OFFICE OF THE CHILD ADVOCATE
REPORT

ARTHUR BRISBANE CHILD TREATMENT CENTER INVESTIGATION
An Examination of Conditions of Care And Recommendations for Reform

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This Report memorializes the Office of the Child Advocate's (the "OCA") findings and conclusions regarding the conditions of care for children and youth served by the Arthur Brisbane Child Treatment Center ("Brisbane" or "ABCTC") in Farmingdale, New Jersey. This report consists of four sections: (I) Introduction, which summarizes and describes the initiation, scope and framework of the investigation; (II) Conditions of Care, including a summary of the historical background of Brisbane and the findings of the OCA investigation; (III) Systems of Care, which examines developments in mental health services for children and adolescents; and (IV) a Conclusion with Recommendations.

I. INTRODUCTION

A. Summary of the OCA's Findings and Conclusions

Fourteen years ago, court-appointed expert Dr. Robert Friedman described the basis for operating Brisbane as the state's only public psychiatric hospital for children in a report[1] to the New Jersey Superior Court pursuant to *Slocum v. Perselay*,[2] a lawsuit filed in 1986 by the Public Advocate of New Jersey against the Acting Commissioner of the Department of Human Services. The suit alleged harm to children "caused by their institutionalization in a single centralized state hospital isolated from their families and communities of origin outmoded by current psychiatric theories and techniques."[3] The Friedman report concluded "[t]he primary rationale for providing residential treatment in a centralized, statewide facility such as the ABCTC would be if it were uniquely able, by virtue of its physical facility, staff, and program, to provide an exceptionally high quality and cost-effective service, or if there were no other way to meet the need."[4] Based on a

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1 Robert M. Friedman, Ph.D., Recommendations to the Superior Court: *Slocum v. Perselay* (Aug. 1990) at 5 (*hereinafter* Friedman Report).
2 *Slocum v. Perselay,* Docket No. L86-2715 (N.J. Super. Ct. Law Div. June 27, 1986) (*hereinafter Slocum v. Perselay).*
3 *Slocum v. Perselay*, Compl. at 3.
4 Friedman Report at p. 5.

comprehensive investigation into conditions of care for children at Brisbane over the past seven months, the OCA concludes that Brisbane generally fails to meet the rationale for providing exceptionally high quality and cost effective mental health services to children. Our investigation also considered the efficacy of services available within the broader children's behavioral health system. We conclude this system is plagued by gaps that prevent children from being able to leave Brisbane when ready.

Brisbane consistently operates over-census and is crowded. In Calendar Year 2003, Brisbane exceeded its permitted census of 40 children on 132 days. Four or five children are assigned to each bedroom. Programming is similarly sub-optimal, involving not more than one hour of individual therapy per child per week, minimal group therapy sessions or recreational activities, and a system for conducting family therapy that has only recently managed to include fifty percent of the patients' families.

Nearly one in five children who were discharged from Brisbane between April 21, 2002 and March 31, 2004, had a prior admission to the facility. Of these (25) children with a history of past admissions to Brisbane, 17 were discharged, re-admitted, then discharged again within the period (April 21, 2002 to March 31, 2004). All of these children were readmitted within one year of their first discharge from the hospital, and most were readmitted within four months. The cycling of children into and out of Brisbane draws into question the efficacy of the hospital's ability to stabilize children.

The utility of Brisbane cannot be evaluated in isolation from the broader behavioral health system. Indeed, a pivotal question arising out of the Public Advocate's *Slocum* litigation was whether New Jersey would develop the community-based capacity to provide a true continuum of

care for children. Sadly, it has not. Recognition that a comprehensive, community-based system of behavioral healthcare was sorely needed was evidenced in 2000 with the creation of the Children's System of Care Initiative, later renamed the Partnership for Children and most recently incorporated into the newly created Division of Child Behavioral Health Services. Huge hurdles remain. As Human Services Commissioner James M. Davy stated in his April 7, 2004, testimony before the New Jersey Senate, "Because we lack resource families, treatment homes and community-based residential services for teenagers, too many children end up spending too much time in institutions."[5]

Throughout Calendar Year 2003, the vast majority of youth at Brisbane was designated as Conditional Extension Pending Placement (CEPP), which is the legal classification applied to youth who no longer meet the standard of dangerousness required for civil commitment to a psychiatric hospital. These are children who have been determined ready to be discharged, who nonetheless remain confined at Brisbane because of a scarcity of step-down placements and services. On January 31, 2003, 66 percent of the ABCTC population, (21 children), were on CEPP status. As of June 30, 2003, 60 percent of children, (27 children), at Brisbane were on CEPP status, and as of December 31, 2003, 70 percent of the facility's children, (32 children), were on CEPP status. Based on our review of the children's records, we are not aware of a single child, either independently or through their guardians, opposing placement in community-based care. Yet, the State continued to keep them isolated at Brisbane and failed to provide services to these youth in the most integrated settings appropriate, due primarily to a lack of services and programs in the community. As best stated in New Jersey Protection and Advocacy's 1999 Report, *A Review of the Care and Treatment Provided by New Jersey's Arthur Brisbane Child Treatment Center*, "[b]ehind the questions of whether

5 Testimony of James M. Davy, Commissioner of Human Services, April 7, 2004.

Brisbane should be closed, or whether Brisbane can be fixed to continue to serve the [] severely mentally ill adolescents who need long-term psychiatric inpatient care, hides the fundamental issue of the ***defacto or real role of Brisbane-to house the much larger group of adolescents who no longer need commitment but have no where else to go.***" [6]

At its most basic level, Brisbane's physical plant is unsafe due to its age, poor physical layout and condition. Despite the fact that 79 percent of the children admitted to the facility are suicidal or evidence self destructive behavior, suicide risks pervade in the bedrooms, bathrooms and common areas. Despite the fact that a child attempted to hang himself with a cord attached to a cage surrounding a smoke detector in May 2003, the OCA observed identical suicide risks throughout the physical plant in a March 2004 field survey. Moreover, the living areas have lead paint and asbestos concerns, and sections of the slate roof break off and fall, causing a hazard to children and staff.

Safety concerns created by the poor physical plant result in high staffing needs, which is not cost-effective. Brisbane currently employs 216 staff to serve 38 to 47 children per day. A significant number of employees are unqualified to work with children in need of acute psychiatric treatment. Most of Brisbane's Charge Nurses, for example, have no prior experience working with persons with mental health needs. During this investigation, OCA conducted a sample audit of 40 youth workers' personnel files and determined that 50 percent of the staff had absolutely no prior experience working with youth. Another 16 youth workers' prior experiences were limited to child-related summer positions, such as camp counselors. Four workers had prior employment experience at Marlboro Adult Psychiatric Hospital.

As part of this investigation, the OCA identified ten employees who were most frequently

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6 Nancy D. Feldman, J.D., New Jersey Protection and Advocacy, Inc., *A Review of the Care and Treatment Provided by New Jersey's Arthur Brisbane Child Treatment Center*, May 1999 (*hereinafter* Feldman Report), p. 39

identified as alleged perpetrators of abuse and neglect against children at Brisbane from April 1, 2002 to December 31, 2003, according to Human Services Police Reports and documents from the Institutional Abuse Investigation Unit at the Department of Human Services. These ten employees were identified in 62 separate incidents. Most of these employees had no prior work experience with children, and none had any prior professional experience working with mentally ill children.

The essential issue is whether the data and information available to the State over the past fourteen years, in concert with the findings from this investigation, suggest that Brisbane provides the quality of behavioral healthcare that children need and deserve. Sadly, it does not. It should not go without saying that there have been significant and positive leadership changes at Brisbane in the last year, and the vision and commitment of this new leadership team perhaps portend better days ahead for children on the campus. But the record is clear that Brisbane has been and continues to be a warehouse of sorts for many of New Jersey's most acutely ill children.

While no one disputes that a very real need exists for some cohort of children to have ready access to intensive, in-patient, perhaps even long-term care, continued reliance upon Brisbane as the State's safety net for its sickest children ignores the fundamental flaws, indeed crisis-level deficiencies, which have been identified in detail, publicly reported, and essentially ignored for the last fourteen years. Indeed, the State, through a number of Administrations, has largely dismissed the experts and advocates who have identified the problems associated with Brisbane and the need for community and alternative investments for quality care. This present generation of children served by Brisbane should not look to 2004 as the year that conditions and treatment could have improved but did not. Surely these children - many of whom were not even born when the *Slocum*

(emphasis in original).

case was litigated - could have fared much better than they are doing now.

B. Background of the OCA's Inquiry

1. The Initiation of the OCA Inquiry

The OCA was created to, among other things, "seek to ensure the provision of effective, appropriate and timely services for children at risk of abuse and neglect in the State;"[7] "inspect and review the operations, policies and procedures of...any other public or private residential setting in which a child has been placed by a State or county agency or department;"[8] and "review, evaluate, report on and make recommendations concerning the procedures established by any State agency providing services to children who are at risk of abuse and neglect, children in State or institutional custody, or children who receive child protective or permanency services."[9]

Brisbane is New Jersey's only public psychiatric hospital that serves children and youth, ages eleven -17. The OCA's jurisdiction extends to this facility and the conditions of care and mental health services to its residents. On October 14, 2003, based upon concerns raised by mental health advocates, the OCA launched a formal investigation into the conditions of care for children and youth served at Brisbane.

