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

Facility Monitoring Report:
Finger Lakes Residential Center
Lansing, NY

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INDIVIDUAL FACILITY MONITORING REPORT:

FINGER LAKES RESIDENTIAL CENTER

Lansing, NY

I. INTRODUCTION

This is the sixth 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 visit to the Finger Lakes Residential Center (Finger Lakes or FLRC) on March 27-29, 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

Finger Lakes is a 109-bed limited secure facility with 10 units in one building that also contains the school and gym.

On March 26, 2012 there were 51 boys at Finger Lakes on four generic units (revocators/CRPs are all on units). The 51 boys ranged in age from 14 to 18, with an average age of 16 (14-7; 15-16; 16-19; 17-7; 18-2). They had been at Finger Lakes from 1 day to 259 days (16 had been there for about a month or less, 19 for one to about three months, and 11 for five months or more). The 51 boys were committed for: Robbery (12), Assault (7), Stolen Property (5), Weapon Possession (4), Grand Larceny (3), Criminal Mischief (3), Menacing (3), Petit Larceny (3), Burglary (2), Obstructing Government (2), Forced Sexual Touching (1), Stolen Car (1), Reckless Endangerment (1), Possession Marijuana (1) and Criminal Contempt (1).

Eleven of the 51 boys at Finger Lakes are prescribed psychiatric medication. Their diagnoses are Mood Disorder, ADHD, Oppositional Defiant Disorder, and Insomnia. They are prescribed the following psychiatric medications: Risperdal (5), Concerta (4), Seroquel (2), and Strattera (1). Additionally, ten boys are prescribed Benadryl and one Melatonin for insomnia.

During the past several months, the Finger Lakes leadership team has worked hard to stabilize the facility. The Director and Assistant Director for Treatment are permanent, and additional clinicians and Youth Development Assistants (YDAs) were hired. YDA

interviews continue every week. Fewer staff were out on worker compensation and overtime was reduced. The facility population was held at four units to allow most of the staff to be trained in the New York Model. Reconstruction of the units to allow the juncture between two units to house clinicians and Youth Counselors (YCs) (for continuity of relationships with residents) and to move the school classrooms for incentive areas such as a comfort room and for an EBP room is progressing. During the NY Model implementation sessions, staff were encouraged to participate in decision-making about how the new program would unfold. A newly decorated Welcome Unit with fresh paintings on the walls looked welcoming and will provide a structured 2-week introduction to the program, with a lot of DBT and Sanctuary groups, completion of the youth's IIP, and getting a youth ready for a unit assignment. It was anticipated that soon after the site visit, the regularly meeting representative committee would finalize the Daily Achievement System (DAS) and Phase System. The expectation is that the population of the facility will expand: Units 7 and 8 will open, and all six units will be limited to 10 youth each.

There was positive feedback on the NY Model training at Finger Lakes. Staff feel involved and morale and communication have reportedly improved. As a result of the NY Model implementation sessions, there was a commitment to revise the approach to Rounds and to emphasize treatment teams, and videoconferencing equipment was added to the large conference room.

The leadership team was excited about their progress: "We actually know what we're doing. We know where we're going and how to get there." The Monitors cautioned the leadership team not to move too quickly to fill up the facility so they could have the opportunity to get the DAS, Phase System and Welcome Unit stabilized without the stressors of an influx of residents.

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 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 have worked with Home Office on the delineation of reliable data that will support compliance determinations, and the final issues were resolved during the FLRC visit. 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 27, 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: Brenda Aulbach, Facility Director; Sandra Carrk, Settlement Agreement Project Manager; Diane Deacon, Assistant Deputy Counsel; Kathy Fitzgerald, Social Work Supervisor; Scot Lamphier, Acting Facility Assistant Director; Edgardo Lopez, Settlement Agreement Coordinator; Ines Nieves, Associate Commissioner; Lou Renzi, Senior Attorney; Charles Snowberger Jr., Education Director; Beverly Sowersby, Facility Coordinator; Scott Steelman, Assistant Director for Treatment Services; and Dr. Joseph Tomassone, 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. The renovation of the Junction Office areas continues. The construction appears to be near completion; and even though there were no reported incidents regarding youth access to contraband or construction materials, the situation continues to require close supervision by staff when youth are in the area.

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 two treatment team meetings, Rounds, a DBT group, Sanctuary education group, met with the clinicians, met with two other groups of staff and visited the clinic. The MH Monitor reviewed ten residents' records (from the four units).

6. Staff Interviews

The Monitors interviewed 30 staff members. In addition to group meetings with staff, the MH Monitor interviewed a YC, a therapist, the substance abuse counselor, and the Physician Assistant individually. PH Monitor's interviews included five Youth Development Assistants (YDA), one Facility Director, one Assistant Facility Director, one Administrator on Duty (AOD), four nurses, one Physician's Assistant, and 14 YCs.

7. Resident Interviews

Twelve residents participated in interviews with the Monitors. The MH Monitor interviewed six (6) residents individually (from the four units). The PH Monitor interviewed six (6) youth with an average age of 15.7 years old. The names of the six youth interviewed by the PH Monitor came from a list of restraints provided by Home Office. The purpose of the interviews was to ask questions of youth about the restraint process. All had been physically restrained within the past four (4) months. 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 FLRC and OCFS staff. The Monitors then highlighted areas of importance and concern, but not findings. The exit meeting was a time for questions, clarifications, and explanations of events and impressions before the draft report goes to both Parties. Those in attendance included: Brenda Aulbach, Facility Director; Jason Allen, YC1; David Bach, Quality Assurance Director; Jessica Badman, YC1; Sara Bergene, YC1; William Bryant, SW; Sandra Carrk, Settlement Agreement Project Manager; Kimberly Carter, Psychologist II; Jason Cobb, YC2; Diane Deacon, Assistant Deputy Counsel; Kathy Fitzgerald, Bureau of Behavioral Health Services (BBHS) Social Work Supervisor; Tony Hough, Associate Commissioner; Scot Lamphier, Acting Facility Assistant Director; Rebecca Levin, Licensed Psychologist; Edgardo Lopez, Settlement Agreement Coordinator; Donna Moon, Human Services Training Specialist; Tracy Myers, Secretary; Ines Nieves, Associate Commissioner; Haya Novak, Psychologist II; Denise Passarello, Quality Assurance Specialist; John Paz, YC1 SL; Kristin Pisani, LMSW II; Melinda Rivera, BBHS, Support Staff; Mike Seguin, Psychologist II; Gary Skinner, Physician Assistant; Charles Snowberger Jr, Education Director; Beverly Sowersby, Facility Coordinator; Scott Steelman, Assistant Director for Treatment Services; Dr. Joseph Tomassone, BBHS Chief Treatment Services; Rod White, YC2; and Jeffrey Wurst, YC1. Also present by phone: Jim Barron, Director, Labor Relations; Merle Brandwene, Director, Management and Program Support; John Canino, Senior Attorney; Gladys Carrion, Commissioner; Myra DeLuke, Quality Assurance Specialist; Felipe Franco, Acting Deputy Commissioner for the Division of Juvenile Justice and Opportunities for Youth (DJJOY); Larry Gravett, Director, Special Investigations Unit; Pam Kelly, Director, Bureau of Training; Lee Prochera, Deputy Counsel; and Jenne Utting, Quality Assurance Specialist.

