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:**

**Finger Lakes Residential Center**

**Lansing, NY**

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**Mental Health Monitor**

**and**

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**Protection from Harm Monitor**

**December 10, 2011**

**INDIVIDUAL FACILITY MONITORING REPORT:**

**FINGER LAKES RESIDENTIAL CENTER**

**LANSING, NY**

# I. INTRODUCTION

This is the second 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). As noted in the first monitoring report, the Monitoring Team consists of two Monitors, Dr. Marty Beyer, who is responsible for the Mental Health paragraphs of the Settlement Agreement, (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).

This second report summarizes the Monitoring Team's observations following a four-day monitoring visit to Finger Lakes Residential Center (FLRC) in Lansing on October 3-6, 2011. Prior to the visit, Office of Children and Family Services (OCFS) staff contacted the Monitoring Team and U. S. Department of Justice (DOJ) Attorney Alyssa Lareau and expressed their concern that the facility might not be at a point where a formal monitoring analysis would be productive. Their self-assessment was that FLRC was not yet in full compliance with the Settlement Agreement provisions, which provide until at least 23 months from July 19, 2010, the effective date of the Settlement Agreement, to implement the reforms required to comply with the Settlement Agreement. As a result of this disclosure, the parties, in consultation with the Monitoring Team, decided that the monitoring visit would be tailored to assessing the facility's progress toward compliance and providing technical assistance to assist FLRC with obtaining compliance. Thus, all areas of the agreement are at non- or partial-compliance for Finger Lakes Residential Center. The technical assistance provided below should not be construed to create new requirements under the Settlement Agreement, but rather as examples of methods of compliance.

At the outset of the FLRC visit, the Monitors emphasized that the Settlement Agreement places a high value on protection from harm and treatment. We acknowledge the pressures that accompany downsizing of the agency and its institutions during difficult economic times. We further acknowledge that system contraction removes many youth who are responsive to services, resulting in a remaining population of youth with greater difficulties adjusting to an institutional setting. We further acknowledge that this situation is aggravated when a specific facility becomes a repository for youth who are program failures from other institutions due to misbehaviors, particularly aggression. Finally, we acknowledge that there are procedural issues that hinder the implementation of the reforms linked to the Settlement Agreement. However, the existence of a Settlement Agreement with the U. S. Department of Justice regarding protection from harm and mental health services ought to be sufficient to hasten the pace of change and the readiness for monitoring.

Paragraph 65 of the Settlement Agreement allows the Monitors to provide technical assistance on the implementation of general policies and practices that move OCFS toward compliance, even though some of these considerations may be beyond the four corners of the protection from harm and mental health paragraphs. Therefore, the content of this report is not intended to be prescriptive, nor is it intended to establish requirements for achieving compliance or a plan for compliance.

### A. Finger Lakes Facility Background Information

Finger Lakes Residential Center is a limited secure facility for adjudicated male juvenile delinquents. With the closing of juvenile facilities in the state in August 2011, FLRC is now budgeted for 109 residents on ten living units. In earlier months in 2011, the population of FLRC ranged from 33-50 residents. On October 1, 2011, the roster listed 57 youth "In House" on six living units all in one building (two units with 11 residents each, two units with 10 residents each, one unit with 9 residents, and one unit with 6 residents). They ranged in age from 13 to 18 [13 (1), 14 (5), 15 (21), 16 (23), 17 (6), 18 (1)]. They had been at FLRC from 4 days to 136 days: almost half had been there 2 months or less and 5% for 4 months or longer [less than 30 days (5), 30-59 days (20), 60-89 days (15), 90-119 days (14), and more than 120 days (3)]. The offenses for which residents were at FLRC ranged: assault (5), burglary (4) controlled substance (3), criminal mischief (1), criminal trespassing (2), grand larceny (5), petit larceny (2), possession of a weapon (9), possession of stolen property (5), robbery (8), and violation of probation (13, with a variety of new offenses). Thirty-three of the residents were taking psychotropic medication (58% as compared to 63% at Lansing): Seroquel (17), Abilify (6), Risperdal (4), Adderall (1), Buspar (1), Remeron (1), Tenex (1), Trazadone (1), and Zyprexa (1).

### B. Assessment Protocols

The assessments used the following format:

#### 1. Pre-Visit Document Review

The Monitors submitted an extensive list of documents for pre-visit review. OCFS staff conferred with the Monitors on ways to make the document production and review process more efficient. The Monitors agreed to accommodations that would make the transportation of documents easier for Home Office without compromising the quality of information provided.

#### 2. Use of Data

Each monitoring event results in a greater understanding of the OCFS incident data system. A further review of the system and its capabilities during the FLRC visit allowed for the development of Excel spreadsheets that will be provided to the Home Office for the regular collection and dissemination of facility data to the Monitors, including the semi-annual Performance-based Standards (PbS)[1] data.