2. The Scope of the OCA Investigation

The OCA's initial investigation was inclusive of the prior eighteen (18) months, and included an examination of the following documents, produced by the Department of Human Services:

- Critical/Unusual Incident reports;
- Department of Human Services' Police reports;
- Patient Services Compliance Unit reports;
- Joint Commission on the Accreditation of Health Organizations reports;
- Census reports;

7 N.J.S.A. §52:17D-4a.
8 N.J.S.A. §52:17D-5b(3).
9 N.J.S.A. §52:17D-5c.

- Community Eligible Pending Placement (CEPP) reports;
- Information regarding the number of restraints administered; and
- All other investigative and/or evaluative documents and information relevant to the Arthur Brisbane Child Treatment Center.

The following information was also subpoenaed from the Department of Human Services:

- Congregate care safety assessments, conducted pursuant to the settlement agreement in *Charlie and Nadine H. v. McGreevey,* Civ. Action No. 99-3678 (SRC);
- Documentation of restraints/holds;
- Organizational charts for all ABCTC employees;
- Standard operating procedures and policy manual;
- Intake assessment reports for ABCTC residents from April 1, 2002 through December 31, 2003;
- Discharge plans for ABCTC residents from April 1, 2002 through December 31, 2003;
- Medication Records for ABCTC residents from April 1, 2002 through October 14, 2003;
- Medicaid reimbursement rates for Brisbane population;
- Medicaid documents that state the designation or classification of Bisbane for purposes of Medicaid reimbursement;
- State spending plans from 2001 to present, including appropriations to Brisbane;
- Documents pertaining to ABCTC patient savings accounts for the period of April 1, 2002 through October 14, 2003;
- ABCTC census data for the period of April 1, 2002 through December 31, 2003;
- Staff training materials and attendance sheets;
- Chemical restraint or PRN administration log book for the period of April 1, 2002 to October 14, 2003, with attendant trend reports;
- Administrative Order No. 2:05;
- Union Grievances;
- Abuse and neglect histories of personnel (request remains outstanding); and
- Disciplinary actions imposed upon personnel (request remains outstanding).

In addition to this document review, OCA staff interviewed the facility's administration, representatives from the Department of Human Services - Office of Children's Behavioral Health Services, mental health providers, representative child advocates, experts from other state systems, and academicians.

II. CONDITIONS OF CARE

A. Historical Background of Brisbane

Prior to the creation of New Jersey's mental health system as we know it today, the state's only acute residential mental health setting for adolescents was the Adolescent Unit of Trenton Psychiatric Hospital. On June 27, 1986, the Public Advocate of New Jersey, Alfred P. Slocum, filed suit in Mercer County Superior Court against the Acting Commissioner of the Department of Human Services on behalf of children hospitalized at the Adolescent Unit in a lawsuit captioned *Slocum v. Perselay*.[10] The suit alleged harm to these children "caused by their institutionalization in a single centralized state hospital isolated from their families and communities of origin outmoded by current psychiatric theories and techniques."[11] The Complaint alleged many children no longer required hospitalization but remained at the facility simply because of the state's failure to identify, locate, provide, and develop the appropriate and less restrictive placements outside of Trenton Psychiatric Hospital.[12] Harm to the children was exacerbated by specific allegations of dangerous and anti-therapeutic conditions at the hospital, which conditions consisted of "an improperly trained staff, a lack of proper supervision of the patients, exposure to physical injury without protection, improper use of physical bonds to restrain children, overuse of chemical restraints to control behavior, and lack of fresh air and exercise at the facility."[13]

The relief sought by way of *Slocum* included protection to ensure that the children did not endure "further physical and psychological harm and the development of a plan and timetable

10 *Slocum v. Perselay*, Compl. at p. 3.
11 *Id.*
12 *Id.*
13 *Id.*

compelling the defendants to close Trenton Psychiatric Hospital Adolescent Unit and replace it with necessary and appropriate mental health services forthwith either in their homes or in community facilities."[14]

In settlement of the lawsuit, the state agreed to a myriad of provisions,[15] the most relevant of which involved (i) modifying the physical plant of Brisbane and creating a Statewide Back-Up Unit (SBU) there to replace the Adolescent Unit of Trenton Psychiatric Hospital and serve a maximum of 40 children aged eleven to 17 who could not be served in a community based program; and (ii) development of a continuum of care for the treatment of emotionally disturbed children, through regional mental health service delivery which would include 33 community based programs, including an adequate number of residential schools and other placements.[16]

As observed in the *Slocum* litigation, "the ABCTC serves as just one part of the overall system of care in New Jersey for children with emotional disorders, and [] the functioning of the ABCTC is affected by the status and effectiveness of other components of the system."[17] A pivotal question arising out of *Slocum* was whether New Jersey would develop the community-based capacity to provide a true continuum of care. Because it has not, the State has not achieved the goal recognized in *Slocum* of optimally treating children and adolescents in normalized community settings and minimizing the number of children in residential or institutional settings.

B. Present Conditions at Brisbane

1. Brisbane's Mission

Brisbane is designated as a psychiatric inpatient facility and governed by New Jersey's

14 *Id.*
15 *Slocum v. Perselay,* Consent Order at pp. 4-6.
16 *Id.*

Department of Human Services within its new Division of Children's Behavioral Health.[18, 19] "The mission of the ABCTC is to provide quality intermediate to long term psychiatric inpatient care and treatment for the purpose of stabilizing individuals between the ages of eleven and seventeen who are legally committed as a result of an ongoing psychiatric disorder."[20]

2. The Children of Brisbane: An Overview of the 108 Children Admitted in 2003[21]

In 2003, 108 children were admitted to Brisbane. Of the total admissions, 106 (98 percent) were involuntarily committed to the facility; one child (1 percent) was classified as voluntarily admitted; and one child (1 percent) was classified as a *Krol*[22] admission.[23] Approximately half of the

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17 Friedman Report at p. 1.

18 In addition to the treatment program for children in need of acute psychiatric treatment, two other programs operate on the facility grounds. The New Jersey Juvenile Justice Commission (JJC) operates a program known as Fresh Start, a program serving boys aged 13 - 18. The mission of this program is to provide treatment for youth with special needs, particularly those youth identified as seriously emotionally disturbed, impaired or otherwise vulnerable within the JJC's other programs and institutions. Fresh Start is a self-contained program situated on the rear of Brisbane grounds, with residential space and academic and vocational classes held on-site. (ABCTC Standard Operating Procedures Manual at p. 1).

A second program, Phoebe's Place, is a one-year residential program for eight adolescent girls housed in a wing of the Main House. As with the JJC program, the residents of Phoebe's Place are essentially segregated from the hospital patients. The mission of Phoebe's Place is "to provide a safe therapeutic environment for girls who are in need of long term residential treatment and because of their psychiatric and emotional needs, are at risk of being referred to out of state DYFS residential treatment facilities or are being returned from DYFS residential treatment facilities." (ABCTC Standard Operating Procedures, Screening and Admission Policy: Phoebe's Place, April 15, 1999) The programmatic goal is "to move the residents toward self-sufficiency and independence and wherever possible discharge residents to a community based environment." (ABCTC Standard Operating Procedures, Screening and Admission Policy: Phoebe's Place, April 15, 1999).

In 2003, 14 females were admitted to Phoebe's Place, ranging in age from 16-19. Of this population, four (29 percent) entered the program directly from Brisbane. Similarly, four of the females (29 percent) were DYFS involved. The female patients have histories of psychiatric hospitalizations and complex behavioral health needs. For example, of the 14 admissions in 2003, 6 patients, or 43 percent of the total admissions, had at least four prior hospitalizations and one patient had as many as ten hospital admissions prior to entering Phoebe's Place. The most prevalent family issue, identified by eight females, was substance abuse involvement. For the nine females for whom a personal abuse history was identifiable, five females were identified as having been sexually abused; three females were identified as having been physically abused and neglected; and one female was identified as being a substance abuser.

19 Interview with Kathi Way, Director, Division of Child Behavioral Health Services, Department of Human Services (March 30, 2004).

20 ABCTC Standard Operating Procedures Manual, p. 1.

21 2003 ABCTC Population Statistics Charts, provided by ABCTC administration.

22 The standard for commitment was set forth in *State v. Krol*, 68 N.J. 236(1975). In *Krol*, the Court held that "the rationale for involuntarily committing such persons...is, rather, to protect society against individuals who, through no culpable fault of their own, pose a threat to public safety." *Id.* at 246. Further, "The standard for commitment is simply

population was DYFS-involved.[24] Despite fluctuations in the male:female ratio throughout the year, the annual admissions are nearly evenly split. In 2003, 58 males (54 percent) and 50 females (46 percent) were admitted. The majority of the patients are between the ages of 15 and 17 (74 patients, or 69 percent)[25] and have complex behavioral health needs. Most children admitted to Brisbane in 2003 had multiple diagnoses, with over 50 percent diagnosed as having impulse control problems and/or mood disorders; a third classified as having psychosis; nearly 20 percent identified with substance related problems and/or personality disorders; ten percent classified as mildly mentally retarded; and approximately seven percent diagnosed with anxiety disorders.[26] At the time of admission, the most prevalent symptom was suicidal or self-destructive behavior (85 patients or 79 percent of total admissions). Other diagnosable psychiatric symptoms at admission included, in descending order of prevalence, thought or mood disorders; aggressive behavior; homicidal ideations; fire setting; and cruelty to animals.[27]

The overwhelming majority of patients enter Brisbane directly from Children's Crisis Intervention Services (CCIS). In 2003, 77 children, or 71 percent of total Brisbane admissions, came directly from CCIS Units throughout the state.[28] Utilized as part of New Jersey's initiative to help emotionally troubled children, CCIS Units are "acute care psychiatric inpatient units that serve youth between the ages of five and 17 who have been screened by a designated mental health emergency or

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that defendant's 'insanity continues' ." *Id.* at 247. However, the State must do more than "establish a possibility that defendant might commit some dangerous acts at some time in the indefinite future." *Id.* at 260. Further, when the court does order a commitment, it "should be molded so as to protect society's very strong interest in public safety but to do so in a fashion that reasonably minimizes infringements upon defendant's liberty..." *Id.* at 257. *In re Commitment of G.K.,* 363 N.J.Super. 228, 230 (Law Div., April 16, 2003).