C. Preface to Protection from Harm and Mental Health Findings

"We still have a long way to go" is a phrase used by many FLRC staff when describing the changes that have occurred recently. Even considering the accuracy of staff's cautionary phrase, several factors show improvement. The presence of problems that need to be resolved before attaining compliance with various Settlement Agreement paragraphs and the continued uncertainty about facility closures do not overshadow the positive changes that warrant discussion at the beginning of the report. First, there is a noticeable improvement in the perceptions of safety, which translates to a somewhat more calm and stable institutional climate. The New York Model is making sense to more staff who view its concepts and principles as "old school" reliance upon healthy relationships

between youth and staff. Second, resident safety has improved based on direct feedback from youth and staff. The partial and anecdotal descriptions of rates of injuries to youth remain low despite inadequate data. Third, the resident population has remained at a low level (the population at the time of this monitoring visit was approximately 64% of capacity), which has had a positive effect on staff adequacy. Fourth, there has been substantial 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. Fifth, staff show an improved understanding of Crisis Prevention Management (CPM) restraint system and ways to make the techniques better for staff and youth. These factors are important and provide support for continued program development.

One potential problem also deserves a comment at the outset. Youth and staff report a gang problem. The presence of gang activities in a juvenile correctional facility predicts increases in levels of violence and uses of force. Despite the firsthand accounts of youth and staff, there is not presently enough empirical evidence of such gang activity, but this may be more a factor of data quality rather than a comment on gang activities. The consensus among the youth who participated in interviews was that at least half of the fights at FLRC were gang-related.

Gangs are often linked to increased problems with contraband. Because gangs tend to control certain commodities as a means of power and influence, contraband becomes more important; and gang involved youth will work harder to get contraband into the facility. During an interview with one of the gang leaders, he claimed that he has access to smokeless tobacco, marijuana, and other drugs. While unsubstantiated, these are serious allegations and are sufficient enough to warrant a review of security practices and a careful response from quality assurance. There is a greater sense of urgency about contraband and its possible use and distribution by gangs in light of the recent incident where a youth, who had been transferred to FLRC from another facility, smuggled in contraband.

The MH Monitor studied ten Finger Lakes residents from the four units, including file review, assessment, IIP, mental health contact notes, psychiatrist notes, restraint history, treatment plan and interview (in most cases). The review showed the diversity of residents served by Finger Lakes, age 14-18 with different ethnicities from all over the state with a range in severity of offense. These Finger Lakes boys are complicated, with lengthy trauma histories and multiple past residential placements. The study also revealed varied approaches to assessment, treatment planning, and services depending on YC and clinician.

Findings about trauma history: All ten of the youth studied had trauma histories. Eight of the youth experienced loss of a parent as a result of incarceration or parent abandonment after divorce. Exposure to domestic violence was noted in half of the youth, and two experienced severe conflict with a stepparent. Physical abuse was indicated for two youth and sexual abuse for one. For three, close relatives had died. One youth was stabbed and another had a severe head injury in childhood. Two had difficulty with acculturation.

Findings about placement history: All 10 youth had prior placements; two had only one prior residential placement. Most had multiple placements, with at least three having had psychiatric hospitalizations.

Findings about assessment at Finger Lakes: Some of the ten youth's assessments were on the old form (Mental Health Assessment) and more than half on the New York Model form (Integrated Assessment). Most assessments were completed within a week of arrival, which is impressive because the assessments done at Ella McQueen Reception Center, the previous OCFS facility for many of the youth, are uninformative, so most of the Finger Lakes assessment work is original. Trauma history is usually listed. However, the assessments seldom conclude with the trauma-related needs to be addressed while the youth is in OCFS custody. The Finger Lakes substance abuse assessment in the Integrated Assessment is usually excellent. The Finger Lakes school assessment is typically superficial, despite the frequency of learning problems in the population. The listed needs on the Integrated Assessment are usually services instead needs.

Findings about treatment plans at Finger Lakes: Some of the ten youth's treatment plans were on the old form (Mental Health Treatment Plan) and some on the New York Model form (Integrated Treatment Plan). Sometime previous diagnoses are documented, but often new diagnostic formulation is given without referencing past diagnoses. Most have generic treatment goals, not individualized or specific. Most are not written using words a young person could understand. Often the youth's behavior problems in the community are not connected to interventions in the facility.

II. PROTECTION FROM HARM MONITORING

A. Use of Restraints

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

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

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

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

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

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

PARTIAL COMPLIANCE

COMMENT: The Crisis Prevention and Management (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 FLRC 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 an incremental reduction in the rates of restraints? Home Office has been responsive to these questions, and OCFS is reviewing the restraint procedures.

In the absence of mutually agreed upon quality assurance mechanisms, outcome measures, and quantitative data, compliance decisions default to the judgment of the Monitors. Currently, use of restraints 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 assumption is that restraints under the new system will be limited only to exceptional circumstances set forth in the Settlement Agreement, but 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, taking into account the range of variables associated with juvenile institutions, the rates of restraints should go down as staff become proficient with CPM and the New York model; and we noted a decrease in the February and March data. Following this line of thought, one compliance question would be whether the rates of restraints are decreasing. However, to evaluate this question, 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 the six months preceding the monitoring visit. The data, along with the PH Monitor's review, discussed more below, do not yet support a finding of compliance based on a sustained reduction in the total rates of restraints and the rates of the most restrictive uses of force, even prior to consideration of restraints not limited to exceptional circumstances. The intent of the PH Monitor is to use restraint data as one measure of

compliance, but there was no agreement about the utility of the Home Office data at the time of the site visit. While this data concern has been recently resolved, the data were not available for the Finger Lakes assessment.

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, and the absence of audio to accompany the video in the Restraint Packets is problematic. Below is a review of multiple restraint incidents that raise several questions about the minimum amount of force necessary.

Concerns about the minimum amount of physical control and time in restraints necessary to stabilize the youth will become increasingly more important as compliance determinants as the implementation of the New York Model continues. The emphasis on de-escalation strategies in CPM is compatible with New York Model assumptions that program involvement leads to greater emotional regulation by youth and a quicker return to stability following an emotional outburst. Therefore, the efficacy of these strategies predicts a reduced amount of physical control and less time to stabilize a youth. In this regard, several current factors argue against compliance with the intent of the paragraph. These include the need to review and analyze the lengths of time and amounts of physical control in Restraint Packets 316680, 292487, and the packet with no discernible number.

Finally, direct care staff members once again raise the issues of size and strength as factors in the effective use of CPM. A male YDA indicated that size "makes a big advantage" in the application of the techniques, and a female YDA added that "strength is the issue and men are preferred" for physical restraints. These OCFS staff-initiated concerns simultaneously bring into question the issue of staffing adequacy, for one commonly accepted way of mitigating the size and strength issue is through the presence of additional staff members.

Home Office notes and CPM training provides that the supine technique should be performed by three (3) staff, rather than two (2) staff in the old prone technique, which would allow for a better management of potential injuries to staff and youth. The CPM curriculum states (Module 13), Single Person Standing Restraint, Escort and the Seated Restraint, page 1, 3rd paragraph:

> If the youth is larger or stronger than you and you believe there is a possibility of injury to you or the youth, do not attempt these single person techniques. However, you cannot abdicate and just stand back from a situation. You must call for assistance and try to help as much as possible. Use all available resources to obtain additional help. (Refer to Crisis Prevention and Management Policy #3247.12).

