efforts.

At a public meeting in March 2016, the following Justice Center progress was reported:

- **There have been 221 names added to the exclusions list, of which 115 are permanent and the remainder are in arbitration.**
- **The Justice Center has closed 102 criminal cases, of which:**
  - **13 were dismissed,**
  - **21 were deemed violations (not a crime),**
  - **45 resulted in convictions (29 from the voluntary sector and 16 from State operated facilities), and**
  - **33 were suspended sentences.**

The Justice Center is required by statute to "within sixty days of the vulnerable person's central register accepting a report of an allegation of abuse or neglect . . .cause the findings of the investigation to be entered in the vulnerable persons central register." The average time to complete an investigation is approximately 6 months, about triple the time allowed in statute. The Justice Center documents the reasons for these delays in their systems but the reasons are nebulous. Providers are not able to review the explanations since that part of the record is not open to the public for viewing.

There is often a lack of communication and understanding about the delays. Finding letters do not list the responsible staff at the Justice Center in the event that providers or staff want to discuss the case with them.

After the Justice Center's reported rate of 45 convictions since the Justice Center began in 2013, even assuming none of the convictions would have occurred without the Justice Center, the cost/conviction is over $11 million!

Conclusions/Recommendations

Without reflection, we go blindly on our way, creating more unintended consequences and failing to achieve anything useful.

Margaret J. Wheatley

The Justice Center has at its core worthwhile goals, none of which any provider or community member would argue against. Somewhere along the way, as the agency was developed and implementation of functions and responsibilities became realities, we have been left with a large bureaucracy that consumes tremendous amounts of public resources to little apparent public good. At a time when all agencies are looking to make efficient use of public funds in the programs and services they operate, the Justice Center stands as an obstacle in reaching that common goal.

The Justice Center has at its core worthwhile goals, none of which any provider or community member would argue against.

When it comes to goals that State leaders and our voluntary agencies and our communities share – to ensure people with disabilities are healthy, safe, and protected – the Justice Center has not contributed to achieving these outcomes when you consider the systems that were already in place prior to its implementation in 2013. The inefficiencies of the Justice Center have in fact detracted from voluntary provders' ability to achieve these goals. The Justice Center's failing to take action quickly enough to ensure safety – it is often days or weeks before they take action on a report – holds the potential for doing harm to the very people it was intended to protect.

Further, the Justice Center staff often do not possess the level of experience needed to oversee the areas of responsibility – they have failed to work well with the agencies who have program responsibility for the certified programs. The Justice Center has created incredible redundancies – we have multiple reports required for the same incidents, e.g., duplicate entries into IRMA and WISR, etc. – and they have added another layer to the already micromanaged incident management system. Prior to the Justice Center's existence, the Sundram report clearly identified OPWDD programs as having the highest rate of incident reporting and protections in place. Further, our survey confirms that voluntary agencies had already been investigating incidents with experienced investigators who understand our people and programs. Voluntary agencies had been firing employees when appropriate, working cooperatively with law enforcement, and had run the quality OPWDD and other programs their Boards and family members expect. The Justice Center in most instances simply confused and consternated the process.

An unintended consequence created by the Justice Center's bureaucratic trappings is that agencies have seen increased challenges in their attempts to recruit and retain staff; the Justice Center's delays and treatment of staff have only exacerbated severe staffing issues. It takes an average of 6 months or more for the Justice Center to complete an investigation, creating both fiscal and quality of care issues for agencies who have had staff placed on leave during that time. The tone and tenor of the "law enforcement" aspect of the Justice Center has been particularly ill-thought out and implemented, alienating staff unnecessarily and

Conclusion/Recommendations

adding a step that was not needed prior to the Justice Center in the voluntary sector. The need for Justice Center investigators to intimidate staff through their "interrogation" method when conducting interviews is particularly troublesome given that agencies had previously dealt with staff issues much more efficiently and timely than the Justice Center has. It is startling that the Justice Center investigations often fail to handle incident investigations in as professional a manner as standard law enforcement agencies despite their dedicated focus on our field and the vulnerable people we serve. In 2014, our field promoted legislation to protect the rights of vulnerable people in response to numerous instances of inappropriate and/or insensitive conduct from Justice Center investigators. We are proud of this legislation and the protections that passed, but it is unfortunate that we needed to go to this length to protect the rights of the people we serve from the very entity created with a mission to do the same.