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[1] Performance-based Standards (PbS) for Youth Correction and Detention Facilities is a national, voluntary system for agencies and facilities to identify, monitor, and improve the conditions and treatment services provided to incarcerated youth through the application of national standards and outcome measures. Launched in 1995 by the US Department of Justice, Office of Juvenile Justice and

### 3. Entrance Interview

The entrance interview occurred on October 3, 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 methods, and the scheduling of the remaining assessment activities. Those in attendance in addition to the Monitors included: Brenda Aulbach, Assistant FLRC Director; Merle Brandwene, Management Program Support; Sandra Carrk, Project Manager; Diane Deacon, Legal; Alyssa Lareau, DOJ; Edgardo Lopez, Settlement Agreement Coordinator; Ines M. Nieves, DJJOY Administrator; Brian Perszano, Assistant Director QA; Ruben Reyes, Transition Team; Beverly Sowersby, Facilities Manager/Acting Facility Director; Scott Steelman, Assistant Director, Treatment Services; Joe Tomassone, BBHS Chief of Treatment Services.

### 4. Facility Tour

Walkthroughs of the facility followed the entrance interview. The Protection from Harm facility tour included a general inspection of all usable spaces and copies of fire evacuation floor plans on an 8 ½” x 11” format for note taking.

### 5. On-Site Review

The site visit included a review of numerous documents available at the facility but not part of 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 two treatment team meetings, two Rounds (for different units), and three group meetings on the units (and debriefed with participants after the treatment teams, Rounds, and group meetings), visited the clinic (meeting with the PA and a nurse) and met with the clinical team. The MH Monitor reviewed 17 records (of youth interviewed, youth seen in treatment teams and youth discussed in Rounds). 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 or group interviews with 32 FLRC direct care, clinical, supervisory, and administrative staff. The MH Monitor interviewed three unit staff, two clinicians, the Assistant Director for Treatment, and the regional clinical supervisor (individual interviews alone in addition to group discussions

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Delinquency Prevention (OJJDP) to improve the deplorable conditions reported by the 1994 *Conditions of Confinement Study*, PbS asks participants to collect and analyze data that permit the targeting of specific areas for improvement. The participating facilities collect certain data from records, reports, and interviews and enter them online through the PbS website. The data are checked by PbS staff and used to generate an online graphic site report of each facility’s performance in key outcome measures. The report tracks performance over time and shows facility measures compared to field averages.

with a variety of staff). The PH Monitor interviewed 17 staff members (8 unit staff, 3 medical staff, and 6 administrative/other staff) and conducted a focus group with 14 Youth Counselors. 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 six residents alone, one from each unit selected by staff for range of time in the facility and clinical issues (in addition to observing youth in treatment teams and group meetings). The PH Monitor interviewed nine boys, six individually and three in a group. Interviews occurred in areas with reasonable privacy.

#### 8. Exit Interview

The exit meeting occurred on October 6, 2011. The Monitors expressed their appreciation for the cooperation and hospitality of the FLRC and OCFS staff. The Team then highlighted areas of importance and concern, but not findings. The exit meeting was a time for questions, clarifications, and explanations of events and impressions before the draft report goes to both Parties. Those in attendance included: Brenda Aulbach, FLRC Assistant Director; Jessica Badman, YC-1; Mel Barvinchak, LMSW II; Sara Bergene, YC-1; Sheryl Benedict, Nurse Administrator I; Merle Brandwene, OCFS Home Office; Sandra Carrk, Project Manager; Kimberley Carter, Psychologist II; Lori Clark, QAU; Jason Cobb, YC-1; Angela Cole, YC-1; Lerue Culmer, YC-1; Diane Deacon, OCFS Legal; Kathy Fitzgerald, BBHS, Social Work Supervisor; Scott Lamphier, YC-2; Alyssa Lareau, DOJ Attorney; Rebecca Levin, Licensed Psychologist; Edgardo Lopez, Settlement Agreement Coordinator; Ines Nieves, Associate Commissioner; Haya Novak, Psychologist II; Denise Passarello, QAU; Brian Perazonis, QA Wing; Kristin Pisani, LMSW-II; Ruben Reyes, Transition Team; Melinda Rivera, BMS, Counseling Liaison; Ron Rutledge, BOT; Mike Seguin, Psychologist II; Gary Skinner, Physician Assistant; Charles Snowbarger, Jr., Education Director; Beverly Sowersby, Facilities Manager; Scott Steelman, FLRC AD Treatment Services; Joe Tomassone, BBHS Chief of Treatment Service; Eric Warner, YC-1I; Jeffrey Wurst, YC-1.

## II. PRIMARY CONCERNS

FLRC is a facility with dedicated seasoned and new staff who are struggling with many systemic obstacles to providing the care they want to residents:

- New admissions of youth, particularly during downsizing, are unusually high, with almost half the residents having been admitted in the previous 60 days.
- At the time of the visit, FLRC had the lowest ratio of youth to capacity compared to the other OCFS male limited secure juvenile facilities, so a high rate of admissions is likely to continue.
- When limited secure youth have problems in other facilities, they may be transferred to FLRC; as a result (a) the facility might have a concentration of youth with greater problems and (b) units will be affected by new residents' reactions to transfers.