23. *See supra* fn. 21.

24 *Id*.

25 *Id*.

26 *Id*.

27 *Id*.

28 *Id*.

screening service and received a primary psychiatric diagnosis, and who exhibit a level of personal and social functioning impairment warranting psychiatric crisis intervention and/or treatment."[29]

The Juvenile Justice Commission is the second largest referral source to Brisbane, with 23 children, or 21 percent of the total admissions in 2003, having been referred from detention for acute psychiatric services. This data is consistent with a 2001 assessment of youth in New Jersey's juvenile justice system performed by a partnership between New Jersey's Juvenile Justice Commission and the New York Psychiatric Institute and Columbia University. Using the Diagnostic Statistical Manual Diagnostic Interview Schedule for Children (DSM-DISC IV), the assessment revealed that "[n]early two-thirds of youth (63%) had one or more diagnoses on the DSM-DISC IV. More than one-third (34%) of youth had more than one diagnoses. Sixteen percent of the youths had three or more diagnoses."[30]

3. Children Discharged Between April 21, 2002 and March 31, 2004

A striking commonality among patients, regardless of their referral source, is the high number of prior placements they experienced. Of 178 children discharged from Brisbane between April 21, 2002 and March 31, 2004, the OCA obtained and analyzed comprehensive, pre-admission records for 138 youth. The records document that the majority of children had experienced a significant history of psychiatric institutional care prior to their most recent admission to Brisbane. One hundred-twenty five children, or 91 percent of the cohort, experienced 491 episodes of psychiatric hospitalization, outside Brisbane, prior to their admission. But a significant number of children also had an extensive pre-admission history at Brisbane. Twenty-five children, or roughly 18 percent of

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29 Mental Health Programs, www.state.nj.us/humanservices/dmhs/MHDirProgOrder.doc (visited April 2004).
30 Bruce D. Stout, University of Medicine and Dentistry of New Jersey, "Connecting the Dots – New Jersey Juvenile Justice: Past, Present and Future" (December 2003).

the cohort, experienced 35 prior admissions to Brisbane. Taken together, the medical records revealed 127 residents of Brisbane who had experienced 526 prior psychiatric hospitalizations, including a significant plurality of children who had previously cycled through Brisbane prior to their most recent admission. The number of prior stays at Brisbane varied slightly. Seventeen children had one documented admission to Brisbane prior to their most recent stay. Five children had two documented prior admissions; one child had three, and one child had four.

OCA evaluated length of stay data for every child discharged between April 21, 2002 and March 31, 2004. The median length of stay at Brisbane for all children was 3.5 months. In fact, ninety-five youth remained at the facility for not more than 3.5 months. Fifty children experienced a period of hospitalization between four and six months. Twenty-seven children were hospitalized between 6.5 and 9 months. And six children experienced stays that ranged between 10 and 18.5 months.

Of the 25 children with a history of past admissions to Brisbane, 17 were discharged, re-admitted, then discharged again within the review period (April 21, 2002 to March 31, 2004). All of these children were readmitted within one year of their first discharge from the hospital, and most were readmitted within 4 months.

- For example, child D.A. was hospitalized at Brisbane from June 11, 2002 to December 23, 2002; readmitted from April 8, 2003 until August 6, 2003; discharged to a group home; then re-hospitalized at Brisbane from September 4, 2003 until December 2, 2003.
- Child J.L. was hospitalized at Brisbane from February 20, 2002 to June 12, 2002; discharged to a group home; re-admitted from August 2, 2002 until December 4,

2002, when she was placed at Phoebe's Place on the grounds of Brisbane campus; and again re-admitted to Brisbane from May 15, 2003 until October 8, 2003.

In two instances where children were discharged from Brisbane to a juvenile justice setting, the youth were re-admitted within two days of discharge. Both children experienced three distinct admissions to Brisbane totaling 12 and 16 months, respectively, during the review period.

The average number of prior psychiatric hospitalizations was four, and the median number of prior psychiatric hospitalizations per child was three. Forty-two children experienced one or two prior psychiatric hospitalizations, and an additional 46 children experienced three or four previous hospitalizations. Thirty-six children experienced between five and 11 prior episodes of psychiatric hospitalizations, and three children experienced relatively high episodes of prior psychiatric hospitalization (16, 19 and 22 admissions respectively). Five children had also resided at one of three DYFS-operated diagnostic centers in Woodbridge, Vineland and Ewing, prior to their most recent admission to Brisbane.

In general, the recurrent, episodic nature of these children's institutionalization draws into question the effectiveness of the State's continuum of mental health services. If the mission of Brisbane – and psychiatric hospitalization generally – is to stabilize a child's mental health crisis and then transition the child to a less intensive and restrictive intervention, the efficacy of this continuum of care is drawn into question by two findings: (1) nearly one in five children discharged from Brisbane between April 21, 2002 and March 31, 2004 had been admitted to the facility at least once prior to their most recent admission; and (2) 92 percent of children had endured at least one, and typically three, prior psychiatric hospitalizations.

More than one-quarter of the children who were discharged from Brisbane during this period had a history of juvenile detention. Thirty-six children, or roughly 26 percent of the cohort of 138 children whose medical records were reviewed by OCA, had been arrested and detained prior to their admission to the hospital. Of the total 178 children discharged from Brisbane within the review period, 28 children, or roughly 16 percent, were discharged from Brisbane to juvenile detention or post-adjudicative secure confinement.

Forty-seven percent of children with a history of juvenile detention prior to their most recent admission to Brisbane had no previous psychiatric hospitalizations, compared to just eight percent of the total population of children admitted to the facility. This suggests that once children enter a classically defined public system such as the juvenile justice system, they are less likely to obtain mental health services than children for whom the mental health system is their primary portal, regardless of need.

C. Investigation Findings

1. Unsafe setting due to physical plant

In its current state, the physical plant is non-therapeutic and poses serious and immediate risks to children's well-being. Capital Budget Plans dating back to 2002 and independent citations from the Joint Commission on Accreditation of Health Care Organizations ("JCAHO") issued as recently as 2003 evidence that the State has long been aware of, but not adequately addressed all the risks to children posed by Brisbane's physical plant.

According to then-CEO Raymond C. Grimaldi in a 2003 budget request to the Department of Human Services, "[t]he buildings used to house the children in Cottages A, B, Phoebe's Place, and the Co-Ed Unit are aged and are becoming more difficult to maintain, as plumbing and electrical

parts become obsolete. All the living areas have lead paint and asbestos concerns."[31] Plant deficiencies and safety concerns at Brisbane abound, even after a May 2002 Joint Commission survey criticized the following:

- The square footage per patient is inadequate in the living areas resulting in overcrowding of the children.
- The shower stalls do not provide adequate privacy and are inadequate for the number of children served.
- Footbaths leading into the showers in Cottages "A" and "B" present a tripping hazard.
- The bathrooms are inadequate for the number of children served during times of increased census.
- The exhaust fans in the living areas are not adequate, resulting in poor air quality.
- Clouded and marred Plexiglass throughout the units is in need of replacement.
- All asbestos floors must be replaced.

The Main House includes a Co-Ed Unit that currently houses 15 children,[32] despite the fact that its age and poor physical state endanger child welfare. "Sections of the slate roof are breaking and falling causing a hazard to the children, staff and visitors. Leaking water from storms and animals gaining entrance to the building also creates a health hazard."[33] The bathroom and showers in the Main House "leak into the floors and walls causing damage, mold and mildew which pose a safety and health concern for the children."[34] Floor tiles in the Main House living units are more than 50 years old and in disrepair, causing safety and asbestos-related concerns.[35]

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31 Memo from Raymond C. Grimaldi, CEO, ABCTC to Pat Macionis, Department of Human Services, Division of Mental Health Services, Bureau of Planning (June 19, 2003).
32 Population Census as of the OCA's most recent site visit of April 20, 2004.
33 Fiscal Year 2005 Capital Budget submitted on June 19, 2003 by then-CEO Raymond C. Grimaldi at 1 (*hereinafter* FY 2005 Capital Budget).
34 *Id.*
35 *Id.*

Cottages A and B currently house 15 girls and 19 boys respectively,[36] despite similar safety concerns. The main bathroom showers and floor tiles in the cottages were installed in 1958 and "leak into the floors and walls, creating a safety and health hazard for the children."[37] Repairs are complicated by the fact that the plumbing systems are so old, parts have become scarce.[38] The cottage bathroom facilities are otherwise insufficient to meet the children's needs. There are 2 showers, 3 toilets, and 4 sinks in the bathroom in Cottage A for 15 children; and 2 showers, 3 toilets, 2 urinals, and 4 sinks in the bathroom in Cottage B for 19 children. The FY 2005 Capital Budget seeks expansion of these facilities by 2 showers and 1 toilet per cottage bathroom in addition to needed renovations.[39]

Suicide risks pervade the residential units. As recently as June 2003, JCAHO cited the facility as needing corrective action to reduce the prevalence of suicide risks.[40] Still, dangerous conditions persist and threaten the lives of the residents. From April 2002 to December 2003, six children attempted suicide at Brisbane according to Institutional Abuse Investigation Unit or Human Services Police Reports. Of these attempts, four involved youth attempting to hang themselves, including one child who used a cord attached to a cage around a ceiling-mounted smoke detector in May 2003. Nearly one year later, OCA identified identical cages still in place in the children's bedrooms and immediately notified the administration of our concern. The metal cages surrounding the smoke alarms were removed by the time of the OCA's April 20, 2004 site visit. Metal and plexi-glass cages still cover the air conditioners in the sleeping rooms, which creates an opportunity

36 *See supra* fn. 32.
37 FY 2005 Capital Budget for Cottage A & B Bathroom & Shower Replacements.
38 *Id.*
39 *Id.*
40 Joint Commission on Accreditation of Healthcare Organizations, Official Accreditation Decision Report, June 3, 2003.

for patients to hang themselves by their bed sheets or other means.[41] Other concerns identified during OCA site visits include exposed electrical outlets and poorly designed shower stalls, both of which pose suicide risks. The administration compensates for the poor design of the facility and the prevalence of suicide risks by operating with a high staffing level in order to observe patients.[42] The facility currently employs 216 full-time staff, 5 part-time staff, a handful of consultants and 12 temporary workers in order to serve 38 to 47 children a day.

