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:
Columbia Girls Secure Center
Claverack, NY

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INDIVIDUAL FACILITY MONITORING REPORT:

COLUMBIA GIRLS SECURE CENTER

Claverack, 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 monitoring visit to the Columbia Girls Secure Center (Columbia) on June 26-28, 2012. As noted in the first monitoring report, the Monitoring Team consists of two Monitors, Dr. Marty Beyer, who is responsible for the Mental Health paragraphs of the Settlement Agreement, (hereafter referred to as the MH Monitor) and Dr. David Roush, who is responsible for the Protection from Harm paragraphs (hereafter referred to as the PH Monitor).

This 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 Needs, 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. Tryon Girls

On June 8, 2011, Governor Andrew Cuomo announced the closure of Tryon Girls Center and the reduction in the capacity of Finger Lakes Residential Center from 135 beds to 109 beds. The Monitoring Team maintained an ongoing dialogue with Home Office regarding the status of the girls displaced by the closing of Tryon Girls. Dr. Beyer monitored the transfer activities including treatment plans, staffing plans, and the status of operations at the destination facilities, Taberg Residential Center for Girls (Taberg) and Columbia Girls Secure Center (Columbia). The Office of Children and Family Services (OCFS) provided brief transition plans for 12 girls moved on August 31, 2011 from Tryon Girls Limited Secure to Taberg that summarized each girl's presenting problems and treatment while at Tryon.

On September 2, 2011, the Monitors requested an opinion from Home Office regarding questions about how the Tryon Girls closure applied to the Definition Section of the Settlement Agreement. Specifically, Paragraph 36 states that "Tryon Girls shall mean the Tryon Girls Center, located at 881 County Highway 107, in Johnstown, New York, or any other facility that is used to replace or supplement Tryon Girls." Discussions between OCFS legal counsel and DOJ attorneys resulted in an agreement to designate Taberg and Columbia as facilities that qualify for monitoring under the Settlement Agreement. The Home Office also updated the MAP to include Taberg and Columbia and timetables for training at those facilities. The first monitoring visit to Columbia occurred on November 29

through December 1, 2011, and this report reflects the outcomes from the second Columbia visit on June 26-28, 2012.

The Settlement Agreement (Paragraph 61b) provides for *ex parte* communications as an ongoing way for the Monitors to gather information. The Settlement Agreement further stipulates (Paragraph 62d) that the Monitors will provide a draft report to the Parties following the monitoring visit. The Monitors construe the designation of a draft report in advance of a final report to mean that the draft report and the comments provided by each Party are still part of the investigative processes associated with the monitoring visit. Therefore, the Monitors note that statements in a draft report are not final, and they are not wedded to draft report statements. The Monitors acknowledge the option to modify and clarify initial impressions and statements regarding compliance in advance of a final report. Furthermore, the Monitors' final reports apply solely to matters contained in the Settlement Agreement.

B. Facility Background Information

Columbia has a capacity of 16 and consists of two living units, each with a capacity of eight, in a building that also has the school and dining hall and another building with the gym, library, and a classroom. Columbia serves three types of offenders: (1) juvenile offenders/youth offenders who have committed specified serious felonies who are placed by criminal court and who must remain in a secure facility for their confinement. These youth are transferred to the New York State Department of Correctional and Community Services if they must continue to be confined when they reach age 21; (2) juvenile delinquents placed restrictively by the family court who have committed specified serious felonies. These youth must serve a period of the placement in a secure facility and can remain with OCFS involuntarily up to age 21; and (3) juvenile delinquents placed by the family court whose placement in a secure facility has been authorized by the court or who have been transferred from a limited secure facility through an administrative process referred to as "fennered." These youth may remain involuntarily in OCFS up to age 18. At least one of the residents at Columbia at the time of the site visit who has a 15-life sentence is likely to transfer to an adult prison at age 21.

On June 26, 2012, there were 11 girls at Columbia: 7 juvenile offenders/youth offenders and 4 juvenile delinquents. Since the monitoring visit six months previously, one girl was released to her mother's home and one girl was stepped down to Taberg. Between December 2011 and March 2012, Columbia received eight new residents, two new juvenile offenders and six girls fennered after serious incidents at Taberg and Lansing.

The 11 girls ranged in age from 15 to 19. They had been at Columbia (and a previous facility for most of them) from 24 days to 824 days [one had been in OCFS placement for less than a month, one for almost four months, six for five to 12 months, and three longer than a year]. The 11 Columbia girls have been sentenced for: Murder (1), Attempted Murder (1), Assault (4), Attempted Assault (1), Robbery (3) and Petit Larceny (1). Eight of the girls were taking psychiatric medication [Trazodone (2), Zyprexa (1), Remeron (1), Lexapro (1), Zoloft (1), Clonidine (1), Nortriptyline (1), and Adderall (3).] Additionally, several girls are prescribed Benadryl only. Their diagnoses are Major Depression, Generalized Anxiety Disorder, Dysthymic Disorder, Mood Disorder, and ADHD.

C. Assessment Protocols

The assessments used the following format:

1. Pre-Visit Document Review

The Monitors prepared a list of documents for on-site review. The Monitors worked with OCFS to make the document production and review processes more efficient, especially ways to make the transportation of documents easier for Home Office without compromising the quality of information provided.

2. Use of Data

The Office of Children and Family Services (OCFS) has a good management information system with access to a wide range of data. A further review of the system and its capabilities allowed for the development of Excel spreadsheets that were provided to the Home Office for the regular collection and dissemination of facility data to the Monitors, including the semi-annual Performance-based Standards (PbS) data. The Monitors were given OCFS' third Six-Month Progress Report on the MAP on June 20, 2012.

3. Entrance Interview

The entrance interview occurred on June 26, 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: David L. Bach, Quality Assurance Director; Sandra Carrk, Project Manager; Matthew Carpenter, Assistant Facility Director; Diane Deacon, Assistant Deputy Counsel; Dr. Patricia Fernandez, Assistant Director for Treatment; Edgardo Lopez, Settlement Coordinator/Project Director; Anita Sapio, Facility Director; and R.J. Strauser, YC2.

4. Facility Tour

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

5. On-Site Review

The site visit included a review of numerous documents available at the facility and not included in the pre-visit document request list. These documents included many reports that occurred in the time between the documents prepared for the Monitors and the on-site assessment. The MH Monitor observed two treatment team meetings, Mental Health Rounds, and a DBT group, met with the clinicians, and reviewed eight girls' records.

6. Staff Interviews

The Monitors interviewed 18 Columbia staff. In addition to group meetings with staff, the MH Monitor interviewed two case managers (YCs), a YDA, a clinician, and a nurse individually. The PH Monitor interviewed six Youth Development Aides (YDAs), one

Facility Director, one Assistant Facility Director, one Nurse Practitioner, two nurses, and one Youth Counselor 2.

7. Resident Interviews

The MH Monitor interviewed four (4) girls individually, two from each unit, and the PH Monitor interviewed eight (8) girls. Interviews occurred in areas with reasonable privacy from staff. The Monitors selected the youth for interviews.

8. Exit Interview

The exit meeting occurred on June 28, 2012. The Monitors expressed their appreciation for the cooperation and hospitality of the Columbia 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 went to both Parties. Those in attendance included: David L. Bach, Quality Assurance Director; Leslie Branah, Secretary I; Matthew Carpenter, Assistant Facility Director; Sandra Carrk, Project Manager; Diane Deacon, OCFS Legal; Dr. Patricia Fernandez, Assistant Director; Renato Guanga, A.T.T.; Dr. Joan Gerring, Chief Psychiatrist; Frank Kearns, Cook; Chris Latino, Psychologist II; Edgardo Lopez, Settlement Agreement Coordinator; Linda Mattice, RN/Nurse II; Debra Mulligan-Timer, FNP/NPP; Anne Pascale, BBHS Chief of Treatment Services; Kelly Polk, YCI; Jessica Riley, YCI; Jill A. Root, RN/Nurse II; Anita Sapio, Facility Director; R.J. Strauser, YC2; and Kimberly VonWedel, LMSW2. Those participating by phone included: Merle Brandwene, Director, Management and Program Support; John Canino, Counsel's Office; Gladys Carrion, Commissioner; Myra DeLuke, QA Specialist; Felipe Franco, Acting Deputy Commissioner; Larry Gravett, Director, SIU; Alan Kaflowitz, Bureau of Training; Kathryn Shelton, Executive Assistant to Acting Executive Deputy Commissioner; Denise Passarello, QA Specialist; Sheila Poole, Acting Executive Deputy Commissioner; Lee Prochera, Deputy Counsel; Lou Renzi, Counsel's Office; and Beverly Sowersby, Facility Manager.

D. Preface to Protection from Harm and Mental Health Findings

The Monitors concluded last November that Columbia was the model that every unit in the named facilities should aspire to, with strong teamwork, stability, and a safe, caring environment. With the admissions of six fennered girls in three months, Columbia opened a second unit and tried to integrate the new girls into the stable community they had developed. It was a challenging transition with an increased number of restraints. "These were the most difficult girls from Tryon. Most have no home to go to. Now they are back with us. The residents who had been here for months were used to having a staff enriched environment. Suddenly, they had less of our time and said the fennered girls 'ruined our program.' They had trouble helping the new girls settle in. The staff had trouble, too. It was a safe community here. With the fennered girls, there were staff injuries and staff started feeling unsafe." Fatigued by the new demands of a facility almost double in size and all the training for the New York Model, Columbia staff also had additional training requirements imposed on them which required overtime; mandated staff with 1½ hour commutes were working 16 hours. "But as we built relationships with the new girls, things improved." The Columbia staff were able to return the facility to the stability they had achieved previously: "We have recovered. We are doing really good work with the girls.

We are releasing them. By May we implemented the New York Model and the Daily Achievement System and the phase system." [Quotations from several staff.]

The loss of program equilibrium during January through April 2012 at Columbia raised concerns. The physical restraint numbers along with injuries to staff were too high; and while these indicators reflected a very challenging group of youth, they are too high to support a designation of a reasonably safe environment. The encouraging factor was that by the site visit in June, there had been a return of the numbers closer to those experienced in November 2011. Through discussions with staff at all levels, there were other factors that need to be considered when asking how a situation like January through March can be avoided in the future. Previous monitoring reports have addressed staffing and training issues. Furthermore, the unique combinations of histories of trauma, disabilities, and failed mental health and school interventions make the Columbia population some of the most challenging youth in the system.

Other factors also aggravated the problems mentioned above. Three staff remarked that the pace of the new admissions to Columbia, especially the fennered girls, was especially disruptive. Based on the adjustment challenges presented by these girls, staff recommended that there be some type of modification of the rate at which girls are admitted to Columbia, specifically suggesting a 10-day interval between admissions. The suggestion of the 10-day interval between admissions may be more instructive about the length of time needed for a youth's adjustment to Columbia than a realistic recommendation for Home Office, especially because the circumstances surrounding a youth's transfer to Columbia are often of an emergency nature and cannot be held to a timetable.

Home Office has been investigating the staffing concerns and provided an update of activities at a meeting with the Monitors on June 29, 2012. Staffing at Columbia continues to be a problem even though there have been two (2) new hires among the ranks of YDAs. Staff and youth expressed their concerns about staff coverage in interviews and Restraint Packets. For example, in Restraint Packet #313985 (Youth EC, March 18, 2012), the Activity Report filed by Chris Latino, psychologist, stated, "The unfortunate thing was that there were not enough staff to prevent every girl from engaging in a fight." On the Restraint Monitor form in response to the question, "Was the response proportional and appropriate?" it read, "More staff needed." This occurred when there were two (2) additional staff members available at the time, one arriving early for work and the other having been called in to cover visits.

Columbia Administration detailed its staff coverage and assignment strategy. To fill these shifts, the staffing adequacy in June 2012 ranged from 66.7% to 78.3%, depending upon the replacement factor used in the estimate. This range was in contrast to the staffing adequacy calculated during the November 2011 monitoring visit, which ranged from 108.3% to 130%. The changes in staffing adequacy combine with changes in the rates of physical restraints and injuries to youth during January through March 2012 to reveal an inverse relationship.

A positive aspect of the Columbia monitoring visit was access to the report of a quality assurance pilot visit to Columbia. The Quality Assurance Report (QA Report)

reflected a very careful and thoughtful review of the Columbia operations with respect to the requirements of the Settlement Agreement.

II. PROTECTION FROM HARM MONITORING

The data provided by Home Office suggested a substantial reduction of safety at Columbia during January through March. There seemed to be a recovery occurring around the time of the monitoring visit that might return youth safety to a level similar to that experienced during the November 2011 monitoring visit. While there are many factors that contributed to the difficulties experienced during the first several months of 2012, the return to a safe, structured, and orderly environment would confirm the statements of staff that they are committed to make the New York Model successful and that they are capable of working with the most difficult youth in the system. Others expressed a strong desire to prevent a return to the institutional culture experienced at Tryon Girls.

Despite the aforementioned difficulties, there were many optimistic signs during the monitoring visit. Over the past six months, Columbia has had a stable leadership team. Columbia hired 2 YDAs, a YC, a social worker, and a recreation specialist (who has a YMCA background and has enthusiastically tailored a lot of new activities to the girls' interests). On the final day of the monitoring visit, physical restraints were at eight (8), which was the lowest monthly number since the first of the year; and Columbia had gone the entire week without a physical restraint. Eight (8) youth participated in interviews regarding their perceptions of safety, physical restraints, and relationships with staff. With the exception of one youth who said she did not know how to answer the question, seven (7) of the eight (8) girls rated personal safety very highly. This is in spite of the recent increases in physical restraints. Most girls attributed the need for physical restraints to youth-on-youth bullying, conflicts, and fights. In these situations, some girls viewed physical restraint as a way to resolve peer conflicts through staff interventions. That is, it seemed to be easier in some instances to endure a physical restraint than to run the risk of losing face among one's peers.