- Staff said they felt pressure to discharge youth within 4-6 months, often before clinicians, YCs, YDAs, and educational staff believe they have achieved sufficient growth to be able to be successful in community services.
- At the time of the site visit, there were only 79 YDAs available for six units, resulting in a high rate of overtime. In the months prior to the site visit, there were restrictions on the filling of positions that have been lifted, but even though OCFS is recruiting for 25 permanent YDA positions and 5 relief positions, the Monitors are concerned there will not be sufficient staff to address either the exhaustion of staff or the urgency of scheduling training.
- As the population at FLRC has increased, there have been too few staff to open another unit; units have the capacity of 14 youth, but FLRC prefers to have 10 youth on a unit. In the Monitors' opinion, the current units with 10 and 11 residents is too large a caseload for one clinician assigned to each unit; furthermore, there are only five clinicians for six operating units. Consequently, clinicians cannot provide the coaching to staff they want.
- There are only two YC2s; it is too much for a YC2 to manage three units. As a result, YC2s cannot provide the coaching to staff they want.
- Strong working teams are slow to develop because many staff have been transferred to FLRC from other facilities with closures.
- Energetic, caring young FLRC staff want to help residents but (a) are fearful of being injured or having a complaint from restraints, (b) do not get adequate coaching because YC2s, YC1s and clinicians are spread too thin; (c) describe the facility as not having a coherent philosophy; and (d) get the message that restraints are an unavoidable part of daily life.
- The overload on all staff means that regular Rounds on each unit and the new treatment team approach are difficult to schedule despite staff having the ability and interest to do so.
- YDAs, YCs, and clinicians at FLRC appeared exhausted. At the time of the site visit, only 106 of 129 budgeted YDA positions, 14 of 17 budgeted YC1 positions, 3 of 4 budgeted YC2 positions, 4 of 8 budgeted mental health positions, and 5 of 8 budgeted medical positions were filled.

The combination of these factors is instability on the units, which increases acting out among residents and interferes with the facility settling down enough to schedule New York Model training (some FLRC staff had three sessions of New York Model training only). Furthermore, staff had the Crisis Prevention and Management (CPM) training without the full New York Model training at the same time. The two approaches go hand-in-hand. With a population of traumatized youth, crisis prevention is much more difficult without a safe environment where trauma recovery and emotional regulation are being learned.

While the decision to address instability by having a two-unit "juncture" structure with the same YDAs, YCs and clinicians covering both units may increase continuity in relationships between residents and staff, the underlying understaffing, lack of training,

and high rate of incoming residents may cause a continuing crisis atmosphere at FLRC. Stable relationships and a calm environment are key ingredients of the New York Model.

New York Model training is essential now at FLRC. It appears this can be accomplished only by reducing the resident population and borrowing staff, so that one unit at a time can be trained. Training alone will not be sufficient. Coaching in the New York Model, and in achieving unit stability and increasing effective de-escalation so restraints can be avoided, will require relieving the overload on YC-1s, YC-2s, and clinicians so they can actively support skill strengthening after the New York Model training. It appears to the Monitors that it is necessary for the Home Office to reduce the FLRC population for a few months, so that training, coaching, and stability can occur.

## III. GUIDING PRINCIPLES

FLRC compliance-related challenges relate to the implementation of the reforms delineated in the Settlement Agreement. Implementation of systems change is a common challenge, but the OCFS compliance strategy, an integration of CPM and the New York Model, appears to be strong.

### A. Institutional Stability

Consideration should be given to the immediate stabilization of the institutional climate. This guiding principle for implementation comes from Paragraph 41 of the Settlement Agreement that refers to the ability to "stabilize the situation." Providing stability to FLRC is a priority element in effective program implementation.

Organizational and operational stability is important to protection from harm because it affects the institutional culture and, hence, resident and staff safety. Characteristics of stable environments include order and organization, and these elements reduce anxiety by providing youth and staff with the structure and consistency needed to create a peaceful institutional culture. As stability increases and disruption decreases, the institutional staff can implement programs, conduct staff training, provide consistent coaching, and hold treatment team meetings. Given the existing situation, the first challenge appears to be the stability of the leadership, i.e., getting the right people in the right positions with sufficient time and resources to right-size the YDA workforce, train and coach the New York model, empower the treatment teams, and build cohesive living units.

There is a difference between organization-by-function versus organization-by-product. When one administrator described the FLRC organizational structure, a Home Office representative commented about "silos" or the grouping of staff according to function without visible lines of communication between them. These silos are characteristic of organization-by-function. An organization-by-product (the product here is a rehabilitated youth who returns to the home community with sufficient skills and abilities to live a peaceful, law abiding lifestyle) means that all of the institutional actions are focused on the youth. Organization-by-product is similar to a unit management strategy where the unit manager is responsible for all aspects of the intervention. The commitment to the New York Model is also compatible with organization-by-product and ultimately confers upon the leadership the priority decision making about daily structure and routine.

