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 fifth 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), and it describes the second monitoring visit to the Lansing Residential Center (LRC) on March 13-15, 2012. As noted in the previous monitoring reports, 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 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.

A. Facility Background Information

Lansing Residential Center for Girls is a 25-bed non-secure facility with three units in one building, and separate buildings for the school and the gym.

On March 13, 2012 there were 16 girls at Lansing, five on one generic unit, six on the other generic unit, and five on the CRP unit (at the time of the visit, two additional girls listed in the Lansing population were on AWOL—one from a home visit and one from court). The 16 girls ranged in age from 13 to 17. They had been at Lansing from 12 days to 285 days (four had been there for about a month or less, nine for one to about three months, and three for about five months or more). The 16 girls were committed for: Petit Larceny (4), Criminal Mischief (3), Controlled Substances (3), Assault (2), Burglary (1), Grand Larceny (1), Harassment (1), and Weapon Possession (1).

Eleven of the 16 girls at Lansing are prescribed psychotropic (psychiatric) medication. Their diagnoses are Anxiety, Depression, Impulse Control Disorder, and Insomnia. They are prescribed the following psychotropic (psychiatric) medications (most more than one): Seroquel (6), Abilify (5), Trazodone (4), Hydroxizyne Palmoate (1), Imipramine (1), Luvox (1), Prozac (1), and Remeron (1). Additionally, three girls are prescribed Benadryl.

B. Assessment Protocols

The assessments used the following format:

1. Pre-Visit Document Review

The Monitors submitted a list of documents for pre-visit and on-site review. The Monitors worked with the Office of Children and Family Services (OCFS) to make the document production and review processes more efficient, especially ways to make the transportation of documents easier from the OCFS headquarters in Albany, New York (Home Office) without compromising the quality of information provided.

2. Use of Data

OCFS has a good management information system with access to a wide range of data. A further review of the system and its capabilities allowed for the development of Excel spreadsheets that Home Office provides regularly to the Monitors that includes facility-based incident data and the semi-annual Performance-based Standards (PbS) data. The Monitors also received the OCFS second Six-Month Progress Report on the Master Action Plan (MAP) on December 20, 2011.

3. Entrance Interview

The entrance interview occurred on March 13, 2012 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: Sandra Carrk, Project Manager; Diane Deacon, OCFS, Counsel's Office; Kathy Fitzgerald, Bureau of Behavioral Health Services (BBHS), Social Work Supervisor; Annette Larrier-Fulcher, Facility Director; Edgardo Lopez, Settlement Agreement Coordinator; Jennifer Mack, Assistant Director; Donna Moon, Bureau of Training (BOT); Dr. Maria Morog, Psychologist; Denise Passarello, Quality Assurance Unit (QAU); Melinda Rivera, BBMS, Support Staff, Counseling Liaison; Constance Sargent, Psychologist II; and Dr. Joseph Tomassone, BBHS, Chief 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.

The walkthrough of the physical plant looks for potential risks of harm to youth regarding injuries, suicide behaviors, and self-injurious behavior (44.iii.). The expectation that an agency can eliminate all related physical plant risks of harm is unrealistic. Instead, potential risks are noted with administration during the tour and make their way into the report when there is reason to suspect that staffing patterns and/or supervisory practices are not adequate to mitigate the potential risks for harm.

In response to concerns expressed about door hinges and the their potential as suicide hazards, Home Office has secured bids and funds for the replacement of doors and

hinges at LRC. These improvements represent a good faith effort on the part of Home Office to reduce suicide risks and hazards associated with physical plant.

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, a Sanctuary education group and met with the clinicians (due to an emergency, the schedule DBT group observation had to be cancelled). The MH Monitor reviewed eight girls' records.

6. Staff Interviews

The Monitors interviewed 15 LRC staff. The PH Monitor interviewed one Youth Development Assistant (YDA), one Facility Director, one Assistant Facility Director, one Administrator on Duty (AOD), one regional nursing director, three nurses, and two Youth Counselors. In addition to group meetings with staff, the MH Monitor interviewed a Youth Counselor (YC), a Youth Development Assistant (YDA), a clinician, a school staff person, and a nurse individually.

7. Resident Interviews

The Monitors interviewed ten girls. The MH Monitor interviewed four (4) girls individually, two from each unit, and the PH Monitor interviewed six (6) girls with an average age of 16 years old. Interviews occurred in areas with reasonable privacy from staff. The Monitors selected the youth for interviews.

8. Exit Interview

The exit meeting occurred on March 15, 2012. The Monitors expressed their appreciation for the cooperation and hospitality of the LRC 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: David L. Bach, Quality Assurance (QA) Director; Sharon Bell, YDA III, Lansing Residential Center; Sandra Carrk, Project Manager; Diane Deacon, Associate Deputy Counsel; Ron Farley, YC1; Kathy Fitzgerald, BBHS – Social Work Supervisor; Linda Gaydushec, LRC Education Supervisor; Tony Hough, Associate Commissioner; Annette Larrier-Fulcher, Facility Director; Edgardo Lopez, Settlement Agreement Coordinator; Linda R. Lowe, YDA III, LRC YDA; Jennifer Mack, Assistant Director; Kendall McAdams, Teacher II, LRC; Dr. Maria Morog, Licensed Psychologist; Ines M. Nieves, Associate Commissioner; Robert Paoletti, YCI; Denise Passarello, QAU; Theresa Peck, Regional Nurse Administrator; Robert Russell, Teacher IV, LRC; Constance Sargent, Psychologist II; Beverly Sowersby, Facility Coordinator; Dr. Joseph Tomassone, BBHS Chief Treatment Services; Kate Wilks, Teacher IV, LRC; Dave Williams, YDA; Robert Woods, General Mechanic. Those participating by telephone included: Jim Barron, Labor Relations Director; Merle Brandwene, Director Program Support; Gladys Carrion, Commissioner; Myra DeLuke, QA Specialist; Felipe Franco, Deputy Commissioner, DJJOY (Acting); Larry Gravett, SIU, Director; Mikki Ward-Harper, Deputy Commissioner -

Administration; Pam Kelly, Bureau of Training Director; Sheila Poole, Executive Deputy Commissioner (Acting); Lee Prochera, Deputy Commissioner - Legal; Kathryn Shelton, Executive Assistant to the Executive Deputy Commissioner; Jenne Utting, QA Specialist.

C. Preface to Protection from Harm and Mental Health Findings

Since June 2011, the Lansing staff have received a lot of training. Between July and October 2011, 61 Lansing staff completed three-day New York Model training (35 YDAs, 5 YCs, 5 teachers, three nurses, two psychologists, 1 recreation specialist and 10 others). In November 2011, 36 Lansing staff completed one-day Suicide Risk Reduction and Response training (20 YDAs, 5 nurses, 4 YCs, two psychologists, 1 teacher, and 4 others). Donna Moon reported that all the Lansing staff had participated in one-day training on "Mental Health for DJJOY Staff" not yet available on STARS (the OCFS training tracking system) at the time of the site visit.

During the past six months, Lansing has had a stable leadership team—the same facility administrators, clinicians, and YCs were there as in our previous site visit. Since June 2011, Lansing has hired new YDAs, teachers, and nurses. A new social worker will start soon. The Assistant Director for Treatment position has been posted but not yet filled.

There were many references to staff worries about the possible closing of Lansing if New York City youth are removed from upstate facilities. Some staff had taken accrued leave, which had caused serious coverage problems at a time when the population increased. The Director described her efforts to reassure staff that no decisions about facility closing had been made and that the plan to return NYC residents had not been finalized. At the time of the site visit, all but one of the girls on the CRP unit were from New York City; all but one of the girls on the two generic units were from upstate.

II. PROTECTION FROM HARM MONITORING

Many factors signal improvements at LRC. Despite the presence of problems that need to be resolved before attaining compliance with various Settlement Agreement paragraphs and the continued uncertainty about facility closures, the number of changes and positive indicators warrant discussion at the beginning of the report. First, there is a noticeable improvement in the institutional climate at LRC. The New York Model is resonating with line staff and the Daily Achievement System (DAS) component receives positive evaluations. Second, resident safety has improved based on direct feedback from youth and staff. The rates of injuries to youth have remained low despite changes in resident population and staff availability. Third, there has been quite a bit of training, and staff have worked very hard to assimilate these new ideas. Some may describe the past several months as "training fatigue," but there is evidence that staff are beginning to see how the components of the New York Model fit together. Fourth, staff show a substantially improved understanding and appreciation of the Crisis Prevention and Management (CPM) restraint system, its strengths, its weaknesses, and nuanced ways to make the techniques better for staff and youth. These factors are foundational and provide support for continued program development.

The staff shortages continue to affect the Protection from Harm paragraphs negatively. There are many factors that go into the determination of staffing adequacy for any given facility, and Home Office is reviewing staffing issues at the named facilities. One reliable approach includes an analysis of the coverage and assignment patterns, sometimes referred to as the staff scheduling strategy. The Lansing Facility Director explained the YDA staff assignments and posts. Using the National Institute of Corrections (NIC) staffing formula and the information provided by LRC administration regarding allocated positions, vacancies, and leave usage as of February 3, 2012, an estimate of the gap between the number of YDA staff needed to fill the schedule versus the availability of staff to work those shifts revealed that LRC was operating between 63% and 66% of its intended staffing capacity.

Another staffing consideration is when a predominance of males work the living unit shifts in a girls facility. The balance between privacy and safety is an issue with girls with trauma histories. The necessity for security-related observations of girls in a living unit may include times when it would be better if female staff members were primarily responsible for direct supervision. The anxiety resulting from opposite sex supervision that invades privacy can lead to embarrassment, humiliation, and re-traumatization of the youth, which contribute to acting out behaviors. All girls interviewed by the PH Monitor were asked about any behaviors by staff that made them feel uncomfortable sexually. In response to the discussion of inappropriate behaviors or boundary violations by staff, no girl indicated that there was a problem.

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 in the absence of a fully functional quality assurance department, Paragraph 57a invites the Monitoring Team to identify 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.

PARTIAL COMPLIANCE

COMMENT: The CPM policy and procedure 3247.12 fulfills the requirement that OCFS create a new set of requirements on the use of restraints. OCFS lists the policies covering Paragraph 41 as PPM 2081.00, PPM 3247.13, and PPM 3247.14. During interviews, all staff had a working knowledge of the differences between the new policy and the approach to physical restraints before the DOJ Settlement Agreement and appeared to understand the circumstances under which restraint can be used. There were numerous reports of how hard staff have worked to implement CPM effectively. Multiple staff members commented on how the LRC culture has changed, such as how much staff work to avoid situations where a restraint is necessary. This involves increased de-escalation attempts and increased amounts of post-restraint work with youth.

With policy and procedure in place, the compliance challenge becomes the assessment of the new practice, which generates many questions. Do the changes associated with CPM and the New York Model affect undue restraints? Does current practice contribute to a reduction in the rate of restraints as compared to the old model? Does the continued implementation of the new CPM model contribute to a progressive or incremental reduction in the ongoing rate of restraints? Is there a mutually agreed upon benchmark for restraints that will serve as one indicator of compliance?

In the absence of mutually agreed upon QA mechanisms, outcomes measures, and quantitative data, compliance decisions default to the expert opinions of the monitors. Currently, compliance decisions include the PH Monitor's understanding of relevant research, evidence-based best practices, and direct experiences with similarly situated institutions and agencies external to the named facilities, in conjunction with Home Office perspectives and clarifications.