Furthermore, Module 14, Team Restraint and Escort, page 1, 5th bullet:

> All staff must be aware of their own physical size, strength and height compared to that of the youth with whom they work. This is important if staff are going to be effective in restraining out-of-control residents, particularly if you are concerned about your ability to restrain a youth with minimal risk of injury to yourself and the youth. It is policy to call for assistance in every restraint situation.

These policy and training materials, while helpful in establishing an acknowledgment by OCFS of size and strength issues relating to the effective use of CPM, raise other questions that are not addressed. The Monitors will work with Quality Assurance to identify these issues.

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.

PARTIAL 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 IIP. Interviews with YDA 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. There also seemed to be fewer restraint restrictions at FLRC. Despite staff awareness, two incidents regarding these restrictions indicate that there are some additional issues that need to be resolved. The expectation is that future monitoring will reveal a consistent level of compliance with restrictions on physical restraints.

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.

PARTIAL 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. The formal 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 his side if the application of handcuffs is necessary. The responses indicated a clear understanding of the concerns about facedown restraints as expressed in the Settlement Agreement paragraph. The staff-perceived prohibition on facedown or prone restraints is consistent with the CPM strategy, but evidence still exists of the recent uses of facedown or prone restraint techniques at FLRC.

When asked if they had ever been in a prone or facedown restraint, two (2) of the six (6) youth indicated that they had been in a prone restraint. The same two youth were the only ones who answered "yes" to the question, "Do staff ever try to hurt youth during physical restraints?"

Staff responses from across all named facilities, including Finger Lakes, 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 another compliance assessment question: Does YDA staff adherence to OCFS policy emanating from a Settlement Agreement paragraph affect compliance decisions about the paragraph? The issue warrants greater discussion and clarification within the context of Quality Assurance. The current finding uses the Settlement Agreement language.

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 psychiatric medication for restraint purposes. Resident and staff interviews and direct observations provided no evidence of the use of 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. In addition, there have been multiple training programs for staff. However, the STARS system revealed several gaps in CPM refresher training and first aid. These appear to be temporary, and the expectation is that these training expectations will be fulfilled by the next monitoring visit.

The focus group with Youth Counselors raised questions about new staff and how "adequately trained" they are. Youth Counselors attributed the January increases in youth misbehaviors and physical restraints to the large number of new and inexperienced staff that did not fully understand how to work with the FLRC youth or how to implement CPM and the New York Model. The group identified a need for an additional or special training intervention to accelerate the learning curve for these employees. In addition, they recommended an expanded coaching strategy, and they suggested that the coaches be drawn from the ranks of talented veteran staff who should receive specialized training and coaching skills through BOT.

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.

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. Again, an indicator of the least amount of force necessary is perception of safety. The likelihood of getting injured or being hurt in a restraint contributes to levels of fear, which are counter-indicators of safety.

Youth Safety

Youth rated safety highly. For example, when asked to evaluate their own safety on a scale of 1 to 10 with 10 being the safest, their average response was 8.33. When asked what would have to happen to create an even safer environment, youth were very

responsive. In most instances, the threat to safety was identified as other youth as opposed to problems with staff. Again, only two youth were critical of staff behaviors.

The youth confirmed observations by staff about the presence and influence of youth gangs. The consensus among youth was that 50% of the fights at FLRC are gang related.

Most youth talked favorably about YDA staff indicating that there was someone on their unit that they could talk to in times of problems and crisis and could go to when they need advice and guidance. Healthy and positive relationships with staff can increase the effectiveness of de-escalation and reduce the amount of force necessary in physical restraints.

Staff 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. The numbers of staff injuries per month between October and March are 10, 12, 14, 15, 11, and 4, respectively. Since January, staff injuries have shown some reduction. This is a positive indicator, and sustained reductions in the rates of incidence of staff injury would support compliance.

FLRC staff injuries from physical restraints are a concern for two reasons. First, serious injuries to staff during physical restraints seem to escalate the levels of fear among YDA staff. Fear and apprehension erodes confidence, which increases the likelihood of a problematic execution of the CPM techniques. Currently, YDA staff indicate that staff injuries are too high. Second, injured staff are frequently not fully able to perform their job duties, 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 an erosion of staffing adequacy, which is one of several factors that has 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. Anecdotal evidence from within OCFS supports 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 fluctuations in staff injury represent quality assurance 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 training-related mandations.

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 examples where the narrative does not reflect the behaviors on the videos. This is where the administrative review (see 42e) becomes important because it provides an opportunity for coaching, which can improve the documentation skills of staff. Additionally, this is the first review of Restraint Packets at FLRC following the implementation of CPM training, and there is insufficient time, data, and documentation to establish a pattern of adequate and prompt documentation that supports full compliance. The review of this paragraph requires more time and information.

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. Evaluation of the senior management review system requires additional assessment. The mechanisms by which senior management receive and review targeted restraint information appears dependent upon the Facility Administrator review in Paragraph 42e. Until there is sufficient confidence in the quality of information that moves up the system from the Facility Administrator review, it is difficult to find this paragraph in full compliance.

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 encountered with the Lansing monitoring report also applied to Finger Lakes. OCFS does not uniformly keep VRF forms in the Restraint Packets. For example, of the seven (7) Restraint Packets reviewed for this report, four (4) did not contain a VRF to verify the requirements of Paragraph 42e, one contained a VRF that was not informative, and the remaining two (2) packet contained VRFs that were excellent. Home Office will provide VRF forms in all Restraint Packets provided to the PH Monitor in the future.

The physical size and strength of some FLRC residents present challenges for staff regarding the effective and appropriate use of the CPM restraints. While this is a problem with most physical restraint strategies, the inability of certain staff members to implement

effectively the CPM restraint techniques cannot be overlooked. In situations where a staff member has repeated difficulty implementing the CPM techniques or in situations where a staff member repeatedly holds back or delays the implementation of the CPM technique, there needs to be a plan developed through documented instruction or otherwise to assess the efficacy of CPM restraint implementation. (See pages 8-9 above regarding the CPM policy and training materials addressing these issues.) The intent of Paragraph 42e is to identify both staff and systemic 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. For example:

1. Restraint Packet 308892: The Restraint Packet does not contain a VRF. The video showed the youth in the dayroom area with eight (8) staff focusing on his behavior, which was described as a refusal to go into his room at bedtime. At no time did the youth's appear to be a physical or imminent threat to himself or others. During the restraint, which was a two-person escort, there were at least 10 staff members in the area. Administration explained that presence of multiple staff was a result of the incident occurring during shift change. When the restraint moved into the youth's room, there was no video evidence but there appeared to be a lot of movement. Situations where restraints occur outside the view of cameras (for example, in bedrooms and bathrooms where privacy issues exclude fixed camera installations) increase the rationale for the use of hand-held cameras.

2. Restraint Packet 273584: There is no VRF. Following a two (2) person seated restraint, two staff stood the youth up and moved him backwards to medical. The video does not match the documentation. There must have been a mix-up in the assignment of the video to this particular Restraint Packet because the documentation does not contain a description of a two-person supine restraint and makes no references to the movement of the youth to medical. However, the video does show an example of appropriate implementations of CPM techniques.