Three (3) of the eight (8) youth had been interviewed during the November 2011 monitoring visit, so they had a better perspective on the changes that have occurred at Columbia over the past six (6) months. These youth were asked if the situation at Columbia was better or worse than it was in November. All three (3) girls stated that things were currently better at Columbia because of the New York Model. Their belief was that while safety had deteriorated, this was far outweighed by the improvements in treatment. Each girl seemed to be aware of substantial personal problems that she needs to address and resolve before returning home with confidence about a successful reentry.

From the interviews with staff, there was optimism about the way the program was returning to the November 2011 status. Like the youth, the staff who were interviewed rated their safety very highly. They were not currently in fear of injury or assault.

A. Use of Restraints

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 along with PPM 2081.00 and PPM 3247.14 fulfills the requirement that OCFS create a new set of requirements on the use of restraints. During staff interviews, all staff had a working knowledge of the new policy and the physical restraint approach.

Columbia staff appeared to understand the policy and properly identified the circumstances under which restraint can be used. Resident interviews generally confirmed a normally limited and specific use of restraints and partially affirmed staff reports that restraints are not used as punishment. When asked if staff try to hurt youth ("go harder") during restraints, all girls said "no" with a few recurring exceptions. All girls indicated that there were no more than three (3) staff members who use excessive force. All girls were willing to name the staff members, and all mentioned one name. Columbia Administration and Home Office independently identified the same individual. With the exception of the staff members mentioned here, all youth indicated that the remainder of the staff only restrain youth when absolutely necessary, i.e., within the boundaries of the circumstances set forth above.

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; the training on the policies and procedures has occurred; and evidence of a corresponding practice includes

documentation (written and video), staff reports, and resident reports that are consistent with the policy and procedures. Again, OCFS policies comply with the Settlement Agreement. Columbia administration is familiar with policy and procedure that limit the circumstances when the use of restraints is necessary, and staff interviews affirmed a working knowledge of these circumstances.

Restraint data are currently categorized into two (2) types of restraints, those that do not take the youth to the floor (standing restraints), and those that take the youth to the floor (seated and supine restraints) with the range of standing restraint options representing lesser amounts of physical control and, usually, time. OCFS keeps good enough records that permit the restraint data to be disaggregated into these two (2) sets. Additionally, the CSU Restraint Log at Columbia contains the times when the restraint began and ended. Therefore, a baseline for duration can be estimated since these entries are generally accurate. For the months of April, May, and the prorated part of June, there were 19 standing restraints and 26 seated/supine restraints. The length of the restraints ranged from a minute or less to 92 minutes. The restraints also included two (2) mechanical restraints (both seated), one for 15 minutes and the other 14 minutes for an average of 14.5 minutes. Regarding the duration of the standing restraints, the average was 3.2 minutes, whereas the average duration of the seated/supine restraint was 11.85 minutes, verifying the data collection assumption of standing restraints as the lesser amount of time and physical control.

The QA Report (under the heading of Use of Force which begins on page 15) discussed youth interviews where one youth said that staff use more force when restraining youth in their rooms because there are no cameras. Two youth stated that some staff use more force than needed (they qualified that maybe they do not know their own strength, but some may want to hurt them). The QA Report indicated that two youth stated that female staff tend to use more de-escalation.

Regarding Restraint Packet #331180 (Youth TN, May 7, 2012), this was a protracted restraint. From beginning to end, including the application and removal of handcuffs, the restraint lasted 92 minutes. Never during the 92-minute restraint was it evident that medical or mental health staff talked with the youth. This raises again the systemic question about when medical initiates an assessment of a youth in the restraint process based solely on the length of time since the beginning of the restraint. This concept also applies to mental health services. The restraint began at 1:43 pm on a Monday, so this was a time of day when mental health assistance could have been available. Furthermore, the Facility Administrator review did not raise any of these issues (See comments for Paragraph 42 e).

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

COMPLIANCE

COMMENT: The policy and procedures exist; the training on the policies and procedures has occurred; and staff and resident interviews were consistent with the policy and procedures. Interviews with direct care and health care 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. In most instances, staff recited information in the residents' IIPs and seemed quite cognizant of the nature and extent of the limitations.

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

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

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

iii. Medical personnel shall be immediately notified of the initiation of a facedown restraint position, and the youth shall be immediately assessed by medical personnel thereafter. In no event shall more than 4 hours lapse between the end of a facedown restraint incident and the assessment of the involved youth by medical staff.

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. However, concerns remain about facedown restraints in light of reports from youth and a particular incident described below.

Policy 3247.12 describes a "transitional hold" that moves a youth from a supine restraint to a prone position for the purposes of applying handcuffs. Consistent with Settlement Agreement paragraph 41.c.i. which states, "Face-down restraints shall be employed for only as long as it takes to diffuse the emergency, but in no event shall youth be restrained in a face down position for more than three (3) minutes," interviews with staff and youth confirmed the elimination of face-down restraint practices as a primary strategy when the restraint requires staff to place a youth on the floor. In response to the question about when a face-down (prone) restraint is permissible, similar to their November 2011 answers, most Columbia staff responded that a prone restraint is no longer used and that the "transition hold" is not a prone technique because they only move a youth to her side if the application of handcuffs is necessary. The responses indicated a clear understanding of the concerns about facedown restraints expressed in the Settlement Agreement paragraph. However, youth reported to the PH Monitor several instances of facedown restraints; and the QA Report indicated that of the 11 girls in its survey, four (4) reported to have been placed on their stomachs during restraints.

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

COMPLIANCE

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

COMPLIANCE

COMMENT: There has been a substantial amount of training that has occurred over the past six (6) months. Mr. Guanga assembled a staff training history notebook with the training activities detailed for each staff member from 2011 to June 15, 2012. The notebook contained an exhausting amount of information, so it is difficult to imagine the amount of time, energy, and commitment on the part of Columbia staff that went into accomplishing all of the training.

The training materials revealed that all but two staff were up-to-date on first aid and CPR. Those requiring restraint monitoring training had completed it. Regarding completion of the CPM training course as a core prerequisite for conducting physical restraints, only two staff members did not qualify. Both were new employees who had not completed the Academy training. There were copies of individual memos sent to each employee from administration advising them that until they have completed the required CPM and first aid/CPR courses, they are not allowed to participate in physical restraints.

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. No evidence existed of the use of prohibited physical restraint holds, especially "hooking and tripping" and chokeholds.

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; the training on the policies and procedures has occurred; and staff and resident reports are consistent with the policy and procedures.

Support for compliance came from the views of staff, which consistently described situations where their approach to resident misbehaviors was to use de-escalation (verbal strategies) longer than usual to prevent the need for physical restraint. Residents currently confirmed that staff "talk the girls down" because they are responsive to the residents' issues and want to resolve problems without the use of physical restraint. Information from monitoring and QA reviews indicate that (a) women do more and better de-escalation than men and (b) the de-escalation technique of proximity actually aggravates (escalates) behaviors.

On the morning of June 28, 2012, PH Monitor observed an incident on Liberty Unit that involved a loud and profanity-laden verbal confrontation between two (2) of the more frequently restrained Columbia residents. The details of the event are available through an Activity Report and the video from the surveillance cameras. While a review of the details may be instructive for a number of purposes, this was an example of how the elements of the New York Model can combine to resolve emotional crises without physical restraint.

The incident was a combination of extreme cruelty and anger generated by hurt feelings. The Youth C, who made the hurtful statements, came up with some profoundly damning accusations about Youth A and her behaviors. The cruelty of the statements would previously have elicited a violent response from most youth, including these two, but one objective of the New York Model is to lessen hurt and anger.

On the other hand, Youth A, the one enraged by these comments, provided a barrage of threats and profanities that were equally as incendiary. Youth A also made gestures and movements toward Youth C. Ironically, Youth C remained calm throughout the entire event. She would later state that her behavior was simply a payback to Youth A for the mean things Youth A had said to her before this event.

Knowing that these two girls have multiple Restraint Packets documenting extremely violent outbursts that have required multiple staff to complete a restraint, there was a sense that staff might be torn between how to apply the New York Model concepts versus sending a strong and clear signal to the youth that the conflict needed to stop immediately. As the events unfolded, there were multiple statements and behaviors by Youth A that would have been sufficient justification for staff to initiate a physical restraint.

A0D Williams took the lead and showed remarkable patience in calming the situation with Youth A. He moved himself between Youth A and Youth C to prevent physical contact. Throughout the process, the PH Monitor did not see him touch Youth A as a way of directing her away from Youth C. YDA Watson also provided support to Youth A

based on his mentoring status with her. The third staff member, YDA Harkless, was able to talk Youth C into going outside while Williams and Watson dealt with Youth A.

Two likely very serious physical restraints were averted, emotional crises were de-escalated, and the New York Model appeared to work effectively in this instance, which was probably as difficult and as emotionally charged incident that staff have had to deal with.

Examples exist from the numerous physical restraints since the last monitoring visit that argue against full compliance. The QA Report (under the heading of Mechanical and Facedown Restraints/Debriefing) noted a youth's claim that she had been placed into a facedown position, but it supposedly occurred while off-camera in her bedroom. Off-camera restraints are problematic and to treat them as a routine factor in the administrative review of a restraint only compounds the problem. The inability to confirm or deny the appropriateness of use of force due to the absence of video evidence works against a level playing field regarding abuse investigations by giving the staff member the presumptive benefit of the doubt.

Also, even though the rate of injury-to-youth has decreased since the problems of January through March 2012, the injury-to-youth rates offer only lukewarm support for the widespread contention that CPM is a far safer physical restraint strategy. While there may be increasing evidence to support the claim of CPM as safer than the previous system, the rates from January through April cast a shadow of doubt on the larger safety assumption. While there are many factors that contribute to higher rates of injuries, and while there is increasing evidence to suggest that this problem might be more a function of other factors than CPM itself, the data from November through May do not support compliance.

The PbS data were also interesting. Noteworthy was the way that Columbia went from almost no problems in November to one of the leaders in trouble indicators among the named facilities for the April 2012 data collection. For example, Columbia had the highest rate of injury-to-youth (Safety 2), the second-highest rate of injury-to-youth-by-other-youth (Safety 4), the highest rate of injury-to-youth-by-staff (Safety 5), the highest rate of youth injury during physical and mechanical restraints (Safety 10), the highest percentage of youth who fear for their safety (Safety 13), and the highest percentage of staff who fear for their safety (Safety 14).

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; the training on the policies and procedures has occurred; and evidence of a corresponding practice includes documentation (written and video), staff reports, and resident reports that are consistent with the policy and procedures. However, documentation problems existed, which need correction. Here are a few:

1. OCFS data showed an increase in the rate of suicide attempts with injury. A review of the incidents in question revealed that the suicide watches were mostly initiated following the restraint. That is, once the girl was in her room, she made a statement that she was thinking about killing herself or something

of that nature. This initiated the suicide watch, and, in a couple of instances, the youth actually had a shirt or scarf wrapped around her neck. In none of these reports was there any injury associated with the suicidal gesture. Instead, the injuries were associated with the restraint. Therefore, these incidents were mistakenly categorized as a suicide attempt with injury as opposed to a restraint with injury.

2. The QA Report on page 19 further indicated that "supporting documentation for restraint 308696 was deemed poor, as it did not note which staff accompanied the youth to medical or if the post-restraint interview was completed in a confidential manner."

3. The QA Report also stated that a Restraint Monitor failed to document the unauthorized or inappropriate techniques in this and two other packets (308694 and 315881). The Restraint Monitor Report indicated that the youth created an "unsafe environment" by destroying furniture [redacted]. This behavior was not on the video that accompanied the Restraint Packet

4. The Video Review Form for Restraint Packet #326387 noted that Youth MN briefly involved herself in an attempt to calm Youth TN, but there was no mention of this in the documentation.

5. Ongoing problems with the quality of the Restraint Monitor documentation arose in different situations.

6. On the Physical Restraint–Request for Documented Instruction form (#F12005), there is a lack of behavioral specificity when the deficiency observed was described as "improper de-escalation and restraint technique." The documented instruction occurred four (4) days following the event, but there was no information regarding what happened in the documented instruction and whether or not the instructor believed that the staff member demonstrated the proper skills as a result of the instruction.

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

PARTIAL COMPLIANCE

COMMENT: The policy and procedures exist; the training on the policies and procedures has occurred; and staff members report a practice that is consistent with the policy and procedures. An SG-18 or above facility administrator completes a review and logs the information and recommendation on the OCFS 2091 form, which is reviewed by the Facility Director.

Missing from the implementation of the policy and procedure are protocols or guidance regarding the ways in which information gathered in this process should be used to improve training and supervision and to revise policy or programs. Additionally, protocols for the senior management review of information are "in progress."

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, and there is a practice in place. Throughout the monitoring process, this paragraph has become more important because of the "review" and "evaluate" functions contained in this weekly practice. The Facility Administrator review becomes a critical part of the feedback needed to continue the evolution and improvement of CPM and the New York model. With the advent of Quality Assurance, it provides another perspective on the types of staff behaviors that are exemplary or in need of improvement. Similarly, reviews of the physical restraints provide an additional opportunity to raise issues related to the prevention of unnecessary restraints. While an unnecessary restraint may more appropriately fall under Paragraph 42b regarding the least amount of control needed to resolve the situation, the current paragraph has evolved to the point where some of these auxiliary issues are more relevant here. Therefore, much of the narrative for this paragraph identifies issues that affect the nature and extent of physical restraints.

Because of concerns expressed in previous reports about the Facility Administrator's review of Restraint Packets and videos, Home Office clarified the policy on "Documented Instruction." Staff informally viewed documented instruction as a disciplinary or formal corrective action, so there seemed to be a hesitancy to use it in a way consistent with the PH Monitor's interpretation of the Settlement Agreement paragraph. Paragraph 42e is the Facility Administrator's opportunity to review this new and important procedure (CPM) and to provide a learning tool as a safeguard for youth and staff. That is, it requires Facility Administration to identify the types of behaviors that fit the policy, procedure, and training and also mandates Facility Administration to make learning opportunities for those staff members who have difficulty implementing the new techniques effectively. From the Monitors' perspective, the purpose of documented instruction in this paragraph is to create multiple and ongoing opportunities for staff to learn and practice effective implementation of CPM techniques, especially de-escalation.

