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

# Facility Monitoring Report:
# Finger Lakes Residential Center
# Lansing, NY

**Marty Beyer, PhD**
**Mental Health Monitor**

**and**

**David W. Roush, PhD**
**Protection from Harm Monitor**

**January 31, 2013**

**INDIVIDUAL FACILITY MONITORING REPORT:**

**FINGER LAKES RESIDENTIAL CENTER**

**Lansing, NY**

## I. INTRODUCTION

This is the ninth 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 Finger Lakes Residential Center (FLRC) on November 6-9, 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.

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.

### A. Facility Background Information

FLRC is a 109-bed limited secure facility with 10 living units in one building that also contains the school and gym. The physical plant was designed using the latest technical security and open spacious areas optimizing supervision of youth. Patrick Sullivan detailed the physical plant in pictures and narrative in the recent American Correctional Association (ACA) publication on evidence-based design and construction for juvenile facilities.

On November 6, 2012 there were 62 boys at Finger Lakes on six generic units. The 62 boys ranged in age from 13 to 17 (13-2, 14-9; 15-20; 16-20; 17-11). They had been at

Finger Lakes from 5 days to 484 days (16 had been there for about a month or less, 16 for one to about three months, 19 for 4-5 months, and 11 for six months or more). The 62 boys were committed for: Robbery (14), Assault (11), Weapon Possession (9), Grand Larceny (6), Criminal Possession (5), Petit Larceny (4), Burglary (2), Stolen Property (2), Criminal Mischief (2), Trespassing (2), Graffiti (2), Menacing (1), Possession of Marijuana (1), and False Fire Report (1).

Nineteen of the 62 boys at Finger Lakes are prescribed psychiatric medication. Their diagnoses are Mood Disorder (7), Primary Insomnia (7), ADHD (4), Conduct Disorder (3), Disruptive Behavior Disorder (1), Oppositional Defiant Disorder (1), and Dysthymic Disorder (1). They are prescribed the following medications: Benadryl (8), Abilify (3) Concerta (2), Guanfacine (2), Risperdal (2), Trazodone (2), Clonidine (1), Diphenhist (1), Melatonin (1), Naprosyn (1), Remeron (1), Risperdone (1), and Seroquel (1).

## B. Assessment Protocols

The assessments used the following format:

### 1. Pre-Visit Document Review

The Monitors submitted a list of documents for on-site review. The Monitors worked with the Office of Children and Family Services (OCFS) to make the document production and review processes more efficient, especially ways to make the transportation of documents easier for Home Office without compromising the quality of information provided. The Monitors also received the *Pilot Program Review: Finger Lakes Residential Center* (Draft) or the QAI Report from the Quality Assurance and Improvement (QAI) Bureau in advance of the monitoring visit.

### 2. Use of Data

OCFS has a good management information system with access to a wide range of data. A further review of the system and its capabilities allowed for the development of Excel spreadsheets that 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 received the OCFS third Six-Month Progress Report on the MAP on June 20, 2012.

### 3. Entrance Interview

The entrance interview occurred on November 6, 2012 and included the Monitoring Team and OCFS representatives, including key staff members from the facility. The meeting provided an opportunity for introductions, informal discussion of institutional goals and objectives, an overview of the assessment process, a review and discussion of assessment instruments, and the scheduling of the remaining assessment activities. Those in attendance included: Brenda Aulbach, Facility Director; Debby Bacinelli, Assistant Facility Director - Treatment; Sheryl Benedict, Nurse Administrator; Sandra Carrk, Project Manager; Diane Deacon, Assistant Deputy Counsel; Todd Etchison, Assistant Facility Director - Programs; Scot Lamphier, Assistant Facility Director - Programs; Edgardo Lopez, Settlement Agreement Coordinator; Charles Snowberger, Education Director; Scott Steelman, Assistant Facility Director – Treatment.

**4. Facility Tour**

Walkthroughs of the facility followed the entrance interview. The Protection from Harm 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 five support team meetings, two Mental Health Rounds, a Sanctuary group, and a DBT group, met with the clinicians, and reviewed seven residents' records.

**6. Staff Interviews**

The Monitors interviewed 45 FLRC staff. In addition to group meetings with staff, the MH Monitor interviewed two Youth Counselors (YCs), a Youth Division Aid (YDA), four clinicians, and Physician Assistant individually. The PH Monitor interviewed eight (8) Youth Division Aides (YDAs), 12 YCs I and II, one Facility Director, one Assistant Facility Director, one physician's assistant, one (1) nurse administrator, two (2) nurses, and one (1) Administrator on Duty (AOD). Of the eight (8) YDA staff members who participated in interviews, the average age was 43 years old with 12 years of experience, and 88% were male.

**7. Resident Interviews**

The Monitors interviewed 10 boys; the MH Monitor interviewed four (4) boys individually and the PH Monitor interviewed six (6) boys with an average age of 15.5 years old and an average length of stay of 4.5 months. Interviews occurred in areas with reasonable privacy from staff. The Monitors selected the youth for interviews.

**8. Exit Interview**

The exit meeting occurred on November 9, 2012. The Monitors expressed their appreciation for the cooperation and hospitality of the FLRC and other OCFS staff. The Team then highlighted areas of importance and concern, but not findings. The exit meeting was a time for questions, clarifications, and explanations of events and impressions before the draft report went to both Parties. Those in attendance included: Brenda Aulbach, Facility Director; Mel Barvinchak, LMSWII Social Worker; Deborah Bacinelli, Assistant Facility Director - Treatment; Katie Beard, Clerk II; Sheryl Benedict, Nurse Administrator; Sandra Carrk, Project Manager; Diane Deacon, Assistant Deputy Counsel; Anjeanelle Donovan, LMSWII; Todd Etchison, Assistant Facility Director - Program; Bettie Fedrizzi, RN; Michelle Ford, YDAII; Deborah Fowler, Teacher IV; Melissa Fuka, LMSWII; Dr. Constance Graham, Associate Psychologist; Scot Lamphier, Assistant Facility Director - Programs; Steve LeFave, YCI; Dr. Rebecca Levin, Licensed Psychologist; Edgardo Lopez, Settlement Agreement Coordinator; Brittney Mainville, YDAII; Donna Moon, HSTSII; Tom Murphy, Vocational Specialist; Tracy Myers, Secretary; Ines Nieves, Associate Commissioner; Dr. Haya Novak, Psychologist II; Kevin Osst, YDAIII; Kirstin Pisany, LMSWII; Debbie Preston, Secretary I; Gary Skinner, Physician's Assistant; Charles Snowberger, Jr., Education Director; Beverly Sowersby, Facilities Manager; Scott Steelman, Assistant Facility Director -

Treatment; Dr. Joseph Tomassone, Chief of Treatment Services; Robert VanAlstyne, YDAIII; Eric Warner, YCII; Rod White, YCII; Sean Williams, Camera Guy; and John Wilson, ATT. Those who participated by telephone included: Augustine Amissah, QA Specialist; David Bach, Director, Division of Juvenile Justice and Opportunities for Youth (DJJOY) Bureau of Quality Assurance and Improvement (QAI); Merle Brandwene, Director, DJJOY Program and Management; Matt Carpenter, Executive Assistant to DJJOY Deputy Commissioner; Gladys Carrion, Commissioner; Erin Cassidy, Executive Assistant to Executive Deputy Commissioner; Lori Clark, QA Specialist; Dr. Michael Cohen, Medical Director; Myra DeLuke, QA Specialist; Felipe Franco, DJJOY Deputy Commissioner; Larry Gravett, Director, SIU; Alyssa Lareau, DOJ; Beth McCarthy, Bureau of Training; David Nasner, Bureau of Behavioral Health Services (BBHS); Denise Passarello, QA Specialist; Sheila Poole, Acting Executive Deputy Commissioner; Lee Prochera, Acting Deputy Counsel; David Sagaties, Assistant Director QAI; Jill Swingruber, Legal; Monique Thompson, Legal; Jenne Utting, QA Specialist; and Iren Valentine, Director, BBHS.

### C. Preface to Protection from Harm and Mental Health Findings

After the last site visit, intake increased, and Finger Lakes now has six generic units. The Director talked with satisfaction about "finally having our whole team. We have two Assistant Directors for Program and two Assistant Directors for Treatment." Intact unit teams are in place and are designed to mitigate the disadvantages of a large facility: "the teams are growing closer, with more investment in their work and a reduction in sick leave as they depend on others in their unit team more. The juncture functions like a mini-facility, with a senior manager, two YCs, and a clinician with their own response teams. There is a weekly staff meeting on each unit, and they will move to unit pre-shift briefing." The Director reported aggressively recruiting new staff at Job Fairs, being very selective to get the most qualified applicants, and hiring 45 new YDAs since the previous site visit six months before. Furthermore, fewer resignations and fewer terminations have contributed to staff stability.

One-quarter of the Finger Lakes population arrived in the month before this site visit (16 residents), many of whom have significant mental health needs and were modifications from other facilities. Managers indicated that frequent Red Flag meetings have been helpful in managing this new, difficult population. Nevertheless, Finger Lakes staff pointed with satisfaction to at least one current success story per unit.

At the last site visit, they had opened a Welcome Unit where youth spent 14 days. Once they populated a new unit with graduates of the Welcome Unit, residents had to be placed based on available beds on any of the five units and changing units was difficult for some of them so the Welcome Unit idea was abandoned. The school was moved to a school wing, separate from the units.

Staff were pleased with the many program enhancements underway, with additional funds. Individuals from the community are coming in to volunteer and staff are finding more places to take residents for enrichment, including the colleges. The garden program this summer generated several hundred pounds of organic vegetables raised at Finger Lakes that were donated to food kitchens. The Finger Lakes Debate Team debated

the Cornell Debate Team during the site visit. For the first time Finger Lakes will have its own basketball team, coached by a YDA, and they will play local high schools.

Before this site visit, the DJJOY Quality Assurance and Improvement (QAI) Bureau completed a thoughtful review at Finger Lakes. The QAI Report commended Finger Lakes for the strengths of the leadership team, the intact unit model, positioning two Assistant Directors' offices in the spine, administration's management of data, including restraint packets and video review, and bringing in a large number of new staff successfully.

The Monitors discussed the draft QAI Finger Lakes report with the QAI staff, particularly the restraint analyses and questions about the importance given to IIPs.