3. Restraint Packet 269683: There is a VRF in the packet, and it is very well done regarding the physical restraint. It first makes note that the video is consistent with the documentation. There is a request for documented instruction. The request results from one male staff member's inability to get sufficient control of the youth so as to move him into a seated restraint. Instead, the staff member struggles with the youth and ends up moving him into a prone position on the floor in order to gain control. Additionally, two (2) female staff are assisting, and they cannot control the youth. Finally, the male staff member moves the youth to a seated position. At that point another male staff member supplies some assistance. The youth begins head butting the lead male staff member. At 07:23 minutes into the restraint, the youth is in a four (4) person supine restraint with seven (7) other staff members in the area observing the restraint.

At one point midway through the restraint, other youth on the living unit noticed that staff were preoccupied with the physical restraint, and multiple youth moved into the classroom area and attempted to barricade the door shut. From a different camera angle, two youth are seen walking to the staff desk and taking things off the desk during the first

part of the restraint. Contraband access is the concern, which is aggravated by the allegation of gang activity.

4. Restraint Packet 281487: There is no VRF in the packet. The video appears to show the youth's head hitting the doorframe on two (2) occasions. The first time is when the staff member is trying to gain control with a single person standing restraint, and the second time is when the staff member moves the youth to the floor in a two-person seated restraint.

The absence of audit audio makes it difficult to know what staff are saying and how to gauge the level of threat in the youth's verbal behaviors. For example, this restraint begins after staff break up a scuffle between two (2) youth. What evolves is a situation where it seems as if the youth's threat to the safety of the other youth is over, but his struggle is now a response to the staff intervention as opposed to the fight. The restraint moves to a five (5) person supine restraint. Midway through the restraint, there are approximately nine (9) staff members involved. Again, the VRF could be the vehicle to raise important questions about the best use of CPM in conjunction with the concepts and principles of the New York Model. To insulate against drifting toward a practice where maximum force is the first versus the last resort, it is important that administration consistently and critically analyzes uses of force and looks for effective ways to circumvent or minimize it.

5. Restraint Packet (the number is not readable due to the quality of the copy): No VRF was in the Restraint Packet provided to the PH Monitor. The restraint appeared to be unusual based on the PH Monitor's understanding of CPM techniques and their application. While it is difficult to tell from the video what particular restraint technique the male YDA staff member used to initiate the restraint, the force with which it was applied knocked the youth off his feet and both the youth and the YDA fell to the floor.

6. Restraint Packet 292487: Administration identified this Restraint Packet as an example of a well-executed restraint. There is some disagreement based on the length of the restraint. The VRF indicates no significant issues; however, the youth is large and apparently very strong and as many as four (4) male staff struggle to get the youth into a seated restraint and then into a supine restraint.

7. Restraint Packet 316680: The information in this restraint packet raised multiple concerns. The analysis of the restraint relates to the concerns expressed earlier regarding Paragraph 42e and the way that the Facility Administrator Review influences the senior management review and improved training and supervision.

From the Restraint Packet, the Facility Administrator Review of Physical Restraint form states that the physical restraint lasted 33 minutes. Discussions with youth and staff indicate that physical restraints routinely last approximately 8-9 minutes. Using youth and staff perspectives as an informal criterion, a 33-minute restraint would appear to be substantially beyond what should be expected. All issues that are substantially outside these expectations should automatically prompt some sort of special review, especially if the anomaly is the length of time a youth and staff are actively engaged is a physical restraint.

A Video Review Form exists dated April 30, 2012 for a March 29, 2012 incident. The evidence suggested that the incident was significant: A protracted physical restraint resulted in a health emergency where the youth was transferred to the hospital. Regarding the designation of significant issues, "none" was the response on the VRF. The administrator indicated that no additional action was required, which raises the question of how an incident that prompts notification to DOJ under Paragraph 73 does not warrant identification on the VRF as significant issues?

The Use of Physical Restraints Staff Briefing Report should be instructive, but the poor quality of the duplication prevents an accurate reading of the contents. The Restraint Monitor Report is also a very poor quality reproduction and difficult to decipher. One readable comment appears to be a note that the youth's complaints of pain were continuous throughout the restraint, even though there was continuous checking to make sure that positions, techniques, and the amount of force were minimal. This raises the possibility that staffs' assessments may have been inaccurate. In a significant incident where staff believe their assessments are correct but where is evidence to the contrary, everyone benefits from an institutional and agency wide openness to critical inquiry and examination of existing practices. The Protection from Harm implications are the same here as in #4 above: Problem situations affecting the safety of youth, even those incidents that do not cause SIU involvement, should initiate careful, interdisciplinary investigations to identify all of the important and correctable elements of the incident in an attempt to improve institutional practices, particularly youth and staff safety, and to prevent future problems. This inquiry should not rule out the need for a reevaluation of the technique, a redesign of the training, or a rewriting of the policy, procedure, and training materials.

The video was not viewable by the PH Monitors due to state imposed regulations regarding the confidentiality of official documents not handed directly to the Monitors. Conveying official documents through non-secured methods such as the U.S. Postal Service, overnight delivery services, and e-mail necessitates a password-protected encryption of the documents. Despite the exceptional efforts by Home Office to resolve the numerous problems associated with these encryptions, this issue continues to impede the ability to review certain important elements of the Protection from Harm paragraphs. These comments are intended as a request for some alternative and appropriate means of transferring confidential information. The present arrangement requires improvement.

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 could be better utilized based on the Restraint Packet reviews from this visit and the supplemental documentation provided by Home Office. Full compliance would mean the routine presence of the VRF with careful comments and recommendations regarding ways to improve physical restraints, report documentation quality, 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 must 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 Calming 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.

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."

COMPLIANCE

COMMENT: Home Office issued a memo rescinding the Finger Lakes "push the pin" directive and included the revocation of the push-the-pin instructions in the policy and procedure regarding physical restraint (PPM 3247.12). Interviews with staff and youth confirm the elimination of a push-the-pin practice

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 3247.13), 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 identify 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. The content includes a review of policy related to the Settlement Agreement or OCFS operations. 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 the reporting process. Verification of this paragraph requires information about appropriate referrals for investigation. Information collected from the nursing staff (discussed below) indicates that they freely report instances of suspected abuse without fear of retaliation. This monitoring visit did not include an extensive review of other referrals, which will be a part of the next monitoring visit.

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.

COMPLIANCE PENDING

COMMENT: Paragraph 44.b. is a function of departments external to FLRC. 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 he can then more easily provide confidential information regarding the use of force incident, allegations of excessive use of force, and injury complaints. The PH monitor requested and received monthly medical summaries of the clinic's activities. The infirmary program continues to be well run.

Interviews with the infirmary staff included four nurses and the Physician's Assistant. All have completed post-restraint examinations, and all have filed child abuse or maltreatment reports with SCR. All nurses described a standard way of doing the post-restraint exam, and the process was demonstrated to show how the youth's confidentiality is safeguarded. Additionally, all nurses described the process for initiating a restriction on restraints and how the restriction is communicated to staff.

In the discussion about conducting an assessment during a restraint, all nurses appeared knowledgeable of proper procedures. When discussing the restraint of youth on restrictions, the nurses indicated that it did not happen very often; but in a case a couple of months ago when a youth was on supine restraint restriction and was restrained in a supine position, a call was made to Child Protective Services (CPS) based on the use of and inappropriate use of force. CPS did not accept the referral and did not assign a case number.