The CPM policy and procedure, PPM 3247.12, sets forth the expectation that all restraints under new system will be limited to only exceptional circumstances, and this requires verification. Implicit in the logic of the New York Model and CPM is that the combination of these two approaches will (a) reduce the number of exceptional circumstances, (b) reduce the number of the more restrictive uses of force, and (c) increase effectiveness of the de-escalation and less restrictive alternatives. Therefore, one determinant that the practice complies with the policy and procedure is a decreasing rate of restraints. So, are the rates of restraints changing? If so, are they increasing or decreasing? To answer these questions, there needs to be a reliable measure of restraints.

Table 1 in Appendix C contains the best available rates of restraint events and injuries to youth for four selected months preceding the monitoring visit. The data do not yet support a finding of compliance as based on the inconsistent changes in the total rates of restraints and the rates of the most restrictive uses of force. To use restraint data as one measure of compliance, there needs to be agreement about the Home Office data. While the process is close to resolution, the Home Office data were not useable for the Lansing assessment.

Assessing the uses of force and physical restraint are critical parts of the Protection from Harm monitoring. Now that there is a QA Department, it is important that QA develop collaboratively with the monitors the policies, procedures, and practices that safeguard

Settlement Agreement issues. This means the mutual establishment of benchmarks, outcomes, and thresholds for compliance.

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: The policy and procedures are established, and the training on the policies and procedures has occurred. At question now is the verification of the practice, but the absence of audio to accompany the video in the Restraint Packet is problematic. Below is a review of multiple restraint incidents that raise several questions about the amount of force necessary. Again, despite the fact that CPM training teaches YDA staff that restraints should be implemented with multiple staff, situations have occurred where a single staff member has had to administer a restraint and may have had to use a level of force that appears to be greater than the amount described in the CPM training in order to maintain control. The use of a single-staff-member application of what staff refer to as multiple-staff-member restraint techniques combines with concerns about the size and strength of staff in relationship to the size and strength of the youth to make the rate of staff injuries a useful Protection from Harm variable.

The use of a single-staff-member restraint should be the focus of quality assurance. Questions arise regarding the circumstances surrounding a single staff member restraint, and QA should collect information about single-staff-member restraints to inform training and program development.

Conversely, there is evidence that supports staff's contentions that they use only the minimum amount of time in restraints necessary to stabilize the situation. One particular video shows two (2) male staff members maneuvering a girl to a position where they initiate a well-executed supine restraint. A third staff member immediately assumes position on the legs. The video shows the restraint monitor (a fourth staff member) checking the restraint while in progress and talking to the youth, presumably in an attempt to talk her down. The release of all staff members occurs at about the 9-minute mark. This is an example of (a) how a three-person, supine restraint can be implemented according to the techniques and strategies taught through CPM training and (b) a use of force that appears to have spent the minimum amount of force and time necessary to restore safety and to stabilize the youth.

Future monitoring must consider outcomes measures developed by QA and endorsed by the Monitors to assess compliance with the practices set forth in policy.

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: The policy and procedures exist; the training on the policies and procedures has occurred; and staff and resident interviews were consistent with the policy and procedures. The nursing staff explained the process of creating a restriction on the use of physical restraints for particular youth. They initiate the process, which is contained in the youth's individualized intervention plan (IIP). Interviews with direct care and youth counselor staff revealed a working knowledge of conditions, circumstances, and plans that limit the restraints to youth due to heightened risk of physical or psychological harm.

Despite this compliance finding, the PH Monitor reviewed one troublesome incident that did not appear to follow policy. The Video Review Form by administration in Restraint Packet #263809 notes that the youth was "not to be placed in a supine restraint;" however, the video shows the youth in a supine restraint. There is no documentation of follow-up with the staff member included in the Restraint Packet.

41. c. *If facedown 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. *Facedown 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: The policy and procedures exist; the training on the policies and procedures has occurred; and staff and resident reports are consistent with the policy and procedures.

Policy 3247.12 does not explicitly prohibit the use of a prone or facedown restraint; however, the list of the approved uses of force does not include a prone or facedown restraint, and interviews with staff indicate that prone or facedown restraints are prohibited based on their understanding of this policy as taught in training. The policy does describe a "transitional hold" that moves a youth from a supine restraint to a prone position for the purposes of applying handcuffs, but the transitional hold can only be used when a youth's behavior cannot be managed safely solely using the supine position. Staff did not consider the "transitional hold" as a prone technique because they only move a youth to her side if the application of handcuffs is necessary.

Staff responses from across all named facilities uniformly indicate that prone or facedown restraints are prohibited. The OCFS prohibition on facedown or prone restraints is consistent with the CPM strategy. This raises a concern regarding compliance assessments: How does adherence to policy emanating from a Settlement Agreement paragraph affect compliance decisions about the paragraph? The failure to comply with OCFS policy developed in response to the Settlement Agreement raises questions about compliance with the Settlement Agreement. The current finding follows the Settlement Agreement language, but this issue requires greater clarification.

Restraint Packet #308183 shows a facedown restraint of a youth on a table in the cafeteria by two (2) female staff members. The facedown restraint lasted over six (6) minutes, violating the three (3) minute limit identified in Subsection i.

Knowing that physical restraints seldom happen according to the scenarios presented in training, there will be circumstances where staff must adapt their strategies to the conditions presented. In these situations, mistakes sometimes happen. An important element in compliance is a process for corrective action that increases the staff member's likelihood to avoid the use of a prone or facedown restraint in the future. A mechanism of this nature already exists in the Facility Administrator's review of weekly review of Restraint Packets (see 42e). No Video Review Forms accompanied the Restraint Packet identified above, so initially there was no opportunity to review suggestions for improvements or referrals for documented instruction.

Point of clarification: Following the Home Office review of the draft version of the report, the PH Monitor received copies of the Video Review Forms. Variations in operating procedures resulted in some of the forms not being included in the Restraint Packets provided to the PH Monitor, even though the Video Review Forms existed at the time. Home Office has taken action to ensure that Video Review Forms will be available in Restraint Packets for all future requests.

Regarding Restraint Packet 308183, the Video Review Form indicates that "additional action required" was a referral for an SIU investigation and an SCR report.

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

COMPLIANCE

COMMENT: Interim policy and procedure clearly prohibit the use of chemical agents such as pepper spray. Resident and staff interviews and direct observations provided no evidence of the use of pepper spray.

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

COMPLIANCE

COMMENT: Interim policy and procedure regarding physical restraint clearly prohibit the use of psychotropic (psychiatric) medication for restraint purposes. Resident and staff interviews and direct observations provided no evidence of the use of psychotropic (psychiatric) medication solely for restraint purposes.

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 policy and procedures are established; the training on the policies and procedures has occurred; and staff reports are consistent with the policy and procedures. Substantial problems occurred in the use of the STARS system to verify CPM training completion for all YDAs. The delays prevented a complete assessment of those YDA staff who are not authorized to participate in CPM. Additionally, information was not available at the time to determine if those who had participated in the 32-hour pilot on CPM had completed a refresher-training program. Regarding first aid and CPR, information provided before the end of the on-site visit indicated that all but one YDA was current in these training areas. LRC administration identified two (2) staff members who have not completed the CPM training as a result of being newly hired, but both had been rescheduled for an upcoming CPM training session within a few weeks. Additionally, information about staff who cannot participate in restraints is posted in the CSU. While the training efforts are strengths within the Protection from Harm paragraphs, there is enough uncertainty about the LRC review to preclude a compliance determination at this time.

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.

COMPLIANCE

COMMENT: The policy and procedures exist; the training on the policies and procedures has occurred; and staff and resident reports are consistent with the policy and procedures. However, the video in Restraint Packet #294880 contains a questionable restraint technique (the video shows what appears to be a female staff member's hand on a youth's throat during the restraint), but the technique did not approximate the "chokehold" identified in this paragraph. The information regarding investigations is addressed in Paragraph 42e.

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: The policy and procedures are established, and the training on the policies and procedures has occurred. Staff and resident reports are generally consistent with the policy and procedures.

Youth Safety

The residents' perceptions of safety are good and suggest relatively little fear of harm. When asked to rate their personal safety at LRC using a scale of 1 to 10 with 10 being the safest, the average response was 9.0. All six girls indicated that staff members do not try to hurt or punish youth during a physical restraint. Likewise, all indicated that staff talk to youth during restraint, imploring them to calm down, quit struggling, and end the intervention as soon as possible. Only one girl accused a staff member of hurting her, but she believed the injury was not deliberate.

The residents' perceptions of safety are probably sustained by positive relationships with staff. Each girl named multiple staff that she felt comfortable talking to about personal issues or problems (a potentially very powerful de-escalation tool). Additionally, each girl named multiple staff when asked to identify those staff members who do a good job. The interest in the nature and extent of youth-staff relationships is that effective staff use good relationships to enhance the success of conflict resolution, crisis intervention, and de-escalation skills.

A 17-year-old from New York City explained the use of physical restraints from a troubling perspective. She would later complain that one of the deficits of the LRC program was the lack of activity, especially large muscle exercise and the ability to get outside. To some extent, these comments help to explain her perspectives on physical restraint. She indicated that she has been restrained often and that she uses the restraint as an outlet for stress and energy. She was clear that she did not believe staff ever tried to hurt youth during restraint. As a result, she feels free to fight and struggle as much as possible, knowing that staff will not hurt her and she will be able to release a maximum amount of pent-up energy.

All girls had an opportunity to suggest ways that LRC could be a better facility. A common theme was the amount of programs and activities. The girls were quick to identify those activities that are reinforcing, but they all asked for more things to do. It is important to note that the gym has been under repair for several months, but it is scheduled to reopen soon. (Home Office reported that the gym reopened the last week of March.) The ability to have a large space for large muscle exercise is different than the Fun World room with stationary exercise machines. Effective large muscle exercise and strenuous physical activity reduce stress, tension, and anxiety, which are all factors that affect the precursors of physical restraints.

Staff Safety

LRC staff injuries from physical restraints affect compliance. Injured staff are frequently unable to perform their job duties fully, including the safe and effective implementation of physical restraints; and injured staff often take some form of leave while recuperating from injury. Therefore, increased staff injuries predict a reduced staffing adequacy, which is one of several factors that have an empirical relationship with physical restraints. All staff absences including those resulting from staff injuries have a negative effect on unit management, teamwork, continuity, and program consistency. Based on anecdotal evidence from direct observations in several of the named facilities, there appears to be a direct positive relationship between staffing variables (program continuity,

teamwork, effective communications, and staff consistency) and improved safety outcomes for youth, including fewer uses of force. Again, the focus is on use of force and youth safety, and these staff injury fluctuations represent QA challenges, especially when more information is needed regarding the strength of other influences on the rates of physical restraints, such as changes in the resident population, changes in social and spatial density, and staff fatigue as measured by the rate of mandations. Home Office has been responsive to staffing issues and has begun a special review of the issues. Additionally, Home Office has also agreed to work with the Monitors on the development of quality assurance instruments and procedures that address staffing.