### 1. Strong, Consistent Leadership

Consideration should be given to the installation of strong, consistent leadership as a critical element of stability. The right person in the leadership role can accelerate the pace of change. Historically, large juvenile correctional agencies in transition tend to rotate administrators through the system. Some of the movement of administrative staff is justified by the belief that the best administrator is someone who has a variety of experiences in different job descriptions and environments. As it pertains to enhanced organizational stability, the designation of a well-trained and well-prepared leader does not eliminate the need for coaching. The leadership team authorizes coaching of staff and provides strong support for coaches. While it is commendable that an acting group of experienced managers, some traveling long distances to FLRC, have guided the facility through a difficult transition, it is essential that the permanent positions of Facility Director and an additional Assistant Director be filled to provide strong, consistent leadership. With these positions filled, hopefully the capable Assistant Director for Treatment can be assigned less day-to-day administrative work and focus on coordinating treatment.

### 2. Staff Sufficiency

Consideration should be given to achieving staff sufficiency as another element of stability. Based on the staffing and scheduling patterns described by FLRC leadership, there are simply not enough YDA staff. On October 3, 2011, FLRC data indicated that there were 150 budgeted YDA positions, 51 vacancies, and an additional 29 full time staff out on leave. When applied to the Program Specific Model (PSM) developed by the National Institute of Corrections,[2] these numbers reveal a shortfall in the number of staff available to work the shifts. The critical variable in these calculations is the replacement factor, a multiplier that accounts for the amount of time a full time employee spends away from the job. Calculations in this report estimate the replacement factor at 1.8.[3] Additional

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[2] Miller, R., & Liebert, D. (1988, January). *Staffing analysis workbook for jails*. Washington, D.C.: National Institute of Corrections.

[3] Agencies that operate 24-hours-a-day, 365-days-a-year, schedule staff so that all positions are covered every day. For example, one YDA position annually requires 2922 hours (8 hours x 365.25 days), but one full time employee works around 2088 per year. The difference (834 hours) represents the two days off in a 40-hour workweek. Thus, the facility needs someone to fill these hours. However, one full time employee rarely works 2088 hours, since the 2088 hours have built-in time away from work. Examples are vacation hours, sick hours, holidays, compensatory time off, Workers Comp, Family Medical Leave Act, and bereavement, to name a few. The amount of time that elapses between an employee's departure from the position (e.g., resignation, promotion, transfer, or termination) and the actual presence of a replacement also expands the replacement factor.

The standard replacement factor ranges from 1.4 to 1.9. The 1.4 value means that it takes one FTE plus 0.4 FTE to fill one position with no additional leave hours taken into account, except normal days off (834 hours). Each 1/100th replacement factor value equals 21 hours of pay expended by the agency for time not worked plus another 21 hours of pay provided to a replacement.

information is needed from Home Office to determine whether or not replacement factor calculations are routinely made for each facility or for the agency as a whole.

The staffing calculations affirm what YDAs report: There is a shortfall in the number of available staff to work the shifts, and staff are mandated to work many overtime shifts. As a result, staff express concerns about fatigue and morale. Staff working overtime who are fatigued and have low morale are not at their best, so the likelihood increases that de-escalation strategies may not be as effective or CPM techniques may not be as carefully implemented as intended.

Staffing shortfalls predict other problems. Why are 29 staff YDA members on leave, including administrative leave? This number seems excessive, and Home Office should consider a special analysis of the YDA use of leave time. Efforts to fill YDA vacancies run the risk that the amounts of leave could continually create a staffing shortage, require ongoing overtime mandations, and perpetuate institutional instability, thus effectively negating recruitment and hiring efforts. If a predictable use of leave removes YDAs from the schedule for extended periods of time without permitting FLRC to secure a replacement, a rationale exists for consideration of a budgeted staffing allocation at 115-120% of the current level in order to fill the shifts.

A second concern relates to the potential increases of the FLRC population. Because the facility is not operating at capacity, the temptation exists to increase the number of youth at FLRC. To do so without achieving a full complement of available staff before the facility achieves stability is likely to be harmful.

### 3. Injuries and Assaults

Consideration should be given to new ways to reduce the indicators of violence. The FLRC visit revealed substantial concerns about the levels of assaults, injuries, and restraints. For example, the April 2011 PbS data report high rates of violence as indicated by excessive rates of youth-on-staff assault, injuries to youth by staff, and physical restraints. Furthermore, 52% of YDA staff expressed fear for their safety. (The April 2011 PbS data were submitted before the implementation of the CPM training, and the expectation is that the October 2011 data will reflect reductions in these rates.) Yet, FLRC staff also expressed concerns for their safety during this visit. Several YDAs described situations where increased youth-on-youth violence and injury resulting from a youth's heightened level of agitation seemed to follow too many inappropriate uses of verbal de-escalations and instances where co-workers were too slow to intervene physically. These circumstances contribute to staff injuries, which expands the numbers of staff who are on some sort of leave due to injury or abuse allegation.

