MONITORING REPORT FOR THE SETTLEMENT AGREEMENT BETWEEN THE UNITED STATES AND THE STATE OF NEW YORK IN THE MATTER OF *UNITED STATES V. THE STATE OF NEW YORK and THE NEW YORK STATE OFFICE OF CHILDREN AND FAMILY SERVICES* (U.S.D.C. NORTHERN DISTRICT OF NEW YORK)

Facility Monitoring Report:
Lansing Residential Center
Lansing, NY

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INDIVIDUAL FACILITY MONITORING REPORT:

LANSING RESIDENTIAL CENTER

LANSING, NY

I. INTRODUCTION

This is the first monitoring report for the Settlement Agreement between the United States and the State of New York in the matter of *United States v. the State of New York and the New York State Office of Children and Family Services* (U.S.D.C. Northern District of New York). The Settlement Agreement addresses improvements in designated areas of mental health and protection from harm for four (4) named facilities within the Office of Children and Family Services (OCFS).

The report evaluates numbered Paragraphs 40-57 and 68 in the Settlement Agreement. Specific headings within these groups of paragraphs include Use of Restraints, Use of Force, Emergency Response, Reporting, Evaluation of Mental Health Needed, Use of Psychotropics, Staff Training on Psychotropic Medications and Psychiatric Disabilities, Psychotropic Medication Refusals, Informed Consent, Treatment Planning, Substance Abuse Treatment, Transition Planning, Document Development and Revision, and Quality Assurance Programs. The Monitoring Team consists of two Monitors, Dr. Marty Beyer, who is responsible for the Mental Health paragraphs, (hereafter referred to as the MH Monitor) and Dr. David Roush, who is responsible for the Protection from Harm paragraphs (hereafter referred to as the PH Monitor).

The Office of Children and Family Services (OCFS) closed one of the named facilities (Tryon Boys Residential Center) before the monitoring activities began. The closure of Tryon Boys was announced on January 19, 2010, and the facility was officially closed on January 19, 2011. On June 8, 2011, Governor Andrew Cuomo announced the closure of a second named facility, Tryon Girls Center, and the reduction in the capacity of Finger Lakes Residential Center from 135 beds to 109 beds. This announcement also included the closure of three other non-named facilities and capacity reductions at three additional sites, as reported in the first OCFS "6-Month Progress Report" for the Settlement Agreement.

A. Monitoring Timelines

Regarding Paragraph 62 (a), the delays in the approval of the Master Action Plan (MAP) were external to the Monitoring Team. (The MAP approval initiated the monitoring schedule.) Following verbal agreements about MAP approval, the Monitoring Team worked with OCFS to arrange agreeable times to conduct a monitoring pre-visit to meet the key OCFS and institutional staffs, explain the monitoring experience and expectations, and assess the level of preparedness of each facility for a monitoring site visit. All Parties agreed with the Monitoring Team that it would be costly to taxpayers and counter-productive to OCFS to monitor a facility and file a report that underscored the same level of unpreparedness or non-compliance acknowledged by OCFS from the beginning. Dates for the pre-monitoring visits were ultimately acceptable in March 2011.

The pre-monitoring visits occurred on March 7-9, 2011 when the Monitoring Team and U. S. Department of Justice (DOJ) Attorney Alyssa Lareau met with Home Office staff, OCFS Commissioner Carrion, and the lead staff from each of the three remaining named facilities. The meetings with Home Office staff occurred in Albany, and the meetings with institutional staff occurred at each respective institution. Each facility appeared to be at a different state of readiness for a monitoring visit, with Lansing emerging as the facility most prepared for a site visit. Site visit readiness focused largely on the status of staff training and implementation of two programs critical to the Settlement Agreement, the New York Model and Crisis Prevention and Management (CPM). The New York Model represents an innovative blend of a new behavior reward system with Dialectical Behavior Therapy (DBT) and a trauma-informed program called Sanctuary, both of which are best-practice programs for adolescent offenders, especially girls with mental health issues. CPM represents the physical intervention alternative that emphasizes verbal de-escalation and eliminates facedown or prone takedown strategies.

Discussions with Home Office and Lansing staff were very productive and informative. Given Lansing staff's assessment of their readiness and the Monitoring Team's concerns about the protection from harm issues, the Lansing monitoring visit was scheduled for June 21-22, 2011. Prior experiences by the Monitoring Team combined with the levels of cooperation by Home Office staff and the relatively small size of the facility to predict that a two-day visit would be sufficient.

The Lansing monitoring experience was informative, and the knowledge gained through the first visit helps explain, in part, the delay in issuing this report. Despite excellent levels of cooperation from OCFS staff and the long hours at the facility on both days, two days of monitoring proved to be insufficient. As the Monitoring Team and OCFS staff moved through this assessment, unanticipated issues arose; and the resolution of some of these issues was slowed due to circumstances beyond the control of Lansing staff. We mention this to explain three things. First, there will be some responses to particular settlement paragraphs that are incomplete or pending further review. In situations where insufficient evidence exists to support a determination of compliance or non-compliance, we will leave the paragraph compliance assessment open to further review at the earliest possible opportunity. Where appropriate, we will identify the critical variables that are needed to support a finding of compliance. The desire is to resolve these "pending" issues in this and the Finger Lakes assessments as they add an unwanted delay to findings and reports. Second, the Monitoring Team has already scheduled four days for the assessment at Finger Lakes so that the additional time and a new data request list will allow for an adequate compliance assessment for each of the paragraphs in the Settlement Agreement. Third, information deficits encountered during the monitoring visit resulted in requests for additional documents, and the production of these documents contributed to the delays in the issuance of this report.

B. Facility Background Information

Lansing Residential Center is a non-secure facility for adjudicated female juvenile delinquents. As of March 1, 2010, the facility budget allowed for 25 residents distributed among two living units of eight (8) residents each and one living unit of nine (9) residents. These three living units are in the main building. On June 21, 2011, the roster listed 24

youth "In House." They ranged in age from 14 to almost 18 [14 (2), 15 (8), 16 (10), 17 (4)]. They had been at Lansing from 19 days to 230 days: fewer than a third had been there 2 months or less and a third 5 months or longer [1 month (2), 2 months (5), 3 months (8), 4 months (1), 5 months (2), 6 months (3), 7 months (3)]. Although it is impossible to discern severity from offense listings, most Lansing residents appeared not to be there for crimes against people: assault (4), robbery (1), menacing (3), resisting arrest (1), distributing illegal substances (1), identity theft (1), grand larceny (2), petit larceny (4), criminal mischief (2), criminal trespassing (3), and obstructing government (2). Fifteen of the girls were taking psychotropic medication: Abilify (7), Seroquel (5), Geodon (1), Lithium (1), and Trazadone (1); two of the girls taking Abilify were also taking Seroquel, one was also taking Remeron and Celexa and one was also taking Trazadone and Imiprimine.

C. Assessment Protocols

The assessments used the following format:

1. Pre-Visit Document Review

In advance of the site visits, the Monitors supplied OCFS with a list of materials and documents for review. The time specific documents and materials, such as special incident reports, child abuse investigations, and population data, started from August 1, 2010. Appendix A contains the list of documents. OCFS distributed the documents electronically by (a) scanning hard copies into PDF format, (b) using existing electronic documents as much as possible, and (c) transferring data into Excel worksheets. Some initial problems with formatting compatibility and password protections were resolved.

2. Use of Data

The Office of Children and Family Services (OCFS) has a good management information system with access to a wide range of data. However, to make use of these data in determining compliance with the Settlement Agreement, all Parties must have confidence in the data. In other words, do the numbers in certain categories of youth behaviors represent an accurate depiction of how often these behaviors occur in the facility? When there are multiple systems for collecting information on the same behaviors, how similar or consistent are the outputs from each system?

As an example, the Lansing Health Clinic compiles a Monthly Summary of the Episodic Care Log. A comparison of restraint information from the Automated Restraint Tracking Systems (ARTS) reports versus the Monthly Health Statistics Report for January and February 2011 shows a difference (or error) of 9% for January and no difference for February. While minor, differences of this nature are the subject of quality assurance investigations. Absent a quality assurance department, clarification of these data systems will occur to resolve the minor differences so that accurate rates of critical behaviors (fights, physical restraints, and injuries to youth and staff) can be established. Data provide a place to start compliance discussions.

3. Entrance Interview

The entrance interview occurred on June 21, 2011 and included the Monitoring Team and OCFS representatives, including key staff members from the facility. The meeting provided an opportunity for introductions, informal discussion of institutional

goals and objectives, an overview of the assessment process, a review and discussion of assessment instruments, and the scheduling of the remaining assessment activities. Those in attendance included: Merle Brandwene, Director of Management and Program Support; Sandra Carrk, Project Manager; Diane Deacon, Assistant Deputy Counsel; Kathy Fitzgerald, Social Work Supervisor; Anthony Hough, Associate Commissioner for Facility Management; Alyssa, Lareau, DOJ Attorney; Annette Larrier-Fulcher, Facility Director; Edgardo Lopez, Settlement Agreement Coordinator; Jenifer Mack, Assistant Director; Beverly Sowersby, Facilities Manager; and Dr. Joseph Tomassone, Chief of Treatment Services.

4. Facility Tour

Walkthroughs of the facility followed the entrance interview. The Protection from Harm facility tour was more extensive and included a general inspection of all usable spaces. The facility tour used copies of fire evacuation floor plans on an 8 ½" x 11" format.

5. On-Site Review

The site visit included a review of numerous documents available at the facility and not included in the pre-visit document request list. These documents included many reports that occurred in the time between the document shipment to the Monitors and the on-site assessment.

The MH Monitor observed a treatment team meeting, Rounds, and three group meetings, visited the clinic and met with the Consultation Team leading the New York Model. The MH Monitor reviewed seven records. The PH Monitor reviewed physical restraint packets, observed videos, and collected information from unit logs and resident interviews.

6. Staff Interviews

The assessment incorporated confidential, individual interviews with 12 direct care, clinical, and supervisory staff. The MH Monitor interviewed three unit staff, two clinicians, and a clinical supervisor. Staff interviews with the PH Monitor began by giving staff the option to answer questions with the PH Monitor alone or in the presence of the PH Monitor and the DOJ Attorney, OCFS Counsel, and an OCFS Administrator. Two of the interviews were with the PH Monitor alone. Five of the staff members have had abuse allegations filed against them, and two have had an "indicated" or substantiated finding against them. The interviews and discussions focused on topics and issues related to the implementation of the Settlement Agreement. Both Monitors selected the staff for interviews.

7. Resident Interviews

The MH Monitor interviewed three girls, and the PH Monitor also interviewed three girls. Interviews occurred in areas with reasonable privacy from staff. The Monitors selected the youth for interviews.

8. Exit Interview

The assessment concluded in the evening of June 22, 2011; but an exit meeting took place earlier in the afternoon with key staff from each program area to provide a general and initial summary of the assessment. The Monitors expressed their appreciation for the cooperation and hospitality of the Lansing and OCFS staff. The Team then highlighted

areas of importance and concern, but not findings. Exit interview participants were advised that additional materials remained to be reviewed and analyzed, and these materials could influence outcomes and alter conclusions. Therefore, this was a time for questions, clarifications, and explanations of events, activities, and impressions before the formal report of findings is provided to both Parties and the Court. Those in attendance included: Merle Brandwene, Management Program Support; Sandra Carrk, Project Manager; Diane Deacon, Assistant Deputy Counsel; Anthony Hough, Associate Commissioner; Alyssa Lareau, DOJ Attorney; Annette E. Larrier-Fulcher, Facility Director; Edgardo Lopez, Settlement Agreement Coordinator; Jennifer Mack, Assistant Director; Ines M. Nieves, Associate Commissioner; and Dr. Joseph Tomassone, Chief of Treatment Services.

II. PROTECTION FROM HARM MONITORING

The Protection from Harm Monitor reviewed issues related to Settlement Agreement Paragraphs 40-44 and 56-57. Representatives from OCFS and the DOJ Attorney accompanied the Protection from Harm Monitor whenever the monitoring activity did not call for confidentiality with the PH Monitor alone.