While some of the data across State agencies might prove useful in analyzing trends, the Justice Center has added too much administrative time through the paperwork and processes, all while no additional funding has been provided to pay for the significant administrative expense. Until recently, our front line workers were not being offered legal counsel and their legal rights were not being honored. Any potential benefit for the people we support has been removed due to the Justice Center's poor communication and posturing as a "law enforcement agency" – Justice Center staff do not share their impressions or findings with QA staff to assist in program changes and the Justice Center staff are not available by phone. In fact, they send determination letters with no signature or contact information; the investigative reports have little information; and, letters have conflicted with investigation findings. The poor level of efficiency in their operations again hold the potential to do more harm for the most vulnerable in our State than any good that might be realized through their efforts.

Further, the Justice Center has not worked well with the systems already in place in State agencies, with the following comment summing up that relationship: "The Justice Center and OPWDD do not seem to be in agreement regarding the classification of incidents; OPWDD has history and experience and the Justice Center has authority."

We need to step back and add a layer of reason to the process. A zero tolerance approach threathens common sense. Our recommendations are an attempt to establish more reasonable approach to advance our common goals.

Sundram Report:

". . . an application of the concept of zero tolerance has been criticized for suspending good judgment and common sense. Making intelligent distinctions based upon the severity of conduct is entirely consistent with sound public policy and common sense."

Conclusion/Recommendations

Our Recommendations

1. There needs to be a complete audit of the Justice Center by the NYS Comptroller's Office to assess the effectiveness and efficiency of the Justice Center to date and to identify opportunities for improvement. This audit must include feedback from providers in the six agencies that the Justice Center oversees.

2. We urge that the NYS Legislature conduct public hearings on the processes of the Justice Center and its impact on the people we support and the provider agencies.

3. Funding diverted for Justice Center investigators and staff needs to be allocated back to the providers for programs and supports – the Justice Center agency funding needs to return to a level no higher than the COC funding in 2012.

4. There needs to be an overarching goal to streamline the incident management activities across State agencies, so that providers operating programs under different agency licensure aren't following different rules for each agency. A uniform definition of abuse and neglect may be in place, but each agency should not be allowed to hold providers to differing standards regarding reporting and investigations. This should be a key function of the Justice Center.

5. That streamlined approach must recognize the significantly higher incident reporting rate and incident management systems in place under OPWDD; special consideration should be given to bring other programs and agencies in line with processes already in place under OPWDD.

6. If history has shown that less than 5% of investigations by the Justice Center are in fact criminal, why does the agency need law enforcement authority? The Justice Center statute needs to position the Justice Center as a referral agent for law enforcement, while ensuring there is a small group of legal/law enforcement experts employed within the Justice Center to help assure that the protections of the most vulnerable, which are in place in multiple ways, are appropriately enforced. The statute needs to be updated to align with the goals of the Sundram Report.

7. The Justice Center statute should outline a method by which State agencies will identify the top 10% of the most egregious events/allegations within their programs for additional oversight/follow up from the Justice Center – but only with the program expertise of the State agency assisting in the determination of which events should be referred for investigation.

8. The Justice Center should emphasize quality and best practices, rather than its current primary focus as simply a prosecutorial entity. The education and family outreach functions in the original statute should also be emphasized.

The Legislature needs to act in the next Session to revise the authorizing legislation in the Justice Center with an eye toward ensuring value added by the proposed actions warrant the funding it draws away from the services and supports for the people it was intended to protect.

Conclusion/Recommendations

9. There needs to be an annual review of the Justice Center by families and providers to identify areas of redundancy, unnecessary oversight, and other activities measured against improvements in the quality of life for the people they are supposed to protect.

10. Redefine "mandated" reporters – develop a system that makes sense and doesn't build in redundancies.

11. Remove opportunities for false reporting; require mandated reporters to identify themselves.

12. At a minimum, the Justice Center authority over/review of incidents between OPWDD program participants needs to be drastically curtailed.

13. State agency coordination with the Justice Center must be improved – Justice Center staff must defer to program staff at State agencies who know the programs and the people.

14. If the Justice Center does get involved in a case, work as a co-investigator with the agency to help move forward with employee relations; the "obstruction" reasoning at the Justice Center must be re-examined with an understanding that, almost 100% of the time, the agency is working toward the same goal as the Justice Center.

15. All Justice Center staff, supervisors, and counsels must be re-trained on the definitions of abuses as stated in statute for proper classification.