A medical related problem occurred with the restraint of a youth during the monitoring visit (see the review of Restraint Packet 316680 above). Following the restraint, the youth was taken to a local hospital where emergency medical staff diagnosed the condition as "vasovagal syncope," i. e., he hyperventilated and fainted. This occurred at the end of a protracted restraint; and even though the infirmary took immediate preventive actions, questions arise about when medical staff should be summoned to the situation. Due to the seriousness over this incident, there is a need to look at the CPM policy regarding role of medical personnel in assessing a protracted restraint.

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.*

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 governing prompt and appropriate corrective measures. Three (3) general classifications of outcomes inform 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, or 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.

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.

COMPLIANCE PENDING

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: Protective Hold; single escort and single standing restraint; team escort and team standing restraint; seated restraint (generally due to some restriction or qualification or condition in the IIP); supine restraint; and 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 issue 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.

PENDING REVIEW

COMMENT: The monitoring visit did not address staff supervision. This will be a focus of future monitoring.

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 for developing uniform working diagnoses for mental health professionals). The MH Monitor cannot fully 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 Finger Lakes.

Mental health staff at Finger Lakes 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 Finger Lakes.

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 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 all-day training (when it includes Psychiatric Medication training) may be too much information to digest.

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. The New York Model has been described extensively in prior monitoring reports and will not be summarized in this report. Achieving trauma-responsive, strengths-based, relationship-driven, and culturally competent teamwork to meet residents' needs is challenging with the Finger Lakes population.

Reviewing the contact notes in 10 residents' records revealed that YCs consistently provide at least once weekly individual counseling, but therapists range from less than once a week individual therapy to several sessions per week. In addition to groups, the substance abuse counselor also had individual sessions with some residents. Some contact notes provide a detailed glimpse of treatment, such as:

- One resident had twice weekly 60 minute individual therapy sessions focused on trauma: hurt, loneliness, relationships, expression of feelings, numbness, having to defend himself in rough neighborhoods since a young age, being torn between anger at his stepfather and guilt for his aggressive behavior; the therapist provided support for avoiding problems on the unit.

- One resident's therapist noted his behavior problems due to anxiety and frustration about not going home (his mother is just out of prison) and his residential treatment facility placement taking so long. His individual counseling with his YC focused on personal boundaries, horseplaying, and walking away from a provocative peer but later getting into a fight.

The MH Monitor observed Rounds at Finger Lakes convened by the YC to discuss six residents on one unit. The history and IIP of a new resident, who is a revocator helped to give all the staff working with him crucial background for their interventions. Another resident making improvements was identified as needing a language disorder evaluation and a medical referral, and his work with the substance abuse counselor was highlighted. The Assistant Director for Treatment praised the staff for their work with another resident who was "very disturbed and has come a long way;" he is excited about his discharge to a residential program, and staff agreed on combined efforts to prevent other residents from sabotaging his discharge. Another resident with an upcoming release date got into an altercation and has a hold date: staff discussed his ambivalence about returning to the community and were reminded that he is one of younger residents in the facility and his immaturity impacts his behavior. Another resident's regression because he feels hopeless since his mother does not want him to return and he does not have a release plan was described as "putting up a wall;" staff discussed how to help him cope with his two best friends leaving soon. The success of a resident's reduced aggression despite gang pressure and how to help him increase school attendance were considered. Thoughtful discussion of each resident and the strong collaboration among staff at Rounds exemplified the New York Model. The struggle for staff, especially if they want to get through all 10 residents on a unit in one hour Rounds, is how to review each youth's behavior during a week with enough—but not too much—history or detail. In the debrief, participants were reminded that treatment team is for more in-depth discussion of a youth, and for a new resident or a resident having a particularly difficult time, a Red Flag meeting (if a treatment team is not scheduled soon) can be convened.

The MH Monitor particularly enjoyed a DBT group at Finger Lakes. The group began with a mindfulness discussion. Then one resident who had been encouraged by his therapist to write a DBT Rap performed it accompanied by another resident. All 12 residents on the unit, YDAs, YCs and clinicians enjoyed his performance and gave him a lot of recognition. The resident was delighted by the possibility of recording his rap for the benefit of future DBT groups.

The MH Monitor observed a Sanctuary group at Finger Lakes that demonstrated creativity by the leaders. Because of illness on one unit, the group was quickly rescheduled to another unit. Then the DVD player did not work, so the planned activity for the meeting had to be changed. The leaders of the group led two successful games to learn SELF, one of which resulted in a meaningful discussion of losses. In the debrief after the group, the leaders described SELF as a useful way to check in about emotions with residents as they return to the unit from school and treatment team.

The contact notes indicate irregular group sessions at Finger Lakes. Almost all of the ten studied residents consistently attended two substance abuse groups a month.

However, in the previous month, two residents had attended weekly DBT groups, three residents had attended two DBT groups, and the remaining residents had no indication of attending DBT groups in their records. There was no indication the ten residents had participated in Sanctuary groups the previous month.

The MH Monitor requested a meeting with staff to discuss gang problems at Finger Lakes and how responding to them fits with the New York Model and also affects residents' gang involvement when they return to the community. They are planning to use the Daily Achievement System to prevent gang presence and conflict on the units. They recognized that residents' cliques give them identity from their home community to meet their need to belong, and they hope to develop a real sense of membership on each unit. They lamented that a month prior to the site visit, one unit had that strong sense of community and they had a series of restraint-free days. But a new group of residents were placed on the unit and "upset the stability." They want to generate unit pride so when a new resident arrives, he hears from other residents, "On this unit we go to school, we don't fight, and we get recognized for our achievements." Staff went on to say, "We have to make it safe and stable on the unit. That's been hard with so many new staff. We have to prove to the kids that we can keep them safe." Ultimately they hope this approach will help residents see the risks of gang involvement in the community and how to avoid them, especially if they are returning to the same neighborhood. The MH Monitor recommends that this work at Finger Lakes addressing the residents' need to belong be incorporated into the New York Model, with some real-life examples of their success.

Finger Lakes is dispersing the revocators to different units instead of having a single CRP unit. To make the New York Model effective with them may include 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. Their effectiveness in including the returnees—who may be angry about being revocated and may bring back gang issues from the community—on all units will be helpful for other facilities to learn from.

In a coaching team discussion at another DOJ facility, it was proposed that treatment progress might be measured by a decrease in the number of restraints for a resident over time. It was hypothesized that as they become more emotionally regulated and develop problem-solving skills, residents will rely less on aggression. The ten youth studied at Finger Lakes revealed a range of restraint histories, from one youth who had no restraints from admission in 10/11 to 3/31/12 and another who had 14 restraints during the same timeframe. One other youth had no restraints and another had one restraint since arrival. One resident had 3 restraints in his first month at Finger Lakes and none since. Another resident had 2 restraints more than 2 months after his arrival at Finger Lakes and none subsequently. One resident was restrained once/weekly the first three weeks in placement, once/weekly the second month in placement, but after nine restraints had not been restrained for a month, then had one seated restraint in 3/12. Another resident had been at Finger Lakes a month and was restrained 8 times. Another resident was restrained 6 times in his first month at Finger Lakes, 8 times in his second month, and 6 times in his third month. Another resident was restrained twice in November 2011, 3 times in

December 2011, once in January 2012, twice in February 2012, and once in March 2012. This small group suggests some interesting patterns in restraints that would be worthwhile discussing further in the context of New York Model coaching.