The large number of restraints during the first part of 2012 provided numerous opportunities for review and evaluation of some difficult restraint situations. From this perspective, there are many emergent issues identified below.

There were several examples of effective uses of CPM provided to the PH Monitor for review. Regarding Restraint Packet #276282 (Youth NB, December 24, 2011), it showed three (3) physical restraints on the video. One was a single person standing restraint, the second was a two-person seated restraint, and the third was a single person standing restraint where the staff member had to chase the youth across the dayroom after she broke free from his grip.

Regarding Restraint Packet #303182 (Youth TN, February 2, 2012), the video showed a staff member containing Youth TN in the laundry hallway while another youth

was in her room with several staff members in the room. Youth TN escalated her behavior, resulting in a 3-person supine restraint. However, there were no visible behavioral antecedents as the precursors to the restraint were outside the camera range, so whatever precipitated the physical contact and any de-escalation strategies could not be evaluated. Once the restraint started, it moved quickly and effectively to a 3-person supine restraint. The documentation indicated that the restraint lasted 9 minutes. Video Review Form noted nothing extraordinary either way.

Regarding Restraint Packet #308686 (Youth EC, February 25, 2012), two (2) girls were fighting and staff broke up the fight, placing each girl in a single person standing restraint and moving them to their rooms. This strategy worked effectively.

Regarding Restraint Packet #315881, there was also an example where another youth entered the area, appeared to be agitated, and might have had to be restrained by one of the two (2) male staff members who moved to prevent her from getting any closer to the restraint area. Then YDA Rowlett came up to the girl and said a few words, and the girl de-escalated and thereafter removed herself from the area.

Regarding Restraint Packet #323781 (Youth TN, April 18, 2012), there was a lot of struggling on the video before staff gain control, ending up in 3-person standing restraint. YDA Rowlett can be seen doing a lot of what appears to be talking and de-escalation followed quickly. In both instances, it would be beneficial from a learning and coaching perspective to know what YDA Rowlett said to these youth because it appeared to have been effective de-escalation.

1. The Restraint of a Naked Youth

Regarding Restraint Packet #326387 (Youth TN, April 25, 2012), the video showed a calculated disruption of the unit by Youth TN by throwing papers on the floor and overturning several chairs. A staff member stood between the youth and other furniture. Youth TN moved to the back of the dayroom and took off her shirt and bra. She was naked from the waist up. Another resident interceded and talked to her. Staff moved away while this occurred. There were five (5) male staff members in the area at the time. At some point, Youth TN pushed a staff member and the restraint began. There was no visual or written evidence of a female staff member's presence during the restraint. Once Youth TN was restrained, a sixth male staff member enters the unit.

It appeared as if AOD Lewis was one of the lead staff members in the restraint, along with YDA Watson. However, Lewis was listed as the Restraint Monitor. The question becomes why the Restraint Monitor played an active role in the restraint when there were a sufficient number of other staff members immediately present at the time to have implemented the restraint, thus allowing AOD Lewis to function as the Restraint Monitor. Given the controversial nature of the restraint (an all-male restraint of a partially naked female), it seems more prudent that the Restraint Monitor would fulfill the intended purpose of providing a more neutral perspective on the process. Additionally, the restraint is problematic due to the absence of a female YDA and due to the absence of any documentation in the Restraint Monitor's report that solicits assistance or guidance about how to conduct restraints of this nature.

The restraint of a naked or partially naked female by male staff members without the presence of a female staff member is a troubling situation, which raises many questions. The concern here is that the Facility Administrator's review did not appear to set in motion action to resolve this issue. This issue requires additional attention by Home Office.

2. Access to Food

Regarding Restraint Packet #312581 (Youth EL, March 15, 2012), the documentation gave the impression that the physical restraint started over a denial of food. Activity/Rule Violation/Incident Report form dated March 15, 2012 at 12:54 pm from staff member Riley states:

> [Youth EL] sat down in the dining room area demanding to be given food. When [Youth EL] was informed that because she refused to move to lunch, she would not be getting food, she became upset and started to take stitches out of her hand.

Home Office maintained that the youth was not denied food, and that she refused food prior to going to medical, so she did not miss her meal because of being in medical. Yet, the Activity Report stated that Youth EL was told she could not have "food." The report also indicated that this occurred on the way back to Opportunity from medical. There was no information in the Restraint Packet about why the youth went to medical.

This does not excuse the youth's assaultive behaviors or the biting of AOD Williams. The question is whether the adherence to policy resulted in the real or perceived denial of food, which most youth believe is a basic right while incarcerated. Emotional upset resulting from the denial of food is important for several reasons, but it was not identified as an issue on the Video Review Form.

Access to food and the denial of food are important factors. In the often-referenced conditions of confinement case law resource *Representing the Child Client* (1990), nationally respected child advocacy attorney Mark Soler writes:

> That children be served three (3) meals each day, plus second helpings for a snack during the evening; that children be allowed to eat communally in a pleasant and relaxed atmosphere; that all food service staff meet applicable public health standards and that *food not be withheld from children for disciplinary reasons*. (emphasis added)

The third edition of the American Correctional Association's *Standards for Juvenile Training Schools* (1991) offers the following guidance about food:

> *3-JTS-4A-08*: Written policy precludes the use of food as a disciplinary measure.
>
> Comment: Food, including snacks, should not be withheld, nor the standard menu varied, as a disciplinary sanction.
>
> *3-JTS-4A-14*: Written policy, procedure, and practice require that at least three (3) meals, of which two (2) are hot meals, are provided at regular meal times during each 24-hour period with no more than 14 hours between the evening meal and breakfast. Provided basic nutritional goals are met, variations may be allowed based on weekend and holiday food service demands.

> Comment: When juveniles are routinely absent from the institution for work or other purposes, at least three (3) meals should be provided at regular times during each 24-hour period.

The concern here is that the Facility Administrator's review did not identify this issue. If the resident missed her unit's lunch period, for whatever reasons related to being in the medical unit and/or her own behavior, she cannot be denied food. The DAS would provide for her learning that her behavior prior to lunch resulted in her not earning points. If she were disruptive before eating her lunch and removed from the dining area, what provisions are made after she calms down for her to have food either in a different location or in the dining room after the normal lunch hours? This issue requires additional attention by Home Office.

3. The Role of the Restraint Monitor (See Appendix A)

Regarding Restraint Packet #291187 (Youth BE, January 14, 2012), at the beginning of the restraint, the Restraint Monitor was not observing the restraint itself but instead was ushering other girls into the cafeteria area. This went on for several seconds while the staff appeared to be quite active in order to restrain the girl. The Restraint Monitor returned and appeared to observe the restraint for a few more seconds, but was called away to unlock the door to the cafeteria. She returned for a third time watching the restraint, but the lead restraint staff member had his back to her and she never appeared to move into a position where she could see the youth's face, head, and chest.

Another staff member seemed to request a towel to keep the youth from spitting, and it was the Restraint Monitor who got the towel and then left the area. The lead YDA was released from the restraint and left the dayroom as the Restraint Monitor returned. The Restraint Monitor left again to get something and came back and sat down to observe the restraint near the youth's head. The Restraint Monitor left again going into the unit control area and returned. Shortly thereafter, the youth somehow broke free of the restraint, and the Restraint Monitor became directly involved in restraint.

The Facility Administrator fails to note the absence of documentation that indicates that the Restraint Monitor was actually involved in the restraint near the end of the process or end of the video. None of these materials indicated that there is to be continuous observation and evaluation; however, Home Office indicated that the training materials do include this instruction. Nothing provided for this review suggested that the Restraint Monitor is allowed to leave the restraint event. The Facility Administrator review did not raise any of these issues.

4. Staff Obstructing the View of a Camera

Regarding Restraint Packet #315881 (Youth MI, March 23, 2012), the documentation indicated that the restraint occurred the way it did because of "space constrictions" that were not apparent in the video. It did not appear as if the staff member intentionally moved her into a corner farthest away from the camera. Furthermore, one staff member stood with his back to the restraint, and his location at that time blocked the camera view of the restraint activity. If there were other youth in the area, which was difficult to determine based on the video coverage, this position could have been a way to prevent another youth from moving to the restraint area. From a video reviewer's

perspective (or from Quality Assurance), the blocking of the camera view during any use of force should prompt the Facility Administrator to conduct a follow-up inquiry regarding the circumstance surrounding every obstruction regardless of whether it is deemed an isolated occurrence.

5. The Quality Assurance Report

The Pilot QA Report found that the review of the videos seemed to be done in a timely fashion, with most completed within hours of the incident, and the QA staff provided a thorough review of the Restraint Packets, which revealed several identifiable deficiencies in the restraint techniques according to the Columbia administration. The QA Report identified areas needing attention as:

a. Of the 11 restraints that the QA Report deemed to be noncompliant, there was a lack of evidence that before physical intervention, the prescribed de-escalation techniques were employed, where possible. The PH Monitor has found the same lack of evidence in previous reviews.

b. The QA Report further stated that, in several instances, staff quickly used force and that the activities on the video did not show attempts made by staff to employ different de-escalation techniques to mitigate the crisis. Again, this appeared to be an absence of patience on the part of staff to allow the strategy time to work.

c. The QA Report indicated on page 8 the need to employ stricter adherence to the IIP. For example, the IIP for one youth specified ventilation as one of the strategies for her crisis prevention and management plan. However, there was no evidence from the video that staff employed this technique prior to using physical force (see restraint 315881). Later in the report, QA report noted, "Staff person is observed chasing the youth across the room and using physical force."

d. The QA Report for restraint 276281 noted that although the Administrative Review of Physical Restraint reported that staff did not demonstrate any inappropriate technique of physical skills, it observed multiple instances of incorrect techniques on the available video. This underscores the need for similar findings from multiple reviews of restraint video as an indicator of compliance.

e. The QA Report indicated that there was consensus that the use of the de-escalation technique of proximity actually provokes (escalates) the youth. Home office reviewed this issue and initiated a change in terminology and a rewriting of the training curriculum. See the MH Monitor's comments for greater explanation of proximity.

f. The QA Report on page 19 recommended "reviewing the process for documenting post-restraint reviews to assure staff involved with the restraint are not present, as well as reviewing documentation regarding the confidentiality of the environment where the youth is interviewed."

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

COMPLIANCE

COMMENT: The training on the policies and procedures seemed to have occurred regularly, and the evidence of a corresponding practice from the STARS system was consistent with the requirements of this paragraph. Training records showed that all direct care staff received the required training on CPM. The records also showed that staff members who required retraining for any number of reasons received the training in a timely fashion. Interviews with staff confirmed the staff member's understanding of the training and an awareness of his or her status regarding completeness of the training requirements. Staff knew when re-training events would occur and in what activities they were permitted to participate.

C. Emergency Response

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

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

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

NOT APPLICABLE

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

COMPLIANCE

COMMENT: The policy and procedures exist (PPM 3246.02 and PPM 3247.13); the training on the policies and procedures has occurred; and staff and resident reports are consistent with the policy and procedures. All staff confirmed with acceptable accuracy the call for assistance procedures based on the color code indicators, where 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 were consistent with the policy and procedures. The PH Monitor verified the existence of the response team chart in the CSU booth and the log entry of response descriptions in the CSU logbook.

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 plan was reviewed, and it is satisfactory.

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

COMPLIANCE

COMMENT: The policies and procedures referenced in paragraphs 41-43 are addressed primarily in policies 3247.12 and 3246.02. These policies are part of the CPM training, and the STARS system confirms the Columbia staff's successful completion of the training.

D. Reporting and Investigation of Incidents

These paragraphs refer largely to the activities of the Special Investigations Unit (SIU). A separate monitoring visit to the Home Office on June 25, 2012 addressed 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.

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.

COMMENT: The QA Report on page 22 (Reporting and Investigations) looked at Special Investigation Unit investigations between November 2011 and April 2012, and there have been a total of 12 investigations involving 11 different Columbia staff. Surprisingly, one staff member has been involved in seven (7) investigations. This suggests something more than chance or coincidence and warrants additional investigation. There is also evidence that administration has taken steps to develop a safety plan for this person.

The walkthrough of the physical plant looks for potential risks of harm to youth regarding injuries, suicide behaviors, and self-injurious behavior (44.*iii*.2), knowing that an agency cannot eliminate all physical plant related risks of harm. During the November

visit, potential risks were noted during the physical plant tour with administration, but did not make their way into the report since there was reason to believe that administration would mitigate the potential risks for harm. The November concerns were about suicide risks in the bathrooms and the tension between privacy versus safety when girls use their bathroom and showers. Conversations with administration resulted in a simple recommendation that Columbia change its supervision practices to include regular auditory responses from the girls when visual observations were inappropriate.

OCFS data showed an increase in the rate of suicide attempts with injury. Did any of these incidents relate to the supervisory issues raised in the November report under paragraph 44, iii, 2? During the review of the documentation, the PH Monitor discovered an incident where a youth [MN] on suicide watch was restrained in the bathroom. The restraint resulted from the youth's protest of having the staff member in the bathroom while she was using the toilet. The verbal conflict escalated; a restraint ensued; and the staff member's head hit the wall resulting in injury. The PH Monitor questioned Columbia Administration about the possible conflict between the youth's dignity (using the toilet with some degree of privacy) and the staff member's adherence to policies and procedures. The response was that the situation was covered clearly by policy and procedure, and there was no need to deviate from it. In fact, there were no deviations from this policy according to administration.

In a review of a file of another youth who was on a recent suicide watch, the notes indicated that a "voluntary strip search cleared her of any contraband while in the shower and bathroom." The note implied that the strip search made it possible for the youth to be in the shower and the bathroom without a staff member being present or without looking at her while she showered, but instead remaining at the bathroom door able to continue verbal contact consistent with suicide watch requirements.