16. Remove the term "likelihood" from all abuse and neglect definitions, terminology in the Justice Center.

17. Remove the conduct between individuals significant incident category. This category is extremely ambiguous and leads to unnecessary reporting. The Justice Center has failed to provide guidance on it in three years. Further, if such conduct occurs between two individuals and is a result of a staff action or inaction, this would be reported as abuse or neglect.

18. The Justice Center should be held accountable for its actions/inactions. The Justice Center must publicly identify reasons for any delay in investigations; if they fail to meet their deadlines/reporting requirements, then the Justice Center should reimburse providers for all costs associated with the delay.

19. Require training of Justice Center staff in the concept of restorative justice and the common sense that is lacking in the current prosecutorial, zero-tolerance approach.

Conclusions/Recommendations

20. Given the low rate of hits (0.8%) on the staff exclusion lists, allow providers to conditionally hire staff to work unsupervised with program participants until the reports are returned – this will drastically improve hiring delays created by the exclusion lists.

The Legislature needs to act in the next Session to revise the authorizing legislation in the Justice Center with an eye toward ensuring value added warrants the funding it draws away from the services and supports for the people it was intended to protect. With swift action and coordinated efforts to restructure what was a well-intended gesture, there is an opportunity to refocus the agency on those aspects which hold great appeal: ensuring the safety of vulnerable people, supporting and protecting the rights of the employees working with them, and, streamlining administrative processes across State agencies. Without such significant revisions to the statute, the New York State Justice Center legacy is likely to be one diametrically opposed to its stated goals – rather than support and protect, the current legacy of the Justice Center may very well be to cause irrevocable harm to the very people it is intended to protect.

"Performance matters. If they don't pass the budget on time, obviously, that is a failure of performance."

Governor Andrew Cuomo on the Legislature's timely passage of the NYS Budget, March, 2016

During the past Legislative Session, Governor Cuomo clearly stated that "performance matters," and we couldn't agree more. The collective implementation of the Justice Center and its impact on the people the agency was constructed to protect stands ripe for significant changes and improvement. We believe there is still time to realize the innumerable opportunities for improved performance that lie ahead.

We look forward to working to recover what ground has been lost in the Justice Center's implementation as we work toward the ideals outlined in Sundram's report, specifically those that would increase the efficiency in the "safety net for vulnerable people." Our employees and the people we support deserve no less.

APPENDIX A

Survey Respondents' Justice Center Experiences

Survey respondents were asked to briefly highlight scenarios that illustrate their experiences with the Justice Center. The following is a representative sampling of the experiences survey respondents shared.

We should all have the same goal – to make sure that people with disabilities are healthy, safe, and protected. The Justice Center does not take action quickly enough to ensure safety – it is generally days or weeks before they take action on a report, and then the process moves slowly.

"[T]he entire Justice Center concept has become a momentary lapse of reason."

When different staff call the incident into the Justice Center and different operators take the call, the same incident is often classified differently. We are not told when another agency calls in an incident – inconsistency is problematic.

In a Justice Center investigation that took 7 months to complete, we would have concluded the investigation in approximately one week, with the same outcome of a substantiated instance and termination of the employee.

Our main concern has been misclassifications by the Justice Center and the incredible redundancies – we have multiple reports required for the same incidents, duplicate entries into IRMA and WISR, etc. The Justice Center has simply added another layer to an already redundant and micro-managed incident management system.

In the never less than 3 months for the Justice Center to complete an investigation, our Agency has experienced both a quality of care and fiscal hardship as the subjects of investigations are taken out of work and paid by the Agency. Justice Center communication is lacking, with little to no information provided, and the Justice Center has demanded staff time and agency resources to make copies and gather resources to review outside rather than on agency premises.

Justice Center investigators have intimidated staff through their "interrogation" method when conducting interviews.

We had a case take 1 year and 3 months to close – we have seen no positive impact of the Justice Center.

Survey Respondents' Justice Center Experiences

It's hard to encourage staff to think of the Justice Center as a resource when so many of them have had bad experiences. Justice Center investigators use scare tactics and threats and do not always treat staff professionally. Why would they work here when Burger King pays the same and they don't have the people from the Justice Center yelling at them?

Too much administrative time needs to be spent keeping track of paperwork and processes based on Justice Center regulation, and no additional funding has been provided to pay for the significant administrative expense.

The process of classifying and receiving their letters takes way too long. This causes staff to be out of service for prolonged periods of time, affecting the service we're providing our people.