A key to implementation of the New York Model is a strong coaching team to ensure that it becomes a way of thinking by staff and youth, rather than simply a clinical service. The Finger Lakes clinicians met with the MH Monitor to discuss their role as coaches of the New York Model. The said they prefer the Integrated Assessment and Treatment Plan because both encourage collaboration. They want to "keep the momentum going of getting everyone working together." Their biggest obstacle to full implementation of the Integrated Assessment, Treatment Plan, Rounds, Treatment Teams and the DAS are logistical problems of scheduling and insufficient staff: "We're always behind with treatment teams, and that will get worse as the numbers increase." They want stable units and stable teams for coaching the New York Model, but there has been too much turmoil at the facility for either. One clinician complained, "There are so many new staff I don't even know all the YDAs." They also observed that because shift assignments are based on seniority, new YDAs are concentrated on the less desirable shifts and do not get sufficient mentoring. They are frustrated that YDAs do not participate in DBT and Sanctuary groups. They are coaching staff not to write the treatment plan before the treatment team meeting so the young person's goals discussed at the team meeting can drive treatment planning. Another challenge is translating the deficit focus of past assessments into a strengths-based approach to working with each resident. They are also frustrated that the CMSO (aftercare) staff are not trained in the New York Model, have difficulty contributing to assessments because they do not know the youth or family, and may not read the Integrated Assessment online before joining a treatment team in videoconference. Home Office indicated that CMSO staff are being trained in the New York Model and consideration is being given to providing coaching to them as well.

During the site visit, Finger Lakes was working on defining Daily Achievement System reinforcers. One of the behaviors being addressed is the problem of poor school attendance at Finger Lakes. It is unknown whether Finger Lakes plans to use a similar description of the DAS written for residents at Taberg, which was excellent. The DAS is another New York Model component that meets the requirements of the Settlement Agreement.

The MH Monitor observed IIPs (Individual Intervention Plans) consistently in the Finger Lakes records. 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.

Other challenges for New York Model implementation at Finger Lakes include:

- The New York Model is designed for a fully staffed facility. The Finger Lakes psychiatrist only works 10 hours/week, which is insufficient to see the residents prescribed medication with their therapists and participate in Rounds and treatment teams. An additional substance abuse counselor appears necessary for the facility. As the number of residents increases, there may not be sufficient clinicians to keep

caseloads low enough for therapy, groups, treatment teams, Rounds, and coaching.

- The MH Monitor remains concerned that Finger Lakes staff require considerable New York Model implementation coaching from the BBHS Support Team. 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 at Finger Lakes.

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 New York Model coaching and the strengthening of treatment teams and Rounds, and the Daily Achievement System.

The MH Monitor will review contact notes regarding the consistency of counseling and individual therapy.

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 residents who are revocated.

The MH Monitor will continue the discussion of decrease of restraints as an indication of treatment success.

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

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 Finger Lakes 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" which was described in detail in previous monitoring reports. The suicide policy complies with the Settlement Agreement.

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 the Finger Lakes Assistant Director for Treatment is to be contacted for mental health crises after hours.

The MH Monitor observed exemplary practice in the facility's response to a suicidal youth during the site visit. The resident is a [redacted] 16-year old who arrived at Finger Lakes a month before with a Criminal Mischief offense [redacted] He experienced physical abuse [redacted] He had a history of Autism Spectrum Disorder and cruelty to animals. At age 4, he started special education; at age 12, his tested IQ was 78 with severe memory and processing deficits that meant he had difficulty with auditory information and multi-step directions. He lived with his mother and siblings [redacted] where he was placed in a group home at age 12 and then a year in a psychiatric facility. In 2010, he was placed with his father in upstate NY and had a series of residential placements, where he was described as aggressive, depressed, and uncooperative, and having auditory hallucinations. At Finger Lakes he was diagnosed with ADHD and prescribed Melatonin for sleep. In his first individual therapy session at Finger Lakes, his IIP was developed and he discussed his continued placement for five years and parent-child issues. In individual time with his YC, he talked about not wanting to live with his [redacted] and not caring that his [redacted] did not want him to live with her. He refused all further therapy or YC counseling. During his first 1½ weeks at Finger Lakes the psychiatrist tried to see him three times, which he refused, although in the third contact he asked for sleep medication. He started refusing to eat or drink, a Red Flag meeting was held and staff were alerted to the importance of monitoring his fluid intake; his plan was to do nothing but stay in his room and read until discharge. He was taken to the hospital after burning his scalp with a hair product; he returned and was kept on the medical unit where he could get individual attention and he gained six pounds. He was returned to the unit, still refusing psychiatric, therapy or counseling assistance. During the site visit, the MH Monitor observed thoughtful, collaborative handling of his suicidality after he was sent to the hospital for allegedly drinking a hair product (he acknowledged he pretended to have done so in order to get an opportunity to escape). The Assistant Director for Treatment was in close communication with the hospital and sought to get him admitted to a psychiatric hospital, which was declined by the Emergency Room. The facility immediately initiated a transfer to a MHU in a facility in upstate near his father. The Monitors were briefed each day on his status, and before he returned to the facility a treatment team was convened with the Assistant Director of Treatment and Physician Assistant collaborating effectively. Meanwhile he returned to the medical unit on Suicide Watch. The MH Monitor observed not only the careful written notes for the watch, but that the psychiatrist, therapist and YC visited him several times daily on medical and the Assistant Director for Treatment and Physician Assistant remained actively involved. Although this was a youth who all involved believed required a psychiatric facility, the teamwork and careful attention to meeting the resident's needs exemplified excellent suicide response.

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.

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 Integrated Assessment in the New York Model complies with 48a, d, and e.

Mental health staff at Finger Lakes 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" including the Integrated Assessment and Treatment Plan which complies with the Settlement Agreement.

There is one policy to be finalized and one training curriculum to be reviewed, as well as a discussion among clinicians regarding consistent diagnostic practices for the MH Monitor to determine full 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 3243.33 "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 12 Finger Lakes residents prescribed psychiatric medication have the following diagnoses: Mood Disorder (12), ADHD (3), Oppositional Defiant Disorder (1) and Insomnia (6). Cannabis Abuse and/or Alcohol Abuse were prominent in many of the residents' histories.

Finger Lakes is gradually transitioning to Integrated Assessments on all youth shortly after they arrive. The biggest assessment challenge is to identify specific needs (not services), including trauma-related needs.

For example, the clinical treatment needs section of the Integrated Assessment for one of the ten residents studied was a generic service list, not needs:

Need	Anticipated Provider
Remedial Education + Pre-GED	Education Dept + Aftercare
Anger management + MH counseling	YC / MH clinician
DBT social skills + Mentoring	Unit DBT + YDAs
S/A Assessment + Counseling	S/A specialist + Aftercare

The Integrated Assessment diagnosis of Conduct Disorder was inconclusive, especially given behavior change associated with early head injury, previous treatment of ADHD, and the Finger Lakes psychiatrist's diagnosis of Oppositional Defiant Disorder. Furthermore, borderline intellect was noted by history, but his functioning "appeared to be average;" neither current testing was offered as evidence nor were learning disabilities suggested by an earlier low IQ test addressed.

One resident's Integrated Assessment reported that he had been modified "after repeated incidents of aggression, for which he apparently took no responsibility and states he was the victim." There is no trauma history, despite his family being immigrants, the challenges of acculturation, the ethnicity-related mistreatment he describes, his parents' separation, and his regrets that he has disappointed his parents who have high educational aspirations for him. The substance abuse assessment is thorough. The school assessment ignores the indication of an undiagnosed learning disability in his record. The recreation section indicates his enjoyment of sports, and refers to negative peer influence without considering possible explanations for it. The spiritual section reports he is [redacted], but not whether he is the only [redacted] in the program and how that might affect peer relationships and aggression.