Evidence exists of many accomplishments associated with the changes required by the Settlement Agreement. The new policies and programs promulgated by OCFS appear to be logical, systematic, and best-practices-oriented approaches to resolving the protection from harm and mental health concerns. These elements of program reform are very good tools to produce system change and compliance.

Compliance determinations are complex. The approach employed here is to look at the OCFS responses to the Settlement Agreement paragraphs from multiple perspectives. These perspectives include the organizational structure or the way in which facility policies and procedures influence practice; the social structure or staff and resident perceptions of treatment, safety, and physical restraints; direct observations; and outcome data (e. g., incident reports) or rates of the institutional climate, especially incidents associated with safety and protection from harm. When these different perspectives similarly describe the same phenomenon, decisions about compliance are much stronger.

Important elements of a safe environment appear to be in place. The New York Model is intended to improve mental health and safety over time; there is a competent training curriculum with effective trainers to teach these concepts and principles to new and veteran staff; and Crisis Prevention and Management (CPM) works to increase resident safety through a new physical restraint strategy and enhanced verbal de-escalation skills. What remains in the achievement of compliance is the demonstration of these skills and abilities by staff in the creation of a reasonably safe environment at Lansing.

Several factors implicit in compliance need comment. They are elements that could directly affect the remedial measures in the Settlement Agreement and, as such, will receive ongoing scrutiny. One is the Health Clinic, which is presently a substantial asset. A competent Health Clinic serves as an important safeguard for Protection from Harm issues, especially those related to the use of physical restraint. A Health Clinic that maintains accurate records of post-restraint evaluations lends a greater level of objectivity to the

assessment and reporting of injuries to youth that may have been sustained during a physical restraint and require additional investigation if an injury resulted from a suspected use of excessive force or an inappropriate application of a restraint technique. However, a good clinic program can generate resentment within the ranks of direct care staff when the documentation of a post-restraint injury compels the nursing staff to make a child abuse (Statewide Central Register or SCR) referral in compliance with mandated reporting laws. Evidence exists of a strained relationship between some elements of the clinic staff and the YDA staff that could have a chilling effect on reporting behaviors if unresolved.

Resident and staff perceptions of safety are mixed, but the sample size of both resident and staff interviews is too small to draw compliance inferences at this time. Residents were ambivalent, even though perceptions of safety seem to increase the longer youth are in the facility. The majority of staff was positive about the New York Model, believing it would create a more therapeutic environment and would reduce violent, acting out behaviors. However, the majority also indicated that staff safety was an ongoing concern because of perceived problems with the new physical restraint techniques.

A general safety concern relating to the intersection of mental health and protection from harm (Paragraphs 44 and 53) exists with the physical plant, particularly (a) hinges on the room and closet doors that are not suicide proof hardware as demonstrated by many youth hanging items on the hinges and locks; and (b) blind spots in the resident's rooms so that when looking through the door window from the corridor, sightlines are obstructed by the closet. Treatment planners should be cognizant of these potential suicide hazards.

A. Use of Restraints

Multiple factors influence the use of restraints and Protection from Harm. Not every factor is mentioned in the Settlement Agreement, but Paragraph 57a invites the Monitoring Team to identify issues and concerns that emerge during the monitoring that are related to compliance.

40. The State shall, at all times, provide youth in the Facilities with reasonably safe living conditions as follows:

41. Use of Restraints. The State shall require that youth must not be subjected to undue restraints. The State shall create or modify policies, procedures, and practices to require that the use of restraints be limited to exceptional circumstances, as set forth below, where all other appropriate pro-active, non-physical behavioral management techniques have been tried and failed and a youth poses a danger to himself/herself or others. Restraints shall never be used to punish youth. Accordingly, restraints shall be used only in the following circumstances:

i. Where emergency physical intervention is necessary to protect the safety of any person;

ii. Where a youth is physically attempting to escape the boundary of a Facility; or

iii. Where a youth's behavior poses a substantial threat to the safety and order of the Facility.

w.

d.

a.

youth. This violates most personal space or time and distance guidelines for de-escalations regarding physical restraint.

4. Even though the video is not distinctly clear, there is one point in the restraint where the staff member's elbow appears to bump the youth's face with particular force. The post-restraint review by the Health Clinic substantiates a sufficient level of injury that an SCR (child abuse) referral was made.

5. Finally, the Post-Physical Restraint Health Report indicates that the staff member who accompanied the youth to the Clinic was a staff member who was directly involved in the physical restraint. This is a violation of policy.

Further, the State shall:

41. a. Create or modify and implement policies, procedures, and practices to require that in the limited circumstances when the use of restraints is necessary, staff shall employ only the minimum amount of physical control and time in restraints necessary to stabilize the situation.

PARTIAL COMPLIANCE

COMMENT: This Paragraph applies to the selection and implementation of the CPM system (PPM 3247.12). From a Protection from Harm perspective, successful implementation of CPM should predict reductions in the rates of physical restraints and injuries to youth and staff. Lansing staff completed the CPM training on February 14, 2011, so it was a relatively new procedure at the time of the monitoring visit.

CPM does not use a prone or facedown position as a primary part of the restraint process. The CPM technique moves a youth into a seated position before moving to a supine restraint position, if necessary. In special situations, a youth in restraint may be turned to her stomach (a facedown position) while staff members apply handcuffs. The use of this technique, called a Transitional Hold, is not to exceed three (3) minutes according to policy and the Settlement Agreement and requires a post-restraint examination by the nursing staff within four (4) hours.

CPM also contains a well-developed repertoire of verbal de-escalation strategies. The verbal strategies are adapted from proven techniques in working with troubled youth in residential settings.

Multiple sources indicated that CPM is a safer technique for youth than the prior physical restraint practices. However, multiple sources have also alerted the PH Monitor to concerns about staff safety and staff injuries. First, CPM is described as more difficult to apply. Six of six staff interviews expressed concerns about an increased difficulty in applying the techniques appropriately. Some of the difficulty, according to staff, comes from the increased amount of physical strength required to implement the techniques. Second, with the youth face up, staff and medical report an increase in kicking, biting, spitting, pinching, and occasionally punching by youth toward staff.

Another concern is the risk associated with CPM in close quarters or areas with a lot of furniture. A multi-person restraint requires adequate space to implement. One physical restraint video from the front room off the lobby shows a staff member stumble over furniture, and another staff member suffer a concussion when her head hits the floor during a fall during the two-person part of the restraint. These problems were a function of CPM in a small room, but it is uncertain if other restraint strategies would have fared better given the size of the room.

The most informative perspective on CPM came from a CPM instructor who identified the strengths and weaknesses. The strengths include the increased safety to youth by eliminating a facedown technique and the reliance on a team (multi-person) strategy to conduct the physical restraint. Implicit in the team approach is the recognition that staff can and should wait for other staff to arrive on the scene whenever possible. This creates an opportunity for verbal de-escalation. It also implies that it is better if a single staff member does not initiate a physical restraint unless the youth's behavior dictates a physical intervention through an imminent violation of the restraint conditions in PPM 3247.12.

The disadvantages of the new techniques are (a) the increased need for strength on the part of the staff member to implement the techniques effectively and appropriately; (b) the strain that the restraint places on the staff member's body, particularly the knees, wrists, and lower back; and (c) the increased risk to staff for injury by residents.

41. b. Create or modify and implement policies, procedures, and practices regarding the application of restraints to youth at heightened risk of physical and psychological harm from restraints, including, but not limited to, youth who are obese, have serious respiratory or cardiac problems, have histories of sexual or physical abuse, or are pregnant.

COMPLIANCE

COMMENT: Policy, procedure, and practice (PPM 3243.22) "Health Related Restrictions for Youth" make the aforementioned health issues part of medical restrictions on physical restraints that become part of the Individual Intervention Plan (IIP). References to Health Related Restrictions appear in restraint paperwork, and descriptions of these plans were provided by youth and staff.

41. c. If face-down restraints continue to be used, create or modify and implement policies, procedures, and practices to require that staff utilize them only in emergencies when less restrictive measures would pose a significant risk to the safety of the youth, other youth, or staff. In addition:

i. Face-down restraints shall be employed for only as long as it takes to diffuse the emergency, but in no event shall a youth be restrained in a facedown position for more than three (3) minutes.

ii. Trained staff shall monitor youth for signs of physical distress and the youth's ability to speak while restrained.

iii. Medical personnel shall be immediately notified of the initiation of a facedown restraint position, and the youth shall be immediately assessed by

medical personnel thereafter. In no event shall more than 4 hours lapse between the end of a facedown restraint incident and the assessment of the involved youth by medical staff.

COMPLIANCE

COMMENT: Policy, procedure, practices, resident and staff interviews, and direct observations provide no evidence of the use of face-down restraints. Staff and nurses are aware of the limitations on the Transition Hold, and there was no evidence of a violation or misuse of the Transition Hold.

41. d. Prohibit the use of chemical agents such as pepper spray for purposes of restraint.

COMPLIANCE

COMMENT: Policy, procedure, practices, resident and staff interviews, and direct observations provide no evidence of the use of chemical agents such as pepper spray.

41. e. Prohibit use of psychotropic medication solely for purposes of restraint.

COMPLIANCE

COMMENT: Policy, procedure, practices, resident and staff interviews, and direct observations provide no evidence of the use of psychotropic medication solely for purposes of restraint.

41. f. Create or modify and implement policies, procedures, and practices to require that staff are adequately trained in appropriate restraint techniques, procedures to monitor the safety and health of youth while restrained, first aid, and cardiopulmonary resuscitation ("CPR"). The State shall require that only those staff with current training on the appropriate use of restraints are authorized to utilize restraints.

PARTIAL COMPLIANCE

COMMENT: The Bureau of Training schedule includes ongoing training for staff in these areas. Verification of staff attendance is pending the Monitors review of the Statewide Training and Registration System (STARS).

B. Use of Force

42. Use of Force. In order to adequately protect youth from excessive use of force at the Facilities, the State shall:

42. a. Continue to prohibit "hooking and tripping" youth and using chokeholds on youth.

PARTIAL COMPLIANCE

COMMENT: Policy, procedure, practices, resident and staff interviews, and direct observations provide no evidence of the use of "hooking and tripping." However, one video review showed a staff member take a resident to the floor using a technique that looked very much like a chokehold.

42. b. Create or modify and implement a comprehensive policy and accompanying practices governing uses of force, which shall provide, among other things, that the least amount of force necessary for the safety of staff and youth is used.

PARTIAL COMPLIANCE

COMMENT: Lansing is in compliance with the creation of a comprehensive policy. Video evidence exists of recent situations with multiple examples of interventions in excess of the "least amount of force necessary."

42. c. Create or modify and implement policies, procedures, and practices to require that staff adequately and promptly document and report all uses of force.

PARTIAL COMPLIANCE

COMMENT: The policies, training, and practices surrounding documentation comply with the intent of the Paragraph. The amount of documentation on a physical restraint is exemplary, and it serves as a Protection from Harm safeguard.

There are recent substantiated investigations of staff falsification of documents (incident reports) and "failure to tell the truth to an investigator." This area needs continued monitoring to ensure that the systematic response to these misbehaviors corrects this threat to the integrity of use of force documentation.

42. d. Create or modify and implement a system for review, by senior management, of uses of force and alleged child abuse so that they may use the information gathered to improve training and supervision of staff, guide staff discipline, and/or make policy or programmatic changes as needed.

PENDING REVIEW

COMMENT: The system for review is still in development. More information is needed on the process, including an opportunity to observe a review process from start to finish.

42. e. Establish procedures and practices whereby each Facility Administrator or his or her designee will conduct weekly reviews of the use of force reports and videotaped incidents involving uses of force to evaluate proper techniques. Upon this review, staff who exhibit deficiencies in technique(s) shall be prohibited from using force until such staff receive documented instruction on the proper technique(s).