The Justice Center does not share impressions or findings with QA staff and investigators cannot be reached by phone. They send determination letters with no signature or contact information; investigative reports have little information; and, letters have conflicted with investigation findings.

The fear that has been generated by the Justice Center has made it difficult to promote a trusting environment for staff and the people we support. We have experienced cases where a family member, outside organization, or a staff person has reported an incident to the Justice Center and the agency has not been notified; this has resulted in a delay in implementing safeguards such as suspension or removal of targeted staff.

Justice Center staff have been exceptionally courteous and professional. Due to the volume of incidents being assigned to the Justice Center, investigations are not conducted in a timely manner which jeopardizes the quality of the investigative process. Final determinations are not received by the agency in a timely manner. To date, all Justice Center final determinations have agreed with agency investigated conclusions. This would indicate there is an unnecessary duplication of effort with no added benefit.

Staff identified as suspects were not contacted to set up interviews until 6 weeks after the incident was discovered and filed. Further, we often experience being repeatedly required to send previously copied and submitted records because the Justice Center investigator can't locate the original we sent.

> "We have experienced Justice Center Inspector General auditors who intimidated staff and gave incorrect i nformation – when we showed them the regulations, they did not back down. The Justice Center does not follow regulations and have held us to incorrect interpretations on behavior plans, consent forms, and fire evacuation forms despite OPWDD's supporting the correct information; the Justice Center indicated that they "regulate OPWDD on all matters."

Survey Respondents' Justice Center Experiences

We have experienced Justice Center Inspector General auditors who intimidated staff and gave incorrect information – when we showed them the regulations, they did not back down. The Justice Center does not follow regulations and have held us to incorrect interpretations on behavior plans, consent forms, and fire evacuation forms despite OPWDD's supporting the correct information; the Justice Center indicated that they "regulate OPWDD on all matters."

The last three investigations accepted by the Justice Center for investigation took 3 months and we're still awaiting a final determination; our agency investigators complete most investigations within 3 days.

Hotline calls are not handled well, with inaccurate information, and when calls are needed still unclear. Conduct between people we support seems to be almost always an unnecessary call.

The Justice Center and OPWDD do not seem to be in agreement regarding the classification of incidents; OPWDD has history and experience and the Justice Center has authority.

The lack of timely action on the Justice Center's part force staff suspensions and vacancies which forces us to use staff unfamiliar to the people and families we support, causing anxiety for the service recipients and inconsistency in service provision and care.

Conduct between participants is the category we spend the most time on and have not had any impact on the quality of life for people.

The last three investigations accepted by the Justice Center for investigation took 3 months and we're still awaiting a final determination; our agency investigators complete most investigations within 3 days.

We contend that the use of the Justice Center is contrary to OMIG goals. The Medicaid dollars wasted completing Justice Center documents and requirements (which are often redundant) surely detract from the man hours available to support people.

While we find great value in the charter of the Justice Center and remain committed to working with them to improve protections and safety, our actual dealings with the Justice Center employees have led us to believe that there is still much ground to be made in the areas of open dialogue and collaborative problem solving with this State agency.

Survey Respondents' Justice Center Experiences

One disgruntled staff member sent an anonymous letter resulting in the classification of 23 separate incidents; all were unsubstantiated by the agency's investigation and the Justice Center investigation. The Letters of Determination agreed with the agency's findings.

The OASAS process seems now to be more focused on paperwork whereas we had been able to discuss and obtain input for in-house reviews; there has been no improvement on outcomes of incidents with this new model and I find the Justice Center process overbearing. The burden of the Justice Center has added nothing to the care of the clients.

100% of the time the exchange of information is one way – Justice Center investigators make it clear they can't discuss progress or findings until they clear it with their superiors – this also extends to putting protections in place in a timely manner.

12 months to investigate a matter is not acceptable to agencies or families . . . the Justice Center does not investigate familial or financial as it should . . . there should be a refocusing on the top 10% most egregious events and leave the rest to the agencies . . . the entire Justice Center concept has become a momentary lapse of reason.