Other, more general safety risks abound. An old garage on the grounds is "no longer usable and poses a safety hazard to patients, staff and visitors."[43] The campus is heavily wooded and susceptible to fire hazards. The presence of only one paved road in and out of the facility inhibits the ability of children, staff and visitors to leave the grounds safely in the event of a fire emergency.[44]

2. Overcrowding

The physical plant does not permit patient privacy or personal space. During our April 20, 2004 site visit, we found that five of the facility's sleeping rooms were housing four residents per room and one room was housing five children due to overcrowding. In addition to being cramped, the cottages lack normalized furniture such as dressers and night tables, which results in insufficient patient storage space and privacy.[45]

The facility is often in violation of the *Slocum*-mandated census of 40 residents. In Calendar Year 2003, the facility was over-census on 132 days. (ABCTC Census Data 1/1/03 – 12/31/03) During 2003, the facility was at its most overcrowded with a census of 47 residents on May 28th and

41 In addition, sharp edges around the air conditioning units could allow a child to injure himself or others. According to a HSP report dated August 5, 2003, for example, child BM broke a piece of plastic from the air conditioner unit and repeatedly tried to stab child AS, making contact with AS' upper right arm.
42 Interview with Kathleen Enerlich, Interim CEO, ABCTC, March 31, 2004.
43 FY 2005 Capital Budget at p. 1.
44 *Id.*

29th, June 4th and 5th, July 9th, 17th, 22nd, 23rd, 29th, and 30th, August 5th, and December 29th. During the OCA's most recent site visit on April 20, 2004, the facility was similarly over-census.

3. Non-therapeutic environment

Under the state commitment law, a child is committed to Brisbane because he or she is "in need of intensive psychotherapy that can be provided in a psychiatric facility, special hospital, or children's crisis intervention center and not in a community or at home." But the amount of therapy actually offered is alarmingly low. Simply stated, patients do not receive enough therapy. According to Brisbane administration, the therapeutic staff consists of five full time therapists and two part-time therapists, one of whom works 21 hours per week and another who works 15 hours per week. The administration reports that children receive 30 minutes of individual therapy two times per week, for a total of one hour of individual therapy per week. Half of the families reportedly receive therapy twice per month, the other half receives no therapy. The OCA was unable to substantiate the frequency and duration of patient and family therapy sessions. According to the administration, clinicians are required to document their individual therapy sessions on a bi-weekly basis and do not record the length of the sessions or the frequency of family therapy sessions.[46]

Due in part to the poor physical plant of Brisbane, there is an emphasis on staff "watching" the children rather than working with them. Instead of offering guidance and playing a supportive role, past reports and the OCA site visits support that Youth Workers (YW) are expected to serve as guards and behavior enforcers.[47] As noted by a Safety Assessment Team recently commissioned to review Brisbane by the Department of Human Services, the residents would be better served if the

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45 Safety Action Plan – Addendum Response to January 2004 Review, updated 3/10/04.
46 Interview with Kathleen Enerlich, Interim CEO, Dr. Frank Fortunati, Jr., Esq., Medical Director and Alice Alexander, Ph.D., Clinical Director, ABCTC (April 21, 2004).
47 *Id.*

YWs were asked to facilitate recreational activities, particularly because organized recreation is lacking at the facility.[48] During the OCA's April 20, 2004 site visit the administration acknowledged a lack of recreational programming, and pointed to a recently implemented practice of offering staff overtime to run recreational activities for the residents.

It is common practice among other inpatient treatment facilities to utilize equivalent para-professionals (i.e YWs) and nursing staff to run community groups, goal-setting skills groups, and to work on family issues with the residents.[49] Utilization of staff to increase the availability of these activities would improve the therapeutic environment, since time spent in group activities is acknowledged as beneficial for the residents.

4. High percentage of patients on "Conditional Extension Pending Placement (CEPP)" Status

"CEPP is the legal status applied to Brisbane patients who no longer meet the standard of dangerousness required for their civil commitment."[50] Recent data supports the facility's historical tendency to maintain up to 70 percent of its population on CEPP status.[51] Throughout the 2003 Calendar Year, the vast majority of youth at Brisbane were on CEPP status. On January 31, 2003, 66 percent of Brisbane population, (21 children), were on CEPP status. As of June 30, 2003, 60 percent of children, (27), were on CEPP status, and as of December 31 2003, 70 percent of

48 *See supra* fn. 45.

49 In a study focused on the effectiveness of one specific residential treatment model, the residents almost invariably asserted that "it was their relationship with child care workers that had the greatest impact on them." Martin Leichtman, Ph.D., et al, Am. J. of Orthopsychiatry, *Effectiveness of Intensive Short-Term Residential Treatment with Severly Disturbed Adolescents",* 227, 233 (2001) (*hereinafter* Leichtman). The program involved in the study utilized child care workers as "the central agents of change" who "serve both parental and therapeutic functions and are in continuous contact with the patients in the course of the day.…Emphasis is placed upon forming close relationships with child care workers who provide structure and discipline, help in negotiating tasks of daily living, and extensive individual attention in dealing with the emotional and behavioral problems as they arise in the course of the day. *Id.* at 228.

50 Feldman Report, at 21.

51 NJ Protection and Advocacy Data (03/10/04).

Brisbane's population, (32 children), were on CEPP status.[52] One possible explanation for the high number of children and adolescents with CEPP status is that medical advances allow for more rapid stabilization, thereby converting patients to CEPP status more quickly than in the past. A second possibility, however, is that CEPP status has become a legal solution to a statewide resource problem. A statewide lack of placements makes finding less restrictive placements for children and youth in recovery difficult.

5. Brisbane and the broader behavioral health system for children: Violating Olmstead

The fact that so many children and adolescents who do not meet State commitment standards are living on CEPP status at the most restrictive end of the continuum in inpatient care is problematic. According to United States Supreme Court case law, children with behavioral health problems, including serious emotional disturbances, have the right to receive services in the most integrated setting appropriate to their needs. In *Olmstead v. LC,*[53] the Supreme Court held that under the Americans with Disabilities Act (ADA), it is discriminatory for a state to institutionalize an individual with a disability when that individual can receive appropriate services in a less restrictive environment.[54] The foundation of the *Olmstead* decision rests on two principles: 1) that institutional placement "perpetuates unwarranted assumptions that persons so isolated are incapable or unworthy of participating in community life," and 2) that confinement in an institution "severely diminishes the every day life activities of individuals, including family relations, social contacts, work options,

52 During the 2003 calendar year, the ABCTC daily census ranged from 27 – 47 and the number of youth on CEPP status ranged from 21 - 32.
53 119 S. Ct. 2176 (1999).
54 *Olmstead* involved two mental health patients who alleged that that the State of Georgia violated the ADA integration mandate by unnecessarily segregating them in mental health institutions and failing to place them in community based treatment programs.

economic independence, educational advancement, and cultural enrichment."[55]

The reasoning of *Olmstead* clearly applies to children housed in New Jersey institutions. The unnecessary segregation of New Jersey children in institutions contributes to the assumption that they are dangerous and/or incapable of functioning in their home communities. Placing children in institutions also precludes them from participating in family outings, educational experiences, religious gatherings and community events. At Brisbane, for example, most residents' families live far from the facility; at least half of their families do not participate in therapy sessions with their children. The seclusion of children at Brisbane interferes with their development of close family relationships, which can be critical to positive mental health and development.[56]

The State, by housing children at Brisbane who do not need to be there, is in violation of *Olmstead*. Under *Olmstead,* unnecessary institutionalization violates the ADA when 1) the State's treatment professionals have determined that community placement is appropriate; 2) the affected persons do not oppose such treatment; and 3) the placement can be reasonably accommodated, taking into account the resources available to the State and the needs of others who are receiving State – supported disability services.[57]

In the case of children on CEPP status[58] at Brisbane, and other institutions across the state, the first two *Olmstead* requirements are obviously satisfied. Throughout the 2003 Calendar Year, the

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55 119 S. Ct. at 2187.

56 Family involvement on behalf of children at Brisbane is limited. Staff acknowledges that only half of the children housed at Brisbane have families participating in family therapy.

57 119 S. Ct. at 2176.