## II. PROTECTION FROM HARM MONITORING

Consistent with the long-standing assumptions in juvenile corrections that the way a facility is organized affects strategic outcomes, several organizational changes likely contributed to the more positive climate at FLRC, particularly the improved administrative stability and modifications to the program environment. Improved stability in the leadership team included the addition of two Assistant Facility Directors as an appropriate response to the increased size of FLRC and its anticipated expanded capacity. (Deputy Commissioner Franco told exit meeting participants to expect an increase in the FLRC population.) Also, there appeared to be improved continuity through the leadership of Facility Director Brenda Aulbach. Some of the secondary gains of an intact administrative team can be seen in improvements in new staff retention, in staff morale, and in greater selectivity among potential candidates for employment.

The improved stability in staffing and resident population allowed for a better implementation of the New York Model that should result in increased safety. As safety increases, youth and staff participate more fully in the New York Model programs, and this will create additional stability. The interactions between organizational stability, administrative stability, safety, and the New York Model can spiral in a positive direction. Hopefully, this is what is happening at FLRC. Likewise, these factors have the potential of spiraling in a negative direction. Threats to stability are significant changes to the youth population and a rapid pace of change.

Two changes in the program environment also seemed to have been beneficial. The school program has been moved into the vocational wing, creating a better defined school area. Also, two of the Assistant Facility Directors have offices in the spine as opposed to the administrative area. This has increased access to youth and staff.

To further address an efficient implementation of the New York Model, FLRC moved to staff teams based on the recent redesign of the juncture spaces between living units. With the support of Home Office, these stand alone groupings of staff have been called "intact teams." Again, this long-standing characteristic of effective juvenile correctional practice reflects a positive change at FLRC. The creation of cohesive staff teams has always been fundamental. The development and growth of the intact teams will depend upon continued Home Office and collective bargaining unit support. Thus far, reports are optimistic about the future of the intact team.

YCs are a good source of information. Part of the monitoring included a focus group with J. Allen, Sara Bergene, Lerue Culmer, Jesse Infante, Christina Jirinec, Kristy Kennedy, Steve LeFavre, Robert Nicholas, Joshua Stash, Eric Warner, and Jeffrey Wurst. The YCs were a thoughtful and insightful group, and they appeared dedicated to identifying and resolving issues that impede the full implementation of the New York Model. One valuable discussion focused on staffing ratios and the relationship to safety and physical restraints. These YCs discussed the differences among staff regarding skills and effectiveness. The hope was that training and new staff recruitment would result in increasingly capable staff over time. In the interim, YCs reported that the units were more manageable when there were more staff available, when there were fewer youth on the unit, and when there were more units available to keep the numbers of youth low. This topic included initial references to the influences of spatial and social density on youth behaviors.

The implementation of the stand-alone teams has moved FLRC closer to a unit management strategy. Already, YCs reported an improvement in consistency and uniformity within and between units. While the process is still evolving, reductions in staff turnover have contributed to improved staffing consistency and less staff burnout. The largest challenge still appeared to be moving new staff to the point where they can effectively run a shift. This requires continued training in skill development. From this perspective, YCs believed that the unit coach concept was working. Designating a Youth Counselor as a coach has expanded the strategies and opportunities to support staff development.

The data on safety indicators related to the Protection from Harm Paragraphs improved following the March monitoring visit, but they have deteriorated steadily following population increases. The PH Monitor's youth interviews affirmed the initial statements of staff that some progress has been made but they are not yet satisfied with all of the outcomes. In addition to consecutive months of increasing rates of physical restraints, both standing and seated, the six (6) youth who participated in the interviews rated their safety at 6.25 as measured by responses to the question "On a scale of 1 to 10 with 10 being the highest, how safe do you feel here?" The current responses reflected a 25% drop as compared to the ratings from the March 2012 monitoring visit. In addition, 50% of these youth indicated that they have feared for their safety since being at FLRC. The same percentage indicated that they have had personal property stolen directly by force or by threat during the same time.

Of the FLRC YDA staff interviewed, no one indicated that they had feared for their safety at FLRC within the last 6 months, and they largely attributed this to fewer staffing problems. Staffing adequacy has become a positive factor, but it has not eliminated all of the fear on the part of staff. Even though no one indicated that they had feared for their safety in the past 6 months, the same staff rated their safety at work at 6.7 on the same 10-point scale applied to youth. For example, staff responses to a question about rating their perceptions of safety while at work stayed relatively the same as compared to the March 2012 monitoring visit, showing a 5% increase in perceptions of safety. A common theme among staff was that there has been progress but not enough. Every time this message occurred, the follow-up was to ask what has to happen to get you where you want to be? Predominantly, the perspectives of those caught in the midst of the reform process were:

1. The pace of change and the instability associated with it need to stop temporarily or at least slow down to the point that staff can "find their rhythm" with the implementation of the New York Model.

2. More so than at other DOJ facilities, staff thought there was a bit too much oversight by Home Office.

3. Staff believed that youth assigned to FLRC constitute a manageable population and that the stand alone or intact team concept will increase structure, consistency, and accountability. Within this context, staff did not view the implementation of the New York Model as a huge leap or a reach for staff.

4. Staff were critical of the current implementation of Daily Achievement System (DAS) because they did not believe the incentives were sufficient to have the type of influence on youth behavior that was needed.

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 continues to be a variable in Protection from Harm considerations, and the QAI Reports now contain a section that addresses staffing adequacy. Further development of this quality assurance component is an important addition to the sustainability of the changes resulting from the Settlement Agreement.

**A. Use of Restraints**

Paragraph 40 states, "The State shall, at all times, provide youth in the facilities with reasonably safe living conditions." Many of the explanations regarding the Protection from Harm Paragraphs have assumed that there is a common understanding about the definition of "safe." For clarity, safe living conditions are places where youth are free from the occurrence of or risk of harm, injury, danger, and fear of harm, injury, and danger.

*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: Multiple aspects of restraints apply here. They are undue (unwarranted, excessive, inappropriate or too many) restraints, policy and procedure outlining the circumstances when restraints are appropriate, and a prohibition against the use of restraints as punishment, to name a few. The CPM policy and procedure are in compliance, so the partial compliance finding results from concerns about other aspects in the Paragraph. At FLRC, some compliance concerns existed regarding undue restraints.

When staff are fully trained in CPM, and when they are adequately supervised, and when there is an ongoing mechanism to improve CPM interventions, a physical restraint becomes a last action for the protection of the safety of youth and staff. Under these circumstances, youth should be free from undue, inappropriate, and punitive restraints or uses of force. In other words, physical restraints through CPM are designed to be last resort actions by staff to address harm in such a way as to ensure reasonably safe living conditions. Physical restraints occur in response to real circumstances or real occurrences of and risks of harm, injury, danger, and fear. A safe environment is free (reasonably free) from the occurrences and the risks of harm, injury, danger, and fear and, therefore, has few physical restraints, as one measure of the safe environment. Stated differently, a safe environment has fewer physical restraints i.e., fewer occurrences of and threats to harm, injury, danger, and fear for youth and staff, than does an unsafe environment.

Policies and Procedures

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. Staff again provided accurate answers to the questions about these policies and procedures. The responses were consistent with the intent of the Settlement Agreement. According to the QAI Report, FLRC administration acknowledged concerns about the behaviors that justify physical restraint, held a series of staff meetings, and issued to all staff pocket-sized cards with the three justifications for physical restraint. These cards need to be reviewed by the Monitors.

Of the youth who participated in interviews, (a) everyone had been involved in a physical restraint within the past 6 months, (b) 67% believed that staff use force only when they really need to, but (c) half believed that staff tried to hurt them during the restraint. This is a pattern that appeared in the evaluation of many of the Protection from Harm paragraphs: Most staff were rated as caring, respectful, and competent while a few seemed to be associated with problems. For example, 67% of youth believed that staff are good role models, and half indicated that staff make more positive comments to youth than negative comments. These perceptions should prompt further consideration by Home Office as they underscore the importance of continuity in leadership, supervision, and corrective actions (Paragraph 44e).

Several concerns existed about the use of physical restraints that were not consistent with the exceptional circumstances clause in Paragraph 41, and these instances did not appear to be mere technicalities or temporary failures. For example, in Restraint Packet #384590, it appeared as if the restraint started following two youths' harassment of

a new staff member. Before the restraint, the youths' behaviors could have been described as inappropriate and disrespectful as opposed to criteria (i) and (ii) listed above. The QAI Report stated that multiple restraints lacked evidence that they qualified under any of the exceptional circumstances, e.g., Restraint Packets 344289, 356890, and 364591.

Undue Restraints

There still are too many unnecessary physical restraints. Contributing to this determination are the regular analyses of the Home Office-supplied FLRC restraint data, reviews of Restraint Packets, reviews of restraint videos, along with an understanding of restraint practices and the challenges presented by FLRC youth. The QAI Report cited six instances where the use of appropriate de-escalation might have prevented the youths' behaviors from escalating to a restraint. Supplementing this perspective are comments from knowledgeable FLRC staff who understand CPM and who (a) describe the current rates of restraint as too high, (b) describe some restraints as unnecessary due to the need for improved staff skills, e. g., skills to avoid physical restraint associated with the full integration of the New York Model, and (c) set a reasonable and acceptable level of restraints below current rates even when taking into account the unpredictable nature of both the operational circumstances and the FLRC youth. In staff interviews with YDAs, one stated and the other two agreed that the current youth are not as tough to work with as they were ten years ago; but the lag time between misbehavior and a meaningful consequence permits too many behaviors to escalate to the point of physical restraint. Staff concerns about a not-yet-fully-effective Daily Achievement System (DAS) meant that some behavior chains leading to physical restraint could be prevented.

Restraint Packet #384590 described two preventable restraints that unfortunately resulted in multiple "rug burn abrasions," which, because of their size and deep red coloring, looked more serious to a non-health-trained person than the injury described by the clinic staff. The event started when two youth were harassing a new YDA. In frustration (partially due to not knowing how to manage the situation and due to an absence of veteran staff in the area), the new staff member initiated CPM on one youth for a reason inconsistent with the exceptional circumstances mentioned above. The YDA-initiated action prompted the second youth to try to pull the staff off of the first youth so that the first youth would not get a "Level 3" write up, or so he claimed. The second youth was restrained by another YDA who failed to implement the CPM appropriately. The failure to implement the CPM resulted in the second youth being able to maneuver into a position on two occasions where his face hit the floor/rug because his arms were behind his back. This served as an example of the risks associated with new staff, and it underscored the importance of supervision and coaching.