The perspectives about role of staff injuries and their relationship to the Settlement Agreement are generated, in part, by the comments and observations of DJJOY staff. This anecdotal evidence is not only important, but most is constructive and helpful. To reiterate, the sources of information that support and sustain compliance determinations include reliable data (and documentation), direct observations by the monitors, and responses from youth and staff about current conditions that are consistent with the other sources of information. Regarding staff safety and uses of force, a veteran supervisor expressed concerns for staff regarding the injury potential with CPM. In particular, head trauma led the list of concerns (one LRC staff member has suffered multiple concussions), and he also included problems with lower back, shoulders, and knees. In response to the question of how to improve the safety of the CPM techniques, a discussion ensued that moved from technical suggestions, such as moving from a seated to a supine restraint immediately, to administrative decisions that affect the use of CPM. One particular point addressed the amount of staff required to implement CPM effectively. The consensus among staff has been that CPM requires more staff to conduct a restraint than did the old method. The supervisor acknowledged what he believed to be the accuracy of this observation, but maintained that there are enough staff at LRC to implement CPM appropriately, except in situations when multiple restraints occur. The other difficulty identified as a source of concern is the inability to assign staff to various shifts based on their skills.

In response to questions about the surge in restraints in February, another veteran supervisor made the observation that staff had not yet become fully comfortable with the techniques and strategies presented in the numerous, recent trainings. He suggested that it might be a short-lived phenomenon, but the attempts to use de-escalation and other less restrictive alternatives before moving to physical restraint may be temporarily sending an inaccurate message to youth that staff are afraid of them. The New York Model and CPM have asked staff to change their thinking about how to respond to aggressive and acting out youth in a different, more effective way. Just as it takes time for staff to acquire these new skills and to feel comfortable and confident in using them, so too it may take time for youth to understand the changes in staff's behaviors.

Assessing the appropriateness of uses of force and physical restraint is a critical part of the monitoring. Now that there is a Quality Assurance (QA) Department, it becomes important that QA develop collaboratively with the monitors policies, procedures, and practices that safeguard Settlement Agreement issues. This means the mutual establishment of benchmarks, outcomes, and thresholds for compliance.

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 policy and procedures exist, and the training on the policies and procedures has occurred. The reviews of Restraint Packets confirm the requirement that staff document uses of force promptly. The difficulty arises with the adequacy of the documentation. The review of Restraint Packets reveals multiple examples where the narrative does not reflect the behaviors seen on the videos. This is where the administrative review (see 42e) becomes important because it provides an opportunity for coaching, which will improve the documentation skills of staff.

The need exists for staff to report critical incidents accurately. This requires attention to the content (adequacy) of the documentation as expressed in the policies and procedures and to a mechanism for skill development and accountability. Through Paragraph 42e, a mechanism exists for ensuring that documentation and reports correspond with the intent of the Settlement Agreement. Therefore, regular reviews are conducted with each critical incident; inappropriate behavior is accurately identified; documented instruction occurs; and a record of this action and a follow-up exists.

42. d. Create or modify and implement a system for review, by senior management, 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.

PARTIAL COMPLIANCE

COMMENT: The policy and procedures exist, and the training on the policies and procedures has occurred. Qualitative data exist to support compliance. LRC administration describes situations where the review of restraints results in ideas for CPM improvements. For example, one of the vulnerabilities of the approach is during a supine restraint, but staff found that the use of the "X" grip provided greater safety. Staff also used these reviews to determine that it is safer on a two-person escort to move the youth backwards. The review process also enhances coaching. It is beneficial to provide staff with a video example of what they are doing and then respond with a coaching intervention. LRC administration reports that this process occurs regularly. The challenge now is evaluating the quantitative data on the routine and consistent occurrence of these events. This is another area for Quality Assurance development.

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: The policy and procedures exist. There is also evidence of a practice where administrators conduct a review of the video and place a Video Review Form (VRF) in the Restraint Packet. Problems exist regarding the frequency of the VRFs in the

Restraint Packets and with the quality of these reviews. For example, of the five (5) Restraint Packets reviewed for this report, four (4) did not contain VRFs that verify the requirements of Paragraph 42e. In addition to not being able to find a Video Review Form, three (3) of the packets and videos contained examples of staff behaviors that warrant documented instruction.

The physical size and strength of some girls present problems for staff regarding the effective and appropriate use of the CPM restraints. Home Office notes that staff tend to gravitate toward "stronger" staff as the lead individuals in a physical restraint, regardless of the technique. While this is a common phenomenon with most physical restraint strategies, the repeated inability of one or more staff members to implement effectively the CPM restraint techniques requires ongoing attention. In situations where a staff member has difficulties implementing the CPM techniques, there needs to be a plan developed through documented instruction or otherwise to improve the staff member's effectiveness at restraint implementation. The intent of Paragraph 42e is to identify staff deficits in the CPM process so that action can be taken affirmatively to increase staff skills and competencies regarding use of force. Therefore, it is important to use every appropriate opportunity as a teachable moment, especially when considering how well BOT trainers provide documented instruction and coaching. The critical importance of the administrative reviews is to capture these moments.

1. Restraint Packet Number 263809: The Video Review Form (VRF) is a problem. First, the reviewer notes that the youth was not to be placed in a supine restraint, but the video shows her in a supine restraint. Second, the VRF indicates that the video was not consistent with the documentation but contains no further explanation. Third, Home Office noted that documented instruction was requested; however, this situation warrants a reconsideration of documented instruction on the de-escalation techniques. In several instances, the video shows the YDA chasing the youth without her demonstrating behaviorally a threat to self and others. This runs contrary to Martin's "time and distance" principles and could have escalated the situation by not returning to a de-escalation phase once the initial level of threat had subsided. CPM is a responsive strategy intended to match the least amount of restrictiveness or use of force necessary in response to the behavior of youth. So, hypothetically, if the restraint cannot be applied on the first attempt and the immediate threat no longer exists, is there a requirement that the restraint be implemented anyway? The PH Monitor's understanding of CPM is it is not always a linear crisis intervention strategy.

2. Restraint Packet Number 308183: The video shows two (2) female staff members trying to apply a two person standing restraint, but the youth is at a cafeteria table and resists. The ensuing physical intervention results in the youth in a prone restraint on top of a table with her torso on the table and her legs toward and sometimes touching the floor. No VRF accompanied the restraint materials, and there was no acknowledgment of a facedown restraint on the table in the documentation. Given the multiple restraints that occur in the cafeteria with its fixed tables and seats, this is an opportunity for critical review of restraints in this location.

As mentioned above, Home Office responded by collecting and forwarding the appropriate VRF materials, noting that the matter was referred for investigation. The staff

was not referred for documented instruction because of the assumption that documented instruction is for situations where staff are attempting to use trained skills and have had difficulty, as opposed to a situation where the proper technique clearly was not used/attempted and the matter has been referred for investigation. This discussion led to the conclusion that Home Office should discuss and clarify the instructions for documented instruction.

3. Restraint Packet Number 303080: This video contains two restraints. The secondary restraint is the first restraint on the video, and it is a facedown takedown by a male YDA on Youth A. It appears as if the youth's head and shoulders hit a chair as she is going to the floor. Youth B comes to the aid of Youth A, hitting the male YDA restraining Youth A, so she is restrained by the female staff member on the unit and this action is the focus of the Restraint Packet. The female staff member attempts to get Youth B in a single person seated restraint but cannot implement it. As a result, the female staff member ends up on top of Youth B who is facedown on the floor. No VRF accompanied the restraint materials, even though the Restraint Packet is for the restraint of Youth B. The incident contains prone restraints worthy of review, documented instruction, and coaching.

Again, Home Office responded by collecting and forwarding the appropriate VRF materials, noting that the matter was referred for investigation and restrictions were placed on contact. The matter was not referred for documented instruction because an investigation was proceeding. Home Office is reviewing instructions to provide clarification to staff for when to do documented instruction.

4. Restraint Packet Number 294880: A female YDA initiates a physical restraint but is unable to apply the hold. A male staff member joins the restraint, as does another male staff member. As the restraint continues, the video shows the female staff member with her hand on the youth's throat. No VRF accompanied the restraint materials in the packet or any indication of documented instruction or coaching.

Finally, Home Office responded by collecting and forwarding the appropriate documentation, noting that the staff's action resulted in her removal from the facility on administrative leave pending an investigation of the incident. Home Office provided the notice of administrative leave given to the staff member.

The weekly reviews of uses of force reports and video incidents are one of the more powerful and constructive measures regarding Protection from Harm. It is currently underutilized based on the Restraint Packet reviews from this visit. Full compliance would mean the routine presence of the VRF with careful comments and recommendations regarding ways to improve physical restraints, report documentation, and resident supervision. There should also be additional documentation about the use of documented instruction and coaching as a way to improve staff skills. Quality Assurance needs to track documented instruction and coaching so that information derived from this tracking can be applied to training and staff development.

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. Supervisory 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: There are many topics that constitute CPM training, such as: Physical Skills Use of Mechanical Restraints in CPM; Physical Skills to Prescriptive Interventions - Supportive Touch and PR; Physical Skills Team Restraint and Escort; Physical Skills Skill Review (Physical Skills); Physical Skills - Skill Review (Interventions); Physical Skills - Single Person Standing Restraint and Escort and Seated Restraint; Physical Skills Simulation; Physical Skills - Self Protection; Physical Skills - Quiz on Two Prescriptive Interventions; Physical Skills and Written Test; De-Escalation - Calming Techniques; De-Escalation - Characteristics of Adolescents; De-Escalation - Definition of a Crisis; De-Escalation - Introduction; De-Escalation - Maslow's Hierarchy of Human Needs; De-Escalation Policy - The Use of Physical Restraints and The Role of the Restraint; De-Escalation Quiz on Combing Techniques; De-Escalation - Stress and Buttons; De-Escalation - Walking Styles; Physical Skills - Letting Go and The Egregious Behavior Protocol; Physical Skills Conclusion to CPM; and Overview of Day 2.

This list of CPM training topics does not identify conflict resolution as mentioned by Paragraph 42f. While there may be components of the de-escalation skills training in CPM that include conflict resolution elements, the intent of the Settlement Agreement appears to be a clearer delineation of conflict resolution. There may be additional training in the New York Model, specifically the instruction on chain analysis. The idea of a separate training on conflict resolution seems to be different from the de-escalation skills identified in CPM. In either case, the identification and explanation of conflict resolution as a key component of Protection from Harm skill development for YDA staff is important. While there is a sense that training covers many of the elements and components that constitute conflict resolution training, it would be easier from a compliance perspective if the conflict resolution training skills were more readily identified. This issue needs more discussion with the Bureau of Training. It is likely that any discrepancies can be resolved at the June meeting with the Monitors and Home Office.

C. Emergency Response

The levels of emergency response seemed good, and the policy and procedure regarding response teams and codes are 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: The policy and procedures exist (PPM 3246.02 and PPM 3247.12), and the new Crisis Response and Radio Communications policy and procedures were distributed to staff. All staff interviewees identified all of the call for assistance color codes (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.

COMPLIANCE

COMMENT: The policy and procedures exist (PPM 3246.02); the training on the policies and procedures has occurred; and staff reports are consistent with the policy and procedures. The AOD makes an evaluation of the restraint and documents it in the shift summary. AOD also notes any problems in the Facility Log.

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

COMPLIANCE

COMMENT: The local operation practice (LOP) exists as the emergency response plan. It is posted in the CSU along with the list of responders identified for each code.

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

PARTIAL COMPLIANCE

COMMENT: The policies and procedures referenced in Paragraphs 41-43 are addressed primarily in policies 3247.12 and 3246.02. Home Office mentioned the existence of two DVDs that every staff member is required to view. It would be beneficial to the review of the staff training requirements in the Settlement Agreement, especially the requirement that staff receive training on those policies and procedures affecting the Settlement Agreement, if the Monitors had a copy of the DVD for their review and comment.