PARTIAL COMPLIANCE

COMMENT: A weekly review by the facility administrator or his or her designee occurs according to policy and evidenced by the Weekly Facility Restraint Report. However, there are problems with the Weekly Facility Restraint Report process that need to be resolved to achieve full compliance:

1. Questions exist about the accuracy of the report; not all of the physical restraint incident videos provided by OCFS were listed on the Weekly Facility Restraint Report.
2. Insufficient evidence exists in the Reports to conclude an evaluation of proper techniques occurred as called for in Paragraph 42e.
3. Anecdotal reports by staff indicate that the remedial "documented instruction" occurs, but there was no documentation to corroborate this action.

4. Documentation is missing of a "documented instruction" on the proper techniques. If these records are filed elsewhere, it would help to have them available with the Weekly Facility Restraint Reports.

42. f. Train direct care staff in conflict resolution and approved uses of force that minimize the risk of injury to youth. The State shall only use instructors who have successfully completed training designed for use of force instructors. All training shall include each staff member's demonstration of the approved techniques and require that each staff member meet the minimum standards for competency established by the method. Direct care staff skills in employing the method shall be periodically re-evaluated. Staff who demonstrate deficiencies in technique or method shall be re-trained at least every six months until they meet minimum standards for competency established by the method. Supervisor staff who are routinely involved in responding to incidents and altercations shall be trained to evaluate their subordinates' uses of force and must provide evaluation of the staff's proper use of these methods in their reports addressing use of force incidents.

PARTIAL COMPLIANCE

COMMENT: On June 23, 2011, the Monitoring Team visited the Training Academy at MacCormick Residential Center in Brooktondale, NY. The Team experienced a review of staff training materials for the New York Model and CPM. The Bureau of Training trainers demonstrated high levels of knowledge and training skills. Training is a distinct strength.

The Monitors observed a demonstration of the CPM techniques with an opportunity to ask questions about the restraint techniques and about the strategy to determine competency for trainees. One question that needs more discussion is why trainee competencies are determined by applying techniques to someone who is not struggling? Another concern relates to staff complaints that the proper application of CPM restraint techniques requires more strength than before, yet there are no agility or strength assessments done to determine CPM competencies.

The lesson plans for the CPM training reflect a professional standard of best practice. The lesson plans were complete and represent a model for other state training academies on how to prepare training materials.

The time at the Training Academy was insufficient to review the operations of STARS, the tracking system for trainee attendance, so the Monitoring Team will likely return to the MacCormick-based regional training center during the next monitoring visit to confirm staff attendance data, review the "re-train" requirement for staff with demonstrated "deficiencies," and review the training requirements in Paragraph 43e.

The training materials for the supervisory training need to be reviewed. Lansing staff confirm that the supervisory training has not yet occurred.

C. Emergency Response

The levels of emergency response seemed good, and the policy and procedure regarding response teams and codes is appropriate.

43. Emergency Response. The State shall create or modify and implement policies, procedures, and practices relative to staff use of personal safety devices (sometimes referred to as "pins") to call for assistance in addressing youth behavior. To this end, the State shall:

43. a. Immediately revoke the December 18, 2007 directive to staff of Finger Lakes to "push the pin."

NOT APPLICABLE

43. b. Create or modify policies providing staff with guidelines as to when a call for assistance is appropriate.

COMPLIANCE

COMMENT: All staff confirmed with acceptable accuracy a call for assistance procedure based on several color code indicators, and PPM 3246.02 "Crisis Response and Radio Communication in OCFS Operated Residential Facilities" outlines the Code or call for assistance system described as Code Yellow = personal safety; Code Blue = medical; Code Green = security; Code Gray = mental health issues; and Code White = restraint in progress.

43. c. Create or modify policies and procedures regarding the appropriateness of the response to the situation presented.

PARTIAL COMPLIANCE

COMMENT: The new CPM policy and procedure provide some different responses to various situations presented by youth in a crisis situation.

Missing is evidence that supports the appropriateness of these responses.

43. d. Require administrators of each Facility to submit an emergency response plan for review and approval in accordance with statewide policy.

PENDING REVIEW

COMMENT: A review of the emergency response plan did not occur during this monitoring visit.

43. e. Train all Facility staff in the operation of the above policy and procedures.

PENDING REVIEW

COMMENT: A visit to the Regional Training Academy did not include a review of the training lesson plans and materials for the operation of policy and procedures cited above. Additionally, time did not permit a review of the STARS system to verify the delivery of training to all facility staff.

D. Reporting and Investigation of Incidents

These paragraphs refer largely to the activities of the Special Investigations Unit (SIU). A separate monitoring visit to the Home Office will occur to address these paragraphs. Most of the comments below reflect aspects of the current reporting and investigative process, but they are not dispositive for compliance determinations.

44. Reporting and Investigation of Incidents. The State shall adequately report, investigate, and address the following allegations of staff misconduct:

i. Inappropriate use of restraints;

ii. Use of excessive force on youth; or

iii. Failure of supervision or neglect resulting in:

(1) youth injury; or

(2) suicide attempts or self-injurious behaviors.

To this end, the State shall:

44. a. Create or modify and implement policies, procedures, and practices to require that such incidents or allegations are reported to appropriate individuals, that such reporting may be done without fear of retaliation, and that such reporting be done in a manner that preserves confidentiality to the extent possible, consistent with the need to investigate and address allegations.

PENDING REVIEW

COMMENTS: One employee has expressed a fear of retaliation.

44. b. Create or modify and implement policies, procedures, and practices providing that such incidents or allegations are promptly screened and which establish criteria for prioritizing Facility investigations based on the seriousness and other aspects of the allegation. There shall be a prompt determination of the appropriate level of contact between the staff and youth, if any, in light of the nature of the allegation and/or a preliminary investigation of the credibility of the allegation. The determination shall be consistent with the safety of all youth. The determination must be documented.

PENDING REVIEW

44. c. Create or modify and implement policies, procedures, and practices to require that a nurse or other health care provider will question, outside the hearing of other staff or youth, each youth who reports to the infirmary with an injury regarding the cause of the injury. If, in the course of the youth's infirmary visit, a health care provider suspects staff-on-youth abuse, the health care provider shall immediately take all appropriate steps to preserve evidence of the injury, report the suspected abuse to the Statewide Central Register of Child Abuse and Maltreatment ("SCR"), document adequately the matter in the youth's medical record, and complete an incident report.

PARTIAL COMPLIANCE

COMMENT: Policy, procedure, and practice exist that conform to this Paragraph. Clinic staff demonstrated the procedure to the PH Monitor, and the confidentiality safeguards were sufficiently tested. Both proved to be satisfactory and in compliance.

The implementation of the youth's infirmary visit has had a problem recently. A documented incident of a YDA's refusal to follow the policies and procedures set forth for the infirmary visit calls attention to the need to resolve this discrepancy.

44. d. Create or modify and implement policies, procedures, and practices to require that all allegations of staff misconduct described above are adequately and timely investigated by neutral, trained investigators and reviewed by staff with no involvement or personal interest in the underlying event.

i. Such policies, procedures, and practices shall address circumstances in which evidence of injuries to youth, including complaints of pain or injury due to inappropriate use of force by staff, conflicts with the statements of staff or other witnesses.

ii. If a full investigation is not warranted, then the reasons why a full investigation is not conducted shall be documented in writing. In cases where a youth withdraw an allegation, a preliminary investigation shall be *conducted to determine the reasons for the withdrawal and, in cases where it is warranted, a full investigation will be conducted.*

PENDING REVIEW

44. e. Create or modify and implement policies, procedures, and practices to require prompt and appropriate corrective measures to response to a finding of staff misconduct described above.

NONCOMPLIANCE

COMMENT: There was insufficient evidence of "prompt" corrective measures in response to findings of misconduct. For example, on June 28, 2011, OCFS issued a Notice of Discipline (NOD) to a Lansing YDA based on findings of guilt for misconduct that included (a) the unnecessary use of force on a resident, (b) the failure to call for assistance when physical force was used on a resident, (c) the use of unauthorized physical restraint techniques, (d) failure to report to a supervisor or make an accurate and complete log entry on the physical restraint, (e) failure to use appropriate de-escalation techniques before using physical force on a resident, and (f) failure to tell the truth during an interrogation. The incident occurred on July 26, 2010. The NOD did not state or recommend any actual disciplinary action. It included a statement that indicates that any "proposed" penalty will be imposed at the "discretion" of the agency if the employee fails to appeal.

Regarding the text of the new policy, Crisis Prevention and Management (PPM 3247.12) also appears to reference discipline as an optional issue if a staff member violates the policy.

These statements from the NODs and PPM 3247.12 appear contrary to Paragraph 44e. The wording is "to require prompt and appropriate corrective measures" (i. e.,

identification and elimination of the causes of a problem, thus preventing its recurrence), which, in matters of child protection and protection from harm, often minimally includes some type of formal warning to the employee (if this behavior is repeated, the employee will be subject to increased disciplinary action, up to and including termination of employment). While Paragraph 44e does not prescribe the nature and extent of corrective action, it reads as an imperative. That is, some form of documented corrective action is expected, and it seems curiously questionable to make the inclusion of a disciplinary action discretionary for "strictly forbidden" misconduct.

44. f. Provide adequate training to staff in all areas necessary for the safe and effective performance of job duties, including training in: child abuse reporting; the safe and appropriate use of force and physical restraint; the use of force continuum; and crisis intervention and de-escalation techniques. Routinely provide refresher training consistent with generally accepted professional standards.

PENDING REVIEW

COMMENT: The basic academy curriculum provides training in these areas.

Missing is documentation of the training along with documentation of the routine refresher courses.

44. g. Create or modify and implement policies, procedures, and practices to require adequate supervision of staff.

PENDING IMPLEMENTATION

44. h. The State shall utilize reasonable measures to determine applicants' fitness to work in a juvenile justice facility prior to hiring employees for positions at the Facilities including but not limited to state criminal background checks. The State shall update state criminal background checks and SCR clearances for all staff who come into contact with youth every two years.

PENDING REVIEW AT HOME OFFICE

III. MENTAL HEALTH MONITORING

Of the ten mental health paragraphs of the Settlement Agreement, almost none of the new and revised policies have been completed and much of the training is not underway. The MH Monitor cannot assess compliance until the policies are finalized, staff are trained and the staff demonstration of consistent application of the training and adherence to the policies can be observed.

Nevertheless, there was excellent clinical practice observable at Lansing. To some extent and among some staff, practice improvement is happening before the policies are finalized and staff are trained.

45. The State shall provide adequate and appropriate mental health care and treatment to youth consistent with generally accepted professional standards as follows:

46. Behavioral treatment program. The State shall provide an integrated, adequate, appropriate, and effective behavioral treatment program at the Facilities. To this end, the State shall:

a. Create or modify and implement policies, procedures, and practices for an effective behavioral treatment program consistent with generally accepted professional standards and evidence-based principles. The behavioral treatment program shall be implemented throughout waking hours, including during school time.

b. Create or modify and implement policies, procedures, and practices to require that mental health staff provide regular consultation regarding behavior management to direct care staff and other staff involved in the behavioral treatment program.

c. Create or modify and implement policies, procedures, and practices to regularly assess the effectiveness of the interventions utilized.

d. Explain the behavioral treatment program to all youth during an orientation session, setting forth Facility rules and the positive incentives for compliance as well as the sanctions for violating those rules. The rules for the behavioral treatment program shall be posted conspicuously in Facility living units.

PARTIAL COMPLIANCE

The New York Model and training comply with the requirements of 46a, although from the reviewed BIPs, it is apparent that 46a is not yet fully implemented into practice.

Mental health staff at Lansing were observed complying with 46b, although 46b is not yet fully implemented into practice.

The Daily Achievement System (part of the New York Model) complies with the requirements of 46d.

There are four policies, two training curricula, and staff practices the MH Monitor is waiting to review to determine full compliance with 46 a, b, and d.