Regarding the data as one indicator of compliance, restraints are currently categorized into two (2) types, 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. During July, there was a reduction in the rate of restraints, and the July data contained a shift in the proportion of standing restraints versus seated/supine restraints with standing restraints reflecting the majority of the

restraint activities. This positive indicator along with the reduction in the rates of restraints disappeared in August. The Home Office-supplied numbers for each category of restraint from August through October 2012 affirmed FLRC staff assessments that while there have been improvements in some areas of programs and safety, the present increases in the frequency of restraints has remained unacceptable to them. In their discussions of physical restraints, the YCs noted progress. They also expressed concern that the rate of restraints was more than they believed to be an acceptable level when programs were operating satisfactorily as opposed to perfectly.

A physical restraint is a complicated series of behaviors that interact in various and often predictable ways. A primary concern under this Paragraph is how to understand a facility's physical restraint patterns in such a way that the rate of these restraints can be reduced. The assumption is that reasonable safety increases the more that physical restraints are prevented. Discussed below are FLRC-specific variables that affect the rate of physical restraints. A better understanding and manipulation of these variables could increase the number of preventable events and reduce the rate of restraints. There also needs to be a better way of measuring a successful prevention of restraints.

Gangs

Youth gangs contribute to the amount of violence and restraints at FLRC, e.g., the unprovoked assaults by youth affiliated with the gangs who are attempting to achieve rank or status. Levels of violence also negatively influence perceptions of safety, and the QAI Report noted that the key factor in FLRC gang membership was protection. Discussions among staff focused on how the New York Model will address gang violence. Home Office has identified a local gang resource who will begin to provide technical assistance at FLRC. Additional resources for consideration include the OJJDP-funded National Gang Center, including the materials available on its website; Dr. Melissa Dunphy, psychologist and gangs researcher at the Indian River Juvenile Correctional Facility in Massillon, Ohio; and the Phoenix Program, a purchasable gang reduction curriculum currently used in Ohio juvenile corrections facilities.

YDA and YC perspectives on gang violence agreed that there is little allegiance to outside gang membership when a youth enters FLRC. Instead, gangs seemed to be organized around living units. One staff member described this organization as more like a club than a gang. Another staff member linked certain youth affiliations to prior gang activity in the New York City juvenile detention facilities. Nonetheless, the language and structures of the FLRC gangs seemed to parallel other YB (Young Bosses) and YG (Young Guns) activities.

Weekend Food Service

Youth consistently complained about the weekend food schedule. According to them and confirmed by the Facility Director, brunch occurs around 10:00 AM and dinner occurs around 4:00 PM. Given the schedule on Saturday and Sunday, the length of time between dinner on Saturday and brunch on Sunday is 18 hours. Even with a schedule of multiple snacks, the amount of time between these meals seems too long. Furthermore, youth complaints stemmed from being hungry. The absence of food in the commissary, meaning that youth do not have the opportunity to supplement food services with snack

items purchased through appropriate behavior, further complicates the weekend food complaint.

Daily Achievement System (DAS)

FLRC staff identified two gaps in the implementation of the New York Model that they believed contribute to higher than acceptable levels of disruption and violence and the need for physical restraints. First, they maintained that the time lag between a youth's inappropriate behavior and a DAS consequence is too long. Part of the rationale for a token economy, i.e., the use of points or achievement indicators, was to bridge the time gap between the behavior and the consequences. The assumption is that consequences lose effectiveness as the time increases between the target behavior and its delivery.

Second, staff complained that their understanding of the New York Model accommodates too much violent language by youth. This appears to be a training issue, but the frustrations among staff might be eased a bit if there were some acknowledgment of this issue. Staff also believed these language issues contribute to higher levels of mental stress and burnout among the direct care staff. In the meeting with QAI staff and the Monitors, a discussion occurred about a greater focus on pre-de-escalation circumstances. In other words, if the chain analysis assumes that inappropriate behaviors, especially those that end in a physical restraint, are part of a longer chain of sequential and escalating behaviors, then an earlier identification of the chain may have an increased likelihood of preventing the physical restraint. If the staff intervention and de-escalation occurred earlier in the process and with a weaker behavior link in the chain, the prevention of an increased number of physical restraints could be possible. Several staff suggested that inappropriate youth language might be a place to start this type of intervention.

*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 partially compliant corresponding practice includes documentation (written and video), staff reports, and resident reports that are consistent with the policy and procedures. OCFS policies comply with the Settlement Agreement. FLRC administration was familiar with policy and procedure that limit the circumstances when the use of restraints is necessary, and staff continued to provide accurate answers to the questions about policies and procedures related to CPM. The responses were consistent with the intent of the Settlement Agreement.

Improvements are noticeable. For example, the QAI Report cited 57 examples of restraints within compliance with DJJOY standards.

Regarding Restraint Packet #345380 (Youth EH, July 5, 2012), this was a protracted restraint. From beginning to end, the restraint event lasted 80 minutes, and this was not an isolated instance. For example, in the *ARTS Master Ad Hoc with Staff Names* list from April

1 to October 15, 2012, provided by Home Office, Restraint #321281 listed the duration of the restraint at 58 minutes and Restraint #224552 listed the duration of restraint at 40 minutes.

The lengths of time of these restraints raised concerns. They were substantially longer than other restraints. Protracted restraints indicate that, for whatever reasons, problems existed; and for the reasonable safety of youth, they should alert staff to the need for some type of special review to safeguard that the stabilization of the situation occurs in the minimum amount of time. While the Settlement Agreement only mentions an in-restraint assessment for a face-down restraint (Paragraph 41c) and a Post-Restraint Examination by medical following a restraint (Paragraph 44c), a prior protracted FLRC restraint during the previous monitoring visit showed that the nature and extent of the restraint can have emergency health implications for the youth. Even though the DOJ-approved policy does not have a time limit on restraints, Home Office has proactively begun an evaluation of lengths of restraints. Furthermore, the DOJ-approved policy does not require medical staff to monitor during restraint. Hopefully, the Home Office considerations about length of restraint will include an examination of when medical should initiate an assessment of a youth in the restraint process based on the length of time since the beginning of the restraint. Nevertheless, some form of post-restraint assessment must occur in order to determine whether, in practice, staff are using the minimum amount of physical control and time in restraints necessary to stabilize the situation. This is not currently occurring, and compliance cannot be achieved until it does.

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

PARTIAL COMPLIANCE

COMMENT: The policy and procedures exist; the training on the policies and procedures has occurred; and staff and resident interviews were consistent with the policy and procedures. 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. Interviews with youth confirmed staff's understanding of restrictions as contained in the youth's IIP. However, the QAI Report cited 10 instances of noncompliance in Restraint Packets where there was no evidence of an IIP available for the youth involved in the restraint.

*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 video reviewed and reports from youth that they have been taken to the floor in a facedown or prone position in ways that do not conform to the requirements of this paragraph. Restraint Packet #384590 contained video of serious rug burn injury to a youth's face resulting from a facedown portion of a physical restraint. The QAI Report discussed the continued use of facedown or prone restraints, detailing the number of restraints that occurred and the particular problems with each. The QAI report identified nine Restraint Packets in noncompliance regarding facedown restraints. The impression given by the QAI Report was that the facedown restraint represents an unauthorized technique.

Policy 3247.12 describes a "transitional hold" that briefly moves a youth from a supine restraint to a prone position for the purposes of applying handcuffs. In response to the question about when a face-down (prone) restraint is permissible, similar to their March 2012 answers, most FLRC staff responded that a prone restraint is not allowed and that the "transition hold" is not really a prone technique because they only move a youth to his side if the application of handcuffs is necessary.

Previously, the Bureau of Training demonstrated and reviewed for the PH Monitor the new, proposed handcuffing strategy, which would eliminate the need to use the "transitional hold" that exposes a youth to a facedown or prone position during the administration of the handcuffs. The procedure is a slight modification of the two-person seated restraint as the point of departure for the new procedure. Staff at FLRC were not aware of the new technique, which meant that it had not been approved and implemented at the time of the monitoring visit. The new approach represents a creative alternative to the transitional hold.

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

COMPLIANCE

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

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

COMPLIANCE

COMMENT: 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: Printouts from the STARS system for (a) CPM, (b) first aid, CPR, and AED, (c) CPM Refresher #1, (d) CPM Refresher #2, and (e) the New York Model were provided by Brittany Mainville, FLRC Training Coordinator, and reviewed with her line-by-line. Regarding the status of employees with CPM training, those who were not up-to-date had legitimate reasons for missing training and were being tracked carefully so as to insure their earliest participation in the appropriate training program. For those who had returned to work and were not fully up-to-date, all appropriate notifications were in place regarding restricted status for physical restraints. The same applied to staff who were not up-to-date with First Aid, CPR, and CPM refreshers.

Training continues to exist as one of the strengths in the implementation of the Settlement Agreement. However, care must be exercised to make sure that the training requirements are fulfilled. The expectation is that the training will be up-to-date for a monitoring visit. Also, it was a concern that the QAI Report noted that staff were not up-to-date with CPM and/or First Aid and CPR training at the time of restraint in three Restraint Packets. In addition, Restraint Packet #384590 showed examples of a YDA staff who could not implement the CPM techniques appropriately. These types of findings jeopardize compliance.

**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: Data regarding the use of force are mixed. The discussions and review of Paragraphs 41, 41a, and 42e stand in contrast to the number of restraints that were conducted appropriately. While the number of appropriate uses of force appeared to be increasing, it does not yet sufficiently characterize restraint practices. As noted in the comments for Paragraph 41a, the QAI team identified 20% selected Restraint Packets in the noncompliance range on the use of force.

*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 partially compliant corresponding practice includes documentation (written and video), staff reports, and resident reports that are consistent with the policy and procedures. The QAI Report cited seven (7) instances of restraint documentation that complied with or exceeded its standards. An unintended consequence of the Settlement Agreement is the increased amount of paperwork associated with programs and documentation. The amount of paperwork involved with the documentation of a physical restraint is substantial; therefore, in situations where there are many physical restraints, there will also be a substantial burden on staff time to complete the requisite paperwork. In situations like these, errors occur. Documentation problems existed, which need correction.

One substantial problem with documentation had to do with the Restraint Monitor. The QAI Report cited 30 examples of noncompliance based on numerous issues, including missing Restraint Monitor Reports, lack of complete and accurate details, lack of evidence that there was a surveying of environmental factors, and reports filed when the video showed the Restraint Monitor was not there.