Similarly, the PH and MH Monitors looked for other justifications for the staff member to be in the bathroom. Were there indicators of a high level of suicidality, suicide ideation, or self-injurious behaviors? For Youth MN, serious attempts of suicide or suicide ideation or self-injurious behavior were not marked in the checkboxes on either of two treatment plans on February 23, 2012 and April 26, 2012, both of which preceded the event. On December 24, 2011, there was no endorsement of suicidal views on the admissions inventory. Likewise, there were no indications of concerns about self-injurious behaviors in MN's record. The low level of risk evidence for this individual did not support a "no-exceptions" approach to the staff member's presence in the bathroom. Additionally, the restraint documentation provides insufficient evidence that the incident qualified under the exceptional circumstances requirements of Paragraph 41 or included appropriate de-escalation. Therefore, the restraint was unnecessary (44*i*).

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.

COMPLIANCE

COMMENT: Interviews with staff and youth yielded similar results. No one commented about a reluctance or fear of retaliation when faced with the need to report another worker regarding an alleged incident of and inappropriate use of force or suspected abuse. Some questions remain about an incident and the suggestion that a staff member was reluctant to offer information against a coworker.

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

COMMENT: The review of SIU reports suggested compliance with this paragraph.

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

PARTIAL COMPLIANCE

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

Interviews with the health clinic staff revealed an understanding of the policies and procedures, their professional obligations, and what appeared to be a trusting and helpful demeanor. Nurses appeared to understand their mandatory reporting requirements, and they described a post-restraint examinations (PRE) procedure that allows the examination to occur with a reasonable amount of privacy. The procedure for conducting the PRE in the

clinic remains the same and complies with the intent of the Settlement Agreement paragraph.

For the first time, problems appeared in medical that were uncharacteristic. The concerns about the clinic related to documentation and the confidentiality of youth during a PRE that did not occur in the clinic. For example, several records indicated that PREs were done on the unit and in the classroom. Both QA and monitoring found mistakes in documentation and insufficient documentation regarding the confidentiality requirements in the Settlement Agreement related to post-restraint examinations:

1. The May 2012 Site Visit Report conducted by the regional supervisor indicated concerns about documentation and supervision. The report called attention to a "general lack of consistency in basic functions."

2. The QA Report noted that four (4) PREs occurred "on the unit." These "on the unit" PREs need greater documented detail regarding how and where the exam occurred because of the need to verify confidentiality. PRE forms in these instances did not contain enough information to establish the confidentiality. Similarly, the PH Monitor's review of the Progress Notes for the individual youth in question did not contain sufficient information to determine a level of confidentiality. This needs to be corrected.

   Regarding the location of the PRE, of the 14 Restraint Packets reviewed for this monitoring report, seven (7) (50%) occurred in the clinic with proper documentation; four (29%) occurred on the unit with insufficient documentation to determine confidentiality; and three (3) (21%) did not contain any information about who escorted the youth to the PRE or where it occurred.

3. There was no documentation in the Post-Restraint Health Report for 331180 that the youth was actively restrained, including mechanical restraints, for 92 minutes. A better mechanism is needed to ensure that medical knows when a restraint has lasted for an extended time.

4. Concerns also exist about timeliness of the PRE, and while there was no reason to raise this as an issue during previous monitoring visits, this visit was the first time that a youth complained specifically about the length of time it took for her PRE to occur. In this instance, the length of time between resolution of the restraint and the PRE was more than three (3) hours.

5. Monthly Summary reports from the clinic are one measure of the number of restraints that occurred during the month, and these numbers are compared to the restraint entries in the Restraint Log in CSU. Initially, the comparison revealed a substantial difference, unlike any other previous monitoring experience. For example, comparisons were made with the Restraint Log data and the Monthly Summaries for April, May, and June 2012. The Restraint Log indicated 25, 13, and 8 restraints respectively, whereas the Monthly Reports indicated 16, 12, and 8 PRE. Knowing that multiple restraints can be listed under one PRE, there is an expectation that the numbers from the clinic on the Monthly Summary might be slightly lower than the number in the Restraint

Log. However, the difference of nine (9) restraints for April represented a possible 36% error, an uncharacteristically high and unacceptable rate. A review of the April data revealed counting errors in the preparation of the April report. Upon verification of the PRE by the clinic, the PRE numbers aligned with the Restraint Log entries from CSU. This confirmed the number of restraints at 46 for the months in question.

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

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

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

PARTIAL COMPLIANCE

COMMENT: The Special Investigations Unit conducts investigations under new and updated policy and procedure. Reviews of SIU investigations have revealed careful and thorough investigations, completed in a generally timely fashion. However, as the implications of the Settlement Agreement play out in the daily practice in the DOJ facilities, issues and concerns emerge that may not have been adequately addressed by the previous system. These issues and concerns warrant careful attention because they are systemic and represent an important element of compliance with the Protection from Harm paragraphs.

For example, Youth MI alleged that YDA KC placed his fist on her throat causing her to pass out. This allegation formed the basis for an investigation. Regarding Restraint 315881, the QA Report states that the Restraint Monitor stepped away from the restraint. Of concern is that Youth MI alleged that the actions of the staff performing the restraint impaired her breathing and caused her to lose consciousness. The Restraint Monitor report refuted these allegations. It was not possible based on the videos for QA reviewers to confirm or refute either claim. The Restraint Monitor report indicated that the youth claimed difficulty breathing. On page 11, the QA Report stated that a Restraint Monitor failed to document unauthorized or inappropriate techniques here. The failure of a Restraint Monitor to report appropriately may have an adverse impact on the adequacy of an investigation.

Another example is Restraint Packet #308697 (Youth TL, February 29, 2012). This is the incident where Youth TL accused YDA KC of punching her in her left eye. The Post-Restraint Health Report form did not indicate where the exam occurred or the staff member accompanying the youth to medical. The report indicated that the youth alleged

that staff YDA KC "punched me in my left eye and put his right elbow on my face." The pictures of Youth TL, while of poor black and white quality, seemed to reveal darkness under the left eye and what appeared to be a bump above the left eye. The youth claimed that she went to medical on the following day to have more pictures taken. The PH Monitor asked for these pictures but has not seen them. Similar to the situation created by use of force activities off-camera, the poor quality of some evidence works against the ability of investigators and the Monitor to resolve accurately and fairly allegations of excessive force and abuse.

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.

PARTIAL COMPLIANCE

COMMENT: The expectation of the prompt and appropriate corrective measures is an important part of compliance, even though most of the variables affecting this paragraph are controlled by Home Office and, therefore, systemic. Of concern for the Columbia monitoring is the appropriate corrective measure. The following narrative suggests additional work that needs to be done in order to determine an appropriate corrective response.

For example, regarding Reportable Incident (#F12005, SCR case number 28009410), the Video Review Form indicated YDA KC had his hand on the youth's face and that the takedown was not according to policy. The question here is whether this is an inefficient or unauthorized use of force. How does this relate to Paragraphs 41 or 42b? The Video Review Form contained no recommendation for documented instruction, but this occurred before the new clarification memo from Home Office.

Furthermore, the Post-Restraint Health examination form noted, "Face and nose-lips swollen. Right jaw bruised, states staff member punched resident in face. Left side of face-forehead appraised." Other injuries are noted on the form. The IAB report of investigation conclusion, printed June 5, 2012, was that the findings were unfounded, which seemed to turn on the following statements:

> The nurse reported the minor abrasions on the child's face are consistent with a child struggling with staff and being placed in a restraint. The nurse reported the minor injury is not consistent with the child being punched or staff *maliciously* pushing the child's face into the floor. (Emphasis added)

There are important questions here. Two concerns are expressed in the Settlement Agreement, first that staff do not use excessive force (42b) and second that staff do not use force or restraints as punishment (41). The nurse used the word "maliciously" for determining whether the injuries were consistent with a difficult physical restraint. The use of a non-clinical descriptor from a clinic staff member who did not observe the restraint seems inappropriate, and it should require clarification by Home Office or medical. This seems to be a separate issue from whether the youth's injuries resulted from excessive force. There was nothing in the report that addressed this distinction.

There needs to be greater clarification from medical about the extent of facial abrasions and injuries that are consistent with a physical restraint technique that, when implemented appropriately, does not include a facedown component (See comments for Paragraph 41 c). Clarification is important to guide SIU investigators regarding evidence of unnecessary, inappropriate, or excessive uses of force.

Another question arises about YDA KC who filed a complaint with NYSP resulting in a third-degree assault charge against Youth MI for biting during the restraint. Columbia staff reported that the local prosecutor issued a restraint order against Youth MI regarding any contact with the YDA staff. This is a strange arrangement.

Finally, issues surrounding a Corrective Action Plan require additional explanation. In the April 5, 2012 letter to Anita Sapio from Kerri Barber, Acting Director of the Division of Child Welfare and Community Services (Albany Regional Office), Ms. Barber requests a Corrective Action Plan on YDA KC regarding the physical restraint on January 14, 2012. Of particular concern is the statement in Barber's letter that, "the staff and Restraint Monitor who participated in the restraint on January 14, 2012, were interviewed and offered conflicting accounts when questioned about the use of unnecessary force and unauthorized force during the restraint." The Corrective Action Plan dated May 16, 2012, addressed the consistency of the Restraint Monitor with her report. What it did not do was to identify the "other" staff member referenced in Barber's letter and any information that might have been provided by this individual that could have contradicted the Restraint Monitor's perspective. The confidential interviews with staff during the monitoring visit resulted in a reasonable suspicion that the "other" staff member may have attempted to express concerns about an inappropriate use of force for this restraint. This concern was reported to Columbia Administration, which offered its explanation. If a coworker who was also a participant in the restraint complains about excessive force, the assumption is that the complaint will be handled consistent with Paragraph 44 a. Questions remain here.

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

COMMENT: The policy and procedures exist (PPM 2801.00, PPM 3247.00, PPM 3247.01, PPM 3247.12, 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.

The Daily Achievement System (DAS) was a concern regarding program consistency and, therefore, might require more training, or coaching, or both. Staff described a problem of not knowing how to grade a youth's behaviors. There seemed to be some conflict between the ideas of supplying some type of sanction for minor misbehaviors while simultaneously encouraging youth when they worked on problems identified by the New York Model.

A concern existed about Restraint Packet #315881 and the Physical Restraint-Request for Documented Instruction form, where the deficiency observed was described as "non-physical de-escalation techniques were not exhausted. Crisis Response and Radio Communications Policy was not followed, as it appears that the staff member did not call for assistance. It was not clear whether there was an imminent danger as the youth began to walk away from the furniture and the staff member prior to initiating the restraint." Documented instruction occurred on April 26, 2012 more than a month following the event. Again, there was no narrative or documentation of what the documented instruction included or any description of the employee's response.

Another concern includes the absence of clarity regarding the protocols for situations where youth have released themselves from a CPM hold. For example, in Restraint Packet #315880 (Youth MI, March 22, 2012), the video review included good examples of staff using supportive touch to move youth gently away from the restraint area in two (2) instances. Yet, the youth broke away from a staff restraint, and there was no mention of the larger question, if and how the restraint continues from this point.

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

PARTIAL COMPLIANCE

COMMENT: At the facility level, an isolated but substantial issue identified problems with adequate supervision of staff. Regarding Restraint Packet #277781 (Youth NB, January 1, 2012), the QA Report stated that staff from the Brookwood Secure Center (Brookwood) assisted Columbia staff in performing an unauthorized technique, whereby four staff picked the youth up by all four extremities and moved her to her room. In addition to an inappropriate restraint strategy, which seemed to work effectively because of the absence of strong resistance on the part of the youth, there were few behavioral indicators on the video of any imminent threat of harm.

The Video Review Form also mentioned the use of Brookwood staff. Several questions arise related to the assessment by Columbia Administration that the call for assistance to Brookwood was a mistake. The policy and procedure on this type of assistance indicate that the AOD is the on-site incident commander. Given the use of an unauthorized technique in the absence of an extraordinary circumstance, this event would qualify as inadequate supervision.

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.

COMMENT: These factors are mostly systemic and apply to Home Office.

III. MENTAL HEALTH MONITORING

An impressive amount of work on policies and New York Model training materials has occurred in recent months. The 6/12 OCFS six-month progress report indicated that almost all the activities in the original compliance plan have been completed. For the ten

mental health paragraphs of the Settlement Agreement, three policies have not been finalized (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 protocols related to developing uniform working diagnoses for mental health professionals and standards for substance abuse treatment are being developed. The MH Monitor cannot fully assess compliance until the policies are finalized and 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 Columbia.

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

Through treatment teams and Mental Health Rounds, Columbia staff are complying with 46c by modifying their interventions with each resident based on effectiveness.

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

Columbia reported that all staff attended all nine modules of New York Model training.

The policy 2801.00 "Training Requirements for DJJOY Staff" does not mention the New York Model, Sanctuary, or DBT. While some of the required training topics in the policy comply with the Settlement Agreement, it is the New York Model implementation training—which includes the new integrated assessment, the new treatment plan, and how to utilize both in the new treatment teams—that is more important for compliance with paragraph 46.

The MH Monitor reviewed the curriculum for direct care staff entitled "Mental Health for DJJOY Youth: Disorders, Interventions and Management Basics" which complies with the Settlement Agreement. A single all-day training (which also included Psychiatric Medication training) is too much mental health information to digest. Columbia leadership deserves recognition for re-designing this training for a series of shorter sessions. It has been well-received because mental health staff providing it have applied symptoms and diagnoses to individual residents, making it more relevant. All the Columbia staff, except six YDAs and one Recreation Specialist, attended the mental health and medication training.