It is unclear what OCFS is implementing to comply with 46c.

State Report on Progress (5/31/11)

1. Create the New York Model

   The original completion date was 1/31/11. Draft sent to DOJ 4/11. Monitors provided feedback in 5/11. "Revisions in progress."

2. Create new policy on Case Management and Treatment Team Processes

   The original completion date was 3/31/11. "In progress."

3. Modify PPM 2801.00 "Training Requirements for OCFS Operated Facility and Day Placement Staff" and PPM 3443.00 "Resident Rules."

The original completion date was 10/31/10. Training policy draft sent to DOJ 12/10; comments received 4/11. "Revisions in progress. Resident Rules policy still under revision."

4. Create new policy related to Facility Admission Process.

   Drafted and undergoing OCFS review before submission to DOJ for comment.

5. Revise orientation curriculum

   The original completion date was 12/31/10. "Pending policy completion."

6. Plan for training and train staff in the implementation of the NY Model, including the facility admission process, case management, and treatment team processes.

   The original completion date was 10/31/11. The NY Model train the trainer was completed 5/11. Training for facility staff will be completed on schedule. Facility Admission and Case Management will be provided as separate trainings.

On Site Observations (6/11)

Paragraph 46 of the Settlement Agreement requires an effective program to meet the needs of residents. OCFS has proposed a comprehensive program entitled the New York Model. The New York Model, and the policies and training to support it, are designed to build on the strengths of OCFS services and address weaknesses of past programming. OCFS does not have to implement the New York Model to comply with Paragraph 46, but OCFS is choosing to comply with Paragraph 46 with the New York Model.

The New York Model is a composite of evidence-based practices that have been successful with delinquents elsewhere and have not previously been combined for such a comprehensive program. If research shows that the New York Model is effective in supporting youth to recover from trauma and change their behaviors, it has the potential to be influential in delinquency programming around the country.

The components of the NY Model include: the Sanctuary Model of Trauma-Responsive Care which, through its seven commitments, helps residents understand the links between past trauma and current emotions and behaviors; Dialectical Behavior Therapy (DBT) which is an evidence-based, skill-building approach using behavioral principles such as chain analysis, reinforcement, validation, and coaching; the SELF Model (Safety, Emotional Management, Loss, and Future) which emphasizes providing a safe environment so residents can understand their trauma and communicate their feelings more effectively; the Daily Achievement System (DAS) focusing on earning rewards based on progress in treatment; the treatment team; and community meetings to develop emotional intelligence, demonstrate social responsibility, use open communication, focus on the future, and learn from others.

There was excellent clinical practice observable at Lansing. Practice improvement is happening before the policies are finalized and staff are trained in the New York Model, partly because Sanctuary and DBT implementation have been ongoing at Lansing for some time and staff are receiving considerable clinical coaching. Lansing has progressed to DBT and Sanctuary being the program. Every girl has a therapist. The therapists are now active on the units with girls and coaching staff on responding to the individual girls' needs using

DBT and Sanctuary. The girls describe what they are learning and unit staff were positive about the benefits of DBT and Sanctuary. Dr. Tomassone's clinical guidance and leadership in the training and coaching of the New York Model are outstanding. While it is an advantage to have DBT and Sanctuary trained staff, making the shift to the New York Model which integrates the approaches more and includes a different approach to rewarding positive behavior is the next challenge. Staff are becoming experienced at co-leading groups with clinicians, and the MH Monitor observed skilled leadership of a DBT group. The MH Monitor observed a Sanctuary group, and the leader was well intentioned, but did an inadequate job.

The MH Monitor reviewed the one-page "NY Model Beliefs and Assumptions" which is a commendable consolidation of the main messages of the NY Model (including Sanctuary and some of DBT). But it is (a) not in a language that youth understand and (b) too wordy for a handy reference. It would be more effective to summarize the model in a short list of coaching phrases that any youth or staff could rely on. These are the individualized growth, self-regulation, and SELF concepts that come from Sanctuary, DBT, Daily Achievement, and adolescent development. The Model Beliefs from the two manuals express some but not all of these, and they are too wordy to be phrases staff could coach from when they are "building trusting relationships," "guiding problem-solving," and "teaching self-regulation." Therapists are using trauma phrases, DBT group leaders are using DBT phrases, and unit staff are using behavior phrases, but an integration of all three into one universal set of slogans for all staff is necessary.

The presentation on the New York Model curriculum was impressive. The New York Model train the trainer was completed 5/11. The schedule for training the Lansing staff in the New York Model is: Pilot class on first 3 modules 7/26/11; 15 classes on first 3 modules 7/27/11-8/19/11; Pilot class on second 3 modules 8/23/11; 15 classes on second 3 modules 8/24/11-9/23/11; Pilot class on third 3 Modules 9/27/11; and 15 classes on third 3 modules 9/28/11-10/21/11. New York Model training for the Finger Lakes staff is planned for October 2011.

The MH Monitor observed a Sanctuary group that was troubling: girls were asked to recite the seven Sanctuary commitments, and when they were unable, they looked at the poster on the wall and read them *without any apparent understanding of their meaning*. At this point it appears that the Sanctuary commitments have meaning for staff, which is important in creating a safe environment, but not for girls. For example, *open, non-judgmental communication*: what specifically, in simple words, does this mean to the individual girl and how she talks to adults and peers? Why would a girl want to do this, especially when she feels blamed and demeaned by others? *Emotional intelligence*: what specifically, in simple words, does this mean to the individual girl in how she expresses her feelings and how does this relate to the DBT coping skills she is learning? *Social learning*: what specifically, in simple words, does this mean to the individual in how she changes herself?

In one record, a recent Behavioral Analysis included the effective use of a girl's behavior chain thought process and diagram. She was able to analyze what she felt, how she expressed her feelings, how staff response triggered her, how she reacted, and the outcome. This is a girl who continues to have significant behavior problems, and analysis

by unit staff and clinicians of how to use the behavior chain analysis to help her stop early in the chain is a good example of the New York Model in operation.

The new Daily Achievement System, part of the New York Model, is designed as a research-based approach to behavior change. The challenge is helping staff coach youth in understanding what is *behind behavior* (trauma, immaturity, faulty thought patterns) and also rewarding improved behavior. Shifting to praise and shaping and de-emphasizing criticism and punishment is going to be the biggest challenge in guiding staff.

The New York Model integrates clinical services into what happens on the units as the girl recovers from trauma, changes her cognitions and her regulation of her behavior improves. The two psychologists and one part-time psychiatrist are providing an impressive amount of clinical services. Dr. French saw 17 girls for psychotropic medication in March and April 2011, half of whom he saw more than once monthly. Those 17 girls all participated in individual therapy, with either Dr. Morog or Ms. Sargeant, and all participated in groups with one or both of them. Most of these girls had three or more individual therapy sessions per month (four had only one individual session and two had two sessions in one month and several had four, five or six and one had ten individual sessions in a month). In addition to girls seeing Dr. French, Dr. Morog saw six girls for individual and group therapy who were not receiving medication, typically three individual sessions and four groups or more per month. In March and April 2011, Dr. Morog saw 22 girls for individual, group, or both, and Ms. Sargeant saw 15 girls for individual, group, or both.

FUTURE MONITORING

When they are available, the MH Monitor will review:

- Final New York Model
- New policy on Case Management and Treatment Team Processes
- New policy on Facility Admission Process
- Modified PPM 2801.00 "Training Requirements for OCFS Operated Facility and Day Placement Staff"
- Modified PPM 3443.00 "Resident Rules"
- Orientation curriculum
- Case Management and Treatment Team Processes curriculum

The MH Monitor will discuss how the effectiveness of interventions will be regularly assessed.

The MH Monitor hopes to observe a New York Model training class in October and will interview trainers and staff who participate in the New York Model training.

The MH Monitor will observe youth orientation and the Daily Achievement System and the New York Model in action after training.

47. Mental health crises. The State shall provide any youth experiencing a mental health crisis with prompt and adequate mental health services appropriate to the situation. To this end, the State shall:

a. Train all appropriate staff, including direct care staff, on appropriate positive strategies to address a youth's immediate mental health crisis, including a crisis manifesting in self-injurious behavior or other destructive behavior. Such strategies should be utilized in an effort to stabilize and calm the youth, to the extent possible, while awaiting the arrival of a qualified mental health professional. Staff shall not resort to uses of force, including restraints, except as provided in paragraphs 41 and 42 [of the Settlement Agreement].

b. Create or modify and implement policies, procedures, and practices for contacting a qualified mental health professional outside of regular working hours in the event of a youth's mental health crisis or other emergency situation.

c. Require that any youth who experiences a mental health crisis and resorts to maladaptive coping strategies, such as self-injurious behavior, is referred for mental health services following the resolution of the immediate crisis. A qualified mental health professional shall develop a crisis management plan in conjunction with the youth and his or her other mental health service providers. The crisis management plan shall specify methods to reduce the potential for recurrence through psychiatric treatment, treatment planning, behavioral modification and environmental changes, as well as a strategy to help the youth develop and practice positive coping skills. Such services shall continue throughout the duration of the youth's commitment to the Facility.

PARTIAL COMPLIANCE

The CPM policy and training appear to comply with the requirements of 47a.

Mental health staff at Lansing were observed complying with 47a and c. However, incident reports and restraint videos showed unacceptable practice in de-escalating residents in violation of 47a.

Resident records reflect management of mental health crises that appear to be in compliance with 47 b and c.

However, there are four policies and two training curricula the MH Monitor is waiting to review to determine full compliance.

State Report on Progress (5/31/11)

1. Review and modify if necessary policies: PPM 2801.00 "Training Requirements for OCFS Operated Facility and Day Placement Staff," PPM 3243.33 "Behavioral Health Services," PPM 3247.13 "Use of Physical Restraint," PPM 3247.60 "Suicide Risk Reduction and Response" and PPM 3243.34 "Psychiatric Hospitalizations."

The original completion date was 10/31/10. Sent to DOJ 12/10; comments received 4/11 on training policy but not on behavioral health services or psychiatric hospitalizations. "Revisions in progress for all."

2. Plan for training and train staff in Crisis Prevention and Management

The original completion date was 10/31/11. CPM training was completed 5/20/11.

3. Plan for training and train staff in comprehensive mental health policies, including strategies to address mental health crises and standards and procedures for contacting a qualified mental health professional outside normal work hours.

   The original completion date was 10/31/11. "Pending final approval of policies."

On Site Observations (6/11)

During the site visit, the MH Monitor observed mental health and unit staff helping a girl calm herself outside the classroom. This girl, who has cognitive limitations, had been previously hospitalized, and staff helped her not escalate.

However, the recent videotape of a girl being restrained observed by the Monitors reflected not only unacceptable restraint techniques, but lack of a trauma-informed approach to de-escalation or helping the girl use her DBT skills. Although there was no audio, it appeared that staff escalated her, was physically intimidating, and did not adhere to the Sanctuary ideas of maintaining safety (all before the actual restraint). While training in proper restraint technique is important, staff must understand that traumatized girls quickly become more anxious than they have the skills to manage, and that de-escalation involves supporting them to soothe themselves (so a restraint will not have to be considered). For the staff involved in the videotape, there is more coaching necessary in their de-escalation techniques. In an interview, the girl whose videotaped restraint was observed reported she has therapy twice a week and told the MH Monitor she also gets a lot out of DBT group. She thinks she is doing well on medication. She is learning to listen and stop and think, "being more mindful." She finds it helpful to be allowed to take "time away" in school, and then she can get back to work. Her treatment plan indicated that staff should "use caution" regarding restraint with her because her trauma history includes a rape. [Note: The Crisis Prevention and Management policy, training, and current practice are extensively covered in the PH Monitor's sections of this report.]

The incident reports read in the records also indicate the lack of skills in de-escalation. If a mental health staff person is not immediately involved when a girl becomes anxious, some unit staff are not yet able to help the girl feel safe and de-escalate. Sanctuary and DBT coping skills are available for staff to rely on in de-escalating, but the incident reports do not reflect their use.