58 CEPP status is the legal status applied to Brisbane patients who no longer meet the standard of dangerousness required for their civil commitment but cannot be discharged because there are no available appropriate placements. R. 4:74-7(h)(2). CEPP status is evidenced by a court order, which conditionally extends the patient's hospitalization and schedules a placement review hearing 60 days thereafter. Any subsequent placement review hearings are held at intervals not greater than six months if the patient is not discharged earlier.

vast majority of youth at Brisbane were on CEPP status.[59] Based on the OCA's review of comprehensive case records, we know of no youth, either independently or through their guardians, opposing placements in community-based care. Yet, the State has not timely provided services to these youth in the most integrated settings appropriate to their needs and has not developed and implemented a time-specific plan to assure that this occurs.

With regard to the third prong of *Olmstead,* given the State's resources and the limited number of New Jersey's youth requiring institutional care, the placement of CEPP youth in community-based settings is clearly a reasonable accommodation. Under *Olmstead*, a state's financial burdens can be considered as a factor in a defense, but financial burden cannot, in and of itself, provide the basis for such a defense.[60] Also relevant to the viability of a defense is whether the State has a comprehensive, effectively working plan to place children with disabilities in less restrictive settings and a waiting list that moves at a reasonable pace.

For nearly the last four years, New Jersey's children have been directed to access behavioral health services through the Partnership for Children, a network of behavioral health programs administered by the Department of Human Services. Between Fiscal Year 2002 and Fiscal Year 2004, the Partnership's budget has grown from $116 million to $186.8 million. In addition, the Governor's proposed budget for FY 2005 recommends an appropriation for child welfare reform that is $140 million larger than the 2004 child welfare budget appropriated by the legislature in 2004. The State's Child Welfare Reform Plan, "A New Beginning," first submitted in February 2004 and scheduled to be finalized in June 2004, proposes an additional $180 million for Fiscal Year 2006. With this additional funding, it is clear that the Partnership could create necessary community-based

59 During the 2003 calendar year, the ABCTC daily census ranged from 27 – 47 and the number of youth on CEPP status ranged from 21 - 32.

placements, and place CEPP children in these placements, as appropriate, without jeopardizing the care provided to those youth requiring institutional placements.

Also relevant to *Olmstead* is whether the State has a comprehensive, effectively working plan for placing qualified persons with disabilities in less restrictive settings and a waiting list that moves at a reasonable pace, not controlled by the state's endeavors to keep its institutions fully occupied. In New Jersey, the State's Plan for meeting the requirements of *Olmstead* fails to do so.[61] In November 2000, the Governor convened the "Stakeholder Task Force on the Olmstead Decision"

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60 *Frederick L. v. Department of Public Welfare of Pennsylvania*, No. 02-3721 (3rd Cir. April 2004).

61 The U.S. Department of Health and Human Services (DHHS) provided all states with guidance on how to develop comprehensive, effectively working *Olmstead* plans In this document, DHHS strongly recommends that states factor in several principles and practices, listed here in part, when developing plans tailored to their needs:

1) The plan ensures the transition of qualified individuals into community based settings at a reasonable pace. The State identifies improvements that could be made for this to occur.

2) The plan evaluates the adequacy with which the State is conducting thorough, objective and periodic reviews of all individuals with disabilities in institutional settings to determine the extent to which they can and should receive services in a more integrated setting.

3) The State has a reliable sense of how many individuals with disabilities are currently institutionalized and eligible for services in community-based settings. The plan considers what information and data collection systems exist to enable the State to make this determination and considers improvements in data collection, where appropriate.

4) The State evaluates whether existing assessment procedures are adequate to identify individuals in the community who are at risk of placement in an unnecessarily restrictive setting.

5) The plan ensures the state can act in a timely and effective manner in response to the findings of any assessment process.

6) The plan identifies what community based services are available in the State and their capacity. The state identifies what improvements could be made to make the system better and more comprehensive.

7) The State examines how identified supports and services integrate the individual into the community.

8) The plan examines the operation of waiting lists, if any. It examines what might be done to ensure that people are able to come off waiting lists and receive needed community services at a reasonable pace.

9) The plan ensures that individuals who may be eligible for services in integrated community settings (and their representatives, where appropriate) are given the opportunity to make informed choices regarding whether and how their needs can best be met.

10) The State reviews what funding sources are available to increase the availability of community-based services.

to guide New Jersey in the shaping of a comprehensive working plan that "reflects a statewide vision for achieving community integration for people across all disability groups."[62] That plan, "Achieving Community Integration for People with Disabilities" completed in 2001, outlined core values, guiding principles, expected outcomes and recommendations for change. It did not, however, set forth implementation time frames, discuss with specificity how children's assessment, placement and transitional service needs will be met, or list indicators that will be tracked to demonstrate if the plan is being effectively implemented and whether it is making a meaningful difference in the lives of children. In addition, although the plan was drafted several years ago, there has not been an evaluation of the extent to which the recommendations set forth in the plan have been implemented or the extent to which they are benefiting children.

There appear to be significant gaps in the New Jersey *Olmstead* plan and its implementation as it relates to children.[63] First, the Plan does not identify the number of children in needlessly segregated settings or at risk of entry into these settings. Second, the Plan does not describe an assessment process focused on what is needed for an individual child to receive community-based services. Third, the Plan does not specify the degree to which families and children are informed about and have adequate choice in providers and services. Fourth, the Plan fails to document the extent of transition planning and services in all of the agencies that serve children, barriers to transition, and the steps to address the barriers. Fifth, the Plan does not identify where waiting lists

62 Achieving Community Integration for People with Disabilities, Phase I, NJ's Comprehensive Working Plan for Meeting State Obligations Affirmed by the United States Supreme Court Decision in *Olmstead v. L.C.* (*hereinafter New Jersey's Olmstead Plan).*

63 *New Jersey's Olmstead Plan* does not specifically address issues concerning children and makes no recommendations specifically targeting children. In the third section of the document, the type of mental health programming available for youth through the Division of Mental Health Services and the counties is documented. However, these summaries do not identify the number of children being served or on waiting lists for each program, nor do they show how successful the programs are, relative to one another or to objective outcomes, at meeting children's needs.

exist, either actual or in effect, and time lags in accessing services. Sixth, the Plan does not identify the State's knowledge of the availability of the most and least effective services or specify how resources will be adjusted to expand more effective services and reduce or eliminate less restrictive services. Similarly, the Plan does not identify the availability of culturally competent services. Finally, *Olmstead* principles state that quality assurance, quality improvement and sound management should support implementation of the state's plan. While New Jersey's Plan recommends that there be a "New Jersey Quality Assurance Summit to analyze quality assurance issues," it does not detail any of the outcome measures or accountability structures that will be used to ensure that children are receiving services in the most integrated setting appropriate for their needs.[64]

Since creation of the *Olmstead* Plan, the Partnership for Children has developed its own plan for stepping children down from institutions such as Brisbane, as appropriate, to less restrictive environments. This plan is not yet complete. The Partnership sees as its mission the provision of strong community supports so more children can remain at home, or in home-like settings, rather than in hospitals or institutions. However, according to a recent report on the Partnership from the Association for Children of New Jersey (ACNJ), as of September 2003, six counties had no group homes available for youth with behavioral disorders and 14 had only one or two group homes.[65] ACNJ's work revealed that the Partnership funds only a limited number of Treatment Homes, with 10 counties having only between one and three group homes.[66] It is therefore unclear how, over the

64 *New Jersey's Olmstead Plan* at p. 38.
65 Association for Children of New Jersey, May 2004 Special Report, *Treating Troubled Children: Lessons Learned from New Jersey's Partnership for Children"* at page 1.
66 *Id.* at p. 8.

prior four years, the Partnership expended its behavioral health budget dollars to expand and establish more and sufficient community based behavioral health programming for youth.

Recently, the State has committed to reduce reliance on institutional placements by creating more community based treatment options – 75 treatment beds and 45 emergency treatment beds. This is a very good start. It is not clear, though, that these investments are large enough to sufficiently reduce the number of youth across the state inappropriately placed in institutional settings since they are not based on a system-wide needs assessment of children.

In addition, the Partnership still has not clearly tracked which children are inappropriately housed in institutions; the number of youth on waiting lists for different programs; what needs to occur for each child in an institutional facility to step down to a less restrictive environment; and the extent to which, and the type of, community-based services that must be created to address the needs of youth qualified for community-based services but in, or at risk of placement in, institutional settings. While the State promises that these indicators will be tracked in the future and that "[b]y January 2007, all children in congregate care, psychiatric facilities, and shelters will be there appropriately…,"[67] it does not specify how, and in what time frame, new children entering these facilities will be stepped down to less restrictive environments, post-assessment, when such a step-down is deemed appropriate. Plainly, the State has made important and historic commitments to achieve progress toward community placements for children. Indeed, the Plan articulates a series of strategies, implementation steps and benchmarks to achieve these goals. It must next develop and implement a comprehensive, actionable plan to support integration for qualified youth with

67"A New Beginning: The Future of Child Welfare in New Jersey," Draft (Feb. 18, 2004) p. 101.

disabilities, through community placements or other means, which is deadline-oriented, judicially enforceable and likely to produce meaningful results.

6. Brisbane Staff: Qualifications

Brisbane is fortunate to have among its staff some individuals who have devoted their lives to the care and welfare of children with acute mental health needs. These staff serve as important child advocates on the campus. At the same time, the OCA's review of personnel files for direct-care staff revealed a lack of prior professional experience working with children, let alone children with complex behavioral and emotional needs. The OCA performed an audit of the personnel files of 40 youth workers.[68] Of the 40 files reviewed, 20 employees had absolutely no experience working with youth; 16 had some degree of related work-experience,[69] and 4 workers had prior experience working at Marlboro Adult Psychiatric Hospital prior to its closure.