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46a and b. These remedial measures are implemented at all four facilities with the New York Model. Documents have been developed to supplement the NY Model curriculum and support NY Model implementation components. These include implementation guidelines for treatment teams, facility rounds, phase advancement, individual intervention plans, youth orientation, and mentor program. Each facility will continue to receive implementation guidance and support from the Bureau of Behavioral Health Services. The requirements for behavioral treatment are outlined in the Behavioral Health Services policy (PPM 3243.33). Facility staff were provided orientation on the Behavioral Health Services policy. The requirement for mental health staff to provide regular consultation is part of the New York Model curriculum and is also discussed in the Behavioral Health Services policy (PPM 3243.33).

46c. This remedial measure is implemented at all four facilities. The requirement to regularly assess the interventions utilized is part of the New York Model curriculum and the integrated treatment team process. Oversight of this process and clinical supervision are discussed in the Behavioral Health Services policy (PPM 3243.33).

46d. This remedial measure is partially implemented. Each of the four facilities has a manual and documentation to provide orientation to youth on the New York Model. The current Resident Rules are posted for youth to see. However, the Resident Rules policy (PPM 3443.00) is being revised for consistency with NY Model, and these revisions are not yet finalized and have not been sent to DOJ for approval. OCFS sent a request to DOJ for extension to 12/19/12 for the Facility Admission and Orientation policy.

On Site Observations (6/12)

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, relationship-driven, culturally competent, and strengths-based teamwork to meet girls' needs is difficult with a population as troubled as the Columbia girls. Although it is challenging to meet the needs of girls--including new arrivals who have been ejected from other facilities for disruptive behavior--because of its committed staff, strong clinical team, and small size, Columbia has been successful with the New York Model. Columbia continues to improve its responsiveness to the needs of the girls, such as: to be treated respectfully, to have some control over what happens to them, to be praised, to calm themselves, to be less reactive to threat, to express anxiety, fear and anger safely, to compensate for their disabilities, to feel their family and culture are valued, and to have trusting relationships. Columbia staff support each other to avoid getting angry, defensive, or controlling, engage in power struggles or take girls' behavior personally.

The MH Monitor observed IIPs (Individual Intervention Plans) consistently in all the reviewed records of Columbia girls. It was not evident that any revisions in the IIP form to make it more consistent with the integrated assessment and treatment plan in the New York Model had yet occurred.

"We have done many chain analyses and Egregious Behavior Protocols. From these the girls develop self-control they have never had before, and staff are learning not to restrain and let the girls use their skills. Chain analysis has many clinical benefits. Girls are learning to tolerate distress. We can't just teach skills, we have to understand and help a girl understand what in the past is behind her aggression."

The DAS is another New York Model component that meets the requirements of the Settlement Agreement. The Columbia DAS sheet is well-constructed. It is organized into five sections. The first four are the SELF approach and the fifth is the girl's treatment goal:

<u>Safety</u>

- Follows program norms and expectations
- Uses Safety Plan
- Uses staff to help resolve conflicts
- Uses interpersonal effectives skills (DEAR MAN, GIVE, FAST)

<u>Emotion Management</u>

- Expresses feelings in a safe and respectful way
- Uses mindfulness skills (observing, describing, wise mind)
- Gives words for feelings rather than acting out

<u>Loss</u>

- Accepts directives, uses distress tolerance skills
- Accepts current circumstances without denial or blaming others
- Makes attempts to understand the effect of past losses on present

Future

- Shows by actions that she is working toward future goals
- Identifies realistic plans for the future
- Demonstrates that she is working toward short and long-term goals

Treatment Goal (the individual's goals are listed first)

- Reduce ineffective behavior
- Increase targeted effective behavior

Each of these five areas are scored daily during five periods: afterschool/group, dinner/evening, overnight, wake up/breakfast/AM school, and lunch/PM school. The DAS scoring sheets cover the 24-hour period from 2PM-2PM, and are reviewed at shift change. "In this process we help staff understand why a resident earned or didn't earn. The DAS is a success with the residents. The girls are able to keep it all in their heads, very aware points are being scored, and will challenge staff if they believe they earned points. The YDAs get support from clinicians and case managers (YCs) by talking about points. We saw what was working with the New York Model and we adapted. We've made good use of the mentoring notes and Red Flag meetings. We wanted to give the residents more choices in the DAS. When we don't focus on failures and the girls are using their skills, we were able to achieve a culture change." The staff acknowledge that the DAS has been a major change in the program for them, and it is impressive that staff find the time to review different staff views about whether a resident has earned a point. It is a strength of the Columbia staff that they value each other's different perspectives as they learn DAS together

"For some girls who came from Tryon, it was difficult to change to the New York Model phase system because they had to convert from the highest stage to a lower phase. AH [[redacted] who has been in Tryon/Columbia for more than two years] was in the highest stage, but she would not meet with her therapist or go to group. Eventually she was able to see that she had given up in the old system. She learned she had to demonstrate functional skills in the new system."

A key to implementation of the New York Model is a functioning team of coaches. A strong facility coaching team ensures that the New York Model becomes a way of thinking by staff and youth, rather than simply a clinical service. The Columbia coaching team, including the BBHS Director of Treatment Services who supports them, met with the MH Monitor and described their coaching approach:

- appreciating where staff are
- validating how staff feel
- clarifying the benefits of using New York Model in individual situations
- recognizing staff comfort level with changed practices

"The whole coaching team has to be purposeful and we can't be one-size-fits-all. A lot of coaching was built directly into the trial run of the DAS, with a lot of discussion about reframing, demonstration of skills, and using the pre-shift briefings on point earning as coaching. Everyone is learning to recognize that behavior does not occur in a vacuum and

are asking what is behind it. Staff have seen really difficult kids come here who have done badly elsewhere. The New York Model has worked. We have consistent staff who came back everyday and made it clear they want to be here. Staff here were not feeling recognized for the sacrifice they make spending time away from their families. Part of what helped was making the schedule more individualized, recognizing that when staff can carpool for their 1 1/2 hour commute, it really helps to having the same shifts and the same time off. We are coaching staff to coach girls to use the skills when they are not in crisis. Some of them have 20 years doing things the old way, yet they are learning not to do that anymore. We have a skilled workforce. They are learning to coach a kid through, when to step in and when to step back, but not have to stop the behavior. We don't run to rescue the kid. Let the kid handle it. Likewise, we as coaches have to learn not to rescue staff but encourage them as they handle it."

"We are coaching de-escalation. We help staff use their relationship with a girl to help her calm herself down. We remind them to 'give her some space.' We say, 'she's in crisis, but has not crossed the line in safety.' Then the girl realizes, 'They're going to help me through this without putting me on the floor.' A girl may not stop having restraints, but now they are shorter and she is able to say, 'I recovered quickly.'" Two girls were described who "get loud, but not aggressive or out-of-control who are not getting restrained because they are using their skills to calm themselves. With the QA review, we looked back on restraints in January and February and now feel good about where we are with the New York Model. We learned a lot going through this." The Columbia clinicians are considering how they could chart restraint decreases and recovering quickly for each girl. The Monitors also discussed with the QA Director the possibility of analyzing the type of restraint and length of restraint data for each individual youth to note trends during her stay as a progress indicator.

The challenge for New York Model implementation at Columbia is that girls who make progress may not be able to earn their discharge because they have long sentences. TB, for example, arrived [redacted] as an 18 year old JO with a 15 year to life sentence for murder. "She has a hard time seeing the JDs leave. She started with skills that she has built on and is at a high phase. But she is quietly depressed." TH, a 15-year-old JD, was admitted in March, 2012 and won seven school awards and has strong relationships with staff, but she has an 18-month sentence for assault.

The MH Monitor observed Mental Health Rounds at Columbia; the application of the New York Model was exemplified in the way the girls were discussed and the strong collaboration among the Assistant Director for Treatment, therapist, case managers (YCs), YDA, Psychiatric Nurse Practitioner, Chief Psychiatrist, and BBHS Director of Treatment Services (the teachers were off for summer vacation). In the observed Mental Health Rounds, they talked about two girls--the highest and lowest IQ girls, one JD and one JO. SK is a 17-year-old JD fennered to Columbia from Taberg almost six months ago, originally committed for Petit Larceny. She arrived with a history of many diagnoses, and her Columbia diagnoses are Mood Disorder and Generalized Anxiety Disorder. She is prescribed Zyprexa, Prozac, and Adderall. She experienced repeated physical and sexual abuse; the judge did not release her to her mother who had severely abused her. She presents many challenging treatment dilemmas, and is likely to be discharged in a few

months. She had 18 restraints for peer-to-peer conflict, with none in recent weeks. She is benefiting from therapy, particularly using chain analysis. Her therapist re-opened connection with her mother, "which was a turning point and she realized she loves her mother but cannot live with her. She is bright and insightful—has seen good child care here and now sees her mother's limitations. She has let two staff into her trusted circle, but gets angry if they let her down at all. Her mother taught her to fight, which is SK's only problem solving method." Her case manager (YC) has been doing job interview role-plays and getting applications for jobs to practice on. Mental Health Rounds was a forum for open sharing of disparate views of the resident, with disagreement about future planning. There was a discussion of the pros and cons of RTF placement and her trusting others in the future.

CP is a 16 year old JO with a 2-6 year sentence for attempted murder, who moved to Columbia from Tryon, with a total time more than a year to date and likely to stay another year. Her FS IQ of 72 is lowered by severe deficits in verbal comprehension. She is close to her large family where her aunt makes many decisions because her mother cannot [redacted]; she was abused by her father. She has many past diagnoses, previously Generalized Anxiety Disorder at Columbia, and now ADHD and Mixed Expressive-Receptive Language Disorder. She has been frustrated [redacted], refused medication, became paranoid, and refused treatment. The psychiatrist observed that because she has high anxiety, depression and paranoia, she would benefit from an antipsychotic, but now she will only accept Adderall, which has made her calmer. Her mentor is working 1:1 on anger, recognizing that with her cognitive limitations she has great difficulty learning from information presented verbally. She complains the unit and classroom are noisy and stressful, and she needs more distress tolerance skills. She has good hand-eye coordination, does well in videogames, got an award [redacted], wants to be a cook and seems talented in the kitchen.

The observed Mental Health Rounds was outstanding. These two residents were discussed in depth, with diverse views, and the participants enjoy a discussion where they do not have to rush. But there is disagreement about this approach to Mental Health Rounds with some emphasizing medication and others wanting to focus on therapy and other interventions. The Assistant Director for Treatment advocates having every resident discussed at Mental Health Rounds, not just those on medication. She said the "quietly struggling" residents would benefit from Rounds discussion to improve interventions, even if they are not on medication. The psychiatrist says all but one resident (TB) have a "mental disorder," and more than half are taking psychiatric medication. The MH Monitor observed that regardless of diagnosis, residents have mental health needs. The resident wit no diagnosis has needs from significant past trauma. She has needs related to her offense and the individuals with whom she was involved. She has needs from her long sentence and the knowledge she will go to prison from Columbia. She has educational and vocational needs. Asked by the Monitor, the participants in Mental Health Rounds agreed they are stimulated by what they consider comfortable tension among them—"everyone brings something different." "Rounds are supposed to challenge."

The DBT group the MH Monitor observed at Columbia was skillfully led by the therapist. The skill being taught was how to communicate what you want. DEAR MAN

(Describe, Express, Assert, Reinforce, Mindful, Appear confident, Negotiate) was reviewed. Role playing real situations with the girls was effective, with strong participation by the YDAs. Not all the girls participated which the leader was understanding about—for example, one girl had too much anxiety to participate, especially with a visitor.; another girl was having a bad day. The leader pointed out the disadvantage that only the 2-10 shift staff are able to participate—we discussed the idea of carving out a group time during school hours so morning shift and school staff could learn from such effective DBT role plays with girls.

Few Sanctuary groups have been held at Columbia in recent months.

The QA report reviewed three mental health charts at Columbia prior to the June 2012 monitoring visit. It reported that not all the individual treatment plans had been consistently updated. The QA report summarized positive reviews of services by the Columbia residents, with most of the 11 girls surveyed reporting that they helped develop their treatment goals, their family had participated in treatment team meetings, they were discussing release plans, and understood the DAS and phase system. QA found that of 37 Columbia staff surveyed, 35 reported being aware of the residents' IIPs and 30 said they participate in treatment team meetings. Most staff interviewed said they had not participated in Mental Health Rounds.

FUTURE MONITORING

When they are available, the MH Monitor will review:

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

The MH Monitor will observe the consistency of DBT and Sanctuary groups and the progress being made by residents.

The MH Monitor will observe New York Model coaching and the continued implementation of successful Mental Health Rounds, the Daily Achievement System, IIPs, and chain analysis.

The MH Monitor will discuss with the coaching team charting restraint decreases and recovering quickly for each girl as indicators of emotional regulation and how to reinforce it through the DAS, mentoring and treatment team.

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 Columbia were observed complying with 47a.

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

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This remedial measure is implemented at all four facilities. The CPM manual was developed and staff were trained. Staff received a full-day comprehensive training in Mental Health and Psychiatric Medications, which includes strategies to address mental health crisis. In addition, facilities have dedicated mental health clinicians, and Home Office has a crisis response coordinator to assist with such situations. In addition to implementing the policies listed above, OCFS oriented staff in the Crisis Response and Radio Communications policy. The Individual Intervention Plans (IIPs) are in use at each facility and include specific strategies to help the youth. Staff have training and guidance in how to work with youth in mental health crises.

On Site Observations (6/12)

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

The MH Monitor reviewed the draft policy 3247.60 "Suicide Risk Reduction and Response." "From the point of entry into the DJJOY system when evidence or information arises about the possible suicidal ideation, intent, or behavior of a particular youth, OCFS

will respond effectively to maintain the physical safety and emotional well-being of the youth." Two levels of Enhanced Supervision Status are used to maintain the safety of youth who experience suicidal ideation or who exhibit suicidal gestures or attempts. Suicide Watch (SW) requires entries in the unit log describing the youth's mood and attitude every 15 minutes and Personal Safety Watch (PSW) log entries every 30 minutes. In addition to staff training, suicide risk reduction in the physical plant, and mental health screening at admission, within 72 hours of admission every youth is assigned a clinician who assesses suicidal ideation or intent. Clinicians also do a mental health evaluation to determine when the youth is ready for modification or removal from enhanced supervision status with a safety plan included in the youth's Individual Intervention Plan and communicated to staff. This suicide policy complies with the Settlement Agreement.