In Restraint Packet #384590, the Video Review Form (VRF) documentation was problematic. For example, the form indicated that the video was consistent with the documentation, but this was not the case. The video showed several minutes of two youth harassing a new YDA staff member. Other staff members were in the area and can be seen on the video, but they offered no support or intervention. None of this information appeared in the documentation.

In Restraint Packet #345380, the Post-Physical Restraint Health Report does not list the name of the staff accompanying the youth to medical; two of the Activity/Rule Violation/Incident Reports mentioned a phone call that preceded the youth's outburst of anger and the physical restraint, but the phone call did not appear in the Restraint Monitor Report or the VRF; and a restraint that lasted 80 minutes should be documented as a significant issue. (See the additional discussions for Paragraphs 41a and 42e.)

*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 recommendations on the OCFS 2091 form, which is reviewed by the Facility Director and followed by a Home Office review. This process requires closer attention by the PH Monitor to determine ways in which the information gathered in the review process should be used to improve training and supervision and to revise policy or programs.

*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 QAI, 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.

The Home Office clarification of Documented Instruction (DI) has resulted in a substantially more positive use of DI in response to the Facility Administrator's review of physical restraint video. The shift away from DI as a corrective action with disciplinary overtones to a coaching and supplemental training tool has been beneficial for direct care staff. Paragraph 42e is now the Facility Administrator's tool to review CPM and to provide a learning experience 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 DI in this paragraph is to create multiple and ongoing

opportunities for staff to learn and practice effective implementation of CPM techniques, especially de-escalation.

1. Documented Instruction

Regarding Documented Instruction, the QAI Report noted that in several instances there was evidence of Facility Administration requesting Documented Instruction, but there was no evidence that the Documented Instruction took place. There were several issues that arose from the review of the Restraint Packets that related to Documented Instruction.

In Restraint Packet #384590, the VRF reviewer noted that the two YDA staff "make the attempt to perform the proper tech but due to the youth fighting they go to the floor in an uncontrolled fashion." In contrast, as soon as YC2 Warner arrived on the unit and assumed the primary position in the restraint, the youth stopped struggling, and the restraint moved quickly to resolution and termination. This video suggests that differences in staff abilities yield substantially different outcomes in crisis situations. The video provided dramatic evidence of how a staff member's CPM skill level influences the resolution of physical restraints, especially issues related to safety, the amount of force necessary, and the amount of time required to resolve the physical restraint. In the first part of the restraint, two staff members failed to control the situation in a manner consistent with CPM, and the youth was injured. In the second part of the restraint, a staff member with proficient skills relieved the first staff, and the restraint ended quickly following the appropriate administration of the CPM technique. Documented Instruction was not specifically requested regarding the two staff members' inability to apply the CPM technique appropriately or regarding another veteran staff member's failure to intervene and to file an Activity Report. However, supervisory follow-up was indicated for all. No documentation was available in the Restraint Packet on any follow-up action.

In Restraint Packet #347084, Documented Instruction has two issues. First, the Assistant Facility Director astutely identified environmental factors as preventative measures to increase resident safety during crisis management. He noted that all unit doors were not secured, which would allow unnecessary movement of other youth during a restraint. In these situations where DI addresses the constructive application of policy and procedure, it would be helpful to communicate these issues to the Bureau of Training so that they can be incorporated as examples into CPM training. Second, the YDA in question was referred for DI on this topic, which occurred the same day, but the referral did not occur until approximately 40 days following the restraint. This delay is a problem. Also, Sections 2 and 3 of the Physical Restraint-Request for Documented Instruction form were illegible and incomplete.

In Restraint Packet #345380, two of the Activity/Rule Violation/Incident Reports mentioned a phone call that preceded the youth's outburst of anger and the physical restraint, and there was no explanation in the Restraint Packet about the phone call, including no information about the caller or the content of the conversation. Youth often become upset following a phone call with a family member or significant other. If emotional dysregulation were a function of the phone call, this information needs to be communicated to treatment team members. The investigative and communication aspects

of this potentially significant event should be the subject of further inquiry and explanation. Documented Instruction and coaching are ways to alert and teach staff about this issue.

2. Changes in Practice

In Restraint Packet #347084, the VRF contained guidance to YDA staff under the Additional Action Required section. Assistant Facility Director Lamphier wrote, "Never stay in a youth's room, especially while in restraint. Bring youth out for safety." This is excellent advice on many levels. From a supervisory perspective, this recommendation addresses both youth and staff safety. While others may have thought about the advantages of removing youth from their rooms in potential restraint situations, this is the first time that such advice has been part of the documentation included in monitoring. On too many occasions, allegations of abuse and injury have occurred from physical confrontations in a youth's room. Situations of this nature are even more complicated to resolve due to the lack of camera coverage. Lamphier's recommendation addressed all of these issues, and it is reassuring to know that such a careful and thoughtful approach to the video review process occurs at FLRC. Similar to the above, a recommended adaptation of CPM to address situationally-specific circumstances has DI, coaching, and training implications that require additional follow-up.

Echoing the sentiments in the lead paragraph, the Facility Administrator's review provides a "check and balance" on CPM, allowing each facility to analyze the implementation of the restraint process based on actual events and to implement and create educational responses that enable staff to enhance their skills and abilities. One likely outcome is an adjustment to the CPM strategies as more information becomes available about how staff implement it. The review of these Restraint Packets and their videos prompts new issues regarding restraints and the relationship with the Settlement Agreement. Applying the concept of a chain analysis (the assumption that complex behaviors chain or have a sequential characteristic), this administrative review process should expand its analysis of de-escalation or the ability of staff to disrupt the chain before it gets to a physical intervention. When a pre-restraint problem results from staff escalation and a restraint follows, the restraint is an inappropriate use of force. If an inappropriate provocation by staff results in a technically perfect restraint, it should be categorized as an unnecessary restraint or an excessive use of force and referred for Documented Instruction.

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

COMPLIANCE

COMMENT: Training remains a strength of the Protection from Harm Paragraphs. The training on the policies and procedures 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 staff members who required retraining for any reason 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 members 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."*

COMPLIANCE

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

COMPLIANCE

COMMENT: The policy and procedures exist (PPM 3246.02 and PPM 3247.12); 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 monitoring visit included a review of the Redbook, the red notebook in each DOJ facility that is a collection of emergency policies and plans. Confusion exists here. In response to the question about the facility emergency response plan, administrators have made reference to the Redbook. Home Office has supplied clarity on the specific policy related to this paragraph and continued monitoring will redirect its focus on the Home Office identified emergency response plan.

*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 FLRC 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). 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.*

*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 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 an inappropriate use of force or suspected abuse, including nurses.

*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: There were no issues or concerns about level of contact or priority of investigations from this monitoring visit. Additionally, the QAI Report found in the investigations in their audit visit to be in good shape, conferring a compliance designation for this assessment.

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

COMPLIANCE

COMMENT: The health clinic program represents a Protection from Harm strength. The policy and procedures exist, and staff and resident interviews were consistent with the policy and procedures. On November 8, 2012, the PH Monitor requested the nursing staff to demonstrate how the post-restraint examination (PRE) occurs. The demonstration was satisfactory. The arrangement of youth and staff was consistent with previous practices that met the intent of this paragraph. Youth and staff could not make eye contact, and the use of a radio provided sufficient sound in the room adjacent to the exam room that the voices of the examining nurse and the youth could not be heard.

The key issue here was safeguarding a youth's opportunity for a candid conversation during a post-restraint examination with a trusted, health care provider, so that he can then more easily provide confidential information regarding the use of force incident, any allegations of excessive use of force, and any injury complaints. Medical Director Cohen emphasized the need to document the confidentiality of the PRE. This is more of a concern at the other DOJ facilities where some PRE events happen outside of the clinic in a youth's room or in a classroom.

The health clinic staff was prepared to discuss other PRE issues. The clinic staff noted their special concerns about the PRE occurring within one hour of the restraint event. The QAI Report cited 27 Restraint Packets where youth were not seen by medical for a PRE within one hour of their restraint. Most of the challenges to meeting the one-hour expectation related to the timing of the restraint. When multiple restraints occurred, especially with a large group of youth, additional time was required for processing. Another concern regarding the PRE was the documentation of the name of the YDA who brought the youth to the clinic. (See the discussion for Paragraph 42c.) The Finger Lakes staff reported that the documentation of the staff transporter was a matter of policy. Some nurses even made an entry in the youth's medical record.

The QAI Report stated that the clinic staff had assessed youth while in physical restraints and had stopped the physical restraint due to health concerns. While policy does not require the presence of medical staff absent a health emergency, it does provide that health emergencies always override the physical restraint. Therefore, if medical staff or the Restraint Monitor consider a health emergency to be present, the restraint should be stopped. The documentation of such events is a positive in the provision of health care oversight of restraints. Having policy and procedure that support this strategy is the first part of addressing this concern, and the other part is documenting that the practice is consistent with the policy and procedure. Therefore, the comments in the QAI report were very encouraging. The PH Monitor requested information about these two events, but the information provided to verify the events did not relate to the situations described in the QAI report.

*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.*

COMPLIANCE

COMMENT: The Special Investigations Unit conducts investigations, and the 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, differences may exist regarding the nature and timeliness of the investigations. For example, of the nine (9) FLRC investigations reviewed by QAI, eight (89%) met the QAI compliance standards.

Parts of multiple restraints occurred out of the view of cameras. The discussion in paragraph 42e by Assistant Facility Director Lamphier regarding the recommendation to staff that they remove youth from their rooms during restraints warrants follow-up as it relates to SIU investigations.

*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: Home Office determines the policies, procedures, and practices that govern prompt and appropriate corrective measures. Three (3) general classifications of

outcomes contribute to the assessment of compliance with this paragraph. The first is whether a response occurred. The intent of the paragraph is that there will be a response to every finding. The second criterion is whether the response is prompt, meaning is there a reasonably short time between the event and the response to make the response meaningful. The third assessment is whether the response is appropriate for the nature and extent of the misconduct.

One measure of a prompt response to allegations of misconduct is the length of time between an incident and the date that Labor Relations received the file. Starting with the list of FLRC employees on administrative leave for disciplinary reasons, six (6) staff were listed for April 1 through October 15, 2012. Outcomes were evenly distributed: two individuals resigned (33%), two received a three month suspension and one year probation (33%), one staff member was cleared with no further action (16.5%), and one case was still pending (16.5%). The time between the incident and the date that Labor Relations received the file averaged 24.5 weeks or approximately 172 days.