As part of this investigation, the OCA identified ten employees who were most frequently identified as alleged perpetrators of abuse and neglect against children at Brisbane between April 1, 2002 and December 31, 2003, according to Human Services Police Reports ("HSP") and documents from the Institutional Abuse Investigation Unit at the Department of Human Services ("IAIU"). These ten employees were identified in 62 of 278 separate incidents. Most of these employees had no prior work experience with children, and none had any prior professional experience working with mentally ill children.

A review of the educational and work experience of the Brisbane Youth Workers associated with the largest number of HSP and IAIU reports paints a disturbing picture of the skills valued for

68 The cohort of files included youth worker staff across the three work shifts (day, evening, night) and across the three residences (Cottages A & B and the Main House Co-Ed Unit)

69 Designation "some experience" includes workers whose only youth-related positions were summer camp counselors.

the day to day care of Brisbane's children and youth. None of these staff members possessed a college degree, though some had college credits. Even more disturbing, though, is the paucity of prior work experience with children. Most of these individuals had no prior experience working with children. Two individuals who did have some experience with children had summer camp jobs. One individual reported working at a day care center and another was a babysitter.

After reviewing the applications for employment at Brisbane, however, it is clear that prior professional experience working with children specifically or a mental health population generally has not been an important qualification within the facility's hiring practices. Applications revealed individuals with curious backgrounds for employment with severely disturbed children. The individual with the third highest number of HSP/IAIU allegations of abuse and neglect, 8 in total, had a high school diploma and no work experience with children. His prior job experience included 2 years in the Army. Among the work skills that he listed on his application were "airborne operations," "conducting ambushes," and "chemical and jungle warfare training." Several other individuals with no prior work experience with children reported prior job experiences, including: dishwashing; cashier; car driver; stock boy; laborer and "experience working with big sheets of paper".

By hiring people who appear entirely unqualified for work with acutely mentally ill children and youth, the State may have complicated its efforts to promote recovery for children in a therapeutic environment. Placing individuals with no education or experience in a position of power and responsibility over children with severe histories of psychosis, sexual acting-out and abuse, anger and violence, would seem likely to result in problems and conflict. Would we expect an individual with no experience in hostage negotiation to serve as an effective hostage negotiator or an

individual with no flight experience to serve safely as a pilot?

7. The connection between staff qualifications and child abuse and neglect

In order to assess whether any employees at Brisbane had prior histories of child abuse or neglect before their employment with the State, and whether any correlation existed between those employees and the incidence of HSP/IAIU reports involving those employees, the OCA subpoenaed from the Department of Human Services information to substantiate any and all allegations of child abuse or neglect committed by Brisbane employees. To date, the Department has not satisfied the subpoena. The Department recently requested additional time to evaluate its options and position, which the OCA granted.

One statutory tool that is available to determine whether a prospective or existing staff member at Brisbane has committed acts of child abuse or neglect is the Child Abuse Record Information (CARI) check.[70] Essentially this check involves a computer run of confidential child abuse report data, obtained by DYFS during the course of its investigations and maintained on a central registry in DYFS. The statute was recently amended to provide unified child care agencies, which contract with the Department of Human Services, with the results of CARI check information to assist the agencies in their evaluation of prospective approved home providers.[71] This information would prove useful for all State-contracted entities that provide direct care to children and youth, including in-patient facilities such as Brisbane.

Beyond credential gaps, staff is insufficiently trained to meet the needs of the patient population. The DHS Safety Assessment Team cited a need for increased staff training in the following areas: aggressive behavior, self-destructive behavior, sexual behavior, restraints, and

70 N.J.S.A. 9:6-8.10a
71 P.L.2003, c. 185.

interaction with children and adolescents.[72] More recently, on April 5, 2004, CWA Local 1040 expressed a need for "relevant training for staff focusing on the needs of the children, i.e. awareness of patient diagnosis and their symptoms, training required for detainer patients, [and training for] patients with severe illnesses."[73]

8. Institutional Abuse (IAIU) & Human Services Police (HSP) allegations of abuse, neglect, and injury

The OCA reviewed Human Services Police (HSP) Reports and Institutional Abuse and Investigation Unit (IAIU) Reports pertaining to 278 allegations associated with the patients between April 1, 2002 and December 31, 2003. Allegations were categorized based on whether they involved staff versus patient conduct; patient versus patient contact; self-injury/attempted suicide; or elopement/attempted elopement. HSP reports involving staff versus patient incidents included 80 allegations of physical assault; eight allegations of sexual misconduct; and nine allegations of verbal assault. Patient versus patient incidents included 31 allegations of physical assault; 34 allegations of sexual misconduct; and 15 allegations of verbal assault.

IAIU investigated 60 of the allegations documented by HSP reports.[74] The 36 documented findings at the time of the OCA inquiry resulted in 26 "unfounded" findings, five "unsubstantiated" findings, three "unsubstantiated with concerns" findings, and two "substantiated" findings. The failure of IAIU to substantiate allegations of abuse should not ameliorate concerns about the facility. The OCA inquiry found cases in which serious injuries sustained by children either did not lead to an IAIU investigation or a substantiated finding of abuse or neglect. The performance of IAIU in

72 DHS Safety Assessment - October 2003.
73 April 5, 2004 letter from CWA Local 1040 Executive Vice President Donald L. Klein to Director Kathi Way, Division of Child Behavioral Health Services, Department of Human Services, page 2.
74 Several reasons exist for the gap between the number of HSP and IAIU reports. Among the possible explanations are that charges may have been dropped by one or both parties, cases may have been closed for lack of evidence, or cases

connection with these allegations raises significant and separate concerns that will be addressed by the OCA in a comprehensive audit of IAIU to commence this summer. Among the most egregious allegations of abuse or neglect at Brisbane are the following:

- In June 2003, child SP alleged Youth Worker (YW) slammed her into a bathroom door during a physical restraint hold, causing her to strike her head on a light switch. Child suffered a two inch laceration on the left side of her scalp which required emergency medical attention and six staples to close the wound. Although there are no video images of YW striking SP into the door, audio picked ups sounds of thumping and banging. YW, who was identified by OCA as an alleged perpetrator of abuse or neglect in 9 separate incidents from April 2002 to December 2003, stated the injury occurred when he and SP "accidentally" fell into the door during the restraint. A subsequent IAIU investigation found the YW, without justification, assaulted the child, twice "slamming" the child's head against the wall. The videotape did implicate a second YW, however, who stood on SP's hair at one point and yelled at her about a comment she made to the YW, telling the child to "take it back." The second YW was also observed walking up to SP, spanking her and pushing SP's feet off of the couch, whereafter SP fell to the floor screaming and crying. When questioned, the second YW said she plays with SP like that because "they're close." SP was discharged from the facility to her home during the course of the investigation. SP's mother signed a waiver of prosecution**.** IAIU substantiated abuse against both YWs.
- In May 2002, child AR sustained scratches on the right side of his neck from "horse-playing" with YW in his bedroom (out of video camera range). IAIU concluded abuse was

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may have been screened out by IAIU as not warranting further inquiry.

"unsubstantiated" but that YW's conduct raised concerns because the act of wrestling placed AR at some unnecessary risk of harm.

- In December 2003, a staff member witnessed YW go after child MW, push him into a locker, and bang MW's head into locker. IAIU substantiated the abuse allegation.
- In June 2002, child SK self-inflicted a deep laceration to his knee with glass, requiring six stitches. SK has a history of self-destructive behavior and managed to injure himself during a long period unmonitored in the bathroom, despite being on 1:1 arms-length staff observation. IAIU substantiated an allegation of neglect based on its finding that the actions of the YW were inappropriate for the necessary 1:1, which gave SK an opportunity to cut himself.
- In May 2003, child DM attempted suicide by tying a cord around his neck. A review of the incident indicated that the child was not monitored between 8:45 a.m. and 10:30 a.m. DM sustained visible injuries in the form of red marks on his neck from the attempted suicide. There was no IAIU investigation.
- In January 2003, child LH incurred an unusual fracture of her humerous just below her shoulder during a physical restraint hold. The medical doctor who treated LH requested an investigation into the cause of the injury based on his documented concerns about the nature of the injury and concerns for the child's safety. YW acknowledged that the injury occurred during a restraint in which LH fell, and YW fell on top of her. IAIU concluded the allegation of abuse was unsubstantiated because the use of a physical restraint was justified and appropriate.
- In November 2003, an anonymous caller reported that Brisbane staff waited too long to bring child SE to the hospital for medical attention for her sore foot. When the child was ultimately taken to the hospital three days after the injury was sustained, she was found to have broken a

bone in her foot extending from toe to ankle. The caller further alleged that SE was given gifts to bribe her to "keep her mouth shut" about the incident. SE also complained that she was "sedated" too often on pills. There was no IAIU investigation.