The need to move staff to a different work location as a result of an abuse complaint also destabilizes staffing. Staff and youth reported that this disrupts teamwork and is often disturbing to the youth who have a strong relationship with the displaced staff member. The plan for juncture teams is designed to mitigate the disruption, but taking additional steps to prevent youth and staff actions that result in abuse complaints is warranted. For example, one resident who was appreciative of the help he is receiving from his YC and therapist, commented, "the rules change everyday. It's confusing. Some staff make their own rules. They don't even know what are really the right rules. Things are different from

day to day, shift to shift. A big problem is that some staff yell at kids and that triggers the kids. They start yelling back. Staff push them, and next thing is a restraint."

Consideration should be given to improving the FLRC staff morale through the reduction of overtime hours and the increase of training, coaching and teamwork. This would also benefit youth by strengthening treatment teams and Rounds. Furthermore, training in the New York Model and coaching would increase each team's confidence in effective, individualized de-escalation with each resident. Rather than criticism for the number of restraints, staff getting recognition for their effective de-escalation of residents would reinforce the idea that staff actions make it possible for traumatized youth to regulate their emotions.

**B. Coaching**

Consideration should be given to an expanded use of coaching. The urgency to stabilize the FLRC environment and to implement the New York Model requires a more intensive and expansive coaching initiative at FLRC.

An impressive experience was the coaching intervention by Donna Moon and Ron Rutledge with YDAs. In one instance, a YDA was supervising a line movement where two youth started fighting, resulting in an inadequate application of the CPM physical restraint strategy. The incident and the video came to Moon and Rutledge as a result of the administrator's weekly review of physical restraint videos. The new CPM policy requires this review, and the restraints with deficiencies are referred to the on-site Bureau of Training coaches for documented instruction.

Beyond addressing the problem of CPM techniques, Moon and Rutledge provided the YDA a wealth of valuable information on techniques for supervising youth. Also, the knowledge and skill base of Moon and Rutledge result in rich coaching about various de-escalation strategies. Their coaching provided an exceptional educational opportunity, and could have been even more powerful if the suggestions had been made in a language that was consistent with the New York Model (for example, guiding staff in how to help the youth use coping skills learned in DBT and Sanctuary). Following the video review, Moon and Rutledge practiced the proper application of the CMP techniques with the staff member in a training area. The coaching reflected an understanding of adult learning styles that is a particular strength of the Bureau of Training.

Impressive coaching was also seen in the two treatment team meetings. In each, the therapist invited participants to do their treatment plan meeting in a new way. They modeled with the resident by asking each directly about his goals. "This meeting is to figure out how people in this room can help you achieve your goals." This coaching resulted in active participation by the resident and staff in the teams. At one point in the treatment team debrief, the therapist observed that the youth—who was neglected—would benefit from "parenting and emotional holding by team members, but he does not trust that people will come through for him. He and I talk about his being on alert for disappointment, but this is not just an issue for therapy." This exemplifies coaching. In the debriefs after Rounds, treatment teams and group meetings during the monitoring visit, the regional clinical supervisor provided thoughtful coaching to staff learning new approaches and struggling to offer treatment and safety in a challenging environment.

Clinicians lamented that blaming staff is the culture at FLRC. As one clinician commented, "It takes such a toll on staff who are blamed. They feel unsafe. Coaching should be a model for all interactions. A culture of coaching, not blame. How each of us, including managers, treats each other. Everything I do is to make others — staff and youth — be successful at what they want to do." Another clinician added, "We gave up the old punishment model for kids, but we still use it for staff. Praise would work better for staff, too."

Clinicians pointed out that coaching has as its goal that staff who spend the most time with youth must have the highest level of skills and the greatest institutional support. They added that de-escalation, effective chain analysis, and changed behavior are not just applicable to residents. Coaching on the unit, school and recreation are opportunities for staff to step back to analyze their reactions. In Rounds, a YC commented about a youth, "What can we do to help him calm himself down?" Coaching at the moment would have been the ideal time for all staff to appreciate the unique role each plays in the youth learning emotional regulation (not just thinking that would occur in therapy or DBT or Sanctuary groups).

**C. Integration of Treatment and Safety**

Consideration should be given to a better integration of treatment and security. The FLRC visit raised the question as to which function — security or treatment — is more important. Dividing the monitoring of the Settlement Agreement into two discrete components might give the false impression that protection from harm and mental health are separate. The Settlement Agreement describes treatment and security as two interrelated sides of the same coin. Effective juvenile correctional facilities employ approaches that integrate mental health and protection from harm. In an unstable facility, youth act out and staff may argue "safety trumps treatment." But this is a false dichotomy since an integrated treatment program makes safety possible, and youth who feel safe are easier to guide.

Stability permits the full growth of treatment in a safe environment. Residential treatment innovators, such as Harry Vorrath and Larry Brendtro, have written extensively about the primacy of treatment (except in situations of imminent harm). Everything stops in order to resolve treatment issues. Disruptions to the daily schedule, for example missing a meal, a scheduled class, or a scheduled activity, is fully understood by staff, who make accommodations and rearrange the schedule and services so that they are in concert with rehabilitation.

The broken jaw incident that occurred at FLRC during the site visit is illustrative of the dangers of dichotomizing treatment and safety. On October 5, 2011 a youth initiated horseplay with another youth who responded by hitting him in the face with a flurry of accurate and powerful punches. The result was a broken jaw, a serious safety issue and an indicator of staff supervision problems.