D. Reporting and Investigation of Incidents

These paragraphs refer largely to the activities of the Special Investigations Unit (SIU). Recently, a separate monitoring visit to the Home Office reviewed these paragraphs. Most of the comments below reflect aspects of the current reporting and investigative process as they relate to the responsibilities of the individual facility staff. Compliance implications relate more to Home Office activities in these areas than to the local facility implementation.

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.

PARTIAL COMPLIANCE

COMMENT: Home Office determines the policies, procedures, and practices that govern prompt and appropriate corrective measures. The previous LRC monitoring visit included a concern by the former clinic director about nurses feeling uneasy about reporting allegations of abuse by YDA staff. LRC administration gave the impression was that the clinic director, who is no longer at LRC, was the source of the problems. Director Larrier-Fulcher advised the PH Monitor during the visit that nursing staff told her earlier this year that there was no longer a problem. However, during this visit, nurses expressed a different perspective, indicating an existing concern about the relationships between themselves and certain YDA staff. Even though staff did not express concerns about direct retaliation or intimidation by YDA staff following a report of possible abuse to SCR, a discussion arose about a strained working relationship with specific staff who will not participate fully in the activities of the infirmary. Some medical staff reported feeling uncomfortable working with one YDA who has allegedly stated that she will not come into the infirmary because every time she does she gets "turned in."

Teresa Peck, Regional Nursing Administrator, provided evidence from multiple Site Visit Reports (documentation of an assessment or audit of the clinic by the supervising nurse administrator) where she raised with Facility Director Larrier-Fulcher the issue of a lack of cooperation by the line staff. Following a discussion with the PH Monitor about reporting issues and the relationships between YDA staff and medical, Facility Director Larrier-Fulcher created and produced handwritten notes from a core team meeting where she described the relationship as better between LRC staff and the clinic due to the absence of the clinic director. No information was available relating to any other actions by Facility Director Larrier-Fulcher addressing the lack of cooperation issue with staff.

An SIU investigation (File #11-304) presents a different perspective on a past event that still seems to influence these relationships. The investigation's findings place responsibility for the intimidation of an infirmary worker with a YDA staff member. SIU recommended a referral to labor relations for disciplinary action against the YDA. The PH Monitor will continue to monitor the situation as it also applies to Paragraph 44e, particularly the actions of LRC administration in light of SIU findings and

recommendations. No additional explanation was available regarding how Home Office or LRC administration addressed this issue.

From all the available information and considering administrative comments to the contrary, it appears a problem still exists. While the relations between YDA staff in the clinic may be better than in the past, the situation is so important regarding Protection from Harm issues that PH Monitor must conclude that the current situation does not yet meet the intent of this Settlement Agreement paragraph. There needs to be resolution of this issue.

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.

PARTIAL COMPLIANCE

COMMENT: Paragraph 44.b. is a function of departments external to LRC. The review of this paragraph did not occur during this monitoring visit.

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.

COMPLIANCE

COMMENT: The policy and procedures exist, and staff and resident interviews are consistent with the policy and procedures. The key issue here is the safeguarding a youth's opportunity for a candid conversation during a post-restraint examination with a trusted, health care provider, so that she can then more easily provide confidential information regarding the use of force incident, allegations of excessive use of force, and injury complaints.

On March 13, 2012, the PH Monitor was present in the infirmary at the time that a post-restraint exam took place. Located in the same area as the YDA who accompanied the youth to the clinic, the exam took place in the examination room with no opportunity to make eye contact with the youth. Furthermore, the use of a radio provided sufficient sound in the room adjacent to the exam room that the voices of the examining nurse and the youth could not be heard.

The infirmary program represents a Protection from Harm strength. Despite the absence of an infirmary director, the Regional Nursing Administrator provides temporary supervision along with medical care supplanted by a nurse practitioner and physician's

assistant from neighboring Finger Lakes. It is important for the continuity of the infirmary to have a new director named soon.

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 withdraws 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.*

PARTIAL COMPLIANCE

COMMENT: The SIU conducts investigations while new and updated policy and procedure work their way through the review and approval process. The review of this paragraph did not occur during this monitoring visit.

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

NONCOMPLIANCE

COMMENT: Home Office determines the policies, procedures, and practices that govern prompt and appropriate corrective measures. Three (3) general classifications of outcomes contribute to the assessment of compliance with this paragraph. The first is whether or not a response occurred. The intent of the paragraph is that there will be a response to every finding. The second criterion is whether or not the response is prompt, meaning is there a reasonably short time between the event and the response to make the response meaningful. The third assessment is whether the response is appropriate for the nature and extent of the misconduct.

Regarding the second criterion, the information provided by Home Office regarding staff with disciplines related to youth supervision between July 1, 2011 and February 29, 2012 identified six (6) Notices of Discipline (NOD). Two (2) of the NOD dates were 51 weeks following the date of the incident. Conversely, two (2) other NOD dates were less than 10 days following the date of the incident. For the six (6) NODs, the average length of time = 26.5 weeks between the date of the incident and the NOD with a standard deviation = 20.1 weeks. An average of six (6) months between the date of the incident and a notification to the employee that a disciplinary action may be forthcoming seems to be too long and does not fit with the requirement that a response be prompt. A reduction in the amount of time between the date of the incident and the completion of disciplinary action is another compliance issue that requires the attention of quality assurance.

Regarding the appropriateness of corrective action, the case of a YDA where the SIU investigation (Case ID: 24671164) substantiated allegations of inappropriate custodial conduct and lack of supervision during an incident on January 30, 2011 continues to attract monitoring attention under this paragraph. The employee in question was interviewed during this LRC monitoring visit and described the disciplinary action as (a) a monetary penalty (a fine of the equivalent of 120 hours of pay or $2700, deducted at the rate of $75 per pay period every two weeks), (b) a leave time accrual deduction penalty of 160 hours of accrued leave time (the employee reported having accrued approximately 400 hours, meaning that the penalty reduction to 280 hours left the equivalent of seven weeks of paid leave on the books), and (c) a suspension penalty of four (4) months without pay held in abeyance or itself suspended pending any further serious disciplinary infractions of this nature. These disciplinary actions were the result of an August 24, 2011 Expedited Disciplinary Arbitration with a decision on August 29, 2011, which reduced the Home Office proposed penalty of 12 weeks of disciplinary suspension without pay to the penalties cited above. The Home Office proposed penalty seemed appropriate, especially when considering the seriousness of the incident. In this instance, the disciplinary arbitration lessened the appropriateness of the corrective measure.

Did corrective action change the employee's behavior? The SIU investigation accurately identified two (2) critical failures that formed the bases of its disciplinary recommendation. From a Protection from Harm perspective, both failures are highly serious threats to the safety of youth but are distinctly different in nature. When asked what job performance changes were made as a result of the corrective action, the employee could only mention one of the two issues related to changed job performance. Additionally, the employee mentioned a requirement to attend a remedial training on Suicide Risk Reduction and Response but was not at work when the training occurred. There was no date for the training at the time of this visit. Home Office reports that it has been rescheduled.

This paragraph represents a substantial challenge. Neither element of the paragraph, promptness or appropriateness, seems to comply under the current arrangements. The paragraph represents an opportunity for QA, and it would be beneficial to begin the process of articulating a mutually agreed picture of compliance as soon as possible.

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.*

PARTIAL COMPLIANCE

COMMENT: The policy and procedures exist (PPM 2801.00, PPM 3247.00, PPM 3247.01, PPM 3247.13, and PPM 3456.00); the training on these topics has occurred as documented in STARS; and staff descriptions of the training are consistent with the policy and procedures. To determine if a continuum of force exists in the various physical restraint techniques, several CPM experts, i. e., individuals trained to train others in CPM,

identified consistently the following continuum of use of force in CPM moving from least restrictive to most restrictive:

1. Protective Hold
2. Escort, Single; Standing Restraint, Single
3. Escort, Team; Standing Restraint, Team
4. Seated Restraint (generally due to some restriction or qualification or condition in the IIP)
5. Supine Restraint
6. Supine Restraint with Handcuffs.

A compliance determination is pending review of the refresher training documentation. Based on the past record of providing documentation of training through the STARS system, compliance is likely; but the caution from Paragraph 41f applies here also. This paragraph will require closer scrutiny on the next monitoring visit in order to maintain the compliance status.

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

PARTIAL COMPLIANCE

COMMENT: At the facility level, the Monitors are aware of no concerns about the adequacy of staff supervision of current LRC staff. Further review of this paragraph did not occur during this monitoring visit.

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 OF HOME OFFICE

III. MENTAL HEALTH MONITORING

An impressive amount of work on policies and New York Model training materials has occurred in recent months. For the ten mental health paragraphs of the Settlement Agreement, four policies have not been finalized (PPM 2801.00 "Training Requirements for DJJOY Staff," PPM 3247.60 "Suicide Risk Reduction and Response," new policy on Facility Admission Process, and an update on the integration of PPM 3443.00 "Resident Rules" in the New York Model) and one training curriculum has not been completed (and protocols related to developing uniform working diagnoses for mental health professionals). The MH Monitor cannot assess compliance until the policies are finalized, staff are trained using new curricula and the staff demonstration of consistent application of the training and adherence to the policies can be observed.

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, and 46a is being implemented into practice at Lansing.

Mental health staff at Lansing were observed complying with 46b.

The Daily Achievement System (part of the New York Model) complies with the requirements of 46d, and is being implemented at Lansing.

What the MAP referred to as a new policy on Case Management of Juvenile Delinquents Placed in the Custody of OCFS is no longer planned as a policy. What was to be the contents of that policy—including treatment teams and substance abuse treatment—is being incorporated into training curricula. The New York Model implementation training includes the new integrated assessment, the new treatment plan, and how to utilize both in the new treatment teams.

The MH Monitor reviewed the draft policy 2801.00 "Training Requirements for DJJOY Staff." The policy does not provide any details about supervisory training, although the role of supervisors as coaches of expected practice is endorsed: "Supervisors are required to supervise and evaluate the work of their staff and provide communication, mentoring and coaching to improve and increase employee's skills and capabilities." The New York Model, Sanctuary, and DBT are not mentioned in "Training Requirements for DJJOY Staff." While some of the required training topics in the policy comply with the Settlement Agreement, these would be in addition to the New York Model training.

The MH Monitor reviewed the 8/11 curriculum for five-hour training for direct care staff entitled "Mental Health for DJJOY Youth: Disorders, Interventions and Management Basics" which complies with the Settlement Agreement. However, the MH Monitor heard during the site visit that staff found the all-day training (which also included Psychiatric Medication training) to be too much information to digest. Perhaps a 2-day format with application to case examples would be preferable.

There are two policies 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 (12/20/11)

1. Create the New York Model

   Completed June 2011.

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

   "This policy is drafted but the content is different than originally intended. New tasks will be provided to address the remedial measures in the upcoming revised MAP."

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

   2801.00 Renamed Training Requirements for Division of Juvenile Justice and Opportunities for Youth Staff "has been implemented as interim at the DOJ facilities. Pending discussion with unions."

   3443.00 Resident Rules "This policy is being evaluated for integration with NY Model."

4. Create new policy related to Facility Admission Process.

   "The Non-Secure and Limited Secure version is drafted and ready to submit to DOJ. Secure version in progress."

5. Revise orientation curriculum

   Completed March 2011.

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.

   NY Model training was completed at Lansing 10/27/11, Columbia 12/14/11 and Taberg 12/22/11 and will be completed at Finger Lakes 6/19/12. The full training schedule is being developed. Treatment team planning is being implemented at each facility.