Document #16 *Staff Discipline* from the documents supplied Home Office identified 7 (14%) of 50 staff whose disciplinary outcome was "timed out." Home Office indicated that this category reflects a situation where Labor Relations received the file after the one-year requirement. Failure to resolve disciplinary issues within a calendar year runs contrary to the "prompt" aspect of this paragraph. The 14% also is too large a proportion of the disciplinary actions.

*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 3247.03, 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. (See the discussion of the DAS in Paragraph 41, particularly as it applies to the training of staff "in all areas necessary for the safe *and effective* performance of job duties.") There was some additional disagreement between YDAs and YCs about how to supply some type of sanction for minor misbehaviors while simultaneously encouraging youth when they worked through the problems using strategies identified by the New York Model.

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

PARTIAL COMPLIANCE

COMMENT: QAI recently recommended a system, complete with backups, for the no-contact list with regular and consistent review and monitoring. QAI further

recommended that administrative reviews of Restraint Packets should be cross-referenced with the no-contact list and the staff conducting the restraints. This recommendation makes sense, and it should be applied to each DOJ facility.

At the facility level, there were no concerns expressed by YDA staff or supervisors during the monitoring visit about the adequacy of staff supervision of current FLRC staff. However, the concerns discussed in Paragraph 41a have supervisory implications regarding the safety of youth in a protracted restraint that need to be included in the Home Office review of length of restraint and supervision. Additionally, Restraint Packet #318983 as reported in the QAI Report contains a Reportable Incident Report describing the situation where a youth in a single person standing restraint was assaulted by another youth causing a bruise under the victim's left eye. Home Office reported that follow-up to address was requested for two YDAs regarding adequate supervision.

The concerns about the Restraint Monitor discussed in Paragraph 42c also reflect similar concerns about the inconsistencies and inadequacies of the Restraint Monitor as a requirement for the supervision of staff. Problems with documentation parallel problems with adequate 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

This review at Finger Lakes revealed continued progress in implementing the New York Model and fluctuations in facility functioning with changes in population. 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, two policies have not been finalized (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 regarding uniform working diagnoses for mental health professionals and the OCFS substance abuse manual and treatment program are being developed. The MH Monitor cannot fully assess compliance until the policies are finalized and staff demonstration of consistent application of training and adherence to practices and policies can be observed.

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

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

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

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

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

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

PARTIAL COMPLIANCE

The New York Model and training comply with the requirements of 46a, and 46a is being implemented into practice at Finger Lakes.

Mental health staff at Finger Lakes were observed complying with 46b.

Through support teams (formerly treatment teams) and Mental Health Rounds, Finger Lakes staff are complying with 46c.

The Daily Achievement System description in the New York Model training materials complies with the requirements of 46d and is being implemented at Finger Lakes.

The IIP description in the New York Model training materials complies with the Settlement Agreement.

The Facility Admission and Orientation policies and PPM 3443.00 "Resident Rules" (renamed "Youth Rules") has been revised for consistency with NY Model are being developed.

Forty-three new staff at Finger Lakes have had a 7-hour introduction to the New York Model at the Academy, and they are scheduled to have the full training. Because (a) the New York Model is a philosophy for responding to troubled youth that is probably different from what new staff have learned through their education and past experience and (b) having the training together helps to build strong teams at the facility, it is essential that all Finger Lakes have the full New York Model training followed by coaching as soon as possible.

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 training—which includes the integrated assessment, the support plan (formerly treatment plan), and how to

utilize both in support teams (formerly 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 at one time and would be best delivered in shorter sessions with follow-up discussion at Mental Health Rounds and in coaching.

The QAI review of the NY Model Implementation is being developed with guidance from BBHS staff, and the MH Monitor anticipates that more program indicators will be designed after the pilot of QAI reviews at all four facilities. At Finger Lakes, the QAI review examined residents' records for integrated assessments, psychiatric evaluations, support plans (including a review of trauma history), working diagnoses, psychiatric contact notes, medication, family outreach, suicide response, substance abuse services and transition plans.

In addition to two policies, full compliance with this paragraph requires consistency in groups, Mental Health Rounds, and DAS, effective New York Model coaching, improvement in IIPs and recognition of the importance of calming before de-escalation is necessary.

*State Report on Progress (6/21/12)*

46a and b. These remedial measures are implemented at all four facilities with the New York Model, including 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 support 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 New York Model, and these revisions are not yet finalized and have not been sent to DOJ for approval. OCFS requested an extension to 12/19/12 for the Facility Admission and Orientation policy.

*On Site Observations (11/12)*

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. Finger Lakes has continued to manage New York Model implementation with an Implementation Team composed of two representatives from each of six NY Model training groups from all parts of the facility. They meet once a week to finalize the Daily Achievement System (DAS), the DAS, achievements, and the phase system and also guide support teams and Mental Health Rounds. Achieving trauma-responsive, relationship-driven, culturally competent, and strengths-based teamwork to meet residents' needs is a slow process with the Finger Lakes population.

With the addition of two new clinicians, Finger Lakes now has a full-time therapist on each unit. Finger Lakes also has a new psychiatrist 12 hours/week. In addition to Sanctuary and substance abuse groups, DBT groups meet twice weekly on each unit with the lead being taken by YCs. The DBT consultant from Seattle consults with the DBT team at Finger Lakes in monthly conference calls.

Unlike other facilities, Finger Lakes has Mental Health Rounds once weekly on every unit for discussion of all the residents on the unit (without the psychiatrist) and the psychiatrist has one Mental Health Rounds per week for a unit to discuss one challenging resident (the psychiatrist's Mental Health Rounds are once every six weeks for each unit). The MH Monitor observed the psychiatrist's Mental Health Rounds, which two clinicians, the two Assistant Directors for Treatment, two YCs, 3 YDAs and a nurse attended. It was a 45-minute discussion of an aggressive sexually abused 14-year old who had arrived at Finger Lakes nine days previously. The psychiatrist built on the staff presentation to describe the resident's "fight or flight" response when he is re-experiencing trauma: the resident does not like being touched, is frightened at night, and when he feels afraid he reacts with aggression. "Physical force won't work with him. It is best for staff to stay calm, reassure him he is safe, and take him aside before his arousal is too high." The psychiatrist said that the resident's homophobia makes physical touch something to avoid, and he suggested increasing his work with female staff and collaborating closely as a team. Regarding the previous diagnosis of ADHD, the psychiatrist said that symptoms were not evident and a stimulant could make his behavior worse. He diagnosed PTSD and proposed a hypertension medication useful in reducing nightmares and fight/flight reactions and an antidepressant. The psychiatrist's Mental Health Rounds provided a thoughtful discussion supporting staff with practical approaches in becoming more trauma-responsive.

The MH Monitor also observed weekly Mental Health Rounds on one unit, convened by the YC, and attended by many staff on the unit team. They discussed all 12 residents in 60 minutes, including two youth who were making progress, two who are especially immature and require daily time with their therapist, and four with worsening behavior. In

the debriefing session, the unit team expressed satisfaction with the value of discussing every youth on the unit efficiently and also in depth in Mental Health Rounds: "it is good sharing of information and good team-building." The team was also able to give each other support: "We had a tight unit a few weeks ago, but some real difficult kids got moved on the unit and disrupted it." The staff acknowledged the stress of the combination of (a) very needy kids with attachment issues (almost half the unit is adopted, which is unusual); and (b) several residents who had deteriorated because of discouraging home problems. The result is a frustrating shift in culture of the unit to a negative peer environment in which some residents are making other residents feel unsafe which did not seem to exist a few weeks before.

The MH Monitor observed a Sanctuary group at Finger Lakes attended by all the residents on the unit, 3 YDAs, and 2 YCs and led by a clinician. The discussion was ACCEPTS, specifically how to use the skills of Compare and Contribute. She used pictures of the destruction of hurricane Sandy to illustrate the idea of helping oneself by recognizing that others have it worse and by contributing to others in need. One of the YCs observed how the residents helped each other. At the conclusion of the group, a resident asked the MH Monitor about her role, leading to several of the residents making suggestions about how Finger Lakes could be improved, including "more trips out," "longer phone time," "shortening the length of the program," and mixing different units in classes so residents can be taught at their own grade levels. The ease with which the residents discussed their ideas with a visitor was a demonstration of the success of group process at Finger Lakes.

The MH Monitor observed a DBT group at Finger Lakes. Although the group of residents was challenging to get engaged, the staff patiently drew some of them into participating. Staff believe that consistent, frequent exposure to mindfulness practice each day will have gradual benefits for residents.

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. In an innovation different from the other facilities and consistent with intact unit teams, Finger Lakes has two YC positions on each unit, one designated as case manager and one designated as coach. The YC Manager has individual counseling sessions with each youth on the unit, convenes support teams, manages family visits and maintains contact with families and aftercare. The YC Coach leads the group counseling on the unit and coaches other staff in "putting the New York Model into action." The Director of Treatment discussed with the MH Monitor how the YC coaches will be recognized for successfully coaching staff.

Eight clinicians, the two Assistant Directors for Treatment and Assistant Director of Program participated in a thoughtful exchange of ideas with the MH Monitor about coaching and how to assist staff in using their relationships with youth effectively. Helping staff support residents to calm themselves is the coaches' primary activity and requires learning to be more patient and to respond early to a resident rather than reacting as he escalates. Coaching also provides support for staff to avoid getting angry, defensive, or controlling, engage in power struggles or take residents' behavior personally. The Finger Lakes coaches discussed how to remind staff about trauma triggers for residents, pick up on their early signs of feeling unsafe, and use their relationship to support self-calming in

youth. "Our kids don't do change—big or small—well. A unit with *a reliable rhythm* is necessary for youth to feel safe and become more able to regulate emotionally." Coaches also help staff tolerate the distress of having a stable unit be destabilized by one or two difficult residents and the tendency to think other units have an easier group of residents. Clinicians support staff with the challenge of dysregulated residents who deteriorated after making progress and new residents who do not yet feel safe and lack skills.