APPENDIX B

Justice Center Responsibilities

The Justice Center was created in legislation known as the "Protection of People with Special Needs Act" to establish the strongest standards and practices in the nation for protecting people with special needs. It serves both as a law enforcement agency and as an advocate for people with special needs. The Justice Center's responsibilities include:

- *Advocating on behalf of people with special needs and overseeing the quality of care they receive;*
- *Ensuring that all allegations of abuse and neglect are fully investigated. The Justice Center has legal authority to investigate incidents involving people with special needs. Its Special Prosecutor/Inspector General has the authority to prosecute allegations that rise to the level of criminal offenses;*
- *Operating a 24/7 Hotline which receives reports of allegations of abuse, neglect and significant incidents. Reports are made by service providers and others who are "mandated reporters" as well as by any individual who witnesses or suspects the abuse or neglect of a person with special needs;*
- *Maintaining a comprehensive statewide database that tracks cases until they are resolved and allows the Justice Center to monitor trends and develop abuse prevention initiatives;*
- *Maintaining a "Staff Exclusion List" of individuals found responsible for the serious abuse or neglect of a person with special needs. Anyone entered into this statewide register is prohibited from ever working again with people with special needs in New York.*
- *Operating an Information and Referral Line to respond to general disability-related inquiries;*
- *Continuing existing advocacy programs including the Developmental Center Ombudsman Program, Surrogate Decision-Making, Technology Related Assistance for Individuals with Disabilities (TRAID), and Adult Homes Advocacy;*
- *Administering the Interagency Coordinating Council for Services to Persons Who Are Deaf, Deaf-Blind or Hard-of-Hearing;*
- *Monitoring the quality of mental health care in New York State correctional facilities; and*
- *Promoting the inclusion of people with special needs in all aspects of community life.*

APPENDIX C

Glossary of Acronyms and Terms

- **FTE** – Full Time Employee
- ***Incident Classification***
  - ***Reportable Abuse and Neglect***
    - ***Physical abuse*** *shall mean conduct by a custodian intentionally or recklessly causing, by physical contact, physical injury or serious or protracted impairment of the physical, mental or emotional condition of the individual receiving services, or causing the likelihood of such injury or impairment. Such conduct may include, but shall not be limited to: slapping, hitting, kicking, biting, choking, smothering, shoving, dragging, throwing, punching, shaking, burning, cutting, or the use of corporal punishment. Physical abuse shall not include reasonable emergency interventions necessary to protect the safety of any party.*
    - ***Sexual abuse*** *shall mean any conduct by a custodian that subjects a person receiving services to any offense defined in article 130 or section 255.25, 255.26, or 255.27 of the penal law, or any conduct or communication by such custodian that allows, permits, uses, or encourages a person receiving services to engage in any act described in articles 230 or 263 of the penal law; and/or any sexual contact between an individual receiving services and a custodian of the program or facility which provides services to that individual whether or not the sexual contact would constitute a crime (see especially section 130.05 (i) of the penal law). However, if the individual receiving services is married to the custodian, the sexual contact shall not be considered sexual abuse. Further, for purposes of this subparagraph only, a person with a developmental disability who is or was receiving services and is also an employee or volunteer of an agency shall not be considered a custodian if he or she has sexual contact with another individual receiving services who is a consenting adult who has consented to such contact.*
    - ***Psychological abuse*** *includes any verbal or nonverbal conduct that may cause significant emotional distress to an individual receiving services. Examples include, but are not limited to, taunts, derogatory comments or ridicule, intimidation, threats, or the display of a weapon or other object that could reasonably be perceived by an individual receiving services as a means for infliction of pain or injury, in a manner that constitutes a threat*

of physical pain or injury. In order for a case of psychological abuse to be substantiated after it has been reported, the conduct must be shown to intentionally or recklessly cause, or be likely to cause, a substantial diminution of the emotional, social or behavioral development or condition of the individual receiving services. Evidence of such an effect must be supported by a clinical assessment performed by a physician, psychologist, psychiatric Nurse Practioner, licensed clinical or master social worker or licensed mental health counselor.