The most recent psychiatric hospitalizations of a Lansing resident prior to the site visit occurred twice in February, once in March and once in May for the same girl who stayed in the hospital from 4-29 days due to suicidal ideation and self-mutilation. Since the site visit, the same resident was hospitalized again.

FUTURE MONITORING

When they are available, the MH Monitor will review:

- Revised PPM 2801.00 "Training Requirements for OCFS Operated Facility and Day Placement Staff"
- Revised PPM 3243.33 "Behavioral Health Services"
- Revised PPM 3243.34 "Psychiatric Hospitalizations."
- Revised PPM 3247.60 "Suicide Risk Reduction and Response."

Training curriculum on comprehensive mental health policies and standards

Training curriculum on procedures for contacting a qualified mental health professional outside normal work hours.

The MH Monitor will interview trainers and staff who participate in the mental health policies and standards training

The MH Monitor will review recent incident reports, suicide-related reports, and hospitalization reports and interview girls and clinicians

48. Evaluation of mental health needs. The State shall require that youth with mental health needs are timely identified and provided adequate mental health services. To this end, the State shall:

a. Create or modify and implement policies, procedures and practices to require that each youth admitted to a Facility is comprehensively screened by a qualified mental health professional in a timely manner utilizing reliable and valid measures. The State shall require that any youth whose mental health screening indicates the possible need for mental health services receives timely, comprehensive, and appropriate assessment by a qualified mental health professional and referral when appropriate to a psychiatrist for a timely mental health evaluation.

b. Require that any youth whose mental health screening identifies an issue that places the youth at immediate risk is immediately referred to a qualified mental health professional. The qualified mental health professional shall determine whether assessment or treatment is necessary. A determination to transfer a youth to a more appropriate setting on other than an emergency basis shall require consultation with a committee designated by OCFS' Deputy Commissioner for Juvenile Justice and Opportunities for Youth (DJJOY) or his or her designee or successor. Such committee may include qualified mental health professionals at OCFS' central office. If a determination is made that the youth should be transferred to a more appropriate setting, the State shall immediately initiate procedures to transfer the youth to such a setting.

c. Require that assessments take into account new diagnostic and treatment information that becomes available, including information about the efficacy or lack of efficacy of treatments and behavioral interventions.

d. Create or modify and implement policies, procedures and practices to require that for each youth receiving mental health service, the youth's treating qualified mental health professional(s), including the treating psychiatrist, if applicable, develop a consistent working diagnosis or diagnoses. The diagnosis or diagnoses shall be updated uniformly among all qualified mental health professionals providing services to the youth.

e. Create or modify and implement policies, procedures, and practices to require that both initial and subsequent psychiatric evaluations are consistent with generally accepted professional standards. Initial evaluations should be legibly written and detailed, and should include, at a minimum, the following information for each youth evaluated: current mental status; history of present illness; current medications and response to them; history of treatment with medications and response, including adverse side effects or medication allergies; social history; substance abuse history; interviews of parents or guardians; review of prior records; and explanation of how the youth's symptoms meet diagnostic criteria for the proffered diagnosis or diagnoses.

PARTIAL COMPLIANCE

The new mental health assessment format complies with 48a, d, and e.

Mental health staff at Lansing were observed complying with 48b and d.

Some resident records demonstrate compliance with 48a, b, c, and e.

However, there are four policies, two training curricula, and a report the MH Monitor is waiting to review to determine full compliance, as well as a discussion among treating clinicians regarding consistent diagnostic practices.

State Report on Progress (5/31/11)

1. Modify policies: PPM 2801.00 "Training Requirements for OCFS Operated Facility and Day Placement Staff," PPM 3243.33 "Behavioral Health Services," PPM 3247.13 "Use of Physical Restraint," PPM 3243.34 "Psychiatric Hospitalizations" and PPM 3247.60 "Suicide Risk Reduction and Response."

   The original completion date was 10/31/10. Sent to DOJ 12/10; comments received on training and suicide policies but not on behavioral health services or psychiatric hospitalization. "Revisions in progress" for all.

2. Identify assessment instruments.

   The original completion date was 12/31/10. "In progress."

3. Plan for training and train staff in comprehensive mental health policies and standards.

   The original completion date was 10/31/11. "Pending final approval of policies."

4. Formalize committee for mental health transfers.

The original completion date was 10/31/10. "In progress."

5. Update Memorandum of Understanding with Office of Mental Health.

   The original completion date was 12/31/10. Completed 1/11.

6. Communicate and implement policy and procedures to qualified mental health professionals.

   The original completion date was 3/31/11. "Pending."

7. Plan for training and train mental health professionals on protocols related to developing a uniform working diagnosis(es) and comprehensive mental health policies and standards.

   The original completion date was 3/31/11. "Pending final approval of policy."

On Site Observations (6/11)

The MH Monitor reviewed a thorough Lansing mental health assessment on a revised form. At Tryon previously, the girl's treatment focused on behavior control, with a diagnosis of conduct disorder (although she was medicated for bipolar disorder). When she arrived at Lansing, the assessment indicated a diagnosis of PTSD, noted her strengths of being bright, motivated, and insightful and identified her low frustration tolerance, tendency to respond to even mild stressors, and being hypervigilant for insults. She was not receiving medication at Lansing.

An earlier Lansing mental health assessment in another record was a two-page narrative, providing the girl's history, IQ, diagnosis and a helpful strength-based conclusion: "She responds well to problem solving and benefits from clear, fair and consistent guidance; she knows she needs to learn how to accept feedback and be respectful."

Of 17 girls Dr. French saw for psychotropic medication in March and April, 2011, seven of them were listed as having different diagnoses than Dr. Morog and Ms. Sargeant's clinical services reports reflected: he indicated anxiety for one girl they listed as conduct disordered, one girl they listed as depressed, one girl they listed as adjustment disordered, and one girl they listed as having oppositional defiant disorder; he listed grief reaction for one girl they listed as conduct disordered, he indicated dissociative for one girl they listed as depressive disorder, and he indicated panic disorder for a girl they listed as having PTSD.

The MH Monitor reviewed the MOU with the Office of Mental Health, which provides a framework for OCFS, and OMH to work together to meet the needs of "children with mental illness" in OCFS operated facilities. It envisions OMH staff trained by OCFS and assigned to and fully integrated within OCFS facility operations. The MOU requires that all OCFS and OMH clinical staff have access to mental health information about youth and that OCFS mental health staff receive HIPAA compliance training. It also describes the handling of psychiatric hospitalization and the possibility of placement of OCFS youth in OMH Psychiatric Center Adolescent Inpatient Services. Since the clinical staff at Lansing work for OCFS, the MOU with OMH does not appear to have much relevance for mental health services in the facility.

FUTURE MONITORING

When they are available, the MH Monitor will review:

- Revised PPM 2801.00 "Training Requirements for OCFS Operated Facility and Day Placement Staff"
- Revised PPM 3243.33 "Behavioral Health Services"
- Revised PPM 3243.34 "Psychiatric Hospitalizations."
- Revised PPM 3247.60 "Suicide Risk Reduction and Response."
- Assessment instruments
- Training curriculum on comprehensive mental health policies and standards
- Training curriculum for mental health professionals on protocols related to developing uniform working diagnoses
- Reports from the Committee for Mental Health Transfers
- The MH Monitor will interview trainers and staff who participate in the mental health policies and standards training and discuss consistency in diagnostic practices with the psychiatrist and psychologists.

49. *Use of psychotropic medications. The State shall require that the prescription and monitoring of the safety, efficacy, and appropriateness of all psychotropic medication use is consistent with generally accepted professional standards. To this end, the State shall:*

    a. *Create or modify and implement policies, procedures and practices to require that any psychotropic medication is: prescribed only when it is tied to current, clinically justified diagnoses or clinical symptoms; tailored to each youth's symptoms; prescribed in therapeutic amounts, as dictated by the needs of the youth served; modified based on clinical rationales; documented in the youth's record with the name of each medication; the rational for the prescription of each medication, and the target symptoms intended to be treated by each medication.*

    b. *Create or modify and implement policies, procedures and practices for the routine monitoring of psychotropic medications, including: establishing medication-specific standards and schedules for laboratory examinations; monitoring appropriately for common and/or serious side effects, including requiring that staff responsible for medication administration regularly ask youth about side effects they may be experiencing and document responses; establishing protocols for timely identification, reporting, data analyses and follow up remedial action regarding adverse drug reactions; monitoring for effectiveness against clearly identified target symptoms and time frames; requiring that such medications are used on a time-limited, short-term basis where such use*

is appropriate, and not as a substitute for adequate treatment of the underlying cause of the youth's distress; requiring that youth are not inhibited from meaningfully participating in treatment, rehabilitation or enrichment and educational services as a result of excessive sedation; and establishing protocols for reviewing such policies and procedures to require that they remain consistent with generally accepted professional standards.

c. Require that the results of laboratory examinations and side effects monitoring are reviewed by the youth's psychiatrist, if applicable, and that such review is documented in the youth's record.

PENDING REVIEW

Given the complex requirements of 49 a, b and c, the MH Monitor will engage an adolescent psychopharmacology expert subcontractor to assist the MH Monitor with her review of compliance with the psychotropic medication section of the Settlement Agreement.

The MH Monitor is awaiting two policies and a training curriculum to review

State Report on Progress (5/31/11)

1. Modify policies: PPM 3243.32 "Psychotropic Medications" and PPM 3243.33 "Behavioral Health Services."

   The original completion date was 10/31/10. Sent to DOJ 12/10; no comments received. "Revisions in progress."

2. Plan for training and train qualified health professionals in prescribing and monitoring practices related to psychotropic medication.

   The original completion date was 3/31/11. "Pending final approval of policies."

On Site Observations (6/11)

The MH Monitor observed careful documentation of diagnosis, symptoms, dosages, and administration of psychotropic medication in the individual records. In the thoughtful Rounds discussion observed by the MH Monitor of the seven girls with highest mental health needs, the psychiatrist explained the decision about particular medications and medication changes based on efficacy. The psychiatrist was ably assisted in the meeting by the Nurse Practitioner presenting each individual girl's medication information. Lansing has continued the practice of the youth's therapist attending the medication review with the psychiatrist with each youth, resulting in the youth being better informed and more able to discuss efficacy and side effects. Diagnoses range from Anxiety Disorder, Dissociative Disorder, PTSD, Depression, and Panic Disorder. Primary medications are antipsychotics (Abilify, Seroquel and Geodon), with some girls receiving anti-depressants (Celexa, Trazadone and Remeron). Apparently OCFS is recruiting a Psychiatric Nurse Practitioner to insure increased monitoring of dosages and laboratory tests for psychotropic medications.

FUTURE MONITORING

When they are available, the MH Monitor will review:

- Revised PPM 3243.32 "Psychotropic Medications"
- Revised PPM 3243.33 "Behavioral Health Services"
- Training curriculum on prescribing and monitoring psychotropic medication

Expert review to determine appropriateness of medications for diagnoses and whether correct dosages and standard monitoring of effects are the practice at Lansing.

50. Staff training on psychotropic medications and psychiatric disabilities. The State shall create or modify and implement policies and procedures requiring staff in Facilities to complete competency-based training on psychotropic medications and psychiatric disabilities.

a. The training shall provide, at minimum, an overview of the behavioral and functional impact of psychiatric disabilities on youth, common treatments for such psychiatric disabilities, including both behavioral and pharmaceutical interventions; commonly used medications and their effects, including potential adverse side effects and intended benefits; and warning signs that a youth may be suffering a serious adverse effect of a psychotropic medication and the immediate and follow-up actions to be taken by the staff in such an incident.

b. The State shall create or modify and implement policies, procedures and training materials for staff at all Facilities as follows: Staff employed at the Facilities who routinely work directly with youth (but not including qualified mental health professionals or medical professionals) shall complete a minimum of six (6) hours of competency-based training regarding psychotropic medications and psychiatric disabilities annually for the term of this Agreement. Such staff includes, but is not limited to, Youth Division Aides, Youth Counselors, teachers, recreation staff, licensed practical nurses, Facility Administrators, and Deputy Administrators. All other staff at the Facilities shall be required to complete a minimum of one (1) hour of competency-based training on psychotropic medications and psychiatric disabilities annually for the term of this Agreement.