There were 14 Personal Safety Watches at Columbia in the six months prior to the site visit, half in May 2012. One resident had four, one resident had three, one resident had two, and five had one. These were documented in their records.

As the PH and MH Monitors recommended under Paragraph 44 above, unless there are documented extraordinary self-mutilation risks for a particular resident, residents on suicide watch should be allowed the privacy of using the toilet and showering without being looked at directly. Staff should be vigilant about ensuring that a resident on suicide watch does not have access to ways to harm herself in the bathroom while at the same time protecting traumatized residents from being triggered by being looked at unclothed. When the MH Monitor inquired about the interpretation of "supervision" in the suicide watch policy, OCFS responded: "Supervision of a resident on Suicide Watch or Personal Safety Watch is considered to be focused on the youth, at close proximity (arms length), without staff assigned other responsibilities. This also applies during showers and hygiene. During training the staff is instructed to be discrete during showers and hygiene. Knowing that the youth is at high risk of hurting himself/herself, proximity is emphasized. Visual can be done by looking at their feet or head area, while maintaining discretion. Maintaining an unsafe distance or not being visually aware of what the resident is doing will increase the possibility of harm." It is recommended that in staff notes about SW and PSW and incident reports, staff describe using discretion during showers and toilet and looking at the resident's feet, which is trauma-informed conformity to policy to maintain visual contact with the resident.

The PH Monitor concluded under Paragraph 44 above that when a suicide watch follows a restraint, documentation must carefully distinguish between a restraint with injury from a suicide attempt with injury.

No Columbia resident went to a psychiatric hospital in the past six months.

IIPs were reviewed in residents' records at Columbia. That all residents have IIPs and that staff are familiar with each girl's IIP is a strength of the program. IIPs could be more individualized, although doing so and still keeping them brief is a challenge. Most girls include Time Away which is more complex than it sounds since it includes first, separating oneself from a provocative situation (without unacceptable behavior) and second, calming oneself down once separated. While separating might appear the same for most girls, the self-calming portion will be unique. What staff has to know from an IIP is

that to support a girl's emotional self-regulation they must individualize; for example, "How about time away? You could go in your room and read or draw or listen to music (depending on the girl) to calm yourself." Staff may say that they do this, but part of an IIP being a changing document is that a girl learns about self-calming from defining what others suggest she do before she escalates. Since so many girls are having difficulty learning to accept 'No" without feeling rejected or victimized, adding a specific response that may be more effective for that particular provocation than Time Away or Not Having an Audience is an improvement to safety plans that should be considered.

There is a difference in perspective between residents and staff about "proximity" as indicated by the PH Monitor above. Proximity is a term used in training and policy to encourage staff to help girls de-escalate by remaining close and attentive but not intervening, particularly in a way that might precipitate a reaction leading to a restraint: "By using positioning, proximity, restructuring and other proactive supervision practices and techniques, staff are expected to intervene and prevent potential crises from developing" (p. 3, CPM policy; see also PPM 3247.03 "Supervision of Youth"). But every girl the MH Monitor interviewed at Columbia described "proximity" in negative terms. They indicated that when staff "crowd" them, especially if they are upset, they will react to it and may lose self-control. For example, in one chain analysis the girl wrote, "They were using proximity and I didn't like that so I pushed staff." In an interview, she said, "We want our distance. Staff get too close. They should give girls space." Based on staff and youth feedback, OCFS is changing the use of the term proximity and revising the curriculum for more specific training on this technique.

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 observe coaching of staff on using IIPs to calm youth, de-escalation and chain analysis.

More discussion of the proximity issue, also noted in the QA report, is warranted.

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

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

b. Require that any youth whose mental health screening identifies an issue that places the youth at immediate risk is immediately referred to a

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

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

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

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

PARTIAL COMPLIANCE

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

Mental health staff at Columbia 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, complies with 48a.

There is one policy to be finalized as well as standards for treating clinicians regarding consistent diagnostic practices for the MH Monitor to determine full compliance.

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48a. This remedial measure is implemented. First, all youth arriving at Reception or any facility are initially screened by staff using OCFS 1448 Admissions Screening Interview. Youth arriving at Reception or directly at Secure Centers from detention receive an initial comprehensive mental health assessment. Within 72 hours of arrival at a facility other than reception or the initial secure facility, the youth is assigned a clinician who reviews prior mental health assessments, conducts and documents a clinical interview and screens for suicide ideation and symptoms of anxiety, depression or PTSD (OCFS revision, 9/27/12).

48b. This remedial measure is implemented in all four facilities. The procedure for referring a youth to a qualified mental health professional for evaluation is in place. The committee and procedure to transfer youth to a more appropriate setting was created. A memo outlining the procedure was re-issued 2/2/12.

48c. This remedial measure is implemented in all four facilities. The New York Model treatment team process addresses this remedial measure. In addition, the OCFS chief psychiatrist distributed psychiatric standards as well as articles on new diagnostic entities to psychiatrists. Psychiatric contact notes are shared as a regular part of communication with the treatment team. The Bureau of Behavioral Health Services offers ongoing training to professional staff.

48d. This remedial measure is implemented in all four facilities. The New York Model treatment team process and facility rounds address this remedial measure by facilitating regular communication between the psychiatrist and clinicians on each youth's working diagnosis.

48e. This remedial measure is implemented in all four facilities. All of the components listed in the remedial measure are part of the Psychiatric Evaluation form.

Review of Psychiatric Practices (3/12)

The MH Monitor's compliance review was assisted by record reviews, interviews and observations of Daphne Glindmeyer, M.D. (Board certified Child and Adolescent Psychiatrist) at a March 28 and 29, 2012 site visit; her review was at Lansing and Finger Lakes, but her findings are relevant to psychiatry practices at the four DOJ facilities. The MH Monitor adopts Dr. Glindmeyer's recommended finding that OCFS did not have current policy and procedure indicating the acceptable timeframe within which the psychiatric assessment must be completed following referral. Generally accepted practices are that emergency evaluations must be performed within 24 hours, urgent evaluations within 72 hours, and routine evaluations within 7-10 days. Timeframes should be stated in policy and procedure, with Quality Assurance determining whether assessments are completed within the designated time period.

The MH Monitor adopts Dr. Glindmeyer's recommended finding that psychiatric assessments and follow-up psychiatric treatment documentation was sparse, making it difficult to determine how they were utilized in clinical decision-making. In addition, in many cases clinical decision-making was hampered by the absence of prior treatment

records. The full implementation of electronic medical records is designed to resolve this problem soon.

The MH Monitor adopts Dr. Glindmeyer's recommended finding regarding the lack of diagnostic concordance between psychiatry and the other clinicians. She found that case formulations determining how specific diagnoses were made were lacking, so some psychiatric assessments noted symptoms on a checklist, but a diagnosis with no relation to the symptoms designated was assigned. Youth with significant substance abuse disorders did not have any recognition of substance abuse in the diagnoses assigned by psychiatry.

The MH Monitor adopts Dr. Glindmeyer's recommended finding that although the OCFS Chief of Psychiatry developed a format for psychiatric assessments that was updated 2/27/12, the psychiatric assessments reviewed were not consistent with generally accepted standards. They lacked detail, over-relied on checklists, and did not include appropriate case formulations or treatment recommendations. A psychiatric medication management progress note should document symptoms, response to treatment (or the lack thereof), treatment plan recommendations, and the youth's physical condition including weight, vital signs, and laboratory. The psychiatric review may include some checklist items for the mental status examination, but the psychiatrist should write about the youth's individual response to medication or other issues.

On Site Observations (6/12)

The Columbia staff are using the Integrated Assessment. In the assessments reviewed by the MH Monitor, a psychological evaluation was completed soon after the girl's arrival at Columbia, which resulted in more attention being given to the effects of past trauma and more clarity about the impact of cognitive impairments on her behavior. In addition, the Psychiatric Nurse Practitioner also considered past diagnoses in formulating a new diagnosis and medication (in some cases with the involvement of the Chief Psychiatrist). Observations from the unit, school, groups, and recreation were also included. The result is an Integrated Assessment that helps everyone understand the complexity of what is behind the girl's behavior that enhances the Integrated Treatment Plan.

If the Integrated Assessment and/or treatment plan has a different diagnosis than the psychiatrist's diagnosis, agreement must be arrived at about a diagnostic formulation through a collaborative process of considering the resident's history, the basis for the psychiatrist's conclusions, and the basis for the other clinician's conclusions. Youth must have diagnoses based on the presence or absence of specific symptoms and symptoms must meet criteria for the diagnosis. These collaborative case formulations should be documented in the Integrated Assessment initially or in a later addendum. The target symptoms necessitating treatment with psychiatric medication must be documented in order to determine to efficacy of medication.

OCFS indicated that "clinical staff are instructed to discuss the clinical diagnostic issues with the psychiatrist and other mental health providers, and that they are to then a reach a consensus diagnosis which encompasses all of the available clinical data. This may occur in one of the formal New York Model settings (such as Mental Health Rounds, Red Flag, or other meeting), but might also be via a spontaneous consultation between the

clinicians. A consensus working diagnosis is reached at the first support team meeting 30 days after arrival of the youth to the facility. The working diagnosis is updated as necessary. At the last team meeting, the discharge diagnosis will be reached by support team consensus."

The OCFS Chief Psychiatrist indicated that she composed the Psychiatric Diagnostic Evaluation and Psychiatrist Contact forms after consultation with colleagues elsewhere. Scales assessing anxiety, depression and ADHD were recommended to psychiatrists because of their good psychometric properties. This diagnostic and treatment documentation is placed in JJIS where it is accessible to clinicians, medical staff and administrative staff. The psychiatrists also read the BBHS contact notes prior to seeing the resident in order to see what has transpired since the last visit. A psychiatric evaluation is performed upon entrance to a facility if one has not been done within the prior 6 months within OCFS. If an evaluation has been performed within this time period, the psychiatrist can either do another or complete a Psychiatrist Contact Form at the time of the youth's first visit to the psychiatrist at the new facility.

Both peer review and quality assurance could assess achievement of this requirement. Peer review can be implemented for any clinical service professional (e.g. social work, psychology, physician). It is necessary that the reviewer is a peer of the reviewed (e.g. physician reviews physician). Quality Assurance could also document case formulation, designation of target symptoms, review of behavioral data, and appropriate documentation with regard to the efficacy of medication.

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.
- Protocols for developing uniform working diagnoses
- 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.

PARTIAL COMPLIANCE

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 required by the Settlement Agreement entitled "Introduction to Psychiatric Medicine" which is designed to inform direct care staff at DJJOY facilities about the principles of psychiatric treatment with medication and the side effects and complications that may occur with psychiatric medicines.

State Report on Progress (6/21/12)

This remedial measure is implemented at all four facilities. Staff received orientations on the Psychiatric Medications and Behavioral Health Services policies. Psychiatrists have been provided instruction and forms have been distributed to track psychotropic medication prescription and monitoring. The Standard Psychiatric Evaluation form covers the documentation required in the remedial measure. Psychiatrists

are required to enter psychiatric contact notes into the Juvenile Justice Information System (JJIS). A more targeted and specific procedure for psychiatric standards and guidelines is in development and will be provided to health professionals this year. Orientations for nurses on psychiatric medications monitoring are in progress; these are expected to be completed before the end of June 2012.

Review of Psychiatric Practices (3/12)

The MH Monitor's compliance review was assisted by record reviews, interviews and observations of Daphne Glindmeyer, M.D. (Board certified Child and Adolescent Psychiatrist) at a March 28 and 29, 2012 site visit; her review was at Lansing and Finger Lakes, but her findings are relevant to psychiatry practices at the four DOJ facilities.

The MH Monitor adopts Dr. Glindmeyer's recommended finding that in the cases she reviewed medication dosages were not excessive and there was not evidence of polypharmacy (the prescription of two or more medications from the same class or three or more medications from any class). When youth are prescribed three medications, the rationale for polypharmacy must be documented. Generally accepted practices require that therapeutic levels of specific medications are obtained within a period of time (generally two weeks) following the start of a medication, within a period of time (generally two weeks) following a dosage increase, and then periodically (every three to six months) during continuing treatment. Abnormal involuntary movement scale monitoring should occur prior to the prescription of antipsychotic medications and then regularly at intervals of three to six months. In addition, the laboratory parameters must be reviewed regularly as new medical information on monitoring specific side effects becomes available. Policy should include the requirement for frequent review and revision of the laboratory parameters. Policy requires that adverse drug reactions are reported to the Chief Psychiatrist and the Medical Director. There are certain adverse drug reactions that are reportable to the Food and Drug Administration. Quality Assurance monitoring, which could also include peer review, could monitor compliance with these laboratory practices.

Dr. Glindmeyer noted that youth in juvenile facilities frequently experience difficulty with sleep onset and maintenance and another sleep intervention should be used instead of psychiatric medications that have side effects.

Dr. Glindmeyer found that appropriate laboratory examinations were present in the youth records, but in many cases psychiatric documentation was inadequate to determine review of the laboratory results or the use of the results in clinical decision-making.

On Site Observations (6/12)

Ten of the Columbia girls have psychiatric diagnoses: Major Depression, Generalized Anxiety Disorder, Dysthymic Disorder, Mood Disorder, and ADHD. Eight of the girls were taking psychiatric medication [Trazodone (2), Zyprexa (1), Remeron (1), Lexapro (1), Zoloft (1), Clonidine (1), Nortriptyline (1), and Adderall (3)].

The MH Monitor observed documentation of diagnosis, symptoms, dosages, and administration of psychiatric medication in the individual records at Columbia. The Psychiatric Nurse Practitioner discussed medication in Mental Health Rounds (with input from the Chief Psychiatrist) and at the observed treatment teams.