Another resident's Integrated Assessment had a full listing of his trauma history, including that he had been in outpatient counseling since age 9 and had been referred to substance abuse counseling. His strengths were: his mother loves him and is committed to him; he is verbal; he avoids negative behavior on the unit. His IIP called for staff to de-

escalate him with time away, gentle humor and one-to-one validation. His Sanctuary Safety Plan was journal, read, and exercise. His diagnosis was Conduct Disorder, Cannabis and Alcohol Abuse, R/O ADHD, R/O Depressive Disorder. The needs listed were actually clinical services: Individual therapy; Family therapy; Psychiatric follow-up; Speech evaluation; and Substance abuse treatment.

For a resident who arrived at Finger Lakes in August 2011, the assessment was on the old format, but was more thorough than some Integrated Assessments. It indicated he "has extreme deficits in all skill areas (emotional regulation, distress tolerance, problem-solving, and interpersonal effectiveness). It is important to remember that he is only 13 years old." In addition to attention and impulse problems, "it is likely he has cognitive problems" with a WASI in the borderline range, but he was not cooperative with a full evaluation. The assessment recommended therapy to talk about his losses in the past year and educational testing with an IEP.

The BBHS Support Team is revising the Integrated Assessment to fit the New York Model. For example, it might be preferable not to use the term "Clinical Treatment Needs" in the Integrated Assessment. In addition, consideration should be given to summarizing past assessment findings in the Integrated Assessment instead of just referencing them since some staff may not review them. Furthermore, when a new diagnostic formulation is given, past diagnoses should be referenced. Part of the BBHS Support Team coaching for Finger Lakes staff hopefully will focus on the specificity and trauma-related needs listed in the Integrated Assessment.

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

The MH Monitor will 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 psychiatric medicines required by the Settlement Agreement.

An adolescent psychopharmacology expert reviewed medications at Finger Lakes on March 28, 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 psychiatric medication.

   "Curriculum in development."

On Site Observations (3/12)

The MH Monitor observed documentation of diagnosis, symptoms, dosages, and administration of psychiatric medication in the individual records at Finger Lakes. The Finger Lakes one-page Psychiatrist Contact Forms were not as informative as those at other DOJ facilities: for several of the ten youth studied, the psychiatrist saw them once/month but for months checked no symptoms and indicated no lab results.

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 Finger Lakes will be forthcoming.

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 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 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 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 residents' individual records that they had refused psychiatric medication.

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 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 Finger Lakes records reviewed by the MH Monitor.

For example, contact notes indicated that one resident listed as having a Mood Disorder diagnosis was seen by the psychiatrist on 2/8/12 and 3/5/12 and "seemed to be calmed down by medication." On 3/23/12 the psychiatrist saw him again, and he was described as irritable, restless, showing poor concentration, disruptive and socially inappropriate. Consent had already been given for Seroquel; the psychiatrist requested consent to prescribe Concerta and also increased Seroquel.

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

Staff at Finger Lakes 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 to make it fit the New York Model, and the term "treatment" will be replaced. Once the document is revised, more coaching by the BBHS Support Team will be provided for Finger Lakes staff to improve their skills in writing goals with the young person and to strengthen treatment team meetings.

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)

Some of the ten youth studied at Finger Lakes had treatment plans on the old form and some on the New York Model Integrated Treatment Plan. Most have generic goals of complying with the program, most are not written using words a young person could understand and most do not connect behavior problems in the community to interventions in the facility. Learning how to write specific treatment goals based on the needs behind each resident's behavior is the challenge of the new treatment plan.

For example, the goals in one resident's Integrated Treatment Plan (3/12) were:

1. Adaptive Coping Skills/Problem Solving Skills
2. Decrease Aggression and Assaultiveness

These goals do not reflect the youth's needs. The words used are jargon: "Problem Solving" (and "Distress Tolerance" and "Emotional Regulation" in other plans) might have no meaning to a youth soon after arriving in the program. The plan criticizes him for not taking the program, his behavior, and his safety plan seriously, but does not question what else staff could do to engage him effectively.

A youth with a Depressive Disorder had two goals that were a starting point for addressing his grief and related behaviors, although his third goal was program compliance:

1. Demonstrate a brighter, fuller affect and a decrease in depressive feelings
   - Express worries and frustrations contributing to depression
   - DBT groups-distress tolerance, mindfulness, self-soothing
   - Activities to lift depressive feelings
2. Refrain from acting out behavior in facility and community
   - Identify feelings and stressors preceding acting out and what can deter it
   - Distress tolerance skills
3. Comply with psychiatric care

His Finger Lakes substance abuse assessment indicated that he recognized marijuana caused problems in his life—schoolwork and school absence--and that his goal was to maintain sobriety in the community, but this was not reflected in his treatment plan.

The MH Monitor observed two treatment teams at Finger Lakes. One treatment team was the 15-year old youth's 150 day meeting, with a new treatment plan. His mother, stepfather and aftercare worker were on videoconference from upstate; a psychologist

from the regional office participated in the meeting at Finger Lakes. Team members informed his family and aftercare worker about his progress in therapy, school, his job, and with other residents. When he arrived in the meeting, he greeted his mother, did not acknowledge his stepfather and his YC prompted him to greet his aftercare worker. The team gave him positive feedback about his progress, including the nurse who told him that she would be glad to provide information to further his goal of becoming a nurse. He had been working on managing his anxiety, and the meeting demonstrated how staff help him because it was very frustrating that his aftercare worker told him his April release date is set "as long as the community school approves his enrollment." Initially he said, "It's not working" (meaning the efforts to get him released) and looked dejected and his aftercare worker said, "Keep your head up, kid." A team member said to the aftercare worker that the resident wanted information as soon as the aftercare worker had it. The resident asked quietly, "When is the meeting with the school?" and his YC repeated the question to his aftercare worker. Team members followed up by requesting that he go to the school meeting. The YC skillfully brought the meeting to a positive close by asking the youth, "What's your strength?" He answered, "Honesty." His mother said, "You are much more honest on the phone now." His YC said, "We will continue to have honesty in open communication like at this meeting." The treatment team meeting was an example of some New York Model principles. But neither the meeting nor his treatment plan goals addressed lack of supervision at home, an "enmeshed" relationship with his mother described in his history, and serious conflict with his stepfather which were major contributors to his behavior problems and would affect transition home.

The second treatment team was the 30-day meeting for a 15-year old whose mother and aftercare worker were on the telephone (and Spanish translation was provided for his mother by a Finger Lakes staff person). The team described his adjustment to the program. When he arrived, his therapist said their purpose was for staff to talk with him about how they could help him. His vocational teacher's feedback was especially positive, telling him that he does so well in class he wanted to recruit him to do OJT in the shop with him. The resident was pleased and his participation in the meeting increased. Another teacher asked him, "What is your goal?" and he surprised everyone by saying, "I want a Bachelor's degree so I can help kids. I want to go to a regular high school, not an alternative school." He responded to his substance abuse counselor's support of his goal to stay off drugs, "I'm worried I'll get in an argument with my Mom or get a bad grade and fall back into using." His YC offered family counseling with his mother and stepfather at Finger Lakes and he agreed. His mother said how glad she is that he is doing so well. His aftercare worker also became more positive about how he could help. The team evolved from his original plan of "going home" and "getting a job" to a plan in his words: "Get a Bachelor's degree to help kids" and "Stay away from drugs even when I'm upset with Mom or get a bad grade." The treatment team was pleased with the outcome of the meeting and his plan for himself. Stated in the words he used to ask for help from team members, his integrated treatment plan reveals needs behind behavior that can be met by all staff and is explicitly connected to the skill building of the New York Model.