PENDING REVIEW

There are three policies and a training curriculum the MH Monitor is waiting to review to determine compliance.

State Report on Progress (5/31/11)

1. Modify policies: PPM 2801.00 "Training Requirements for OCFS Operated Facility and Day Placement Staff," PPM 3243.32 "Psychotropic Medications" and PPM 3243.33 "Behavioral Health Services."

The original completion date was 10/31/10. Sent to DOJ 12/10;comments received on training policy; no comments received on behavioral health or psychotropic medications. "Revisions in progress."

2. Plan for training and train staff on psychotropic medication and psychiatric disabilities.

The original completion date was 10/31/10. "Pending final approval of policy."

On Site Observations (6/11)

Other than the Rounds discussion described above, there was no opportunity for observation of staff understanding of medication.

FUTURE MONITORING

When they are available, the MH Monitor will review:

- Revised PPM 2801.00 "Training Requirements for OCFS Operated Facility and Day Placement Staff"
- Revised PPM 3243.32 "Psychotropic Medications"
- Revised PPM 3243.33 "Behavioral Health Services"
- Training curriculum on psychotropic medication and psychiatric disabilities

The MH Monitor will review staff practices regarding psychotropic medication and psychiatric disabilities.

51. Psychotropic medication refusals. The State shall create or modify and implement policies, procedures, and practices regarding psychotropic medication refusals by youth which provide, at minimum, as follows:

a. All youth who are scheduled to receive medication shall be taken without the use of force to the medication administration location at the prescribed time. Any youth who expresses his or her intent to refuse medication shall communicate his or her refusal directly to medical staff.

b. In circumstances where staff's verbal efforts to convince a youth to report to the medication administration location results in an escalation of a youth's aggressive behavior, staff shall not forcibly take the youth to receive medication. The supervisor shall document the youth's refusal on a medical refusal form, and shall complete an incident report documenting the circumstances of the refusal, including the justification for not escorting the youth to medication.

c. A medical refusal form shall be completed each time a youth is scheduled to receive medication and refuses. In addition to the date and time, youth's name and prescribed medication which the youth is refusing, the form shall include an area for either the youth or a staff person to record the youth's stated reason for refusing medication, an

area for the youth's treating psychiatrist to certify that s/he has reviewed the medication refusal form, and signature line for the refusing youth.

d. The youth's psychiatrist shall receive, review, and sign all medication refusal forms prior to meeting with the youth.

e. The youth's treatment team shall address his or her medication refusals.

PARTIAL COMPLIANCE

Some resident records demonstrate compliance with 51 a, b, c and d.

However, there are two policies, a training curriculum, and refusal forms in records that the MH Monitor is waiting to review to determine full compliance.

State Report on Progress (5/31/11)

1. Modify policies: PPM 3243.15 "Refusal of Medical and Dental Care by Youth and PPM 3243.32 "Psychotropic Medications"

   The original completion date was 10/31/10. Sent to DOJ 12/10; no comments received. "Revisions in progress."

2. Plan for training and train staff on psychotropic medications, including refusal of treatment

The original completion date was 1/31/11. Medical staff training complete on refusal of treatment as of 5/31/11.

3. Educate youth on refusal of medical protocols.

   The original start date was 1/1/11, with no completion date. "Ongoing."

On Site Observations (6/11)

The MH Monitor observed documentation in girls' individual records of refusal of psychotropic medication. If a girl does not want to take her medication, the medical staff's practice is to ask about her reasons and counsel her about making a wiser decision. If they cannot persuade her to take her medication, she is asked to write her reason on the medication refusal form, which is reviewed by the psychiatrist.

FUTURE MONITORING

When they are available, the MH Monitor will review:

- Revised PPM 3243.15 "Refusal of Medical and Dental Care by Youth Revised PPM 3243.32 "Psychotropic Medications"
- Training curriculum on psychotropic medication and refusal of treatment
- The method for educating youth on refusal of medication
- The MH Monitor will interview trainers and staff who participate in the psychotropic medication and refusal of treatment training and review refusal forms in other records

52. Informed consent. The State shall revise its policies and procedures for obtaining informed consent for the prescription of psychotropic medications consistent with generally accepted professional standards. In addition, the State shall require that the information regarding prescribed psychotropic medications is provided to a youth and to his or her parents or guardians or parson(s) responsible for the youth's care by an individual with prescriptive authority, such as a psychiatric nurse practitioner. This information shall include: the purpose and/or benefit of the treatment; a description of the treatment process; an explanation of the risks of treatment; a statement of alternative treatments, including treatment without medication; and a statement regarding whether the medication has been approved for use in children.

PARTIAL COMPLIANCE

Some resident records demonstrate compliance with Paragraph 52. The MH Monitor is concerned that the complexity of medical information presented in the consent forms may be too difficult for parents to understand.

There is a policy and a training curriculum the MH Monitor is waiting to review to determine full compliance.

State Report on Progress (5/31/11)

1. Modify policy: PPM 3243.32 "Psychotropic Medications"

   The original completion date was 10/31/10. Sent to DOJ 12/10; no comments received. "Revisions in progress."

2. Plan for training and train qualified mental health professionals on psychotropic medications, including informed consent requirements

   The original completion date was 1/31/11. In progress

On Site Observations (6/11)

Informed consent forms were in the records reviewed by the MH Monitor. For one girl whose medication had to be changed because of side effects, medical staff made repeated attempts to contact her mother until she was reached and gave permission. It was impressive that for most of the girls discussed in Rounds, the Nurse Practitioner had had several phone conversations with parents which would likely make the parent better informed about the treatment being provided, not just giving consent to medication.

A parent's signed consent form for the antipsychotic Abilify explained that the Lansing psychiatrist was requesting permission to treat her daughter for depression and anger. This was followed by a jargon-filled explanation that this medication can "help the patient be less upset and agitated. They can improve the ability to think clearly…sometimes they are used to reduce…very serious behavior problems in young people." This paragraph could cause a parent to fear that his/her child is very disturbed. The next paragraph lists serious possible side effects, explaining that close observation will be provided and what will be done if side effects occur. The parent is invited to call the physician with any questions, and the form ends with a statement that the parent can withdraw permission at any time. The vocabulary used in the consent form may be difficult for parents to understand.

FUTURE MONITORING

When they are available, the MH Monitor will review:

- Revised PPM 3243.32 "Psychotropic Medications"
- Training curriculum on psychotropic medication and informed consent requirements

The MH Monitor will review recent consent forms in records

53. *Treatment planning. The State shall develop and maintain adequate formal treatment planning consistent with generally accepted professional standards. To this end, the State shall:*

    a. *Create or modify and implement policies, procedures and practices regarding treatment planning which address, among other elements, the required content of treatment plans and appropriate participants of a youth's treatment team.*

    b. *Require that treatment teams focus on the youth's treatment plan, not collateral documents such as the "Resident Behavior Assessment."*

    c. *Require that the youth is present at each treatment team meeting, unless the youth is not physically located in the Facility during the meeting or the youth's presence is similarly impracticable, and that, if applicable, the youth's treating psychiatrist attend the treatment team meeting a minimum of every other meeting.*

    d. *If a youth has a history of trauma, require that treatment planning recognizes and addresses the youth's history of trauma and its impact and includes a strategy for developing appropriate coping skills by the youth.*

    e. *Require that treatment plans are individualized for each youth, and that treatment plans include: identification of the mental and/or behavioral health issues to be addressed in treatment planning; a description of any medication of medical course of action to be pursued, including the initiation of psychotropic medication; a description of any individual behavioral treatment plan or individual strategies to be undertaken with the youth; a description of the qualitative and quantitative measures to monitor the efficacy of any psychotropic medication, individual behavioral treatment plan or individual strategies utilized with the youth; a description of any counseling or psychotherapy to be provided; a determination of whether the type or level of treatment needed can be provided in the youth's current placement; and a plan for modifying or revising the treatment plan if necessary.*

    f. *Require that treatment plans are modified or revised as necessary, based on the efficacy of interventions, new diagnostic information, or other factors. The treatment plan shall be updated to reflect any changes in the youth's mental health diagnosis.*

PARTIAL COMPLIANCE

Mental health staff at Lansing were observed complying with 53b and c.

The treatment plans in resident records do not comply with 53.

There is a new policy and a training curriculum the MH Monitor is waiting to review to assess compliance.

State Report on Progress (5/31/11)

1. Create new policy on Case Management and Treatment Team Processes

   The original completion date was 3/31/11. "In progress."

2. Modify treatment plan documents

   The original completion date was 12/31/10. First draft completed 11/29/10. Undergoing revisions.

3. Plan for training and train staff on case management and treatment team processes

   The original completion date was 10/31/11. The estimated schedule, pending finalized comprehensive training schedule, 4/11 Pilot class at Lansing; 4/11-6/11 Curriculum revisions, train the trainers; 6/11-classes at Lansing; 7/11-8/11 Classes at Finger Lakes. "Pending policy completion and approval.

4. Create the New York Model

   The original completion date was 1/31/11. Draft sent to DOJ 4/11. Monitors provided feedback in 5/11. "Revisions in progress."

On Site Observations (6/11)

The MH Monitor had the opportunity to observe a treatment team meeting, with the girl's parents (who were out-of-state) on speakerphone and her aftercare worker on videoconference. It was a difficult meeting, with an unsupportive aftercare worker planning to extend her commitment despite her progress and parents whose filing of court documents to have her commitment vacated so she could move with them to Florida delayed by her sister's and mother's serious illnesses. It was impressive that the resident was supported to manage many feelings during the meeting and to play a central role in the discussion among all participants. The focus of this meeting was important logistics, and at the next site visit the MH Monitor will have the opportunity to observe a more typical treatment team meeting to see how the treatment plan is more important in the discussion.

The records had examples of poor treatment plans on the old format. They had the same problems: they were generic, vague, not trauma-informed, focused only on behavior problems and written in jargon the girl is unlikely to understand. For example, for one girl diagnosed with PTSD and Anxiety Disorder, the wording of the treatment plan was surprisingly: "Goal 1 No assaultive behaviors; Goal 2 Decrease school refusal depression and relationship problems; and Goal 3 Increase emotional regulation, interpersonal effectiveness, distress tolerance and mindfulness." The treatment for all three goals was the same: weekly therapy, DBT, and medication. Helping her understand the connection between her past trauma and her behavior may be what therapy is for and DBT should help

with emotional regulation and distress tolerance, but the role of unit, school and other staff who are not her therapist or leaders of her DBT and Sanctuary groups is ignored. Another girl had an unreasonable 13 goals in her Treatment Plan, which were more the therapist's plans than in a language the girl would use, including: Establish therapeutic relationship and contract for treatment; Elicit resident goals and develop a plan to work collaboratively toward them; Develop skills in core mindfulness; Address therapy interfering behaviors of the resident ("behaviors that burn out the therapist or reduce the therapist's motivation to treat the resident"); Develop, maintain and assess helpfulness of IIP; and Develop strategies to encourage and support long-term goals. Another girl's goals included: Cooperate with psychiatric treatment; Develop skills in core mindfulness; Eliminate violent behaviors; Identify and decrease susceptibility to emotional vulnerability; and Identify and address cognitive distortions that maintain ineffective behaviors and lead to emotional dysregulation. The "Treatment Team Plan Notes" for a third girl were on a form that was confusing and could not serve as a reference for the girl. Although she has many mental health needs, none were noted. Her RBA Focus Items were controlling impulsive behavior and leadership. Her plan was returning to her mother in a few weeks, but there were no details about how to maintain her progress at Lansing in the community. These unacceptable treatment plans illustrate the training and coaching that will be necessary to help staff, especially clinicians and YCs, in using the girl's words to specify her unique trauma-informed goals for personal change.