Dr. Glindmeyer concurred with the MH Monitor's previous conclusion that meeting with the psychiatrist and their therapist together is often helpful for youth and informative for the clinicians about more than symptoms, medication, and side effects. Psychiatrists may meet with the therapist prior to seeing the resident and the therapist may not be in the psychiatric session with the youth; the psychiatrist may develop a therapeutic relationship with the resident that is separate from other relationships with facility staff, depending on a variety of circumstances.

There are draft standards in the final stages of revision that address the above requirements so that psychiatric practice will be consistent with generally accepted standards of care. Quality Assurance monitoring, which could also include peer review, can monitor compliance with these standards.

The Director of Psychiatry has developed schedules for laboratory monitoring and nursing review of medication side effects that hopefully will be revised and implemented soon.

The MH Monitor recommends a sleep hygiene program consistent with the coping skills taught in the New York Model.

QA reported that the Columbia residents knew which medications they were taking, that the side effects had been discussed with them, and most said the medications were helping them. Of 37 staff surveyed, 24 reported knowing the side effects of medications and 16 reported knowing which residents were taking medication.

FUTURE MONITORING

The MH Monitor will:

- examine final practice guidelines for psychiatry
- review case records at Columbia of residents prescribed psychiatric medication
- observe discussions of efficacy of medication at Mental Health Rounds and treatment teams at Columbia

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 (6/21/12)

This remedial measure is implemented at all four facilities. Staff received orientations on the Psychiatric Medications policy, the Behavioral Health Services policy, and the Refusal of Medical or Dental Care by Youth policy and received a full-day comprehensive training in Mental Health and Psychiatric Medications. The medical refusal forms are completed and kept in charts for psychiatrists' review.

On Site Observations (6/12)

During Mental Health Rounds the MH Monitor observed staff discussing medication.

Staff discussed their learning at the "mental health training" which was presented by facility clinical staff in a series of sessions including examples of youth known to the staff.

FUTURE MONITORING

The MH Monitor will continue to observe Mental Health Rounds, review records and interview staff regarding psychiatric medication.

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 (6/21/12)

This remedial measure is implemented at all four facilities. Staff received Orientations on the Psychiatric Medications policy and the Refusal of Medical or Dental Care by Youth policy, and received a full-day comprehensive training in Mental Health and Psychiatric Medications. All requirements of this remedial measure are in practice. The medical refusal forms are completed and kept in charts for psychiatrists' review.

On Site Observations (6/12)

The MH Monitor observed documentation in individual records that Columbia girls had refused psychiatric medication. Of the seven girls prescribed psychiatric medication, all refused medication at some point between 11/11 and 4/12. DK refused meds 63 times, CP 53 times, SK 23 times, and TH 20 times. The MH Monitor discussed this high rate of medication refusal with medical staff at Columbia. When a girl refuses her medication, the AOD, NPP and Chief Psychiatrist are informed. The Chief Psychiatrist reviewed the reasons for a high rate of medication refusal among Columbia girls and concluded that most were due to mother-daughter dynamics and peer pressure. The MH Monitor also observed that some medication refusers were late risers who might have benefited from more flexible medication scheduling.

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.*

COMPLIANCE

State Report on Progress (6/21/12)

This remedial measure is implemented at all four facilities. Staff received Orientation on the Psychiatric Medications policy, which includes informed consent procedures, and received a full-day comprehensive training in Mental Health and Psychiatric Medications.

On Site Observations (6/12)

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

FUTURE MONITORING

The MH Monitor will continue to review informed consent forms in records

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

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

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

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

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

e. Require that treatment plans are individualized for each youth, and that treatment plans include: identification of the mental and/or behavioral health issues to be addressed in treatment planning; a description of

any medication of medical course of action to be pursued, including the initiation of psychotropic medication; a description of any individual behavioral treatment plan or individual strategies to be undertaken with the youth; a description of the qualitative and quantitative measures to monitor the efficacy of any psychotropic medication, individual behavioral treatment plan or individual strategies utilized with the youth; a description of any counseling or psychotherapy to be provided; a determination of whether the type or level of treatment needed can be provided in the youth's current placement; and a plan for modifying or revising the treatment plan if necessary.

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

PARTIAL COMPLIANCE

Mental health staff at Columbia were observed complying with 53b and in the two treatment team meetings observed by the MH Monitor.

The, New York Model implementation training included 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. BBHS is revising the treatment plan and integrated assessment to make them fit the New York Model training. Once the documents are revised, more coaching will be necessary improve staff skills in identifying needs and writing goals with the young person.

State Report on Progress (6/21/12)

53a, b, d, e, and f. These remedial measures are implemented at all four facilities. Sanctuary, the SELF (Safety, Emotions, Loss and Future) model, the Individual Intervention Plan (IIP), DBT, and the integrated treatment plan, all components of the NY Model, as well as the psychiatric evaluation, directly address this remedial measure. As part of the New York Model, the Integrated Treatment Plan and Integrated Assessment Form were completed in July 2011. The Integrated Treatment Plan includes all of the requirements in the remedial measure, which are outlined in the Behavioral Health Services policy. Integrated treatment planning is part of the New York Model program and process, and treatment team meetings are required to be held for each youth every thirty (30) days. The psychiatrist's input is included through contact notes and the psychiatric evaluation (including working diagnosis). NY Model Treatment Team Implementation Guidelines were completed in October 2011 and staff from the Bureau of Behavioral Health Services have worked with each facility to implement the new procedures and forms. The documents and forms undergo continuous evaluation and modifications based on actual experience and feedback from the Mental Health Monitor.

53c. This remedial measure is partially implemented. While youth are present for every treatment team meeting, it has not been possible to have the treating psychiatrist present at every other treatment team meeting for every youth in his/her care. OCFS

intended to address this measure with increased psychiatrist availability, and received approval to hire full time psychiatrists at each facility. However, recruitment remains a challenge. Currently, psychiatrists are available at each location only part time, and their limited number of hours prevents them from attending treatment team meetings. To meet the spirit of this remedial measure, OCFS has taken steps to include the psychiatrist's input at the treatment team meetings by using their contact notes, and to generally increase communication between the psychiatrist and clinicians during facility rounds and other informal communication. The State has requested an extension until December 19, 2012 to give time to discuss this remedial measure with the Department of Justice and the Monitors.

On Site Observations (6/12)

The MH Monitor observed two treatment teams at Columbia.

LH is a 19-year-old JO/YO who arrived at Columbia six months ago for a robbery in 2008. The integrated assessment (1/12) was superficial, finding no trauma because she "denied physical or sexual abuse." But she had a history of being bullied, her parents separated, she moved to her father's because of conflict with her mother, [redacted] There was no assessment of her emotional needs, her substance abuse, or her educational needs (in 11th grade), nor did the integrated assessment reflect the care put into her diagnosis by the Chief Psychiatrist and NPP in evaluating symptoms and scores on anxiety and mood questionnaires. Her Integrated Treatment Plan (4/12) indicated that her strengths were being close to her father, cooperative decision-making, staying focused on goals and being spiritual; she also is determined to attend college. She wanted to be calmer, was learning in therapy that "her anger was controlling her life, but everyone irritated her." She had Red Flag meetings regarding school and medication. Four months after admission [redacted] "her ability to control her emotions" appeared to be declining. She escalated quickly, was often aggressive, had several restraints, and was difficult to de-escalate but would calm down in her room; she discontinued the antidepressant after her brother convinced her the side effects were harmful. The goals in the previous treatment plan in her record were: (1) Decrease number of times she has a negative attitude (in addition to using the skills of "asking for time away when angry and reflecting on overreaction and negative behavior," she was meeting with her therapist weekly to work on ignoring others); (2) Decrease number of time restrained (by "using safety plan before losing self-control and mindfulness to recognize situations that triggered her anger, and observe others' behavior rather than react to them). Individual therapy notes about every 9-10 days indicated that her self-control was improved on Remeron, with no restraints in a week in early June. In the treatment plan dated the day of the treatment team, her treatment goals were "would like to remind herself that accepting the word 'no' can have positive consequences. She wants to take the GED exam and pass it before she leaves placement." In both treatment plans, staff roles in helping her meet her goals was not spelled out—clinical care, rather than each staff's New York Model work with her, was the focus so the plan was more of a mental health plan than an Integrated Treatment Plan. Her family treatment goal was "She would like her family to focus on her present goals and let go of her past negative behaviors." At Mental Health Rounds her

diagnosis was listed as Major Depressive Disorder. "She's now taking Remeron, despite a lot of pressure from her mother. She had to reach bottom." [Note: 6/26/12 psychiatric medication list did not indicate than LH is prescribed Remeron] "Accepting 'No' is really hard for her. She is learning it can have positive consequences, not just taking things away and not allowing her to do what she wants." The observed treatment team was LH's last before leaving and she was described as stable, happier with herself, and hoping to pass the GED soon. LH, responding to a question about her accomplishments at Columbia, said, "My behavior and attitude are not as hostile. I have more self-control. Medication is helping me. My mentor made me a new journal and I use it as my safety plan. I am motivated to go home. [redacted] Her mentor gave her feedback: "I'm going to miss you when you leave, but I know you are going home to what you want to do [redacted] Being here you had to face your problems. You are an asset on our unit. You teach other girls DBT and we appreciate how you help in groups." Her teacher said, "You are bright and capable. You became very focused." The NPP said, "I'm really proud of where you came from. You didn't want medication, you didn't want to come to my office." LM responded, "There are so many people here to pick you up, but you have to want to help yourself. In here, I learned how to handle my emotions, calm down, not lash out." This treatment team was a strength-based rewarding experience for the resident. The MH Monitor's concern is that the final treatment team meeting has not been conceptualized as a formal transition during which the resident and staff plan the details of what she will do in the community to use the skills she has learned so that her gains made at the facility continue. JOs released from Columbia is sent home on parole with no supports. LM has to be prepared to advocate for herself and organize support at home and in her community that can pick up where Columbia staff left off. It is not enough to have the final treatment team be a recognition of progress and everything learned. The resident should be prepared to come to the final treatment team having worked with staff on concrete, realistic plans for how the skills learned at Columbia will be applied at home.

LM is a 17-year old JO/YO at Columbia for almost seven months with a one-year sentence for robbery. Prior to admission, she was diagnosed with PTSD as a result of domestic violence at home, people being shot at and killed in her neighborhood, and painful and scary medical treatment in a hospital. Her 4/12 Integrated Treatment Plan included a diagnosis of Major Depressive Disorder and Generalized Anxiety Disorder: "…assaultive and self-harming behavior for a long time, but now engaged in individual treatment, complying with the program and is highly motivated by visits from her mother." She had a negative reaction to Abilify, and was prescribed Lexapro. The goals in her treatment plan were: (1) Decrease verbal and physical aggression to solve problems (using mindfulness skills to prevent aggressive actions/words) and 2) Develop methods of self-control (mindfulness, coping skills in safety plan and accept help from staff). The plan contained a list of some staff roles, but not all, to support her meeting her goals. Her fights with peers led to almost weekly chain analyses in April and May. In an interview, LM talked about getting along well with staff. The MH Monitor observed LM's last treatment team before she leaves, and staff reported that "She gets a lot of support at Columbia and not at home. People in her life use aggression to solve problems—it is very hard for her to reject the values she grew up with. Her mother is lenient. Her father uses violence to gain control. LM is working hard in therapy, especially connecting the past to her present

behavior. She is struggling with not getting her way. Her mother wants her released off medication, but she is taking an antidepressant that has benefits." The team discussed her language disorder—the psychologist explained, "She can't tell you her emotion because she can't retrieve the words for it. Also her reading level is low and she requires 1:1 teaching. Because she appears to be aggressive, people might not see how much effort she's putting into managing all her challenges." LM, responding to a question about her accomplishments at Columbia, said, "People have helped me. Here I got to be a kid. I've improved my reading. I'm a blunt person. I sometimes don't have a lid." Her goals were discussed:

1. Decreasing aggression to solve problems
- Increasing self-control.
- Past has to be the past
- "I'm trying to have a screen so I don't say bad things."

2. Go to school
- Hard to focus without medication
- Accepted help from teachers

Her mentor gave LM feedback: "You made a complete turnaround here. It wasn't easy. You are using coping skills on your own. You are learning that people are always going to talk and you can keep yourself from getting mad." Her therapist gave LM feedback for handling something effectively on the unit: "You use DBT skills and don't even know it." LM commented, "I'm trying to take responsibility for my choices, my actions. I deserve my phase. I struggled, I achieved." She also talked about improvements in her relationship with her mother: "She tells me I've changed. It feels good to hear her say she's proud of me."

Columbia staff are making progress at learning how to write specific treatment goals based on the needs behind each girl's behavior. An integrated treatment plan states needs that can be met by all staff differently, many of which will not be therapy. Figuring out the unmet needs behind their behaviors to make sure each girl is an active player in getting her needs met requires a specific, needs-driven treatment plan explicitly connected to the skill building of the New York Model.

"OCFS Consulting Child Psychiatry Services" (2/14/12) requires that, in addition to seeing residents individually for medication management, the psychiatrist, "will attend a 1 hour weekly mental health rounds with clinicians, teacher, and representative from the on-line staff to discuss youth in his/her case load. He will attend other treatment meetings if time permits." Columbia has been fortunate to have a Psychiatric Nurse Practitioner, but her recent departure may present the scarcity of psychiatric resources noted by Dr. Glindmeyer at Lansing and Finger Lakes. Hopefully, OCFS is successful in its exploration of telepsychiatry, physician extenders (e.g. psychiatric nurse practitioners, physician assistants, residency/fellowship programs (including possibly a consultative rotation for forensic or child/adolescent psychiatry fellows via telepsychiatry or "moonlighting" program for residents or fellows under the supervision of a board certified/board eligible child and adolescent psychiatrist), contracting with a locum tenens company, and/or the identification of a "floater" who would provide services and coverage across the system. An objective measurement should be developed of the amount of psychiatric resources

necessary at each facility's maximum population level (e.g. amount of time necessary for initial evaluations, medication management, crisis intervention, Mental Health Rounds and treatment team meetings) and from the estimated time required, an optimal full time equivalency level should guide recruitment.