- **Deliberate inappropriate use of restraints** shall mean the use of a restraint when the technique that is used, the amount of force that is used, or the situation in which the restraint is used is deliberately inconsistent with an individual's plan of services (e.g., individualized service plan (ISP) or a habilitation plan), or behavior support plan, generally accepted treatment practices, and/or applicable federal or state laws, regulations or policies, except when the restraint is used as a reasonable emergency intervention to prevent imminent risk of harm to a person receiving services or to any other party. For purposes of this paragraph, a restraint shall include the use of any manual, pharmacological, or mechanical measure or device to immobilize or limit the ability of a person receiving services to freely move his or her arms, legs or body.
- **Use of aversive conditioning** shall mean the application of a physical stimulus that is intended to induce pain or discomfort in order to modify or change the behavior of a person receiving services. Aversive conditioning may include, but is not limited to, the use of physical stimuli such as noxious odors, noxious tastes, blindfolds, and the withholding of meals and the provision of substitute foods in an unpalatable form. The use of aversive conditioning is prohibited by OPWDD.
- **Obstruction of reports of Reportable Incidents** shall mean conduct by a custodian that impedes the discovery, reporting, or investigation of the treatment of a service recipient by falsifying records related to the safety, treatment, or supervision of an individual receiving services; actively persuading a custodian or other mandated reporter (as defined in section 488 of the social services law) from making a report of a reportable incident to the statewide vulnerable persons' central register (VPCR) or OPWDD with the intent to suppress the reporting of the investigation of such incident; intentionally making a false statement, or intentionally withholding material information during an investigation into such a report; intentional failure of a supervisor or manager to act upon such a report in accordance with OPWDD regulations, policies or procedures; or, for a custodian, failing to report a reportable incident upon discovery.

- **Unlawful use or administration of a controlled substance** shall mean any administration by a custodian to a service recipient of a controlled substance as defined by article 33 of the public health law, without a prescription, or other medication not approved for any use by the federal food and drug administration. It also shall include a custodian unlawfully using or distributing a controlled substance as defined by article 33 of the public health law, at the workplace or while on duty.
- **Neglect** shall mean any action, inaction, or lack of attention that breaches a custodian's duty and that results in or is likely to result in physical injury or serious or protracted impairment of the physical, mental, or emotional condition of a service recipient. Neglect shall include, but is not limited to:
  - failure to provide proper supervision, including a lack of proper supervision that results in conduct between persons receiving services that would constitute abuse as described in paragraphs (1) through (7) of this subdivision if committed by a custodian;
  - failure to provide adequate food, clothing, shelter, or medical, dental, optometric or surgical care, consistent with parts 633, 635, and 686, of this Title (and 42 CFR Part 483, applicable to Intermediate Care Facilities), and provided that the agency has reasonable access to the provision of such services and that necessary consents to any such medical, dental, optometric, or surgical treatment have been sought and obtained from the appropriate parties; or
  - failure to provide access to educational instruction, by a custodian with a duty to ensure that an individual receives access to such instruction in accordance with the provisions of part one of article 65 of the education law and/or the individual's Individualized Education Program.

- **Reportable Significant Incident** – 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.

- **Incident Report and Management Application (IRMA)** – OPWDD's incident reporting and management database.
- **Investigation** – The systematic collection of information to describe and explain an event or a series of events.
  - **Substantiated** – A finding based on a preponderance of the evidence that indicates the incident occurred and the subject of the report was responsible or, if no subject can be identified and an incident occurred, that the agency was responsible.

Glossary of Acronyms and Terms

  - **Unsubstantiated** – A finding based on a preponderance of the evidence that indicates it did not occur or the subject of the report was not responsible, or because it cannot be determined that the incident occurred or that the subject of the report was responsible.
- **NYS Justice Center for the Protection of People with Special Needs (Justice Center)** – Health and Human Services Agency given oversight authority under the Protection of People with Special Needs Act. This law applies to service providers that are operated, certified, licensed by the following state agencies: Office of Alcohol and Substance Abuse Services (OASAS), Office of Child and Family Services (OCFS), Office of Mental Health (OMH), Office for People With Developmental Disabilities (OPWDD), and certain adult homes operated by the Department of Health (DOH), and residential schools and programs certified or operated by the State Education Department (SED).
  - **Office of Alcohol and Substance Abuse Services (OASAS)** – oversees one of the nation's largest addiction services systems with nearly 1,600 prevention, treatment and recovery programs. OASAS chemical dependence treatment programs assist about 100,000 people a day.
  - **Office of Child and Family Services (OCFS)** – serves New York's public by promoting the safety and well-being of our children and families.
  - **Office of Mental Health (OMH)** – promotes the mental health and well-being of all New Yorkers. Our mission is to facilitate recovery for young to older adults receiving treatment for serious mental illness.
  - **Office for People With Developmental Disabilities (OPWDD)** – Coordinates services for more than 126,000 New Yorkers with intellectual and developmental disabilities, providing services directly and through a network of nearly 800 non-profit agencies.
- **Office of Medicaid Inspector General (OMIG)** – To enhance the integrity of the New York State Medicaid program by preventing and detecting fraudulent, abusive, and wasteful practices.
- **OPWDD Incident Management Unit (IMU)** – was established to provide real time oversight of critical elements of incident management across the state. This unit reviews incident reports and Significant and Critical Events to assure appropriate measures are put in place to protect persons with disabilities, including required notifications to law enforcement when appropriate. This is accomplished through the use of the Incident Report and Management Application (IRMA), which is a secure web-based statewide database. It is used to ensure consistency in incident reporting and is used by State operations and non-profit providers in the OPWDD system. (Employees 37 people.)