The clinicians looked at three examples of resident goals from current Finger Lakes support plans and discussed how to use the resident's life goal ("Go home" or "Not fight" or "Better communication with family") to get specific about personal change goals that could be started at the facility and continue in the community. For example, when the support plan has a universal, vague goal such as "Go home" and the steps to achieve that goal are "Participate in school program" and "Increase program participation," examining why the resident is not participating in school or program is an important missing step. Is he unable to do schoolwork and/or embarrassed about his deficits? Is he not falling asleep until late and unable to get up in the morning to go to school? Does he feel unsafe in the classroom with his peers? Does he have difficulty comprehending abstract concepts in DBT group? Does he feel unsafe to speak up in group? Does he feel hopeless and/or too depressed to get involved with peers? Does he have trouble trusting staff? Each of these reasons would call for different responses from staff: if he could not fall asleep, was too hopeless to participate and/or could not trust, his support plan might call for his therapist to focus with him on past trauma causing these reactions, a staff person would reach out to him to build a connection, and the psychiatrist and his therapist might discuss medication. On the other hand if he had comprehension problems, school and unit staff would respond differently and if he felt unsafe with peers, still other interventions would be described in his support plan. In one of the example cases, a 14-year old's significant learning disabilities (reading at the 3rd grade level) and family problems described in the Integrated Assessment were not brought into the crafting of interventions to fit him. In the example of a 13-year old with a goal of not fighting, his early, severe trauma and significant cultural differentness described in the Integrated Assessment did not seem factored into the interventions other than "individual work on distress tolerance and Wisemind ACCEPTS" which probably had little meaning to his mother, aftercare worker or possibly the youth. In the coaching discussion, the clinical team described working hard to guide improvements in the support plans and commented, "These forms do not reflect what happens in the team."

The MH Monitor observed IIPs (Individual Intervention Plans) in the reviewed Finger Lakes records. The QAI review found that at Finger Lakes IIPs were not updated every 30 days and as required following crises. IIPs were the same from month to month. Even when residents had 15-20 restraints, their IIPs were not modified. In one record, QA found that after the youth was on Personal Safety Watch, his IIP was not modified. QA noted that during Mental Health Rounds, Finger Lakes staff were observed discussing de-escalation strategies for particular youth but these were not recorded on their IIPs. Finger Lakes held a series of three all-staff meetings about the QAI findings and de-escalation was emphasized at the meetings.

While the de-escalation techniques are useful, staff require coaching in how to accurately read each youth's unique internal state at any time and respond with help for self-calming that fits the resident. This "pre-de-escalation calming" is a crucial teaching approach for helping residents learn emotional management. Whether the resident is able with staff support to de-escalate or not, this minute-by-minute work is about the particular relationship between that staff and that resident. On an intact unit team, staff know each resident and are being coached to use their relationships for teaching residents about recognizing their internal state and managing their emotional expression.

The IIP appears to be serving too many functions, and OCFS is revising it. It is essential that all staff know what physical actions could put each resident at risk of harm. But the Safety Plan and the de-escalation techniques for each resident belong in his support plan and his Safety Plan must be where the resident (and staff) have immediate access to it. The MH Monitor recommends that instead of using the IIP, QAI should work with staff to develop other indicators for how well staff read the youth's internal state and intervene to support self-regulation before escalation. An important part of the shift in philosophy with the New York Model is an emphasis on giving recognition to staff for helping a resident calm himself, use his skills to avoid a restraint or recover quickly and have a shorter restraint. A resident recently released after six months, for example, had 16 restraints in the first four months of his stay at Finger Lakes. Each of those months he had a seated restraint lasting 13 minutes or more; in his third month he had two supine restraints lasting six and seven minutes. In the second to last month of his Finger Lakes stay, his final restraint was standing for two minutes. AM (whose support team meeting is described below) was restrained 17 times in the first five months of his stay at Finger Lakes, including five supine restraints (one lasted 27 minutes, one lasted 20 minutes, one lasted 16 minutes). In the six weeks prior to the site visit he had one restraint (supine-6 minutes). These examples demonstrate the range in number, length and type of restraints youth may have, decreasing toward the end of their stays.

In another approach to coaching, a clinician who has been esteemed at Finger Lakes for years has become part-time and has started a support group for staff to apply DBT in their own lives. She advocated each new staff person having a staff mentor.

The DAS is another New York Model component that meets the requirements of the Settlement Agreement. The Finger Lakes DAS is organized into almost the same five sections as the Columbia, Taberg, and Lansing DAS, but the content is different:

<u>Demonstrates Safety:</u> Non-violent/Follows program rules and norms

- Wears Safety Plan/Uniform
- Attends school and group/program activities
- Seeks help from staff to remain safe
- Avoids physical/verbal aggression or horseplay
- Avoids kicking, punching, breaking objects, throwing objects/food, spitting
- Avoids inappropriate sexual language/acts or unauthorized organizational/gang activities

- Line movements
- Attends meals

Manages Emotions: Uses skills to avoid conflict or problems

- Makes attempt to use safety plan
- Responds to coaching from staff
- Uses skills to manage emotions (ART, problem solving, DBT skills)
- Avoids verbal threats, use of racial slurs, or swearing

Deals with Loss: Accepts circumstances

- Accepts responsibility for behavior
- Accepts being told "no" or having to wait
- Avoids engaging in blaming others

Works toward Future: Plans for the future/follows current program

- Avoids being disruptive in school and group/program activities
- Participates in community meeting-engages in goal settings

Shows Effort: Beyond simple compliance with program, shows effort and works towards goals (is active, not passive)

- Raises hands and answers questions
- Attempts assignments
- Volunteers for tasks
- Actively engages in program

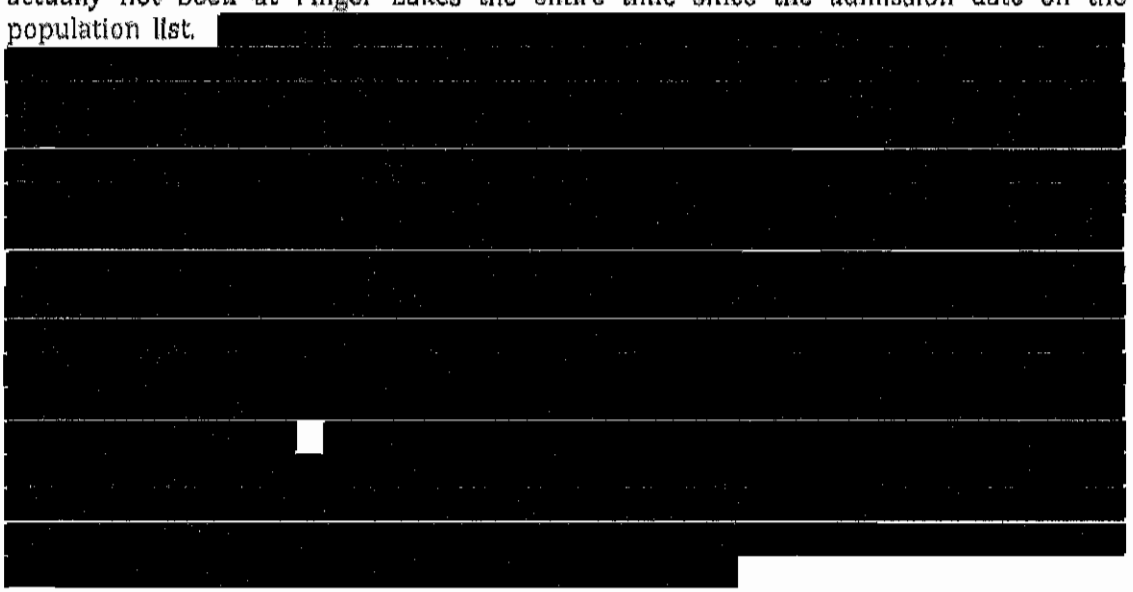
The five elements of the Finger Lakes DAS are scored in five intervals every 24 hours: 6-10 PM; 10 PM-6 AM; 6-10 AM; 10 AM-2 PM; 2-6 PM. The greatest incentives are for residents earning A (21-25 achievements) and B (11-20 achievements). Finger Lakes also compiles a monthly tally sheet of achievements for all the residents on a unit. On one unit, many residents were at A level for most days of the week (for example, 4 out of 9 at A level on average each day of one week, and 5 out of 9 the next), and everyone else except one or two residents at B level. If this means that the unit has consistent positive behavior, this is an achievement for residents, staff, and the DAS. It is possible that it means that the behavior required to achieve A level is not sufficiently challenging.

There was inconsistency in how the DAS sheets were completed, with some staff writing the reason for not earning (e.g., "arguing," "not accepting 'No,'" "no gym," "not a role model," "horseplay," "no effort in class," "no breakfast," "poor line," "refused group"), and others simply writing 0 or N. Both the DAS elements and explanations written in the boxes were standard noncompliance with rules. Residents using or not using DBT or Sanctuary skills was never noted in the reviewed DAS sheets. Finally, on some sheets whole time periods went unscored. If the youth is not earning achievements because he is completing an EPB, the DAS should so indicate but otherwise it should be scored. Finger Lakes staff

describe the DAS as a work in progress. As the PH Monitor described above, to be effective the DAS at Finger Lakes must be improved in what is being scored, how quickly residents get feedback about their achievements, and what their achievements entitle them to.

A behavior issue that continues to be troubling at Finger Lakes is gang involvement of residents in the community and when those rivalries affect dynamics within or between units in the facility. Some Finger Lakes staff recently attended training on youth gang involvement, and as the PH Monitor noted above, the facility plans to bring in motivational speakers for youth and experts for staff on this issue. Staff described using their intact unit teams to make each unit a strong community and applying DBT and Sanctuary skills to deal with gang affiliation. They said a relationship-based approach helps to unite each unit around shared goals and ensure each resident feels accepted. The QAI Review noted the problem of gangs at Finger Lakes and their contribution to some of the group disturbances. One youth commented to QAI that seasoned staff quickly reduced gang tensions on the unit, making residents feel safer than with new staff not yet experienced enough to pick up on subtle gang cues.

Multiple placement youth are a sizable group at Finger Lakes and raise questions about how the facility should tailor the New York Model to ensure that their placement this time is more effective. All of the residents whose records the MH Monitor reviewed had been in a private residential facility (Children's Village, William George, Graham Windham, Cayuga Home for Children and St. Mary's Children and Family) before their placement at Finger Lakes. Because of family problems and difficulties staying substance-free and non-delinquent in the community, there are many multiple placement youth who feel hopeless and are harder to engage in the Finger Lakes program. The three residents with the apparently longest stays in the facility are examples of unsuccessful returnees—they have actually not been at Finger Lakes the entire time since the admission date on the population list.



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, and chain analysis.

The MH Monitor will discuss coaching for self-calming as a priority prior to de-escalation techniques as well as a reconsideration of the IIP.

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

COMPLIANCE

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

Mental health staff at Finger Lakes were observed complying with 47a.