Knowing it is difficult to eliminate all fights in a juvenile correctional facility, FLRC still has to improve safety. The rate of youth-on-youth assaults (fights) is too high, which increases the probability of serious injury, such as a broken jaw. However, there should be an assumption among all staff that injuries are preventable by staff actions; and when

serious injuries occur, staff should routinely do a post-event analysis to identify the oversights and omissions that, if corrected in the future, could prevent a similar situation.

The Monitors and leadership team together reviewed this incident, focusing on the communications among staff about security and treatment. The review of the broken jaw incident revealed some unresolved communication obstacles between staff despite attempts by key individuals to improve communications. In fact, several appropriate events occur on a regular basis that are intended to increase the interaction among clinicians and YDAs. The post-event review allowed a refocus on issues of how much communication occurs and how well it occurs. From the YDA perspective, an insufficient amount of information was provided to them about psychological and behavioral implications related to one of the youth's upcoming release. From the clinicians' perspective, insufficient information was communicated to them about the frequency and intensity of the youths' recent disruptive and aggressive behaviors. This incident review also suggested a re-thinking of ways to accommodate the integration of treatment and security through changes in the table of organization.

Like the guidance provided to the YDA mentioned earlier, this is an ideal situation for coaching all staff. Like the situation described earlier, coaching provides an opportunity to integrate security and treatment. The Settlement Agreement provides the framework for CPM and the New York Model to work in concert, not in isolation.

## IV. ADDITIONAL OBSERVATIONS

The Health Clinic is a substantial asset at FLRC. The Health Clinic serves as an important safeguard for Protection from Harm issues, especially those related to the use of physical restraint. The Health Clinic maintains accurate records of post-restraint evaluations that lend a greater level of objectivity to the assessment and reporting of injuries to youth that may have been sustained during a physical restraint and that require additional investigation if an injury resulted from a suspected use of excessive force or an inappropriate application of a restraint technique. Good clinic programs sometimes 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. No evidence exists from this onsite visit of a strained relationship between the clinic staff and the YDA staff that would have a chilling effect on reporting behaviors.

There was excellent clinical practice observed at FLRC. In both treatment teams, youth with significant family dysfunction were supported to manage their feelings and communicate with their families. The youth appreciated their progress being recognized by staff. After the treatment team meetings, non-clinical staff said they were pleased to be included on the team and they understood their unique role with each youth better. In addition to each young person being supported to identify his needs, the treatment team meetings helped each get clarity about who is helping him work on his goals and each team member could see their own and others' next steps to support the resident. The mentoring provided to each resident by different vocational teachers was given special recognition. Although participants indicated that it was unusual to have the parent, community worker, and service provider (who drove the parent three hours to the meeting which was on the

youth's birthday) at a treatment team meeting, it had a powerful impact. The resident made concrete plans with the provider, and the community worker and parent showed their support in ways that would not have been as meaningful in a videoconference. With practice, the teams will be able to organize the treatment plan and the meeting around the youth's goals derived from understanding the needs behind his behavior. With practice, participants will learn to speak directly to the youth during team meetings about what he has done well and about how the speaker can specifically help him achieve his goals (instead of talking about the resident as they had in the past). Coaching and practice will help staff learn how to make progress with a youth during a treatment team without turning the team meeting into treatment (it is tempting for team members to seize every teaching moment, but doing so may derail the team). Team members will improve in avoiding lecturing, talking less, and listening more.

Although they were doing Rounds for the first time, one meeting was well orchestrated by the therapist and YC1. Insightful discussions occurred of a youth who was "not acting out, but is not engaged in the program or with staff, " a youth who staff observed "doesn't like 'No'" (put into the context of his trauma), a youth who arrived at FLRC right after his mother's death ("Bereavement is a major influence. His anger and guilt are easily triggered."), and a youth "who has been on every unit here and is finally starting to come around, beginning to have positive relationships with staff and show some concern for peers."

In a memorable moment in a treatment team, the youth expressed his goal "To be a world leader." Team members did not laugh at his naïve dream. They reflected with him on his interest in discussing political issues, and pursued with him how "letting my anger control me" was something to change so he could become a world leader. His YC drew a clear connection between coping with his anger at FLRC and at home, and the youth responded, "I didn't get along with you when I first got here, but now you are my favorite counselor."

Even if they had eight youth on a unit, it appeared to the MH Monitor that clinicians have too many responsibilities: the integrated assessment, getting informed consent, therapy, preparing the youth and parent for treatment team, convening treatment teams and Rounds, facilitating DBT and Sanctuary groups, coordinating with the psychiatrist and medical, making family and community contacts, and preparing the transition plan may be too much to do in addition to coaching staff. Managers must appreciate the importance of coaching by clinicians and YCs. If clinicians are pressured to intervene in constant problems on the units, not only does it undermine their other roles as therapists, assessors and transition planners, but also their coaching which requires time and should not always be done in crisis. Clinicians showed signs of lowered job satisfaction, attributed to the combination of complicated youth, shortened length of stay, larger caseloads, and increased responsibilities. A reconsideration of their caseload size and/or their responsibilities is suggested.