9. Labor-Management

Significant and positive leadership changes at Brisbane occurred in 2003, including a new CEO, a Ph.D. Clinical Director and a Board certified child psychiatrist Medical Director. Beginning June 2004, a Deputy Director with experience working with children with acute mental illness is scheduled to begin work. This new team inherited a badly damaged management-labor relationship. The OCA's review of grievances filed by the unions representing the Brisbane staff evidences an adversarial relationship between the facility administration and staff which developed over many years as work conditions deteriorated for the staff. In several instances, the grievance process has consumed months of time and prevented Brisbane from implementing change. For example:

- In April of 2003, a grievance was made on behalf of four staff therapists regarding a change in the way that they were instructed to schedule therapeutic sessions with patients. In the past, therapists had been free to schedule patients for their sessions on a daily basis, as they saw fit. The administration instructed therapists to begin making weekly therapy schedules for their patients due to the "need for accountability," "twenty four hour programming" and for "structure and uniformity in scheduling."[75] The therapists objected because the new system was "raising the anxiety level of some of the patients" and it did not afford them the flexibility that they had experienced with their previous scheduling process.[76] Representatives for the clinicians alleged that their clinical sessions, when scheduled on a weekly basis, were often subject to cancellation

75 Grievance Procedure Form, State of New Jersey (April 2003).
76 *Id.*

because clinicians were forced on little notice to attend to other responsibilities, making children both disappointed and anxious. The grievance process lasted until June, 2003. The final compromise of requiring the therapists to submit a weekly schedule with individual time slots but without resident's names, required two hearings and the attendance of sixteen staff and union personnel.

- At the end of April 2003, four grievances were submitted by members of the educational staff after the administration attempted to increase the school day by one class period. The educational staff claimed this change violated contractual agreements and created "an unsafe working environment for both staff and clients." The administration reported that the change was in response to the need for increased education. One year later the issue has yet to be resolved.

III. SYSTEMS OF CARE

A. Historical Perspective

Historically, behavioral health care for children in the United States has been provided in inpatient hospitals, residential treatment settings, or in outpatient settings.[77] Despite this historical tendency, questions have always loomed as to the efficacy of institutionalized care. Most recently, the National Institute of Mental Health concluded that "[s]ome forms of institutional care do not lead to lasting improvements after the child is returned to the community. Some peer-group-based interventions have been found to actually increase behavior problems among high-risk adolescents (e.g., boot camps and residential programs)."[78]

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77 Barbara J. Burns *et al, Effective Treatment for Mental Disorders in Children and Adolescents*, 2 Clinical Child & Fam. Psychol. Rev. 199 (1999)(*hereinafter* Burns).

78 The National Advisory Mental Health Council Work Group on Child and Adolescent Mental Health Intervention Development and Deployment. "Blueprint for Change: Research on Child and Adolescent Mental Health." Washington,

The introduction of managed care during the last ten years has shifted this treatment philosophy based on monetary concerns about the high cost of inpatient care, with little data to support its effectiveness. Through the years, managed care providers have attempted to curtail the use of institutional services by severely limiting the length of stay, often risking the rapid readmission of children and adolescents in their care.[79] Additionally, managed care providers typically will only pay for the most basic of outpatient services, i.e. once a week counseling at a clinic, rather than comprehensive, community based support and services.

This shift in philosophy away from inpatient services could have been beneficial had it resulted in greater promotion of comprehensive outpatient treatment. Instead, many children are forced into the child welfare or juvenile justice systems for care due to the inability or disinterest of their parents or private insurers to pay for more comprehensive services.[80] With a history of perceived failings in inpatient hospitalization, children and adolescents are often placed in other intensive residential programs. The result has been the creation of "systems kids," who "live in mental health facilities and often shuttle in and out of the juvenile justice and child welfare systems—separated from families and mainstream schools.[81]

"Although this population's problems are usually severe and complex, most of these children could be helped to return successfully to their communities with timely, intensive care."[82] Indeed, "[t]oday the range of community-based services available to children and adolescents with serious

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D.C.: 2001.

79 *See supra* fn 77.

80 Testimony, Child Welfare and Juvenile Justice; *Several Factors Influence the Placement of Children Solely to Obtain Mental Health Services* (Statement of Cornelia M. Ashby, Director Education, Workforce and Income Security Issues) United States General Accounting Office (July 17, 2003).

81 Warner L.A. & Pottick K.J. (2003). *Nearly 66,000 Youth Live In U.S. Mental Health Programs. Latest Findings in Children's Mental Health, Policy Report submitted to the Annie E. Casey Foundation. New Brunswick, NJ: Institute for Health, Health Care Policy, & Aging Research, Rutgers University. Vol. 2 (1).*

emotional or behavioral problems and their families is vast. New ways of delivering care to children and families in need are being introduced in communities across the country. Stemming in part from greater awareness of and demand for community-based alternatives to traditional care, families, policy makers, and service planners are experimenting with new services and are recognizing the inefficiencies, and even hazards of restrictive services.[83]

B. Best Practices

It is widely accepted that the ideal system for providing mental health treatment to children and adolescents includes the following aspects[84]:

- Programs should be community based provide a broad array of services, including a range of intensive nonresidential and residential options including outpatient therapy, home-based services, day treatment, crisis services, respite care, case management, therapeutic foster care, therapeutic group care and other services;
- Treatment should be individualized and flexible, in the least restrictive appropriate setting and include family involvement in all aspects of the planning and delivery of services; and
- Services should be culturally competent and responsive to the needs and characteristics of diverse ethnic and racial populations.

Community based mental health treatments are further bolstered by research into the efficacy of various treatment models. "[E]valuations of the effectiveness of community-based systems of care for children indicate fewer re-institutionalizations after discharge from residential settings, reduced out-of-state placement of children, and improvement in other individual outcomes such as

82 *Id.*
83 *See supra* fn 77 at 237.
84 Feldman Report at p. 3.

the number of behavior problems and satisfaction with services."[85] Furthermore, comprehensive community-based mental health services for children and adolescents can cut public hospital admissions and lengths of stay and reduce average days of detention by approximately 40 percent."[86]

Several evidence-based programs have proven records in community-based treatment. Four of the better known models, (i) Multisystemic Therapy (MST), (ii) Partial Hospitalization/Day Treatment, (iii) Intensive Case Management and (iv) Therapeutic Foster Care have been shown to have a positive impact upon individuals and families engaged in such treatment methodologies. By utilizing evidence based, less restrictive, community approaches, adolescents and their families can get the help that they need to function in community settings, such as home and school.

1. Multisystemic Therapy

MST is family-oriented, home-based program. It views youth as "involved in a network of interconnected systems that encompass individual, family and extrafamilial factors, and recognizes that it is often necessary to intervene in more than one of these systems."[87] "Therapists have small caseloads of four to six families; work as a team; are available 24 hours a day, 7 days a week; and provide services at times convenient to the family. The average treatment involves about 60 hours of contact during a 4-month period."[88] "Multisystemic therapy has a well-established evidence base, including both efficacy and effectiveness studies, and is being widely disseminated."[89]

2. Partial Hospitalization/Day Treatment

Partial Hospitalization/Day Treatment "is a specialized and intensive form of treatment that is

85 *Community-Based Mental Health Works*, www.nmha.org/federal/appropriations/factsheet2.cfm (visited 04/15/04).
86 *Id.*
87 U.S. Dept. of Health and Human Services, Substance Abuse and Mental Health Services Administration, *Multisystemic Therapy* (*hereinafter* SAMHSA).
88 *Id.* at 2.

less restrictive than inpatient care, but is more intensive than the usual types of outpatient care. An integrated curriculum combining education, counseling, and family interventions is the most frequently used service model."[90] This treatment model provides the benefits of a structured environment, while allowing the youth to return home at night, thus continuing his or her involvement with family and peers. "Overall, the literature points to positive gains from adolescent use of day treatment."[91]

3. Therapeutic Case Management

Case management is a widely used treatment strategy. "The main purpose of case management is to coordinate the provision of services for individual children and their families who require services from multiple sectors."[92] "Although the evidence base is small, there are indications that case management is an effective intervention for youth with severe emotional disorder."[93] Studies have been conducted utilizing case management with a "wraparound approach" to service delivery. These studies have provided "encouraging evidence of the effectiveness of case management utilizing the wraparound process."[94]

The programmatic philosophy of "wraparound" involves finding the unmet needs of the child and family. It focuses upon strengths and develops child and family teams with assigned care managers.[95] In this way "the plan is needs-driven rather than service-driven."[96] "The initial plan should be a combination of existing or modified services, newly created services, informal supports,

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89 *See supra* fn. 77 at 240.

90 *Id.*at 208.
91 *Id.*
92 *Id.*at 216.
93 *Id.*at 219.
94 *Id.*at 219.
95 *What is the Wraparound Process?,* www.air.org/cecp/wraparound/intro.html (visited 04/15/04).
96 *Id.*

and community resources, and should include a plan for a step-down of formal services."[97]

4. Therapeutic Foster Care

Therapeutic Foster Care is considered the least restrictive form of therapeutic placement for children with severe emotional disorders. "Children are placed with foster parents who are trained to work with children with special needs, usually one child is placed is a therapeutic foster home at a given time, and caseloads of supervisors remain small (allowing close work with each child and family)."[98] Clinical trials suggest that "therapeutic foster care can result in better outcomes than more restrictive types of placement."[99] It is also less expensive than common alternatives like therapeutic group homes or other residential placements.