Training and coaching in the New York Model should ensure incorporation of Sanctuary and DBT skills in treatment planning. For example, in a record reviewed during the site visit, the reason for a BIP was "resident's behavior disrupting program of peers" and the goal was "resident needs to follow rules and norms." This is not trauma-informed, nor does it reference the coping skills the resident is learning in the program so it is unlikely to help the girl regulate her emotions and behaviors effectively. The focus of her earlier BIP was to "be respectful—treat others how you would like to be treated" because she was threatening staff. Given her past victimization, it is possible that the resident was reacting to what she considered disrespectful in the staff's treatment of her. A trauma-informed treatment plan would instead support the resident's coping skills to calm herself and reduce her reactivity when she feels unfairly treated. In another resident's BIP, identical wording was used regarding "accepting no, use listening skills, safety plan," and "resident needs to follow basic rules." Treatment planning with this resident should not be global instructions, but instead provide support individualized for the resident to process her past trauma in order to become less reactive. An individual counseling session log by the YC indicated the girl should control her impulsive behavior by thinking prior to making a decision, taking ownership, accepting no, and listening, but these are not trauma-informed and do not make sense for an immature resident with a severe learning disability.

Originally case management and treatment team processes training were expected to be part of the New York Model training. The treatment team form has been revised and will be piloted at Finger Lakes with training and coaching during August 2011. The new form will be rolled out at both Finger Lakes and Lansing after the pilot and the form is finalized. Case management training will be scheduled upon completion of the new policy.

FUTURE MONITORING

When they are available, the MH Monitor will review:

- New policy on Case Management and Treatment Team Processes
- Treatment plan documents
- Training curriculum on case management and treatment team processes

The MH Monitor will interview trainers and staff who participate in the case management and treatment team processes training

The MH Monitor will review treatment plans and observe another treatment team meeting

54. Substance abuse treatment. The State shall create or modify and implement policies, procedures, and practices to require that:

a. All youth who have a suspected history of substance abuse are provided with adequate prevention education while residing at a Facility; and

b. All youth who are known to have current problems with substance abuse or dependence are provided adequate treatment for those problems while residing at a Facility.

PENDING REVIEW

The MH Monitor is waiting to review a service description, an MOU, two policies, and a training curriculum

State Report on Progress (5/31/11)

1. Develop collaboration with NYS Office of Alcohol and Substance Abuse Services (OASAS)

   The original start date was 1/5/10 with no completion date. Draft MOU currently under discussion with OASAS

2. Modify PPM 3243.33 "Behavioral Health Services"

   The original completion date was 10/31/10. Sent to DOJ 12/10; no comments received. "Revisions in progress"

3. Create new policy on Case Management and Treatment Team Processes (to include substance abuse services)

   The original completion date was 3/31/11. "In progress."

4. Plan for training and train staff on case management and treatment team processes, including substance abuse services

   The original completion date was 10/31/11. The estimated schedule, pending finalized comprehensive training schedule, 4/11 Pilot class at Lansing; 4/11-6/11 Curriculum revisions, train the trainers; 6/11-classes at Lansing; 7/11-8/11 Classes at Finger Lakes. "Pending policy completion and approval.

5. Plan for and provide, with the support of OASAS, substance abuse treatment, prevention and educational services to youth commensurate with their needs

   The original completion date was 6/30/11. Substance abuse training being coordinated with OASAS

   On Site Observations (6/11)

OCFS provided the MH Monitor with the descriptions and manuals for chemical dependency programs being considered for implementation (Teen Intervene, a cognitive behavioral approach by Hazelden, and the Residential Student Assistance Program (RSAP) by SASCorp). While there are benefits to implementing any program with a positive track record or evidence base, there are at least five significant concerns with using an existing chemical dependency program at this point in the evolution of the New York Model: (1) chemical dependency programs are not trauma-informed; the youth connecting past trauma with substance use maybe dismissed as denial; in contrast, in the New York Model, a young person recognizes past methods of managing bad memories and anxiety about being unsafe and is supported to practice more effective coping skills; (2) daily marijuana use as self-medication for attention problems, learning disabilities, and to reduce triggers from past trauma is a challenge to face in trauma treatment and is typically simplistically responded to with sobriety messages in chemical dependency programs; (3) most chemical dependency programs fail to assist youth with the dissonance of seeing the negatives of substance abuse and living with loved ones who use; this anti-family bias is inconsistent with OCFS goals of family engagement; (4) reliance in substance abuse treatment on professional assessment driving treatment; the New York Model avoids adults telling youth they have a problem and is explicitly designed to support youth self appraisal and choosing different thinking and actions; and (5) separating drug education from drug treatment and keeping them self-contained groups led only by certified treatment staff may undermine integration into the New York Model even when OCFS staff are certified.

In the example of the girl above, the last seven of her 13 treatment plans goals targeted her substance use: Enhance motivation to address challenges and pressures surrounding drug use; Functional/behavioral chain analysis of history of drug use; Learn basic skills for refusing offers of drugs; Develop a plan for pleasant drug free activities; Establish a social network that will support recovery; Develop strategies for coping with high-risk situations for drug use; and Develop skills for recovering from a relapse should one occur. Some of these statements use New York Model concepts, but they seem unlikely to be understood by the girl or her own intentions. When a "treatment plan" is seen by a resident as requirements or goals of the facility, it encourages her not to plan for real change when she returns to the community.

The MH Monitor recommends that OCFS distill the proposed chemical dependency program into the coping skills being taught to youth and figure out how those messages can be integrated in a trauma-informed way into the New York Model. This will be a difficult process. OCFS is also encouraged not to run separate chemical dependency groups but to integrate all the learning into practicing self-care skills, applicable to their time in the facility and when they return to the community. The triggers and cravings material, for example, while not in conflict with a trauma-informed understanding of triggers, would

have to be used with residents differently in the New York Model than presented in Teen Intervene. Calling the relief traumatized youth and youth with disabilities feel from marijuana "escape" is pejorative. The Teen Intervene approach to a family meeting for setting family rules about substances has to be considered individually with each youth depending on their family members' substance use. Some of the ideas about participatory rule-making might be useful for the transition plan team meetings that include parents and community workers by videoconference. Since there are evidence-based curricula for informing youth about drugs and alcohol, one option would be to offer this as a credit-granting educational class in the school, and integrate a trauma-informed self-appraisal of substance use into the New York Model.

If OCFS intends to operate a specialized chemical dependency service unit at Lansing or Finger Lakes, it must operate as part of the trauma-informed New York Model, including using the same coping skills and behavior achievement system.

Originally substance abuse training was expected to be part of the New York Model training, but it will be provided separately at an unspecified date. In the meantime, at Lansing treatment and prevention services are being provided to youth by a certified Substance Abuse Social Worker and a Youth Counselor certified in Substance Abuse. The MH Monitor observed a substance abuse education group that was skillfully led by a chemical dependency counselor who has piloted the group at Lansing in order to assist in the integration of substance abuse treatment in the New York Model.

FUTURE MONITORING

When they are available, the MH Monitor will review:

- Description of substance abuse treatment and education services in the facilities that complies with 54 a and b
- MOU with OASAS
- New policy on Case Management and Treatment Team Processes
- Revised PPM 3243.33 "Behavioral Health Services"
- Training curriculum on case management and treatment team processes including substance abuse services

The MH Monitor will interview trainers and staff who participate in the case management and treatment team processes training including substance abuse services.

The MH Monitor will observe substance abuse treatment and education services being provided to residents.

55. Transition planning. The State shall require that each youth who has mental health issues, or who has been or is receiving substance abuse treatment, who is leaving a Facility has a transition plan. The State shall create or modify and implement policies, procedures, and practices for the development of a transition plan for each such youth. The transition plan shall include information regarding:

a. Mental health resources available in the youth's home community, including treatment for substance abuse or dependence if appropriate;

b. Referrals to mental health or other services when appropriate; and

c. Provisions for supplying psychotropic medications, if necessary, upon release from the Facility.

PENDING REVIEW

The MH Monitor is waiting to review three policies and a training curriculum.

State Report on Progress (5/31/11)

1. Modify policies: PPM 3243.32 "Psychotropic Medications" and PPM 3243.33 "Behavioral Health Services."

   The original completion date was 10/31/10. Sent to DOJ 12/10; no comments received. "Revisions in progress."

2. Create new policy on Case Management and Treatment Team Processes

   The original completion date was 3/31/11. "In progress."

3. Plan for training and train facility and community based staff on case management and treatment team processes, to include transition planning

   The original completion date was 10/31/11. The estimated schedule, pending finalized comprehensive training schedule, 4/11 Pilot class at Lansing; 4/11-6/11 Curriculum revisions, train the trainers; 6/11-classes at Lansing; 7/11-8/11 Classes at Finger Lakes. "Pending policy completion and approval."

On Site Observations (6/11)

Instead of the training schedule outlined above, transition planning is being addressed through the development and training of the Continuity of Care (COC) Plan. Facility clinicians have recently been directed to complete Continuity of Care Plans for all youth with mental health, substance abuse, or sexual offending behavior treatment needs when they are released from the facility.

The Continuity of Care Plan for a girl who left the facility during the site visit was actually called a Mental Health/Psychiatric Medication Continuity of Care Plan. It was only a single page and simply provided the date of release to her mother; the mental health therapist's name and appointment date; the psychiatrist's name and appointment date; and the three medications, including an antipsychotic, for which she had a 30-day supply. This is not a Continuity of Care Plan—it is an appointment schedule, which is important for continuity of care.

The language of the Settlement Agreement in Paragraph 55 is a transition plan to include information regarding mental health, psychotropic medication and substance abuse services the resident will receive in his/her next location. Good practice in juvenile justice is a transition plan that defines how a resident's treatment plan and gains in the facility will continue in the community (or other placement). Thus, the OCFS Continuity of Care Plan should not be limited to mental health transition information (and should not be called a Mental Health/Psychiatric Medication Continuity of Care Plan, although mental health and psychiatric medication are important sections of a Continuity of Care Plan).

FUTURE MONITORING

When they are available, the MH Monitor will review:

- New policy on Case Management and Treatment Team Processes
- Revised PPM 3243.33 "Behavioral Health Services"
- Revised PPM 3243.32 "Psychotropic Medications"
- Training curriculum on case management, including transition planning
- Transition plans in records

The MH Monitor will interview trainers and staff who participate in the case management and treatment team processes training including transition planning.

The MH Monitor will observe residents working with staff on transition plans that connect their successes in the facility with their plans in the community and review transition plans for youth with mental health needs.

IV. DOCUMENT DEVELOPMENT AND QUALITY ASSURANCE

These paragraphs reflect the need for an ongoing mechanism to be responsive to monitoring and program developments as OCFS moves through the reform and compliance process. No determinations of compliance or non-compliance are made at this time. The first visit did not generate many concerns about Paragraph 56. However, Paragraph 57 has yet to be implemented.

Concerns exist related to Paragraph 57. First, the delay in the implementation of Quality Assurance Programs means that the Monitors must address issues, such as data quality, that are an administrative responsibility of OCFS. The intent of Paragraph 57 seems to be the formalization of a system that will provide good information about facility operations and improvements over time. Second, there are some areas where current OCFS practices may be contrary to the general intent of the Settlement Agreement. The issues reported in 57a notify OCFS that monitoring will continue to explore the nature and extent of a relationship between these variables and compliance determinations. They warrant continued discussion as applied to quality assurance.

56. Document Development and Revision. Consistent with paragraph 68[1] of this Agreement, the State shall create or modify policies, procedures, protocols, training curricula, and practices to require that they are consistent with, incorporate, address, and implement all provisions of this agreement. In accordance with paragraph 68 of this Agreement, the state shall create or modify, as necessary, other written documents – such as screening tools, handbooks, manuals, and forms – to effectuate the provisions of this

[1] 68. Document development and revision. The State shall timely revise and /or develop policies and procedures, forms, screening tools, blank log forms, and other documents as necessary to ensure that they are consistent with, incorporate, address, and implement all provisions of this Agreement.