In the records reviewed, the MH Monitor found a range from outstanding to inadequate clinical assessment on the new integrated assessment format. At the treatment teams, participants agreed that the integrated assessment format makes it possible for everyone on the team to be informed about education, recreation, vocation, medical, and

mental health. However, it takes clinical skill and time to integrate diverse conclusions into a coherent picture of the youth's needs in preparation for treatment team. Furthermore, integrating information from assessment centers and other sources is crucial. For one youth in Rounds, for example, the integrated assessment had not picked up from a prior evaluation that the young person had significant cognitive difficulties, which would affect not only FLRC school services but also the youth's ability to function in groups and on the unit. The assessment was a single page, simplistic and without individualized intervention recommendations. A weakness of the FLRC mental health assessment, even on the new form, is generic recommendations for individual and group therapy. To be useful, the mental health assessment combines everyone's input to explain what is driving this youth's behavior—what unique needs will be addressed by everyone on the team, not just in therapy and groups but on the unit, in class, in recreation and with his mentor. Instead, assessments contained the same generic plan for a resident with a low IQ and one with a high IQ, a resident with multiple psychiatric hospitalizations and one with no apparent significant mental health problems, a resident who is a gang member with a long history of aggression and one who only has property offenses and one who is a daily marijuana user. It is commendable that clinicians complete the integrated assessment remarkably soon after each young person arrives at FLRC, but the pressure to do so cannot be allowed to reduce the quality of the assessment.

The effects of trauma on behavior were not a strong theme during the FLRC site visit. It is essential that the integrated assessment presents a trauma history for each youth. The assessment should also suggest how these traumas affect the youth's behavior. Rounds and treatment team are an opportunity for staff to refine their understanding of the effects of trauma and what each can do to help the young person learn about his trauma so he can alter his behavior. DBT and Sanctuary, as well as mentoring and individual interaction between unit, education, vocation and recreation staff and the youth, are the way the young person is helped to keep past trauma from interfering with present success.

The new treatment plan form allows for clear statement of needs behind behavior and youth goals, but the form itself will not necessarily generate this innovative way of thinking. Learning to write strong treatment plans that reflect the combination of the youth's articulated goals and staff trauma-informed understanding of the underlying needs behind the youth's behaviors is an example of an area where skilled coaching is necessary. Coaching can help staff individually and in teams draw reasonable goals out of each young person that he wants for himself. Coaching can help staff articulate what specific effects of trauma, immaturity, and disabilities are behind his behavior. Coaching can help the team figure out how each staff person can contribute to the young person understanding what is behind his behavior and become more emotionally regulated and more effective at using his coping skills. Possibly some examples of skillfully crafted integrated assessments and treatment plans would be useful for training and coaching.

The collaboration of the psychiatrist, therapist, and nurse in presenting at Rounds and treatment team is crucial and was not strong at FLRC. While the psychiatrist and medical team are responsible for titrating medication and monitoring efficacy and side effects, all staff working with a young person must be informed about how medication fits into the youth's overall treatment, and observations of staff are important for medical

decision-making. Of concern was one youth who was prescribed the anti-psychotic Abilify although his mental health assessment did not include a diagnosis (other than a past history of ADHD and a previous evaluation which found that he was experiencing depressed and anxious feelings). He had arrests for two minor offenses and felt anger and helplessness over his conflicted relationship with his father and loss of his mother. The youth decided not to continue the anti-psychotic after 10 days, telling the psychiatrist that he did not need a medication prescribed for "anger control." Anti-psychotics—Seroquel, Abilify, Risperdal and Zyprexa—are prescribed at FLRC for a diagnosis of Mood Disorder, which is the most common diagnosis of youth on the medication list at the facility (in contrast to Lansing where diagnoses range from Anxiety Disorder, Dissociative Disorder, PTSD, Depression and Panic Disorder). As treatment teams and Rounds become consistent, it is important that all the clinicians at FLRC use uniform diagnoses and that medication is prescribed specifically to treat the symptoms of those diagnoses. A third of the FLRC population take Benadryl at night (18 residents, 12 of whom also take psychotropics), which staff explained was because they were accustomed to a much later bedtime and could not fall asleep at 9:00 PM.

Part of youth treatment plans will be success at school and the improvement in self-esteem that results. Although a review of the education program is not part of the Settlement Agreement, when the youth's goal for himself is getting a GED, his treatment will be affected if the youth is as frustrated as several interviewed youth were about inflexible requirements preventing the achievement of this goal. The reading scores of FLRC residents are much higher than typical in juvenile facilities. Several of the interviewed youth had reading scores at the college level. These youth complained that they are not permitted to prepare for or take the GED at FLRC, which is a primary benefit they see in being in the facility. Youth complained that FLRC school staff gave them "excuses" for why the GED is not available for them. For one high-scoring 17-year old who had been at the facility for five months, this appeared to undermine his trust in his treatment team and his confidence he could have success when he returns to the community. [4]

FLRC staff innovated with an honor unit for youth whose progress is limited by other youth on a regular unit. Some youth appear motivated to work harder to earn the honor of being placed on the unit.