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." Updates regarding the staff person to be contacted for mental health crises after hours at Finger Lakes are decided at the facility level and are maintained at the Central Services Unit (CSU), which complies with 47b.

The revised PPM 3247.60 "Suicide Risk Reduction and Response" was finalized and complies with the requirements of 47a and c.

*State Report on Progress (6/21/12)*

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 (11/12)*

The MH Monitor reviewed the finalized policy 3247.60 "Suicide Risk Reduction and Response" and summarized its contents in previous monitoring reports.

QA found that Finger Lakes had run out of the Suicide Risk Assessment form (ISO-30) so they were missing from records, although clinicians were informally assessing for suicide risk. Since November 2012, OCFS reported that the Finger Lakes clinical team is completing ISO 30s.

No Finger Lakes residents went to a psychiatric hospital in the six months prior to this site visit.

At Finger Lakes, 22 residents were on 33 suicide and personal safety watches in the three months prior to this site visit. They ranged from threats to harm self (most situations) to tying shoelaces around neck (3), scratching wrist (2), depression with broken glass in room (1), and agitation with piece of plastic bag in mouth (1). Two youth had three suicide watches, seven youth had two, and 13 had one during the three months. One resident arrived from reception on Personal Safety Watch, which was continued at Finger Lakes for several days. Over half of the watches lasted 1 day (19 out of 33), almost a third lasted 2 days (10/33); one youth was transported to a Mental health Unit after 10 days on suicide watch at Finger Lakes. The MH Monitor found documentation of Suicide Watches and Personal Safety Watches in the Finger Lakes records. [redacted]

[redacted]. His desperation over his homelessness was discussed in the Psychiatrist's Mental Health Rounds on 10/31/12 (and documented in a psychiatric contact note): "to understand his apparent bravado and sense of confidence and power he attempts to display on the unit towards peers and female staff. It seemed clear from our discussion that his behavior masks his deep sense of loneliness, lack of sexual education, poor interpersonal skills, etc. When added to his tendency to act impulsively, and be peer centered (for approval) this becomes a volatile situation. It was recommended to work on relationship building with this young man and to use selective focus (when not a safety issue), which raises the bar of our tolerance for his behavior in program, along with staff (especially female staff) trying to ignore his sexual expressions in an attempt to not reinforce this behavior and thus work towards extinction of this behavior." Detailed therapy notes also demonstrate a strong team effort in responding to the complex needs behind this resident's suicidal thinking and other behavior.

FUTURE MONITORING

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 teaching youth to self-calm, de-escalation, and chain analysis.

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

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

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

*State shall immediately initiate procedures to transfer the youth to such a setting.*

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

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

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

PARTIAL COMPLIANCE

The Integrated Assessment sample in the New York Model training materials provides clarity about what should be contained in the assessment and the Integrated Assessment format complies with 48a, d, and e.

Mental health staff at Finger Lakes were observed complying with 48d.

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

Standards for treating clinicians regarding consistent diagnostic practices are being developed and will be reviewed by the MH Monitor to determine full compliance.

*State Report on Progress (6/21/12)*

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 at Lansing and Finger Lakes. The MH Monitor adopted many of Dr. Glindmeyer's recommended findings detailed at length in site visit reports since July 2012. Many of Dr. Glindmeyer's findings are being addressed as OCFS continues to work on psychiatric standards.

When Dr. Glindmeyer reported poor diagnostic concordance between psychiatry and the other clinicians, she noted the lack of case formulations determining how specific diagnoses were made by the previous psychiatrist at Finger Lakes. This has been a continuing concern of the MH Monitor in the other facilities and will be reviewed at each site visit.

*On Site Observations (11/12)*

The Finger Lakes staff are using the Integrated Assessment.

If the Integrated Assessment and/or support 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.

At Finger Lakes in six records reviewed, QAI found that three were missing the Integrated Assessment and the other three were superficial. The FLRC Assistant Director

for Treatment said that the Integrated Assessment was only recently implemented at Finger Lakes. The MH Monitor found Integrated Assessments in the Finger Lakes records that were reviewed. It appeared that several sections of the Integrated Assessment may be excerpted from reception center documents, including negative adjectives about youth that are not strength-based. It is impressive that Finger Lakes' Integrated Assessments are completed within a month of admission. However, if they are based primarily on the resident's brief stay at reception, with the same paragraphs from reception documents repeated for several sections of the Integrated Assessment, it is much less informative than what was intended which was pulling together the Finger Lakes staff's impressions of the youth during his first weeks in the facility and referencing prior assessments. On the Integrated Assessment, the source and date of the finding should be included (if excerpted from a reception center report or if an assessment is from a Finger Lakes psychiatrist, other clinician, school or other staff). The Integrated Assessment form indicates "Reception Diagnostic Impression" but frequently the psychiatrist and therapist at the facility decide that the resident's symptoms fit another diagnosis better. This conclusion and the new working diagnosis might not appear until a subsequent psychiatric contact note, making it more difficult for the Finger Lakes team to know the current diagnosis and to track a resident's symptoms. OCFS indicated that "a consensus working diagnosis is reached at the first support team meeting 30 days after arrival of the youth to the facility. If the psychiatrist is not present at the support team meeting, then his/her diagnostic notes are presented by the clinician. The working diagnosis is updated as necessary at subsequent support team meetings. At the last support team meeting, the discharge diagnosis will be reached by consensus. The diagnosis and support team plan are both being built into JJIS. Staff currently scan the psychiatric evaluation and attach it to the youth's record in JJIS." The MH Monitor found that a resident's most recent diagnosis was on the latest psychiatric contact note and may be in JJIS, but (a) all staff may not look for it there, (b) it may not be entered into the current support plan, (c) it may not reflect the consensus of staff regarding the symptoms they are addressing with different interventions.

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: "All of 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."

The QAI review occurred just after the retirement of the former psychiatrist and as the new psychiatrist began. The MH Monitor had the opportunity to review many psychiatric contact notes prepared by the new psychiatrist and observe his leadership of Mental Health Rounds. Within his first month, the psychiatrist had thoroughly reviewed each resident prescribed medication, re-considered his diagnosis, and discussed possible

medication changes with the resident. The detail in the psychiatric contact notes was exemplary, including thoughtful consideration of symptoms and psychosocial history.

FUTURE MONITORING

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 protocols for mental health professionals on developing uniform working diagnoses.

The MH Monitor will discuss consistency in diagnostic practices with the clinicians.

The MH Monitor will review the thoroughness of the Integrated Assessments and how, as the consensus diagnosis of the resident is refined over time, it is reflected in the support plan.

*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.

Psychiatric Contact Notes, recording of laboratory tests for residents taking psychiatric medication, and nursing review of medication side effects are improved. The MH Monitor is waiting for the final psychiatry practice guidelines.

*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. The MH Monitor adopted many of Dr. Glindmeyer's recommended findings detailed at length in site visit reports since July 2012. Many of Dr. Glindmeyer's findings are being addressed as OCFS continues to work on psychiatric standards. Dr. Glindmeyer reviewed medications that were prescribed by the previous psychiatrist at Finger Lakes. The MH Monitor continues to review medications at each site visit.

*On Site Observations (11/12)*

Nineteen of the 62 boys at Finger Lakes are prescribed psychiatric medication:

- ADHD – Guanfacine
- ADHD, Conduct Disorder – Guanfacine
- ADHD – Concerta, Melatonin
- Dysthymic Disorder – Trazodone
- Mood Disorder – Abilify, Benadryl
- Mood Disorder – Resperdone, Benadryl
- Mood Disorder – Benadryl

- Mood Disorder, ADHD, Oppositional Defiant Disorder – Risperdal
- Mood Disorder, Disruptive Behavior Disorder – Seroquel
- Mood Disorder, Insomnia – Risperdal
- Mood Disorder, Cannabis and Alcohol Abuse – Abilify
- Primary Insomnia – Abilify, Benadryl
- Primary Insomnia – Clonidine, Benadryl
- Primary Insomnia – Concerta, Benadryl
- Primary Insomnia – Benadryl
- Primary Insomnia – Diphenhist
- Primary Insomnia, Conduct Disorder – Remeron
- Primary Insomnia, Conduct Disorder – Benadryl
- No diagnosis - Trazodone

The MH Monitor observed documentation of diagnosis, symptoms, dosages, and administration of psychiatric medication in the individual records at Finger Lakes. The psychiatrist discussed medication in Mental Health Rounds.

An OCFS draft document requires that "the psychiatrist will use no more than three psychotropic medicines in his/her treatment of a youth. At presentation, the number of medications may be greater, but needs to be tapered to no more than three. If the psychiatrist can justify the usage of more than three medicines, then it is important to discuss this usage with the Chief Psychiatrist. The psychiatrist will use no more than one medicine per class, i.e., one antipsychotic, antidepressant, mood stabilizer. If the psychiatrist can justify the usage of more than one medicine per class, then it is important to discuss this usage with the Chief Psychiatrist." None of the Finger Lakes residents are prescribed three psychiatric medications.

The QAI Review recommended a plan for routine scheduling of laboratory tests for residents taking psychiatric medication, and reporting lab results on the Psychiatric Contact Notes.

The Chief Psychiatrist has developed schedules for laboratory monitoring and nursing review of medication side effects to be consistent with generally accepted standards of care. The MH Monitor observed completed forms for laboratory and clinical monitoring of residents prescribed psychiatric medicine (Weight and Vital Signs Flow Sheet and Psychiatric Medicine Monitoring Flow Sheet) in the Finger Lakes records.

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.

More residents have a diagnosis of Primary Insomnia at Finger Lakes than at other facilities, and an unknown number of residents who are not receiving medication have sleep problems. Residents may be accustomed to staying up late and getting up late. Some may also be accustomed to relying on substances to induce sleep. Putting adequate sleep and getting up for school in the context of each resident's individual goals is important. The MH Monitor recommends that sleep-enhancing skill building be incorporated into the New York Model—which is a wellness approach--and implemented in groups and individually by evening staff. Traumatized youth have to learn how to put themselves to sleep, which requires feeling safe and trusting that staff will take care of them. Not only may bedtime remind them of night fears, but they miss home and the familiarity of sleeping with family members so going to bed may accentuate their loneliness. Because they cannot control the lighting or temperature, soothing routines including relaxation techniques and music may assist residents in sleeping at the facility and when they are discharged. Chain analysis might be used effectively to help residents understand and prevent their sleep problems. No one staff person has the answer to a resident's sleep problems so operating as a team is crucial to figure out his unique needs and meet them. Given the importance of sleep to emotional regulation, more attention to self-soothing strategies for sleep is a priority.