Agreement. The State shall submit all such documents to the United States for review and approval, which shall not be unreasonably withheld.

PENDING REVIEW

57. Quality Assurance Programs. The State shall create or modify and implement quality assurance programs consistent with generally accepted professional standards for each of the substantive remedial areas addressed in this Agreement. In addition, the State shall:

NONCOMPLIANCE

COMMENT: A Quality Assurance program did not exist at the time of the monitoring visit. The elements of the program are outlined in the MAP, but the staff members have not been hired or assigned. See page 16 of the "6-Month Progress Report."

57. a. create or modify and implement policies and procedures to address problems that are uncovered during the course of quality assurance activities; and

57. b. create or modify and implement corrective action plans to address identified problems in such a manner as to prevent them from occurring again in the future.

The opportunity to use the monitoring experience as a way to identify issues relevant to the Settlement Agreement that may have a substantial influence on Protection from Harm and Mental Health outcomes only strengthens the Quality Assurance process by highlighting factors that could support the sustainability of these changes. We mention these issues here because their incorporation into the Quality Assurance program has compliance implications.

The review of Lansing identified several issues for a Quality Assurance program. They include data quality, gender, personnel file access, and physical conditions of staff. Quality Assurance must oversee data quality to ensure the reliability and validity of critical incident data. Quality Assurance also needs to collect gender information on all youth and staff involved in critical incidents, particularly as applies to PREA and best practices. There also needs to be a plan devised for access to personnel related data for Quality Assurance purposes. The Monitors discovered several challenges to personnel file access during the Lansing audit, which will be alleviated by reviewing the files at the Home Office.

Finally, the Parties have constructed an interactive definition of physical restraint where the acceptable use of force by staff is the least amount necessary in response to the youth's behaviors. In Paragraph 41b, the Settlement Agreement and CPM policy introduce into the discussion the physical conditions of the youth that restrict or limit physical restraint involvement, i.e., obesity and respiratory or cardiac problems, without addressing how those and similar physical conditions apply to staff.

V. SUMMARY

Lansing has made substantial progress toward compliance with the Settlement Agreement. This first monitoring visit establishes a baseline and acknowledges that the policy, procedure, and practice (training) portions of the responses to some Settlement Agreement paragraphs have made substantial progress. What is lacking are the performance-based measures or outcomes measures for those paragraphs and policy and

training for other paragraphs. These are important components in the accurate assessment of compliance, and it is the hope that this report will focus OCFS on the issues that need to be addressed for full compliance.

Appendix A

List of Documents Reviewed for Lansing Residential Center

I. Priority Documents for Pre-Site Review

1. Policies and procedures with the following emphases:

   A. New and revised policies (or old policies that are not being revised) regarding use of force, appropriate and inappropriate staff interaction with youth, staff misconduct, investigations of child abuse allegations, incident reports, behavioral treatment plan (Daily Achievement Program, DBT and Sanctuary); mental health crises; evaluation of mental health needs; use of psychotropic medications, psychotropic medication refusals, and informed consent; treatment planning; substance abuse treatment; and transition planning.

   B. A list of policies that are not final and when we can expect to receive them.

   C. Training dates for staff in each policy.

2. Training Curricula and Materials.

   A. The draft New York Model training curriculum for providing immediate feedback.

   B. The new training curricula, or those under development for mental health and line staff (for which there is an interest in Monitors' feedback): de-escalation techniques and self-protection; physical skills and testing; psychotropic medications and psychiatric disabilities; mental health crises; evaluation of mental health needs; treatment planning; substance abuse treatment; and transition planning.

   C. Crisis Prevention and Management (CPM) curriculum and materials and any additional training related to the use of force and freedom from harm.

   D. Where training is competency-based, list of competencies expected for each training.

3. The integrated assessment and family engagement and assessment tool, Individual Intervention Plan, and the Behavior Incentives (being piloted).

4. Current Memoranda of Understandings (MOUs) regarding mental health and substance abuse.

5. The plan for new behavioral health staff in CMSO assisting with transition of mental health and substance abuse treatment in community.

II. General Documents Requested for Pre-Site Visit Review:

1. Complete set of current policies, procedures, and practices.

2. Current floor plans or diagrams (on 8.5 x 11" format) of living units and other program space in each of the facilities, including information regarding segregation

and disciplinary units, and other special management units.

3. Current program descriptions, including daily and weekly schedules for youth by living units, including mental health program activities and schedules (i.e., groups, other therapeutic activities).

4. Each facility's rated capacity (including the capacity breakdowns by living units) and current census by facility and living unit. Also, the monthly aggregate count or census number (the total number of youth in custody) for each facility and each living unit in the data collection time range (August 1, 2010 through February 28, 2011).

5. Youth population rosters by facility for August 1, 2010.

6. List of youth on the mental health caseload (regardless of whether they are housed on a specialized unit), including the youth's diagnosis and prescribed treatment since August 1, 2010.

7. A current organizational chart of each facility, including the names, gender, and titles of all employees, including supervisors, mid-managers, and upper level managers.

8. Lists by facility of names, titles, and OCFS identification numbers of all staff employed on August 1, 2010 and on the first day of the monitoring visit.

9. Total staffing for the mental health program(s) according to program, and specifying the job category or discipline, including all contract personnel.

10. Reviews of each facility including, monitoring reports, accreditation reports, audit reports, and other reports prepared for or by facility management or external entities since August 1, 2010.

    A. Facility Self Assessment – OCFS, Other State Agencies, and Corrective Action Plans, including the Annual Assessment of the MAP and Facility Improvement Plans (FIP) through Performance-based Standards.

    B. Staff Vacancy Report – Weekly or Monthly.

    C. Fire Safety Reports – Annual, Semi-Annual, Monthly (consistent with statutory inspection intervals by the state or local fire marshal).

    D. Nutrition Site Visit.

    E. Special Investigations Unit (SIU) Reports (both ongoing and completed).

    F. Behavioral Health Site Visit.

    G. Workforce Development Site Visit.

    H. Physical Restraint Reports.

    I. Use of Isolation Reports (August 1, 2010 through February 28, 2011), including "Cool Off" logs, Disciplinary Reports, Pre-Hearing Confinement Reports, and supporting documentation for these logs and reports.

    J. Overtime Relief Reports.

K. Consultant Reports.

L. Regional Coordinator Site Visit (Monitoring) Reports.

11. Aggregate monthly numbers and types of incidents by facility and living unit since August 1, 2010.

12. A list or log of incident reports indicating the type and date of each incident, and any incident identification number, including all suicides, attempted suicides, and self-injuries since January 1, 2011.

13. List of all youth on any level or type of personal safety watch, specifying the date, length of time, and precipitating cause since January 1, 2011.

14. Incident reports or youth grievances regarding use of force, injury, and sexual misconduct since August 1, 2010.

15. A list or log of all youth who were injured (requiring more than on-site first aid) or who were transported to an emergency room or other off-grounds medical facility for medical or mental health treatment, including the source and date of the injury, and a description of the injury or condition for which treatment was sought, particularly youth on the mental health caseload who appear on this list since August 1, 2010.

16. List of all youth seen by medical following a physical restraint incident since August 1, 2010.

17. List of youth who were admitted to a psychiatric facility, the precipitating cause, and the length of each youth's stay at the psychiatric facility since August 1, 2010.

18. Use of force reports from August 1, 2010 through February 28, 2011, including a list of youth who were restrained, specifying the date, precipitating cause, and method of restraint (i.e., physical, mechanical, chemical).

19. List of all youth who received a psychiatric, substance abuse, or other mental health intervention, including diagnosis and date and type of treatment since January 1, 2011.

20. List of youth taking psychotropic medication, identifying the medication, dosage, and the condition it is treating since January 1, 2011.

21. A list of staff who are or who have been in the process of any corrective action or discipline as a result of disobeying laws, regulations, or OCFS policies or procedures regarding the supervision of youth since August 1, 2010.

22. A list of staff who are or who have been on administrative leave or no-contact status pending the outcome of any investigation or injury since August 1, 2010.

23. A list of incidents that have been referred to social services agencies, the local police, or other State or County law enforcement authorities since August 1, 2010.

24. Complaints from parents, guardians, attorneys, or other interested third parties regarding use of force or fear of safety, including sexual misconduct, and the status of the complaint since August 1, 2010.

25. Civil complaints or criminal charging documents alleging professional misconduct against staff or facility administrators, and the results of those complaints or charges since August 1, 2010.

26. Reports of investigations involving allegations of abuse, neglect, or mistreatment since August 1, 2010.

27. The number of budgeted security staff positions and vacancies for the first and fifteenth day of each month since August 1, 2010.

28. Total staffing for the mental health program(s), including substance abuse and Bureau of Behavioral Health, broken down by program, and specifying the job category or discipline.

29. Description of all physical plant improvements since January 1, 2009, including any changes to the interior and exterior visual surveillance systems.

III. Materials for On-Site Reference and Review:

When we visit each facility, we will continue to examine documents at the facility such as policy and procedural manuals, logbooks, orders, files, and other documents and records. In addition, we may wish to review on-site or have access to the following documents:

1. Youth medical, mental health care, and medication records – both current and past residents.

2. Medical and mental health unit logbooks.

3. Medical and mental health care staffing logbooks and schedules.

4. Medical and mental health care training materials.

5. Credentials and CV's/resumes of all licensed, registered and certified personnel, including full-time, part-time, and contractual.

6. Staffing logs that identify the name and gender of the staff members who worked the shifts since August 1, 2010.

7. Training records from the STARS system for each staff member in the facility indicating the training session or experience completed.

8. Youths' institutional records.

9. An alphabetical list of juveniles held at the facilities for the first day of the site visit, including names, ages, admission dates, living units, housing classifications, detaining offenses, and any personal safety watch alerts.

10. Any list or log of youth grievances indicating the type, date, and outcome of each grievance since August 1, 2010.

11. Any list or log of youth discipline indicating the type, date, and outcome of each disciplinary event.

12. Incident reports, use of force reports, disciplinary infraction reports, and disciplinary hearing reports.

13. Any video camera tapes of specific incidents.

14. Any manual and electronic housing unit logs.

15. State of New York laws, rules, and regulations regarding confidentiality for adolescents.

16. State of New York Child Health Care Standards.

17. State of New York Child Abuse/Maltreatment law(s), including mandatory reporting.

The Monitoring Team will likely review additional documents during the time at the facilities. We may wish to take copies of certain of these documents or, if impracticable, request that facility staff or home office staff copy and forward the selected documents after the conclusion of our site visits. We will make every effort to provide advance notice of the documents we will review on-site; however, we may have follow-up requests for documents that are not listed above.

Appendix B

List of OCFS Staff Who Contributed Information

Merle Brandwene, DJJOY, Director of Management and Program Support

Sandra Carrk, OCFS Project Manager

Gregory Copeland, YDA III

Diane Deacon, Assistant Deputy Counsel

Kathy Fitzgerald, Social Work Supervisor

Scott Gilbert, YDA III

Anthony Hough, DJJOY Associate Commissioner for Facility Management

Pamela Kelly, Bureau of Training – Home Office

Shaun Lang, YC

Annette E. Larrier-Fulcher, Facility Director - Lansing

Edgardo Lopez, Settlement Agreement Coordinator

Lydia Lowe, YDA III

Jennifer Mack, Assistant Director – Lansing

Beth McCarthy, Bureau of Training – Home Office

Sheree Massey, YC

Donna Moon, Bureau of Training – Lansing FLRC HSTS-I

Ines M. Nieves, DJJOY Associate Commissioner for Program Services

Robert S. Paoletti, Jr., YC

Rick Quinn, Bureau of Training

Munna Rubaii, Bureau of Training – HSTS-II

Beverly Sowersby, Facilities Manager

Dr. Joseph Tomassone, Chief of Treatment Services.