Groups at FLRC observed on three units showed the problem of engaging the youth. The three group leaders were skilled, but many of the participants made it clear they did not want to be there. By relentlessly drawing them into the DBT group, the leader made some headway in helping youth apply a mindfulness concept to their lives. The drug group leader brings an enthusiasm to her groups that drew in most of the youth, who were

[4] Although youth said no residents were getting a GED, OCFS indicated it was possible to do so at FLRC. But the New York State Education Department requires that in order to study for a GED youth must qualify by reading and doing math at the 9th grade level, have a deficit in high school credits, have completed the school year in which he turns 16 prior to taking the GED, have at least 150 hours of instruction at an OCFS facility prior to taking the GED (35 school days), and have parental consent. It is likely that FLRC youth who met all these qualifications except turning 16 after the school year ended would be frustrated and wonder why they should have to settle for another educational goal during their stay.

interested in the material, but a few were not participating. The Sanctuary group on the revocator unit was too didactic for youth who are angry about being returned to the facility and wanted a platform for expressing criticisms of the facility to the MH Monitor.

The New York Model training at FLRC should tackle staff's struggle with youth who simply endure the program because their only goal is to go home. These youth are demoralizing to staff because (a) the youth has not been effectively supported to do a self-assessment of what has to change in his life; (b) Sanctuary's seven commitments, SELF and DBT have not helped the resident understand the links between past trauma and current emotions and behaviors, develop emotional intelligence, demonstrate social responsibility, and use open communication; and (c) the usefulness of coping skills in the facility has not been convincingly applied to the real world he will face at release. Coaching will play a key role in recognizing staff skills in helping youth from self-assessment to emotional regulation in the facility to success in the community. Developing in youth the insight and trust so they can answer the question, "What in you will get in the way of your being able to leave and not come back?" takes talent, as does designing a truly individualized set of supports in response to his answer. Coaching and teamwork help staff with the anguish of responding to youth, "Probably you cannot change your parent or neighborhood. But what you can control is learning how to stand the pain and function well in the stress you will face when you go back."

As the New York Model is implemented, with Rounds, treatment teams, and enhanced de-escalation of residents, staff can address two problems together: (a) how to keep the high rate of admissions, especially of youth from other facilities, from de-stabilizing the units (this might include considering having an admission unit); and (b) inventing a way of handling CRP residents consistent with the New York model (this might include considering not having a CRP unit and giving "revocators" a special role on units).

The New York Model designers and the FLRC staff should also tackle two other problems together during implementation: (a) having a separate substance abuse treatment program outside Sanctuary and DBT does not make sense; the coping skills youth learn through the New York Model must help them prepare to resist the pressures to resume using when they are released; and (b) the New York Model must incorporate effective treatment for gang involvement; just forbidding youth to flash gang signs or to be hostile toward rival gang members does not prepare them to get out of gangs and avoid them when they are released.

## V. SUMMARY

FLRC has made progress toward compliance with the Settlement Agreement. Key institutional elements, such as stability, consistency, training, and coaching must improve so that full implementation of the New York model can occur.

**Appendix A**

**List of OCFS Staff Who Contributed Information**

Jason Allen, YC-1

Brenda Aulbach, Assistant Director

Jessica Badman, YC-1

Sheryl Benedict, Nurse Administrator I

S. Bergene, YC-1

Mel Barvinchak, LMSW II

Merle Brandwene, Management Program Support

Sandra Carrk, Project Manager

Kimberly Carter, Psychologist II

Jason Cobb, YC-1

Angela Cole, YC-1

Lerue Q. Culmer, YC-1

Diane Deacon, Legal

Scott Diego, YDA

Joseph Donoghue, YC-1

Kathy Fitzgerald, Social Work Supervisor BBHS

Christaline Germain, YDA

Chelsea Howarth, YC-1

Kristy Kennedy, YC-1

Denise Kleinman, YDA

Scott Lamphiere, YC-2

Rebecca Levin, Licensed Psychologist

Edgardo Lopez, Settlement Agreement Coordinator

Donna Moon, Bureau of Training

T. Murphy, YC-1

Ines M. Nieves, DJJOY Administrator

Haya Novak, Psychologist II

John Paz, YC-1

Teresa Peck, Regional Nurse

Brian Perszano, Assistant Director QA

Kristin Pisani, LMSW II (Substance Abuse)

Ruben Reyes, Transition Team

Lynette Roys, YC-1

Ron Rutledge, Bureau of Training

Ezra Scott, Jr.

Dr. Sillars, Psychiatrist

Gary Skinner, Physician Assistant

Beverly Sowersby, Facilities Manager/Acting Facility Director

Scott Steelman, Assistant Director, Treatment Services

Joe Tomassone, Chief Treatment Services BBHS

Eric Warner, YC-2

Curtis Williams, YDA

Jeff Williams, YDA

Jeffrey Wurst, YC-1