On Site Observations (3/12)

Paragraph 46 of the Settlement Agreement requires an effective program to meet the needs of residents. OCFS is implementing the New York Model, and the policies and training to support it, to build on the strengths of OCFS services and address limitations 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.

During the Lansing site visit, the Monitors again urged the New York Model developers to write about the approach for publication because its comprehensive integration of evidence-based practices has the potential to be influential in delinquency programming around the country.

The New York Model has been described extensively in prior monitoring reports and will not be summarized in this report. Achieving trauma-responsive, relationship-driven, culturally competent, and strengths-based teamwork to meet girls' needs is difficult with a population as troubled as the Lansing girls. Lansing has been the facility where elements of the New York Model were first implemented. Lansing staff learned DBT in 2010 and Sanctuary, IIPs and the Egregious Behavior Protocol in 2011 before the New York Model was finalized. Because of its small size (and operation below capacity), stable staff and strong clinical team, Lansing has demonstrated how to tailor the New York Model to a particular population. Lansing continues to improve its responsiveness to the needs of the girls, such as: to be treated respectfully, to have some control over what happens to them, to be praised, to calm themselves, to be less reactive to threat, to express anxiety, fear and anger safely, to compensate for their disabilities, to feel their family and culture are valued, and to have trusting relationships. It was evident during the site visit that Lansing staff help each other avoid getting angry, defensive, or controlling, engage in power struggles or take girls' behavior personally.

The MH Monitor observed IIPs (Individual Intervention Plans) consistently in the records of Lansing girls. The BBHS Chief of Treatment Services advised that the IIP form is being revised to make it more consistent with the integrated assessment and treatment plan in the New York Model.

During the site visit, Lansing was in the midst of defining Daily Achievement System (DAS) reinforcers the girls will value that the facility can sustain over time. In addition to reinforcers such as staying up later and "spa" hair and fingernail treatments, the recreation specialist has used community connections to generate impressive rewarding activities such as movies and other community outings; a group of girls were invited to lunch at Ithaca College while we were on site. A Lansing clinician commented, "The DAS is an extremely effective tool. The residents are enthusiastic about it. In the DAS it will be important to have flexible reinforcers that can change and be made to fit (for example, if a girl is not motivated to attend school, what reinforcer would she respond to?). We recognize that the DAS is for behavior management. Behavior treatment is a different activity, through groups, therapy, and individual interventions, that is integrated with behavior management." Hopefully Lansing plans to use a similar description of the DAS written for residents at Taberg, which was excellent. More coaching for staff on the benefits of the DAS is necessary. A Lansing YDA complained, "The DAS sheets are confusing. We really haven't been trained. We get different instructions each day. It's unclear if a girl with a tongue ring she won't take out gets N once or 5 times a day." Lansing has begun to convert from the old system to the phase system, which is more oriented to long term status (major privileges, not just "I did well today"). The OCFS Home Office must approve reinforcers such as wearing one's own clothes and community activities. It is

likely to take several months for the DAS and phase system to get stabilized at Lansing. The DAS is another New York Model component that meets the requirements of the Settlement Agreement.

Challenges for New York Model implementation at Lansing include:

• The New York Model is designed for a fully staffed facility. Lansing does not have an Assistant Director for Treatment. The Lansing psychiatrist only works 10 hours/week which is insufficient to see the residents prescribed medication with their therapists, convene Rounds, and participate in treatment teams.

• The original idea was that a facility would implement New York Model most effectively for the facility culture through dialogues about what was working and what should be adjusted, but the BBHS Support Team has been assisting with implementation elsewhere and has been unable to provide sufficient support to Lansing.

The MH Monitor remains concerned that the talented BBHS Support Team has been expected to create the New York Model implementation training and prepare for the monitoring site visits, leaving them little time to coach staff in the New York Model. It is recognized that coaching takes more time than training, and Lansing staff required more New York Model implementation coaching than the BBHS Support Team could provide in the past six months. It is hoped that during the time between the monitoring site visit in March and August 2012, the BBHS Support Team will be allowed to provide substantial coaching to its three DOJ facilities.

A key to implementation of the New York Model is a functioning team of coaches. A strong facility coaching team ensures that the New York Model becomes a way of thinking by staff and youth, rather than simply a clinical service. The Lansing coaching team met with the MH Monitor to discuss how they are "walking together with all staff in a new way of thinking." They added, "We value collegial collaboration." They described their goal of unifying staff: "We are struggling together to learn new ways to encourage girls as they struggle to change." The clinicians on the coaching team commented that "for awhile we felt like we were rowing the boat alone." But they have found that "as we 'de-clinical' the way we work with girls, we can all help them together with their trauma." The biggest obstacles they see to being effective coaches of the New York Model are staff frustration with mandated overtime and pressured schedules making it difficult to arrange participation in treatment teams and Rounds.

Dr. Morog's notes from individual therapy sessions revealed an unusual practice, which results in calibrating her interventions not only to each girl's unique needs, but her internal state at the time of the session. Dr. Morog adapted the Brief Mood Survey developed by David Burns, M.D. to a 5 scale score on depression, suicide urges, anxiety, anger, violent urges and sleep; it also asks about the girl's IIP and whether she would like to meet with the psychiatrist about her medication. Dr. Morog asks the girl to complete the quick questionnaire before and after each therapy session, allowing her to adjust her intervention to the girls' mood and assess its effectiveness; changes in mood state from session to session are also informative.

Ms. Sargeant's individual therapy session notes showed the thoughtfulness with which a resident was helped to manage complex losses. The 15-year old, who had been at

Lansing less than two months, was depressed and hopeless. [redacted] understanding of them will make success in the community more likely.

The MH Monitor observed Rounds at Lansing; the application of the New York Model was exemplified in the way the girls were discussed and the strong collaboration among the therapist, YC, educational coordinator, psychiatrist, and nurse. Unfortunately, the other therapist, YC and YDAs were unavailable. In an hour, Rounds discussed the six residents having treatment teams during the following week plus a resident with special concerns. Each girl's strengths and current struggles were presented, with clear application to the work each participant was doing with her. Helping girls avoid being influenced by peers and becoming less reactive to triggers were discussed. Specific approaches to validation, cue removal, and self-soothing techniques were recommended. One disturbed girl was described by the therapist: "Her thinking becomes unclear when her emotions surge. She has more internal distress than she shows. We have to support her bringing her emotions down so she can use reason. We have to use de-escalation sooner." The school coordinator responded with a request for the therapist to assist them to de-escalate her in the classroom more effectively. They discussed a Red Flag meeting for another girl who was described as "making great progress in talking about her feelings, but she has to manage, not just be aware of, her feelings." The advantage of having Rounds focus on the upcoming treatment teams results in Dr. French's input being available to the treatment teams (which he does not have the time to attend), but has the disadvantage of inconveniently requiring all the therapists and YCs to participate in Rounds.

The MH Monitor observed a Sanctuary group at Lansing. The YC leading the group acknowledged that groups had seldom been held in recent weeks due to reduced staffing. He led a didactic session about safety, and physical safety and moral safety were the residents' greatest concern. Participation in the group was affected by one resident's outspoken belief that discussing safety was pointless.

The MH Monitor reviewed in individual contact notes documentation of mindfulness practices during the Mind the Music group, which is a favorite of the residents.

Services for girls placed at Lansing, some of whom are returnees, for violating conditions of community placement (the "revocators" or CRPs) have not been revised to fit the New York Model. The Lansing CRP unit is problematic for several reasons: (a) the residents are usually told by aftercare staff that they will leave in 90 days, which undermines the Daily Achievement System that ties graduation to progress; (b) the residents' interest in skill learning is reduced by their assertion that they completed the program already; (c) the residents may get stuck in their anger—at themselves, the "system" and/or their family—for being revocated; and (d) staff report they are volatile, bringing back aggression (and gang issues) from the community. The revocators are discouraging for staff, making them question how much residents changed their behaviors in response to the program and how much due to removal from the cues for undesirable behaviors (in the community). Because facility staff, not just residents, feel disappointed

when a girl returns, unique coaching for those who work with revocators is necessary. Whether the revocators are in a separate CRP Unit or not, to make the New York Model effective with them will require special implementation, including utilizing chain analysis for the reason for their revocation, identifying skills for responding more successfully when they return to the community, and figuring out how to make release contingent on progress rather than a length of stay defined in advance. At Lansing the treatment teams meet with the CRP girls every two weeks, which is an advantage. They hope to reduce revocators' behaviors through a strategic use of a DAS and phase system designed for the CRP unit. Finding other placements for girls who realize they are unlikely to be successful if returned again to the same home will necessitate more efforts by the overextended YCs. Redefining CRP in the New York Model will require the BBHS Support Team collaborating with Lansing staff; doing so if OCFS does not change CRP timeframes will be complicated.

FUTURE MONITORING

When they are available, the MH Monitor will review:

- New policy on Facility Admission and Orientation
- Decision about whether PPM 3443.00 "Resident Rules" will continue to be used or will be integrated into the New York Model

The MH Monitor will observe the consistency of DBT and Sanctuary groups.

The MH Monitor will continue to review the effectiveness of adapting the New York Model to effectively meeting the needs of girls who are revocated.

The MH Monitor will discuss how the effectiveness of interventions will be regularly assessed (46c).

The MH Monitor will observe New York Model coaching and the strengthening of treatment teams and the Daily Achievement System.

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.

There is one policy the MH Monitor is waiting to have finalized to determine full compliance.

State Report on Progress (12/20/11)

1. Review and modify if necessary policies: PPM 2801.00 "Training Requirements for DJJOY 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."

   PPM 2801.00 and the new restraint policy have been implemented as interim at the DOJ facilities. PPM 3243.33 is approved for implementation. PPM 3243.34 is approved for implementation. PPM 3247.60 is pending further revisions.

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

   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.

   Mental health training is being scheduled.

On Site Observations (3/12)

The MH Monitor reviewed the draft policy 3247.60 "Suicide Risk Reduction and Response." "From the point of entry into the DJJOY system when evidence or information arises about the possible suicidal ideation, intent, or behavior of a particular youth, OCFS will respond effectively to maintain the physical safety and emotional well-being of the youth." Two levels of Enhanced Supervision Status are used to maintain the safety of youth who experience suicidal ideation or who exhibit suicidal gestures or attempts. Suicide Watch (SW) requires entries in the unit log describing the youth's mood and attitude every 15 minutes and Personal Safety Watch (PSW) log entries every 30 minutes. In addition to staff training, suicide risk reduction in the physical plant, and mental health screening at admission, within 72 hours of admission every youth is assigned a clinician who assesses suicidal ideation or intent. Clinicians also do a mental health evaluation to determine when

the youth is ready for modification or removal from enhanced supervision status with a safety plan included in the youth's Individual Intervention Plan and communicated to staff. This suicide policy complies with the Settlement Agreement.

No Lansing resident went to a psychiatric hospital in the past six months. Only one Lansing resident at the time of the site visit had been on suicide watch since their admission. She is a 17-year old who was admitted to Lansing on 12/8/11 from the reception facility on suicide watch. Her suicide status was communicated to Lansing the day before her move by a Bureau of Classification and Movement Admission Notice. Because she was on suicide watch, she had a one-on-one staff sitting next to her during her transport to Lansing. The Lansing Admission Screening form on 12/8/11 completed by the nurse indicated that the arriving resident said she did not have suicidal thoughts and "denied any intention of harming herself," but that she came from Reception on Suicide Watch. The nurse completed a Mental Health Services Request on 12/8/11, checking "possible suicidality" and psychotropic (psychiatric) medication review. Attached to the Lansing Admission Screening form was an almost illegible psychiatrist note from Reception (12/7/11) focusing on diagnoses and medication. The Lansing therapists were away at training on 12/8/11, so a Finger Lakes therapist saw the resident at Lansing on 12/9/11 and sent an email to her Lansing therapist that day reporting on her interview with the resident and her conclusion that the resident could be taken off suicide watch. The first Lansing mental health contact note for the girl on 12/12/11 from Ms. Sargeant referenced the Finger Lakes clinician's interview; the resident saw Dr. French with Ms. Sargeant on 12/14/11 and remained off suicide watch. This approach to managing the protection and evaluation of a new suicidal resident demonstrates the timeliness and thoroughness required by the Settlement Agreement.