FUTURE MONITORING

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

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 1/12 OCFS Bureau of Behavioral Health Services plan outline for substance abuse services. 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 and group chemical dependency treatment using a curriculum that relies on DBT and Sanctuary.

The MH Monitor reviewed the curriculum for the DBT for Substance Abuse training that 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 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, and comes from training and coaching 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 chemical dependency 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)

The substance abuse counselor at Finger Lakes has the most substantial treatment program of the four DOJ facilities, which is integrated into the rest of the program and exemplifies substance abuse treatment as part of the New York Model. Finger Lakes has created a new office for the substance abuse counselor, which will provide group meeting and private individual counseling space. She hopes to develop specialized substance abuse groups that cut across units so that youth with addiction, children of substance abusers and community-bound youth doing relapse prevention can have their own groups. She participated in the DBT and Substance Abuse training and described six DBT skills she has introduced into substance abuse groups—she is pleased how helpful they are for residents. She is developing a new brief substance abuse assessment for clinicians to do as part of the Integrated Assessment. She hopes to provide individual relapse prevention skill-building with every youth who wants it. Given the number of Finger Lakes youth with substance

abuse problems, one substance abuse counselor is not enough. At this point, this substance abuse counselor can only see a resident in group once a week because she barely has time to offer five groups a week plus individual sessions and attending Rounds and treatment teams.

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, transition plans 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 day dose of 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 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)

One of the 10 studied Finger Lakes residents was scheduled to be released a week after the site visit. He is a 16-year old first offender from the Bronx diagnosed with Mood Disorder and prescribed Risperdal. His Mental Health Continuity of Care Plan was a referral to a mental health program in the Bronx (for psychiatry and therapy) and outpatient substance abuse treatment in the Bronx. The Continuity of Care plan did not make a connection with his Finger Lakes treatment plan, particularly his distress tolerance, mindfulness and self-soothing skills and greater understanding of stressors associated with acting out. Without these connections, it is less likely his gains at Finger Lakes will continue in the community. In addition, he is a teen father who wants to provide for his child, and parenting support might be a necessary deterrent to delinquency.

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 the transition plan is a single reference point for each person involved (youth, family, OCFS staff, service providers), 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 himself (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. Finally,

the OCFS Mental Health/Psychiatric Medication Continuity of Care Plan contained the details of about 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 requirement that staff do both the Transition Plan and the Continuity of Care plan (which contains more detailed contact information for youth with continuing mental health needs) seems inconsistent with the New York Model concept of integrated assessment and integrated treatment. A single Integrated Continuity of Care plan—driven by the young person's needs--would ensure that all individuals involved with him/her have a shared understanding of the support each of them can provide to meet them.

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

FUTURE MONITORING

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

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.

PENDING REVIEW

COMMENT: A compliance determination is not made at this time. This visit did not generate 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:

[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.

COMPLIANCE PENDING

COMMENT: The FLRC monitoring visit included some additional interaction with David Bach, the new head of quality assurance. 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.

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 quality assurance 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

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.

See discussion above.

V. SUMMARY

The Finger Lakes monitoring visit follows intense training and program development efforts involving CPM and the New York Model. After periods of transition and instability, staff have worked hard to improve safety and treatment at Finger Lakes. The current goal appears to be to establish continuity and stability to allow the continued and full development of the New York Model.

Preliminary safety data from March are encouraging. The reductions in restraints and injuries are positive indicators. One explanation of the increase in problem behaviors and physical restraints during January 2012 was the inexperience among YDA staff. Others blamed the transfer of "some of the better youth" (in order to keep the population at a low level). The March data might indicate that inexperienced staff are becoming more skillful and that more youth have improved behaviors.

If there is a plan to increase the population at Finger Lakes, OCFS should consider how an increase in the number of youth may alter the progress indicated by the March numbers. There are implications for safety and treatment if the population increases quickly. The Monitors recommend that Finger Lakes increase intake slowly to give the

facility the opportunity to stabilize new unit teams, get the DAS and phase systems operating, have consistent DBT, Sanctuary and Substance Abuse groups, mentor new staff, and get coaching in treatment teams and treatment plans with youth.

Appendix A

List of Documents Reviewed for Finger Lakes 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

Brenda Aulbach, Facility Director

Jason Allen, YC1

David Bach, Quality Assurance Director

Jessica Badman, YC1

Sheryl Benedict, RN

Sara Bergene, YC1

William Bryant, SW

Sandra Carrk, Settlement Agreement Project Manager

Kimberly Carter, Psychologist II

Jason Cobb, YC2

Lerue Culmer, YC1

Diane Deacon, Assistant Deputy Counsel

Amanda Derby, YC1

Anita Derby, RN

Joseph Donoghue, YC1

Marvin Edmonds, YDA

Jennifer Ellingson, RN

Kathy Fitzgerald, Social Work Supervisor

Gregory Hall, YC1

Chelsea Howard, YC1

Riccarda Jarvis, YC1

Christina Jinnec, YC1

Kristy Kennedy, YC1

Scot Lamphier, Acting Facility Assistant Director

Rebecca Levin, Licensed Psychologist

Edgardo Lopez, Settlement Agreement Coordinator

Jennifer Mahoney, YC1

Brittaney Mainville, YDA 2

Nathaniel Malone, YDA

Donna Moon, Human Services Training Specialist II

Tracy Myers, Secretary I

Ines Nieves, Associate Commissioner

Kelly Nordin, YDA

Haya Novak, Psychologist II

Denise Passarello, Quality Assurance Specialist

John Paz, YC1 SL

Kristin Pisani, LMSW II

Lou Renzi, Senior Attorney

Melinda Rivera, BBHS, Support Staff

Mike Seguin, Psychologist II

Gary Skinner, Physician Assistant

Jerry Simpson, YDA

Charles Snowberger Jr, Education Director

Beverly Sowersby, Facility Coordinator

Scott Steelman, Assistant Director for Treatment Services

Joseph Tomassone, Chief Treatment Services

Eric Warner, YC2

Rod White, YC2

Robin Vieira, RN

Sean Williams, YDA

Jeffrey Wurst, YC1

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 six months preceding the monitoring visit include October 2011 through February 2012, including pro-rated rates for the data available at the facility for March 2012. 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, which is 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 October 2011 through March 2012

Rates	Oct-11	Nov-11	Dec-11	Jan-12	Feb-12	Mar-12
All Restraint Events	7.27	5.99	7.30	15.06	9.56	7.48
Escorts/Standing	3.68	2.73	3.05	5.02	3.88	4.70
Seated/Supine	3.58	3.25	4.25	10.04	5.68	2.78
Youth Injury	0.26	0.47	N.A.	N.A.	N.A.	N.A.

Table 1 notes:

1. "All Restraint Events" includes every restraint entry in the Restraint Log. The rates do not show a pattern of reductions 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 Restraint Log data entries on youth injury end on December 1. There is no explanation other than staff forgot to at the column when moving from one month to the other.