If psychiatrists are not board eligible or board certified in child and adolescent psychiatry, clinical consultation with a board certified or board eligible child and adolescent psychiatrist is required, especially for youth under age 16. System-wide, OCFS has eight psychiatrists board-certified in child and adolescent psychiatry and seven psychiatrists certified in general psychiatry only. The Chief Psychiatrist has two monthly phone conferences with all facility psychiatrists. Three psychiatrists also participate in individual monthly scheduled phone conference. The Chief Psychiatrist also provides the required clinical consultation through additional discussions with the psychiatrist individually.

Policy sets the standard of care, (e.g. youth prescribed psychiatric medication will be seen monthly to review their psychotropic medication) and timelines for the completion of psychiatric clinical activities (e.g. youth referred for an initial psychiatric evaluation will be seen within a specified time period). Then quality assurance monitoring of the treatment log could ensure that these standards were met and could guide conclusions about systemic issues such as insufficient psychiatry resources in a facility.

FUTURE MONITORING

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

The MH Monitor will continue to review psychiatry coverage.

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 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.

The MH Monitor reviewed the curriculum for the DBT for Substance Abuse training—including Structuring the Treatment Environment, Dialectical Abstinence in DBT-SUD, Chain Analysis and Task Analysis in DBT-SUD, and Working with Families in DBT-SUD.

The DBT and Substance Abuse training demonstrate progress in complying with the Settlement Agreement. The curriculum does not describe 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. A necessary element of coaching on New York Model implementation is ensuring that each resident integrates DBT skills learned in substance abuse treatment with those learned in DBT group and the coping skills learned through SELF. This will require strong communication in treatment team and MH Rounds among the therapist, substance abuse counselor, YCs, YDAs and the rest of the team on how to support each resident's individual progress in self-calming at Columbia and how that can reduce her reliance on substances. 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 waiting to review the details of the integration of individual and group chemical dependency treatment in the New York Model by OCFS clinicians at Taberg, Columbia, Finger Lakes, and Lansing.

State Report on Progress (6/21/12)

This remedial measure is partially implemented. Regarding substance abuse prevention education, OCFS uses the curriculum Innervisions, which has recently been updated based on information from the National Institute on Drug Abuse. All four institutions will be providing this training by the end of June 2012. Regarding substance abuse treatment, OCFS created and obtained approval to hire a Substance Abuse Social Worker at each of the four facilities. Recruitment over the past two years has been a challenge. OCFS is working with OASAS to finalize standards that will guide substance abuse treatment in OCFS facilities. OCFS has selected a substance abuse treatment curriculum targeted for girls called Triad, which will be piloted at Columbia, Lansing, and Taberg this year. This curriculum is consistent with DBT and Sanctuary concepts. In addition, to facilitate integrated, trauma-informed treatment, each of the SA/SWs will be trained to address substance abuse issues through teaching DBT skills, and all clinicians will be trained to include goals around substance abuse when working with youth. OCFS requested a six-month extension to implement this remedial measure.

On Site Observations (6/12)

The new full time social worker is providing substance abuse services at Columbia. She is using a curriculum for group and individual treatment which she thinks will fit well with DBT at the facility. She got a substance abuse screening form from another facility and was about to screen all 11 residents. When the next new resident arrives, she will begin routine admission substance abuse screening and it will become part of the integrated assessment. She is thoughtful about the connection between trauma and substance abuse.

OCFS indicated that the Triad curriculum is "aligned with the components of the New York Model" and that it is being piloted at the four DOJ facilities. The MH Monitor will review the effectiveness of this treatment approach in preparing residents to resist internal and external pressures to abuse substances when they return to the community.

FUTURE MONITORING

The MH Monitor will review a description of chemical dependency treatment in the New York Model utilizing DBT and Sanctuary and in the context of the integrated assessment, treatment plan and treatment team process, including PPM 3243.33 and a review of the effectiveness of the Triad curriculum.

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

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

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

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

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

PARTIAL COMPLIANCE

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

The MH Monitor reviewed the Transition Plan screens from the OCFS Juvenile Justice Information System dated February 2012. These indicated that iLinc Training scheduled in 2 1/2 hour blocks would be offered several times per week between 3/8/12 and 4/25/12. The 2-page computerized Transition Plan form has ten sections: (1) identifying information, including family, CMSO (aftercare), community service provider, attorney, other important adults, supportive peer resource; (2) housing (where the youth will live and plan if housing must be found before re-entry; (3) health insurance information; (4) educational/vocational program planned and additional steps to arrange for it; (5) adult permanency/alternative release resource; (6) continuing support services and additional steps to arrange for them; (7) important documents still required; (8) workforce support and employment services; (9) pregnant/parenting youth (if applicable); and (10) youth's safety plan.

State Report on Progress (6/21/12)

This remedial measure was implemented at all four facilities. Transition planning for youth with mental health needs (and all youth) is implemented. For youth with continuing mental health service needs, two forms are used: the Continuity of Care Plan, which includes specific contact information for all types of mental health service referrals

and appointments, as well as current medications; and the Transition Plan, which includes more general release information such as legal contacts, housing plans, health and health insurance information, educational/vocational plans and career assessment, permanency plans, continuing support services, identification and other documents, and other safety concerns or issues. The Continuity of Care Plan has been in use since July 2011. The Transition Plan was revised in early 2012 and training on entering the Transition Plan information into JJIS was concluded at the end of May 2012.

On Site Observations (6/12)

MA is a 15-year old JD released to the community shortly before this site visit after six months at Columbia. She had previously been at Taberg for a 2010 Grand Larceny and was fennered to Columbia. Her therapist prepared a detailed summary of her history and progress at Columbia, called a Transition Plan, which had a final paragraph regarding release location and services. Her trauma history included: removal from her mother's care as a young child due to her mother's substance abuse, placement in foster care and return to her mother's home; the death of her stepfather to whom she was close; sexual abuse; she was not communicating with her mother when she arrived at Columbia. Her initial diagnoses at Reception included Conduct Disorder, Cannabis Abuse, Alcohol abuse, Parent-Child Conflict and Attention Deficit Disorder, NOS. At Columbia, depression was diagnosed and she worked in therapy to address her hopelessness and low self-concept, doubting that she could achieve her career goals or even sustain herself outside of a facility. She slowly developed trust in staff, demonstrated many functional skills and moved up in the NY Model Phase System. The treatment plan in MA's record had two goals: think about and discuss how her emotions affect her decision-making and recognize how she has been able to accept help and improve relationships with others. As part of the therapy described above, mindfulness, distress tolerance, and emotional regulation skills helped MA achieve these goals at Columbia. Columbia transported her mother to family therapy at the facility followed by regular telephone sessions, and "ultimately MA was able to go home because that connection was re-built. She was able to tell her mother what was really bothering her about their past life and her doubts about their future together. Her mother was supportive of her daughter's therapy and admitted her past mistakes and what she has learned from her own struggles with recovery." The Transition Plan noted the outpatient mental health center she was scheduled for and indicated her mother was involved in that choice and she and MA had been treated there before. MA's transition plan was much more thorough that her OCFS Mental Health/Psychiatric Medication Continuity of Care Plan, but her detailed report transferring her needs and goals from the facility to the community so everyone in her life understands what they can do to insure her needs are met after she leaves is not typical of the transition plans the MH Monitor has reviewed

The MH Monitor reviewed the one-page Mental Health Continuity of Care plan for MA. It provided the name, location, and phone for the mental health center for counseling, family therapy, and medication management in the community. She was released on Abilify, Trazodone, and Adderall, and dosages were listed in the plan. In contrast to the transition plan, the Continuity of Care plan did not make a connection with her Columbia treatment plan, her future goals, or her progress at Columbia.

OCFS indicated that "Continuity of Care Plans and Transition Plans are meant to be looked at together. Both are used; neither is meant to be a single reference point. They are completed by different staff and meant to be used together when a youth is discharged. The Continuity of Care Plan contains protected health information and as a result of HIPAA laws, it cannot be shared with everyone. The Transition Plan does not have the same restrictions. It is not OCFS' intention to combine these two forms."

The new Transition Plan screens comply in part with the Settlement Agreement by including information about all aspects of the youth's services in the community. However, the two most important functions of a Transition Plan are: (1) Providing specific guidance for a resident's family, school and other providers about her needs and how each of them can support her distress tolerance, self-calming and interpersonal effectiveness skills (including a Safety Plan she will rely on in the community); and (2) Giving a single reference point for assistance for the young person to reach her goals, so each person involved (youth, family, OCFS staff, service providers) has the telephone number and address of each person/service on the youth's community support team. A transition plan should define how a resident's treatment plan and gains in the facility will continue in the community: if, for example, one of a youth's goals in the facility was "Learn how to manage frustration," then in the last treatment team meeting before re-entry, important supporters in the community would have been present or on tele/video conference so they understood their role in helping the youth tolerate frustration in the community. Just as the youth and everyone on her team at the facility use her treatment plan to assess progress and refine supports, OCFS should help the youth, her family and community services be able to rely on her transition plan. Through the New York Model OCFS has implemented the integrated assessment and integrated treatment plan, and an *integrated* transition plan that includes all elements of a youth's successful re-entry to the community without violating HIPAA is necessary.

FUTURE MONITORING

The MH Monitor will review transition planning with recently released residents.

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

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

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

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

PARTIAL COMPLIANCE

COMMENT: A positive element of the monitoring process is the creation and implementation of the Quality Assurance (QA) Programs. The Monitors' discussions with QA staff members have been extremely productive. The quality of the staff and products produced by QA predict that it will become an important component of compliance with the Settlement Agreement paragraphs. QA has already developed a template for conducting reviews of the named facilities. Furthermore, the quality of the QA pilot report for Columbia was excellent. The report was thorough and informative. The recommendations followed policy and procedure and were connected to the Settlement Agreement paragraphs.

The critical and yet to be developed aspect of QA will be the recommendation and approval by the Monitors of empirical compliance indicators and thresholds. The use of OCFS data will be helpful in the establishment of these indicators and thresholds.

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

COMMENT: quality assurance report contains several recommendations regarding issues that need to be addressed. These concerns maybe within the boundaries of existing policies and procedures, but they warrant discussion and consideration.

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

COMMENT: No corrective action recommendations exist as a result of the Columbia monitoring visit.

V. SUMMARY

Following the November 2011 monitoring visit, Columbia was the named facility closest to invoking Paragraph 77.c. Columbia had more Settlement Agreement paragraphs evaluated as "compliance" than any of the other named facilities. The hope was that the current monitoring this would affirm the initial compliance assessments and reveal other paragraphs in full compliance. What happened between January and April proved to be an unsettling even dangerous time for the youth and staff at Columbia. While there is substantial evidence that the Columbia staff can and will return operations and programs to a level similar to or better than November 2011, the fact remains that there was an extended period when the facility was, by all indicators, unsafe. Therefore, partial compliance is the only appropriate designation until Columbia demonstrates a greater ability to mitigate the problems that jeopardize Protection from Harm. With the full

implementation of the New York model, the likelihood of achieving and sustaining November 2011 levels or better seems quite probable.

Appendix A

The Role of the Restraint Monitor

The Participant Training Handout for the CPM policy 3247.12 on page 44 states:

Restraint Monitor - A trained staff member assigned to respond to restraint situations to reduce the risk of harm to youth and staff. The Restraint Monitor observes the youth for signs of physical and emotional distress, and directs and coaches staff regarding the appropriate use of the youth's Individual Intervention Plan.

Additionally, on page 50f, the policy reads:

F. Role of the Restraint Monitor

1. The Restraint Monitor is a trained staff member mandated to respond to physical restraint situations to make them safer for youth and staff. Whenever practical, the Restraint Monitor will respond to situations with the potential need for use of physical restraints before them becoming a restraint situation. When observing a restraint in progress, the monitor surveys the scene for environmental factors (e.g. furniture and potential weapons) that may be dangerous, observes the youth for signs of physical and emotional distress, and directs and coaches staff regarding the appropriate use of physical restraints. Signs of physical and emotional distress may include:
   - Difficulty breathing
   - Youth's claim of difficulty breathing
   - Lack of responsiveness
   - Vomiting
   - Incontinence
   - Inability to speak
   - Loss of consciousness
   - Verbalizations that are disconnected with the events of the restraint situation
2. The Facility Director is responsible for assigning a trained Restraint Monitor to respond to restraint situations for each tour of duty. The Restraint Monitor shall normally be a staff at SG 18 or above. When no Restraint Monitor at SG 18 or above is available, the facility director/person in charge may assign any staff trained to be a Restraint Monitor to fulfill this function.
3. Facilities will designate more than one trained Restraint Monitor per tour of duty to permit timely response to restraint situations.
4. Staff designated as Restraint Monitor(s) will be clearly identified on the facility master staffing schedule.
5. The Restraint Monitor is authorized to direct all activities related to a potential physical restraint incident/restraint incident. Staff will comply with all instructions from the Restraint Monitor.

6. The Restraint Monitor will observe and evaluate the effectiveness of the interventions utilized and report such observations in writing on form OCFS-2094, Restraint Monitor Report.

7. If the Restraint Monitor observes staff-on-youth abuse, maltreatment, or any other non-therapeutic practice, he or she shall take steps to immediately stop the behavior and promptly notify the facility director or person in charge. As required, the Restraint Monitor will report suspected abuse or maltreatment to the Statewide Central Register of Child Abuse and Maltreatment (SCR) in accordance with PPM 3456.00 Child Abuse and Maltreatment in OCFS Facilities Operated Pursuant to Article 19G of the Executive Law, adequately document the matter, and complete an activity report, form OCFS-2079, Activity/Incident Report.