FUTURE MONITORING

When it is approved and implemented, the MH Monitor will document that the elements of revised PPM 3247.60 "Suicide Risk Reduction and Response" are followed with residents.

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

The MH Monitor will observe coaching of staff on using safety plans to calm youth, de-escalation and chain analysis.

A 2/12 email entitled "Contacting Mental Health Professionals Outside of Regular Work Hours" complies with the Settlement Agreement and indicates that "each of the facilities report having an established procedure in place." A follow-up 3/5/12 memo from the Director of BBHS to the facility directors indicated that Dr. Maria Morog is to be contacted for mental health crises after hours at Lansing.

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 Integrated Assessment format complies with 48a, d, and e.

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

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

The MH Monitor reviewed "The NY Model: Treatment Team Implementation Guidelines" (described below), including the Integrated Assessment and Treatment Plan.

There is one policy to be finalized and one training curriculum to be reviewed for the MH Monitor to determine full compliance, as well as a discussion among treating clinicians regarding consistent diagnostic practices.

State Report on Progress (12/20/11)

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."

   PPM 2801.00 has been implemented as interim at the DOJ facilities. PPM 3243.33 is approved for implementation. PPM 3243.34 is approved for implementation. PPM 3247.60 is pending further revisions and review/approval by unions.

2. Identify assessment instruments.

   Form OCFS-1448 Admission Screening Interview completed October 2011.

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

   Training is being schedule.

   Orientation of Form OCFS-1448 to be scheduled at the facilities.

4. Formalize committee for mental health transfers.

   Completed 6/9/11

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

   Completed 1/4/11.

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

   In progress.

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.

   Protocol in development.

On Site Observations (3/12)

The eleven Lansing girls prescribed psychotropic (psychiatric) medication have the following diagnoses: Anxiety (5), Depression (5), Dysthymia (1), Impulse Control Disorder (1), Anger (1) and Insomnia (4). Cannabis Abuse and/or Alcohol Abuse were prominent in many of the girls' histories.

In December 2011 Lansing clinicians were still using the old Mental Health Assessment format and several reviewed residents did not have a more recent assessment in the new format. One of those was a thorough assessment: the resident is a 16-year old [redacted] who has been at Lansing longer than any other resident (since June, 2011) for selling two hydrocodone tablets to a classmate. She was adjudicated a status offender (PINS) at 13, was charged with assault two years later, and was a PINS again in early 2011. She has a diagnosis of PTSD and abuses alcohol "to forget." [redacted] with different relatives and foster homes; one of her siblings remains in a foster home—she hopes to live with her siblings. Since she has been at Lansing, four home studies with different relatives have not located a placement. An Integrated Treatment Plan done in 2/12 indicated that she stays to herself and ignores provocation from peers and participates in individual therapy but refused to go to Lansing school classes she did not like. Her long-term goal was to be able to move back to her family, which seemed unachievable. Her family's goals for her were to finish school and get a job. The primary treatment goal was "stop periodic school refusal" which was not tied to her long-term goal, her strengths or her trauma-related low self-esteem and hopelessness—it appeared to be the compliance goal of facility staff.

Another Lansing resident is an example of an assessment challenge. At 13, she is the youngest Lansing resident. [redacted] Her first of four psychiatric hospitalizations was at age 9 [redacted]; she was medicated for depression. She had behavior problems in 6th grade. In 7th grade she was adjudicated PINS, went AWOL from a private residential program, was "negative and hostile" at a second program, went AWOL, and was placed with OCFS. Her offense in 2011 was criminal mischief for cutting the cable wires in her Westchester home out of anger at her mother (at age 12). She was placed at Lansing in January 2012 after reportedly leading a group disturbance causing thousands of dollars of damage in another facility. The Reception assessment indicated that she "covers her immaturity by becoming combative and disrespectful." Past assessments were noteworthy for their hostility toward her; for example, an emergency room psychiatrist who evaluated her at age 12 in 3/11, a month before her arrest, described her: "This precocious, extremely impulsive and incredibly entitled and narcissistic preadolescent was brought in after yet another contemptible and exhausting outburst at home, involving her extremely petulant acting out, resulting in wild encounters with her mother placing her small siblings at great risk." That providers of failed treatment for four years remain mystified by her behaviors meant that she arrived at Lansing without an assessment identifying her unmet needs. In six weeks she had knocked over the medical

cart, punched holes and smashed a computer at Lansing which frustrated staff who could not understand her anger. Her clinician was putting together information from the past with her behavior to take a fresh look at diagnosis and interventions.

FUTURE MONITORING

When it is approved and implemented, the MH Monitor will document that the elements of revised PPM 3247.60 "Suicide Risk Reduction and Response" are followed with residents.

The MH Monitor will review:

- Completed OCFS-1448 forms in records.
- Training curriculum for mental health professionals on protocols related to developing uniform working diagnoses
- The MH Monitor will interview trainers and staff who participate in the mental health training and discuss consistency in diagnostic practices with the clinicians.

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

Policy PPM 3243.32 entitled "Psychiatric Medications" addresses the requirements of the Settlement Agreement: prescribing, informed consent, medication administration, clinical monitoring, reporting, and training.

Policy PPM 3243.33 entitled "Behavioral Health Services" responds to the Settlement Agreement by describing treatment that is "child and family-focused, culturally competent, developmentally appropriate, trauma informed, empirically validated and well integrated with other facility and community services."

The MH Monitor reviewed the training curriculum entitled "Introduction to Psychiatric Medicine" which is designed to inform direct care staff at DJJOY facilities about the principals of psychiatric treatment with medicine and the side effects and complications that may occur with psychotropic (psychiatric) medicines required by the Settlement Agreement.

An adolescent psychopharmacology expert reviewed medications at Lansing on March 29, 2012 to assist the MH Monitor with her review of compliance with Paragraph 49 of the Settlement Agreement.

State Report on Progress (12/20/11)

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

   "Approved for implementation."

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

   "Curriculum in development."

On Site Observations (3/12)

The MH Monitor observed documentation of diagnosis, symptoms, dosages, and administration of psychotropic (psychiatric) medication in the individual records at Lansing. The Psychiatrist presented medication and medication changes for each girl in Rounds.

FUTURE MONITORING

An expert review to determine appropriateness of medications for diagnoses and whether correct dosages and standard monitoring of effects are the practice at Lansing will be completed in the future.

50. Staff training on psychiatric 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.

COMPLIANCE

State Report on Progress (12/20/11)

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

   PPM 2801.00 has been implemented as interim at the DOJ facilities. PPM 3243.32 is approved for implementation. PPM 3243.33 is approved for implementation.

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

   "Mental Health training is being scheduled. Psych Meds curriculum in development."

   On Site Observations (3/12)

   During Rounds, the MH Monitor observed the staff discussing medication.

   FUTURE MONITORING

   The MH Monitor will interview staff about the Psychiatric Medication training.

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.

COMPLIANCE

Policy PPM 3243.32 entitled "Psychiatric Medications" and Policy PPM 3243.15 entitled "Refusal of Medical or Dental Care by Youth" cover the requirements of the Settlement Agreement: refusal of medication, health professional counseling and administration of treatment over youth objection.

The curriculum for the one-hour training for nurses entitled "Refusal of Psychiatric Medication" covers the requirements of the Settlement Agreement.

State Report on Progress (12/20/11)

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

   PPM 3243.15 implemented. PPM 3243.32 is approved for implementation.

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

   "Medical staff training on refusal of treatment is completed."

"Psych Meds curriculum in development."

3. Educate youth on refusal of medical protocols.

"Ongoing."

On Site Observations (3/12)

The MH Monitor observed documentation in individual records that Lansing girls had refused psychotropic (psychiatric) medication. The record indicated that one girl with repeated refusals met with the psychiatrist and therapist and explained that the antipsychotic made her sleepy. They discussed with her and her mother that the medication was prescribed for emotional regulation, but if it was not effective, they were considering the possibility that her symptoms indicated ADHD and a stimulant might be substituted. ADHD was not mentioned in her 12/11 diagnosis of Generalized Anxiety Disorder and Dysthymia.

FUTURE MONITORING

The MH Monitor will continue to review documentation of medication refusal.

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

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

State Report on Progress (12/20/11)

1. Modify policy: PPM 3243.32 "Psychiatric Medications"

PPM 3243.32 is approved for implementation.

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

"Informed consent is being obtained by qualified prescribers at all four facilities."

"Psych Meds curriculum in development."

On Site Observations (11/11)

Informed consent forms were in the Lansing records reviewed by the MH Monitor.

In one girl's record, the Lansing psychiatrist had completed a contact form and indicated that "Resident's mother did not want her to continue on Abilify because she had

read that it is not an appropriate drug for adolescents. I called her and explained this was a philosophical, not a medical opinion, and assured her that I would reduce or discontinue the drug as soon as we could help [her daughter] by counseling. She agreed to continue Abilify. [Resident] has been complaining of continued inability to control her anger and continued nightmares."

FUTURE MONITORING

The MH Monitor will continue to review informed 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 with the two treatment team meetings observed by the MH Monitor.

What the MAP referred to as a new policy on Case Management of Juvenile Delinquents Placed in the Custody of OCFS is no longer planned as a policy; instead, New York Model implementation training includes the new integrated assessment, the new treatment plan, and how to utilize both in the new treatment teams. "The NY Model: Treatment Team Implementation Guidelines" meets the requirements of Paragraph 53 of the Settlement Agreement. The BBHS Support Team is revising the treatment plan and integrated assessment to make them fit the New York Model training staff are receiving; for example, the term "treatment" will be replaced. Once the documents are revised, more coaching by the BBHS Support Team with Lansing staff to reduce the variability in treatment plans and improve their skills in writing goals with the young person will occur.

State Report on Progress (12/20/11)

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

The new policy is renamed Case Management of Juvenile Delinquents Placed in the Custody of OCFS. "This policy is drafted but the content is different than originally intended. New tasks will be provided to address the remedial measures in the upcoming revised MAP."

2. Modify treatment plan documents

   Integrated Assessment form completed July 2011.

   Integrated Treatment Plan completed July 2011.

   New York Model Treatment Team Implementation Guidelines completed 10/20/11.

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

   "Instruction and implementation on treatment team processes provided by Bureau of Behavioral Health Services in progress: Lansing completed 10/25/11; Finger Lakes starting 12/6/11; Columbia completed 11/15/11; Taberg to be scheduled."