The findings regarding therapeutic foster care are particularly relevant when we consider placements for children without actively involved families or without family in general. "If therapeutic foster care is available, and therapeutic foster parents are willing to take youth with serious histories of acting out, this may be a better treatment choice for youth historically placed in group homes, especially given cost considerations for group homes."[100]

5. Residential Treatment

Despite the efficacy of these community-based treatment modalities, the reality is that there may always be a need for forms of in-patient treatment in New Jersey's continuum of care, particularly for children without families or hard to place juveniles such as sex offending and fire starting children. Research literature regarding the efficacy of residential treatment has led reviewers to make the following recommendations in order to address its historic inadequacies. They suggest

97 Id.
98 *See supra* fn. 77 at 221.
99 *Id.* at 222.
100 *Id.*

that "efficacy can be increased through: 1) intensive work with families; 2) teaching adaptational skills that facilitate reintegration into the community; and 3) implementation of extensive after-care plans."[101]

Utilizing these characteristics, the Menninger Children's Hospital in Topeka, Kansas developed an intensive, short-term residential treatment program that showed effectiveness in treatment outcomes up to 12 months following discharge from the program.[102] Some of the major characteristics of this program included "intensive" work such as:

- Sophisticated psychiatric work and therapeutic work (comparable to good hospital programs), including pharmacotherapy, psychotherapy, group therapy, and family therapy focusing upon treating a delimited number of salient symptoms aggressively in order to prepare patients for more long term work in other less costly settings along a continuum of care.
- Services provided by unit-based staff including clinicians and psychiatrists, psychologists, and social work trainees that provide specialized work with addictions, eating disorders, trauma, gender & sexuality, anger management etc.
- Discharge planning, which includes work with the families, community organizations, public schools, religious organizations, vocational programs, self-help groups, educational and recreational programs, etc.
- Work that is short term, typically three months or less and progress is evaluated by researchers who are not part of the residential staff to determine changes in the patient's symptoms and functioning post-discharge.

101 *See supra* fn. 49 at 227.

Adopting this newer model for residential treatment will not remove all of the problems typically associated with in-patient care. A critical factor to a patient's long term success following his or her discharge from in-patient care is his or her ability to successfully link with prescribed out-patient treatment. "Failure to engage patients in out-patient services greatly increases the probability of relapse and re-hospitalization and reduces patient's quality of life."[103] The inpatient hospitals and residential treatment settings that serve New Jersey's children and adolescents need to make connecting patients to outpatient treatment programs a primary component of their inpatient therapy.

Strategies to promote the linkage between inpatient and outpatient care have shown to enhance the likelihood of patients continuing with their treatment post-discharge. Among the strategies most effective to encourage patients to keep their initial outpatient appointments, according to one study, was having the patient meet with an outpatient clinician prior to discharge and/or having the patient visit the outpatient program prior to discharge.[104] This is especially important, since"[t]he failure of patients to engage in specialty mental health care shortly after hospitalization undermines important clinical gains made during inpatient treatment and thwarts the intended trajectory toward further stabilization, maintenance, and community adjustment. Evidence that patients are connected to ongoing care shortly after a hospital stay is also indicative of a clinically integrated system of care."[105] To better serve its adolescents, New Jersey must strive to create such an integrated system of care.

C. Child and Adolescent Mental Health Service Delivery at a Crossroads

The DHS Child Welfare Reform Plan includes landmark investments in mental health

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102 *Id.*
103 157 Am. J. Psychiatry 10, *Identifying Risk Factors and Key Strategies in Linkage to Outpatient Psychiatric Care,* Carol A. Boyer, Ph.D. et al (Oct. 2000), p. 1592 (*hereinafter* Boyer).
104 *Id.*

services. One of the plan's key strategies hinges upon the institution of a common assessment tool - the Lyons Tool - which will be used for all children entering foster care. It reportedly identifies the strengths and needs of the child as well as the need for care giver supports. In addition, DHS promises to "create a database which will link DYFS, Medicaid and the Division of Child Behavioral Health Services information systems to ensure that each child has a standard identifier and that accurate physical and behavioral health information can be readily reported to case managers, resource families, or to other caregivers involved in the child's care and treatment."[106]

The plan also addresses populations of youth with mental health issues who have historically been neglected, such as those children in congregate care, detention facilities, and shelters. The state, through the plan, promises to cease the practice of warehousing abused, neglected and mentally ill children in institutions because of the lack of resource families, less restrictive DYFS placements, and appropriate mental health services. Instead, the state promises to construct a range of home or home-like living arrangements with progressive levels of supervision and support for youth inappropriately being housed in RTC's, detention centers, secure facilities or psychiatric centers. Such living arrangements include Treatment Homes, In-Home Behavioral Supports and Care Management Organizations.

In order to determine the "right size" of the continuum -- from resource families, to treatment home, through group homes and residential treatment centers -- the state promises to use the Lyons Tool to "assess all children currently in or at risk of placement in a group home, residential treatment center, psychiatric setting, homeless youth shelter"[107] to determine the least restrictive environment appropriate for their needs. Similar assessments will be conducted for all children in detention or

105 *Id.* at 1596.
106 *See supra* fn. 67 at 119.

secure confinement. Once in place, providers will be required to repeat the assessments every 90 days to determine a child's ability to move to a less restrictive setting. If appropriate, based on the assessment process, a child will be transferred to a less restrictive placement. Once a child is deemed ready to transfer to a less restrictive environment, the transition should be made smoothly and timely with the assistance of a case manager who will "oversee any necessary evaluations, identify an appropriate placement, transition the child to that placement, and locate and coordinate needed community-based services."[108] To the extent that a continuum of less restrictive settings appropriate for children's needs does not currently exist, the state promises to create one.

In addition, recognizing that there will always be a percentage of children who require intensive supervision and treatment, the state commits to expand and improve the quality of its congregate care system. The state has promised to conduct a study on the "experiences of and outcomes for youth in congregate care, examining such issues as: the percentage of youth in each facility who were the subject of a substantiated critical incident report; the percentage of youth with weekly in-person contacts with a caring adult; the percentage of youth receiving necessary mental health services, and the percentage of youth enrolled in school..."[109] Based on the results of the study, the state will develop and implement a plan to make necessary improvements to its congregate care system.

IV. CONCLUSION & RECOMMENDATIONS

The DHS Child Welfare Reform Plan contains a very promising series of commitments to the deinstitutionalization of New Jersey's children and the development of adequate community capacity

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107 *Id.* at 99.
108 *Id.* at 100.
109 *Id.* at 102.

to care for children with behavioral health needs. It is critical that the State be held to its promises to improve the delivery of behavioral health services to children and adolescents. The OCA recommends that the Department of Human Services fast-track certain of the Plan's strategies as follows, within the next 6-9 months, and that the agency's commitment to do so become a court-enforceable component of the Child Welfare Reform Plan pursuant to *Charlie and Nadine H. v. McGreevey*:

1. Assess all of the children housed in institutions in New Jersey and identify all children eligible for a less restrictive level of care;
2. Identify the number of youth in the child welfare, behavioral health or juvenile justice systems waiting for placement in a program;
3. Based on the foregoing, identify the types and number of behavioral health services neccessary to support the treatment needs of New Jersey's children;
4. Utilize existing State hospital and clinical resources or issue RFPs, where appropriate, to build adequate capacity in New Jersey sufficient to support the treatment needs of children in New Jersey, particularly children stepping down from institutional care settings, consistent with the best practices discussed in this report. Develop and fund treatment alternatives. As the State considers whether continued operation of Brisbane best serves adolescents' behavioral health needs, it is incumbent upon the State to consider viable treatment alternatives that address a child's individual needs and provide treatment in the least restrictive setting possible. New Jersey must now build and fortify our intensive in-patient services for the most severely psychiatrically disturbed children and adolescents, expand

community based wraparound services, when appropriate, and increase family involvement. The State must develop directly or fund evidence-based programs such as Multi-Systemic Therapy (MST), Functional Family Therapy (FFT), Therapeutic Case Management.

In addition to these Child Welfare Reform Plan-related recommendations, the OCA proposes the following:

1. Undertake a practice-based assessment of the Lyon's assessment tool to ensure that it reliably evaluates the behavioral health needs of children.
2. Following the award of contracts and the development of sufficient programs and services to address the needs of New Jersey's children but no later than the next 18 months, phase out the utilization of the Brisbane campus as it currently exists and develop an alternative utilization for the campus to support children.
3. Immediately remediate all physical plant suicide and health risks to children posed by Brisbane.
4. Identify systematically on a regular basis any staff alleged to have perpetrated abuse or neglect and identify employee-specific action plans, including retraining and disciplinary steps.
5. Continue to utilize the nine existing Children's Crisis Intervention Services (CCIS) in New Jersey for short term hospitalization to stabilize the most severely psychiatrically disturbed children and adolescents. Extend the period of time in which the State's CCIS units are able to serve children with behavioral health needs in order to minimize the cycling of children through various residential settings.

6. Incorporate CCIS Intermediate Term Hospitalization. These beds are already affiliated with some of the existing CCIS units, and extends treatment potentially as long as 30 days, thereby promoting community and family involvement in treatment;

7. Track and publicly report the number of children who cycle through Brisbane and other state-funded psychiatric hospitals.

8. Immediately seek the support of the Legislature to amend the Child Abuse Registry statute to require pre-employment child abuse and neglect perpetrator background checks for all Brisbane employees, and employees of similarly situated programs.

9. Immediately seek the support of the Legislature to devise appropriate standards for the involuntary commitment of minors.[110]

10. Maximize federal funding to support state reforms (i.e. Medicaid home and community based waivers).

11. Coordinate services and treatment options among the Division of Youth and Family Services, the Division of Child Behavioral Health Services, and the Care Maintenance Organization.

110 In 1996, the New Jersey Supreme Court implored the State Legislature to devise appropriate standards for the involuntary commitment of minors. *Commitment of N.N.*, 146 N.J. 112, 137-138 (1996). The Court emphasized that "the standards and procedures governing involuntary commitments should be addressed by the Legislature, which can more fully explore the complex and controversial aspects of the vitally important and sensitive social and governmental concerns and responsibilities implicated in such decisions." *Id.* at 138. In the absence of legislative guidance on this issue, CEPP is relied upon as the only mechanism by which to keep minors in residential treatment short of commitment. It is imperative that the New Jersey Legislature act to improve the commitment process for our youth.