Glossary of Acronyms and Terms

- **Quality Assurance (QA)** – Activities and programs intended to assure or improve the quality of care in either a defined medical setting or a program.
- **Required forms to be completed for OPWDD operated or certified programs for Reportable Incidents:**
  - OPWDD 147: Reportable Incidents and Notable Occurrences (fillable PDF) – effective 1/1/2016
  - OPWDD 147: Reportable Incidents and Notable Occurrences – Completion Instructions
  - OPWDD 148: Report on Actions Taken in Response to an Incident
  - OPWDD 149: Investigative Report Format - Completion Instructions - POST April 30, 2015
  - OPWDD 149: Investigative Report Format - POST April 30, 2015
  - OPWDD 161 – Corrective Action Plan (CAP) Submission Form
  - OPWDD 161a – Corrective Action Plan (CAP) Submission Form Continuation Page
  - OPWDD 162 – Report of Death
  - OPWDD 163 – Reportable Abuse/Neglect Personal Representative Notification Documentation – effective July 1, 2015
- **Required Pre-Employment Checks:** Required for prospective employees or volunteers who will have regular and substantial unsupervised or unrestricted contact with persons receiving services through a service provider.
  - **State Central Registry (SCR)** – Child Abuse Registry maintained by OCFS.
  - **Criminal Background Check (CBC)** – a request for information regarding pending criminal charges and criminal convictions.
  - **Staff Exclusion List (SEL)** – a statewide register which contains the names of individuals (e.g., employee, volunteer, intern, consultant, contractor) found responsible for serious or repeated acts of abuse and neglect. Individuals on the Staff Exclusion List (SEL) are prohibited from being hired by any State operated, certified or licensed agencies/providers that serve people with special needs.
- **Voluntary or Developmental Disabilities Provider** – Non-profit agency certified, licensed, or authorized by OPWDD to provide services to individuals with intellectual and developmental disabilities.
- **Vulnerable Persons Central Registry (VPCR)** – Justice Center's incident management database and staff exclusion database.
- **Web Submission of Investigation Reports (WSIR)** – Web application for Voluntary Providers to submit investigation reports to the Justice Center. Information entered and uploaded is imported into the VPCR.

About the Survey: In 2016, responses from 119 non-profit, voluntary disability service agencies located in NYS were compiled from an online survey asking questions to determine the impact of the NYS Justice Center on the people they support, their staff, and their overall operations through various measures. The data reflects experiences through the end of 2015. All respondents operate programs subject to Justice Center oversight, largely OPWDD programs but with a significant number also operating programs under other State agency licensures. The survey was developed to capture the experiences these provider agencies have had since the implementation of the NYS Justice Center began in July 2013. Some of the time and cost information was collected through time studies performed by a sampling of agencies, and other cost/time information was collected across all survey respondents.

Editor's Note: It must be disclosed that more than one agency representing providers across New York had worked on the early drafts of the document, but chose not to endorse the report as presented. Among the reasons cited for not signing on to the report was that "there have been improvements in the Justice Center's operations" and the timing of this report did not seem right. The organizations presenting these findings remain convinced that even with some operational improvements, the fundamental goals of the Justice Center are not being met. One of the key goals of this survey and report is to use the findings to prompt changes to ensure the Justice Center will efficiently meet its originally identified goals, which we collectively support.

*The document referred to as "the Sundram Report":
The Measure of a Society: Protection of Vulnerable Persons in Residential Facilities Against Abuse & Neglect, Report Submitted to Governor Andrew Cuomo by Clarence J. Sundram, Governor's Special Advisor on Vulnerable Persons, April 2012.

Survey Findings: The NYS Justice Center's Impact on the Disability Sector

October 2016

We report our survey findings with high hopes that policymakers in the State will take swift action to effect meaningful change in the administrative processes the Justice Center has implemented.

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