On Site Observations (3/12)

The MH Monitor observed two treatment teams at Lansing. In one treatment team, the youth's YC convened two therapists, YDA, mentor, teacher, nurse, and recreation specialist. Her mother and aftercare worker were unable to be on videoconference or the phone. She was described as becoming "almost a different child" in her 150-day stay at Lansing. "She has come a long way in dealing with anxiety. She is doing well in DBT group and in school. She caught on to the DAS immediately and it really helped her a lot. She achieved gold everyday this month." Her YC reported progress in identifying services for her return home in May and the support of her mother. She had asked to change therapists, which was discussed without any blaming in the team between the two therapists. When the resident joined the meeting, each team member praised her progress and reminded her how far she had come in trusting them (she responded, "I don't hate you anymore"). She was promoted to Learning Phase and is going on off-campus trips. She is a

16-year old [redacted] whose offense was [redacted] Since 5th grade, although she was bright, she had increasing difficulty with self-control and her identified depression and isolation were not responded to by the school. [redacted]. In the feedback session, it was revealed that referring to trauma is upsetting to her and she had not made progress in therapy in recovering from trauma. The prohibition to reveal family maltreatment may be partly culturally based, but keeping her feelings about what happened to her inside may result in being triggered when she returns home. It is important to do this work while she is at Lansing. Staff commented that the typical four-month stay does not give a girl enough time to develop trusting relationships and invest in trauma treatment. This girl was described as an example of the typical progression from anger for 2-3 months followed by significant progress. Having been there five months, she is a long stay girl who has as a result made a real turnaround.

This girl was cited during the coaching team meeting when the MH Monitor raised the question of the high rate of restraints at Lansing. They objected that counting the number of restraints occurring each week at Lansing was not informative. They said what is most important is not that a restraint occurred, but how it was done: "it must convey to the resident that she is safe. Restraints should not be done as control or in a punitive way. The message from staff is that restraint is to protect you. Staff now release a girl from restraint much more quickly than before." They went on to observe that what would be informative would be to track whether the number of restraints for a girl was decreasing. "These are aggressive kids. They are used to fighting. When they arrive they believe they have to fight to prove themselves to others. Especially in the first two months, they do not respond to de-escalation. We are asking them to change their world view that aggression is a problem-solver. Over time as she becomes more emotionally regulated and more able to solve problems, she does not get restrained any more." The girl in the treatment team above was described as belligerent when she arrived and "staff had to restrain her to keep her safe." She arrived at Lansing on 10/13/11 and had five restraints for aggression in three months (11/10/11 Fight; 12/5/11 Youth/youth assault; 12/15/11 Youth/staff assault; 1/6/12 Youth/staff assault; 1/30/12 Youth/staff assault). Since then, she was not restrained again except for self-harming behavior on 2/4/12.

In the other Lansing treatment team, the youth's YC convened her therapist, YDA, teacher, and nurse. Her mother and aftercare worker were unable to be on videoconference or the phone. The resident was a revocator who arrived at Lansing in 10/11 and went AWOL from a home visit in 12/11 and returned 2/12. Concern was expressed that she had recently become more of a follower and got into a fight the previous week. On the other hand, her therapist said she is more willing to work on emotional regulation. She requested an increase in her medication (Abilify). When the resident joined the team, they did an excellent job telling her what she was doing well at and also asking her about her goals. The positive relationship between her and the staff was evident. She announced that she has "big plans to become a singer." In the feedback session, the BBHS Director of Treatment commended the team for being so strengths-based, and encouraged them to support the girl in making the connection between what happened in the community before she returned and what it will take for her to become a

successful professional singer by "anchoring everything on what's important to her." At the next meeting where the team will include her mother and aftercare worker in planning for her release, they will help her explain what she is learning at Lansing to her mother. Record review revealed that she is a 16-year-old [redacted] whose original offense was Petit Larceny [redacted]. She violated probation, was a PINS, had conflict with [redacted] and did not want to return to live with her family because of his physical abuse, was AWOL from a private facility, and later violated curfew; she was a marijuana user with friends with whom she was truant. The Lansing Integrated Assessment was not completed in detail but noted depression, difficulty controlling anger and insomnia due to nightmares; a previous Lansing assessment had noted short attention span, low frustration tolerance, and losing her temper easily. The Lansing diagnoses were Depressive Disorder, Cannabis Abuse, and Conduct Disorder. Her need was identified as "Develop her emotional regulation skills so she can go home and not return." In her treatment plan, her life goal was "wants to complete CRP, return to her mother, go to the ERP and get a part-time job in a hair salon." Her one treatment goal was "Leadership: Working toward being an effective leader and positive role model on the unit." The treatment plan was inadequate: it did not mention her depression, what did not go well for her in the community or past issues with conflict with her stepfather, truancy and reported gang involvement. How Lansing treatment teams actively engage residents in defining their own goals is crucial because, as this girl's multiple placement history demonstrates, generic services have not been effective. It is essential that each girl's treatment team helps her figure out what has to change for her to end the revolving door and make the most of her strengths so she can be successful.

Learning how to write specific treatment goals based on the needs behind each girl's behavior is the challenge of the new treatment plan. An Integrated Treatment Plan written in 1/12 indicated that another girl's goals are to become a veterinarian and live on her own. Her treatment goals were generic: (1) "learn and practice her skills at interpersonal effectiveness" and (2) "increase her distress tolerance tools." There were no interventions listed to help her meet these goals for YDAs, YC, recreation or school; the only intervention for both goals was for mental health "meet regularly with her therapist to practice interpersonal effectiveness/distress tolerance skills and brainstorm ways these skills can assist her in meeting her goals in life." The treatment plan emphasized the girl's strengths and her relationship with her mother, the treatment goals were more specific than is typical, and were articulated as skills learned in the New York Model. The question this treatment plan raises—to be answered in the improvements being made to the treatment plan form--is whether it is written too much from the perspective of clinicians, rather than in words the girl would use to ask for help from team members (for example, "listening to others and responding without reacting too strongly" or "calming myself down when things are not going the way I want them to"). This kind of wording not only makes it clearer what non-clinical staff and her mother could do to support her, but also is easy to connect to her life goal: to be a successful veterinarian, one has to listen and not judge and be able to cope with the unexpected in animal care. The clinicians discussed the MH Monitor's observation that several of the girls' treatment plans only addressed mental health interventions (things a therapist would do with her). But an integrated treatment plan states needs behind behavior that can be met by all staff differently, many of which will not

be therapy. Figuring out the unmet needs behind their behaviors to make sure each girl is an active player in getting her needs met requires a specific, needs-driven treatment plan explicitly connected to the skill building of the New York Model.

FUTURE MONITORING

The MH Monitor will interview trainers and staff involved in "The NY Model: Treatment Team Implementation Guidelines" training.

The MH Monitor will continue to review treatment plans and observe treatment team meetings

The MH Monitor will discuss with the coaching team the view that the reduction of restraints is a sign of emotional regulation in a resident and how to reinforce it through the treatment team and DAS

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.*

PARTIAL COMPLIANCE

The MH Monitor reviewed the 3-page 1/12/12 OCFS Bureau of Behavioral Health Services plan outline for substance abuse services. Youth going to limited- and non-secure facilities are assessed for chemical dependency at reception (using the SNAP and GAIN-Q). OASAS is developing standards for chemical dependency treatment at OCFS DJJOY facilities with the goal that OASAS will certify OCFS facilities to provide substance abuse services. At Taberg, Columbia, Finger Lakes, and Lansing, OCFS has or will hire a clinician to provide individual chemical dependency treatment and group treatment using a curriculum that relies on DBT and Sanctuary.

The MH Monitor reviewed the curriculum for the DBT for Substance Abuse training—including Structuring the Treatment Environment, Dialectical Abstinence in DBT-SUD, Chain Analysis and Task Analysis in DBT-SUD, and Working with Families in DBT-SUD--which DJJOY used to train 3 staff from Taberg, 3 staff from Columbia, 4 staff from Lansing and 4 staff from Finger Lakes in February, 2012 to meet the requirement for substance abuse treatment in the Settlement Agreement.

The 1/12 plan outline and the DBT and Substance Abuse training demonstrate progress in complying with the Settlement Agreement. Neither provide a clear explanation for all staff of how substance abuse fits into delinquent behavior and will be treated in the New York Model while youth live in a drug-free environment but will return to peer and family substance abuse. Like the process of becoming trauma-responsive, learning to meet the needs behind substance abuse is important for all staff, not just clinicians. This understanding must come out of the training so it can be coached in daily practice. Furthermore, it is crucial that treatment teams support youth confidence that they will be

able to continue to use the skills learned in the facility when they return to the community so substance use does not contribute to re-offending.

The MH Monitor is concerned that the DBT for Substance Abuse training was provided without connection to the New York Model. Substance Abuse services should be integrated into New York Model training by the BBHS Support Team providing coaching on New York Model implementation.

The MH Monitor is waiting to review OASAS standards for chemical dependency treatment at Taberg, Columbia, Finger Lakes, and Lansing, OASAS certification of the facilities to provide substance abuse services, and details of the individual chemical dependency treatment and group treatment using the New York Model by OCFS clinicians at the facilities.

The section of PPM 3243.33 entitled "Substance abuse interventions and treatment" does not address the connection between the NY Model and such treatment, including the applicability of DBT and Sanctuary skills.

State Report on Progress (12/20/11)

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

   "Based in part on comments made by the DOJ Monitors, OCFS is reconsidering the manner in which we will meet this remedial measure, which may not involve collaboration with OASAS."

2. Modify PPM 3243.33 "Behavioral Health Services"

   "Approved for implementation."

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

   New policy renamed Case Management of Juvenile Delinquents Placed in the Custody of OCFS. "This policy is drafted but the content is different than originally intended. New tasks will be provided to address the remedial measures in the upcoming revised MAP. Substance abuse services are incorporated in the integrated treatment team process"

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

   "Instruction and implementation on treatment team processes provided by Bureau of Behavioral Health Services in progress: Lansing completed 10/25/11; Finger Lakes starting 12/6/11; Columbia completed 11/15/11; Taberg to be scheduled."

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

   "Based in part on comments made by the DOJ Monitors, OCFS is reconsidering the manner in which we will meet this remedial measure."

On Site Observations (3/12)

Substance abuse, particularly daily marijuana use, is a widespread, often trauma-related problem among youth that is influential in delinquent behavior. Most of the girls at Lansing have significant substance abuse histories.

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, including OASAS certification of the facilities to provide substance abuse services.
- Revision of PPM 3243.33 addressing the connection between the NY Model and such treatment.
- Presentation of chemical dependency treatment in the New York Model utilizing DBT and Sanctuary and in the context of the new integrated assessment, treatment plan and treatment team process.

The MH Monitor will observe substance abuse treatment being provided to residents and their substance abuse being addressed in treatment plans, treatment teams and through coaching of staff in the New York Model.

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.*

PARTIAL COMPLIANCE

The MH Monitor reviewed the curriculum for the one-hour training for nurses entitled "Psychiatric Medications at the Time of Release" and it explains the policy required by the Settlement Agreement: release plans for youth with a 30 days dose of psychotropic (psychiatric) medication, an appointment with a community-based mental health program, and the involvement of the parent and CMSO case manager.

The MH Monitor reviewed the Transition Plan screens from the OCFS Juvenile Justice Information System dated February 2012. These indicated that iLinc Training scheduled in 2 1/2 hour blocks would be offered several times per week between 3/8/12 and 4/25/12. The 2-page computerized Transition Plan form has ten sections: (1) identifying information, including family, CMSO (aftercare), community service provider, attorney, other important adults, supportive peer resource; (2) housing (where the youth will live and plan if housing must be found before re-entry; (3) health insurance information; (4) educational/vocational program planned and additional steps to arrange

for it; (5) adult permanency/alternative release resource; (6) continuing support services and additional steps to arrange for them; (7) important documents still required; (8) workforce support and employment services; (9) pregnant/parenting youth (if applicable); and (10) youth's safety plan.

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

State Report on Progress (12/20/11)

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

   "Approved for implementation."

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

   New policy renamed Case Management of Juvenile Delinquents Placed in the Custody of OCFS. "This policy is drafted but the content is different than originally intended. New tasks will be provided to address the remedial measures in the upcoming revised MAP."

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

   "Transition planning for youth with mental health needs has been implemented using the Continuity of Care plan, which incorporates the components of this remedial measure."

On Site Observations (3/12)

At Lansing, an important part of planning for transition to the community after the YC and Community Case Manager arrange the services discussed by the treatment team, is a videoconference with the community case manager, community providers and parent. The MH Monitor reviewed a summary of such a videoconference written by the community case manager as a contact note in one youth's record in the information system. "Health, mental health including family treatment, employment and a support group" were described to the youth. Her YC agreed to discuss with her Lansing teachers how to arrange for her to take her final exams if she is released before then."

The MH Monitor requested a copy of a Continuity of Care plan for a Lansing girl recently released to the community. It was completed prior to her release at the end of January 2012. The form used was the "Mental Health Continuity of Care Plan." It simply indicated that the girl had been referred to a child and adolescent outpatient program in Manhattan miles from her Bronx home (instructions for the subway transferring to a bus were included); her mother had talked with her Lansing therapist and indicated distance would not be an obstacle to getting mental health care. The Continuity of Care plan did not make a connection with her Lansing treatment plan, the girl's career goal or her progress at Lansing. Nor was there continuity information for her family and school about how they could support her interpersonal effectiveness and distress tolerance skills. Lacking these connections, how could the gains she made at Lansing be continued in the community?

The new Transition Plan screens comply in part with the Settlement Agreement by including information about all aspects of the youth's community transition. However, if a purpose of the transition plan is to be a single reference point for each person involved (youth, family, OCFS staff, service providers) then it should include the telephone number and address of each person/service. Second, substance abuse recovery support services are not specifically listed. Third, the training for the plan indicated that the last section is to identify if a youth is in immediate danger of serious harm, but for all youth, their Sanctuary safety plan could be written on the transition plan as a reminder of what the youth learned to do to calm herself (to be used in the community). Fourth, a transition plan should define how a resident's treatment plan and gains in the facility will continue in the community: if, for example, one of a youth's goals in the facility was "Learn how to manage frustration," then in the last treatment team meeting before re-entry, important supporters in the community would have been present or on tele/video conference so they understood their role in helping the youth tolerate frustration in the community. Finally, the OCFS Mental Health/Psychiatric Medication Continuity of Care Plan contained the details of medications and the name and telephone of outpatient provider and dates of scheduled appointments, and these are missing from the new Transition Plan screens.

The MH Monitor has not yet reviewed actual transition plans that included all elements of a youth's successful re-entry to the community.

FUTURE MONITORING

When they are available, the MH Monitor will review transition plans in records.

The MH Monitor will interview staff who were trained on the new Transition Plan through iLinc training.

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

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

[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.

COMMENT: A determination of compliance or non-compliance is not made at this time. This visit did not generate many concerns about Paragraph 56.

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:

PARTIAL COMPLIANCE

COMMENT: The LRC monitoring visit concluded with a meeting with David Bach, the new head of Quality Assurance (QA). The discussion of QA issues was beneficial, and the hope is that the development of QA measures will be a collaborative process between Bach and his staff and the Monitors.

At the facility level, there were no indications of a QA presence through a set of QA guidelines, specific data collections, or routine inspections of operations. The new policy on quality assurance is still pending; therefore, the program itself is also pending. See page 21 of the December 2011 "6-Month Progress Report." The QA unit is responsible for monitoring the reportable incidents that require DOJ notification per the Settlement Agreement, for providing support to the DOJ facilities to prepare for monitoring visits, for performing oversight of OCFS facilities' usage of the Performance-based Standards System (PbS), and for developing a QA instrument to measure compliance with the remedial measures.

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

COMMENT: Two QA issues arose from the visit. First, the YDA staffing concerns continue to affect Protection from Harm paragraph compliance negatively. Second, the difficulties associated with a prompt and appropriate corrective response to staff misconduct associated with the Settlement Agreement continue.

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.

COMMENT: Home Office committed to expanding quality assurance development to address these and other issues related to compliance. Discussions between the Monitors and Home Office staff resulted in a decision by DJJOY to meet this summer to review quality assurance mechanisms and compliance issues. This commitment and the formalization that accompanies quality assurance mechanisms supply a reasonable assurance that the resolution of these issues has priority status. QA and Home Office agreed to work collaboratively with the Monitors in the development of quality assurance mechanisms. The review of these quality assurance products and the status of the resolution of the aforementioned issues will be critical parts of future monitoring.

V. SUMMARY

Lansing continues to be a stable facility that leads in implementation of some aspects of the New York Model. Staffing levels and the delay in coaching for the New York

Model are significant challenges. Several factors affected the Monitors' ability to render a complete assessment of Lansing's effectiveness. The resolution of these problems, as outlined in Paragraph 57 and other locations within the report, will permit an assessment of the level of compliance in six months.

Appendix A

List of Documents Reviewed for Lansing Residential Center

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. Current rated capacity (including the capacity breakdowns by living units) and current census by facility and living unit.
5. A current organizational chart of each facility, including the names, gender, and titles of all employees, including supervisors, mid-managers, and upper level managers.
6. Total staffing for the mental health program(s) according to program, and specifying the job category or discipline, including all contract personnel.
7. Facility reviews including, monitoring reports, accreditation reports, audit reports, and other reports prepared for or by facility management or external entities since August 1, 2010.
   A. Fire Safety Reports – Annual, Semi-Annual, Monthly (consistent with statutory inspection intervals by the state or local fire marshal).
   B. All existing Facility Director's reports to DJJOY executive staff regarding an accurate and complete account of incidents involving the use of physical restraint as entered into the Automated Restraint Tracking System (ARTS).
8. List of all youth on any level or type of personal safety watch, specifying the date, length of time, and precipitating cause since August 31, 2011.
9. Incident reports or youth grievances regarding use of force, injury, and sexual misconduct since August 31, 2011.
10. 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 31, 2011.
11. List of all youth seen by medical following a physical restraint incident since August 31, 2011.
12. 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.

13. Use of force reports since August 31, 2011, including a list of youth who were restrained, specifying the date, precipitating cause, and method of restraint (i.e., physical, mechanical, chemical).

14. List of all youth who received a psychiatric, substance abuse, or other mental health intervention, including diagnosis and date and type of treatment.

15. List of youth taking psychotropic medication, identifying the medication, dosage, and the condition it is treating.

16. 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.

17. 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.

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

19. 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.

20. Civil complaints or criminal charging documents alleging professional misconduct against staff or facility administrators, and the results of those complaints or charges.

21. Reports of investigations involving allegations of abuse, neglect, or mistreatment.

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

23. List of employees who have not satisfactorily completed CPM training and who are not authorized to perform a physical restraint.

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

25. Youths' institutional records.

26. 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.

27. Any list or log of youth grievances indicating the type, date, and outcome of each grievance.

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

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

30. Any digital video surveillance camera recordings of specific incidents, especially

those prepared for the Facility Director's review of physical restraint as defined by PPM 3247.17.

31. Any manual and electronic housing unit logs.

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

33. State of New York Child Health Care Standards.

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

Appendix B

List of OCFS Staff Who Contributed Information

David L. Bach, QA 1 Director
Sharon Bell, YDA III, Lansing Residential Center
Sandra Carrk, Project Manager
Dixie Deacon, Associate Deputy Counsel
Ron Farley, YC1
Kathy Fitzgerald, BBHS – Social Work Supervisor
Linda Gaydushec, LRC Education Supervisor
Ellen Holland, YDA 3
Tony Hough, Associate Commissioner
Shaun Lang
Annette Larrier-Fulcher, Facility Director
Edgardo Lopez, S. A. Coordinator
Linda R. Lowe, YDA III, LRC YDA
Jennifer Mack, Assistant Director
Kendall McAdams, Teacher II, LRC
Donna Moon, BOT
Maria Morog, Licensed Psychologist
Ines M. Nieves, Associate Commissioner
Robert Paoletti Jr., YCI
Denise Passarello, QAU
Theresa Peck, Regional Nurse Administrator
Robert Russell, Teacher IV, LRC
Constance Sargent, Psychologist II
Beverly Sowersby, Facility Coordinator
Joseph Tomassone, Chief Tx Suc.
Kate Wilks, Teacher IV, LRC
Dave Williams, YDA
Robert Woods, General Mechanic

Appendix C

Restraint Log Data and Rates of Physical Restraints and Youth Injury

The best available rates of restraint events and injuries to youth for the four selected months preceding the monitoring visit include April and October 2011, the months of the PbS data collection, and January and February 2012, the two months preceding the monitoring visit. The inclusion of April 2011 data is important because the Settlement Agreement monitoring began in Lansing on June 21-23, 2011, in part because Home Office believed Lansing was the named facility the farthest along in its development of the new restraint practices.

Rates convert the incident frequencies to occurrences per youth per 100 bed days. The use of rates allows better intra- and inter-facility comparisons, especially when resident populations differ. All of the data are from the Restraint Log maintained in CSU. Until there is resolution to the Home Office data concerns, the CSU Restraint Log remains the most reliable source of information about restraints. Comparisons of the number of restraints in the CSU Restraint Log with the Monthly Summaries from the infirmary regarding post-restraint examinations yields a 96% agreement for the months cited above. The 96% agreement does not account for possible refusals by youth to participate in a post-restraint examination nor does it indicate if the youth was in multiple restraints for one post restraint evaluation. Therefore, the 96% agreement means that there are now two reliable sources of information regarding physical restraint activity.

Table 1. Restraint and Injury Rates for the April and October 2011 and January and February 2012

Rates	April 2011	October 2011	January 2012	February 2012
All Restraint Events	1.25	5.00	3.96	7.32
Escorts/Standing	0.42	2.71	1.88	2.64
Seated/Supine	0.83	2.29	2.08	4.67
Youth Injury	0.21	1.04	0.42	1.22

Notes:

1. "All Restraint Events" includes every restraint entry in the Restraint Log. The rates. These data do not show reductions in the use of restraints that can be described as systemic. A quality assurance (QA) challenge will be the establishment of a system to assess and then lower the rate of physical restraints.
2. "Escorts" includes single and team standing restraints and escorts as identified in the Restraint Log. The same assessment applies here.

3. "Seated/Supine" includes all restraint activities where a youth is placed on the floor. This category is the total Escorts and standing restraints subtracted from All Restraint Events. The same assessment applies here.
4. "Youth Injury" is an injury associated with a physical restraint. The rates of youth injuries parallel the rates of physical restraints. This is an expected relationship since the more staff are required to engage aggressive or out-of-control youth physically, the greater the likelihood of injury. However, the ratio of injuries to restraints remains low. CPM appears to be a safer strategy for youth. Now the challenge is how to reduce the number of restraints so as to enhance resident safety.

Staff injury associated with a restraint as entered in the Restraint Log is an estimate based on supervisor or staff judgment, so the assessment of staff injury is tentative until there is greater reliance on the incident data supplied by Home Office. With that in mind, the April data reflect zero staff injuries, but the October and January numbers (4 staff injuries each month) show an increase, which supports the observations by staff that CPM has resulted in more staff injuries then the previous system. However, it is the February rate (a doubling of the October and January numbers to 8 staff injuries) that is the issue.