FUTURE MONITORING

The MH Monitor will:

- examine final practice guidelines for psychiatry
- review Finger Lakes records of residents prescribed psychiatric medication
- observe discussions of efficacy of medication at Finger Lakes Mental Health Rounds and support teams
- continue discussion of a New York Model approach to residents being able to put themselves to sleep

*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

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.

The QAI review found that of 42 Finger Lakes staff surveyed, 32 said that the mental health and psychiatric medication training help them perform their jobs; only 20 thought they had received sufficient training on dealing with youth with mental health issues. Twenty out of 36 staff said they did not know what psychiatric medications youth were taking.

*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 (11/12)*

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

FUTURE MONITORING

The MH Monitor will continue to observe Mental Health Rounds, review records and interview staff regarding their application of their learning about 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 (11/12)*

The MH Monitor observed documentation in individual Finger Lakes records when residents refused psychiatric medication. If a resident refuses psychiatric medication, the psychiatrist meets with the youth to clarify why (and why the youth is refusing and what

the psychiatrist has done to address the side effects and/or other reasons for refusal should be included in the Psychiatric Contact Note).

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

Informed consent procedures are in place and staff indicate in individual records that the youth and parent have been informed and consented.

*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 (11/12)*

Informed consent forms were in the Finger Lakes 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 Finger Lakes were observed complying with 53b and in the support team meetings observed by the MH Monitor.

The New York Model implementation training included the integrated assessment and support plan (formerly treatment plan), and how to utilize both in support teams (formerly treatment teams). "The NY Model: Treatment Team Implementation Guidelines" meets the requirements of Paragraph 53 of the Settlement Agreement. BBHS is revising the support plan and the integrated assessment has been revised to make them fit the New York Model. BBHS is guiding the strengthening of staff skills in identifying needs and writing goals with residents.

As discussed further below, concerns with the consistency of support plans and psychiatric coverage preclude a full compliance finding.

QAI found that on average youth were seen more than once a week by their clinician, and clinicians had more family contact than required by agency standard at Finger Lakes.

QAI reviewed two youth records at Finger Lakes in which the support plans indicated one diagnosis and the psychiatrist progress notes had another diagnosis. In other records, QA found that (a) there was no diagnosis in the support plans; (b) support plan

goals were not specific or measurable; and (c) the goals in support plans did not address the residents' trauma histories or identified substance abuse problems.

*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.

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 had an extension until December 19, 2012, and requested that the Department of Justice consider the processes that have been put in place as meeting the spirit of this provision in the Settlement Agreement.

*On Site Observations (11/12)*

The New York Model approach to support teams (formerly treatment teams) is used at Finger Lakes. Three Finger Lakes support teams are described here as examples of New York Model practice that is improving:

[redacted] Since he is not prescribed medication, his last psychiatric contact note is from 6/12. His Goal #1 is not to get suspended, for which he is to use Mindfulness and Wise Mind ACCEPTS. His Goal #2 is Not to fight, for which he is to use Wise Mind ACCEPTS, and Dearman. His family wants him to be less distracted and do better in school. In October he was placed on suicide watch for a suicidal statement and within 24 hours he contracted for safety with his therapist. By the end of October he was attentive and participated in DBT groups, in contrast to his impulsivity in earlier groups. At his support team, AM's aftercare worker, mother, and teen sister were on videoconference (the interpreter had called in sick, so his mother went back home and brought her daughter to translate). His YC praised his progress and throughout the team meeting was supportive. His aftercare worker pushed him to name a mindfulness skill and he struggled. Asked if he has matured, he smiled broadly and gave a thumbs up and the team agreed. His aftercare worker told him, "Your work doesn't stop when you come out here, it continues." His aftercare will consist of electronic monitoring and a referral for mental health services to his neighborhood health center; his aftercare worker wanted him to have Multisystemic Therapy, but there may be too many language barriers. AM was pleased to report that he is doing well in 7th grade at Finger Lakes. His aftercare worker responded that he would have to take the state exam in the spring in order to be promoted. His mother wanted to know when he is coming home, but there was no discussion of the change from his earlier projected release in November to January. In the debrief of the meeting, his team acknowledged that he had a lot of early trauma and it was unknown what else may have happened during the family's adjustment to the U.S., but he is considered "not ready" to talk about his trauma. The cultural issues in talking about trauma were also unknown. He has trouble following rules, but whether this might be the result of culture-related barriers and/or a learning disability was not discussed. The support team limited itself to focusing on his present adjustment and supporting him to discuss re-entry plans with his aftercare worker. The team did not talk about how much his behavior is typical of 13-year olds or the fact that he is readily identified as different from his peers and does not know how to deal with peers picking on him. Furthermore, his mother and sister require education about his safety plan and words they can use to help him use his mindfulness skills.

[redacted] His IIP noted that he had a history of AWOL and "regular contact with his mother is essential to his success." Although his Safety Plan was standard (1. Deep breath-count to 10; 2. Time Away; 3. Drawing), one element of the CPM gave more detail: "Stay focused on goal—he's worried about getting time added to release date." His Integrated Assessment was completed a month after his arrival at Finger Lakes and reported that [redacted]

[redacted] He used marijuana daily to relieve depression. "He has child-like behaviors. Stress leads to emotional upset, he goes to his room and cries. Loses focus easily and must be reminded that he wants to go home." The Integrated Assessment had limited detail about the diagnostic and treatment formulation: "Conduct Disorder, Dysthymic Disorder, Cannabis Abuse; prescribed Abilify for depression and anxiety and reports feeling better and interacting more." There was no information in the Integrated Assessment about his current academic abilities, school placement, relationship with siblings, or gang issues. His initial support plan described him as "engaged in program; positive role model on unit; helpful in promoting non-violence; quiet but when he speaks, kids listen." But two months later, his behavior had changed and no one knew why: he assaulted a resident and was refusing school and DBT after having been resident of the week. His goal #1 was Follow rules and meet program expectations and his goal #2 was OJT position and develop employment skills. These seemed more like staff directives than goals he would articulate. There were five contact notes for substance abuse group between 9/6 and 10/18. He refused two, attended three and was active in one in which marijuana was discussed. His YC convened CP's support team meeting, with his therapist, teacher, substance abuse clinician, Assistant Director for Treatment, nurse and YDA; his aftercare worker was on the phone (his mother cancelled and a videoconference with her was re-scheduled for the following week.) His therapist said he had been prescribed Clonidine for social phobia, which may have caused his aggression since after the psychiatrist discontinued it, his behavior changed: he became withdrawn. He said he was quiet because he was worried about what peers would think. "They will laugh at me. But adults know what I mean." However, he went to an AA meeting with residents from other units and opened up. The focus of the support team meeting was on getting him to program, with a goal of release rather than figuring out what needs are behind his behavior and meeting them. Therapy is focusing on teaching him positive peer interactions. Because he is reading at the 6th grade level and doing math at the 5th grade level, he is ineligible for the GED, but the team did not discuss either his difficulty in school with low skills at age 16 nor what special services he might require to improve his levels. He told his support team that he feels better and is doing better, but still has trouble waking up in the morning. He achieved his goal of OJT, but got fired for an altercation: "I feel bad. I still want OJT." He was praised for talking to his support team and was encouraged to stay focused on his goals. In the debrief the team responded to the MH Monitor's question about their monthly support teams often being scheduled for only 30 minutes, and they said usually that is sufficient "unless the youth talks a lot. If there are special concerns about the youth, they can be discussed in Mental Health Rounds or at greater length in a Red Flag meeting."

[redacted]

[redacted]

He was described as hyperactive and impulsive and having an IEP for learning disabilities. In early October he was trying to get his aftercare worker to get his school record from Mercy First so he could be promoted at Finger Lakes. He expressed frustration to his therapist that he had been locked up for a year. He talked with his therapist about not being able to see a way out of the gang. He acknowledged getting into trouble to defend himself. His diagnosis was Conduct Disorder and ADHD, and he is not prescribed medication. Neither learning disabilities nor family issues were included in the formulation. His support plan Goal #1 was Go home, for which he was supposed to increase school participation and learn mindfulness. Goal #2 was Get a job, for which he was to increase program participation—presumably, since he is 14, this meant a job at the program, but no mention was made in the support plan about OJT. His family goal was increase support for him and increase the family's knowledge of DBT skills so they could help keep him out of trouble. There were six contact notes for substance abuse groups, all but one of which he participated in actively. JM's Support Team was convened by his YC, with his YDA, therapist, teacher, nurse, substance abuse counselor, and another YC to translate for his mother and his mother participating on the phone. The team was most concerned about his lack of participation in the facility school. He was suspended from his job in the kitchen for a week until he gets back on track in school. He told his team that his goal is to go home, and they told him to do so he has to increase his school participation. His mother said she wants him to go to school and do sports, and he said absolutely "No." His brother is in the military, but he has no interest. He commented, "At school I just attend school. I do not work in school. I do just enough to pass." He expressed an interest in becoming a mechanic, and the teacher said he was about to begin the Finger Lakes mechanics class. He was quiet and staff tended to fire questions at him. JM was upset about his DAS sheet--he insisted he earned a radio. He was near tears and wanted to leave the meeting because he understood he was not getting the radio since he did not attend school even though he was certain he earned his points doing other things. Afterwards his therapist commented, "He is 14. He does not think about the future. He does not have educational goals. He has learned to regulate his emotions here. He got upset with the team but he held it together. He is learning to work through his emotions." His therapist said with a reading level of 3rd grade and a math level of 6th grade and struggling with reading and writing in English, he needs tutoring, but his teacher said tutoring had not been approved for him. "He is very focused on his gang" but the team did not know what could be done about his gang involvement although it clearly affects his likelihood of returning to OCFS. In the debrief, his support team members said they did not know resources for gang treatment in the community. Team members noted that teams are always concerned about the resident's behavior after leaving the facility, and suggested that the support plan should have a section for future services in the community. In the debrief staff said that there is too much demand for videoconferencing at Finger Lakes—they are technologically unable to use videoconferencing at every support team meeting.

The observed support teams at Finger Lakes demonstrated major strengths: (a) the caring way staff communicate with residents; (b) including the family; (c) encouraging the resident to communicate about goals and skills with family and aftercare during the meeting. Aspects of the support teams requiring improvement are (a) getting behind the

resident's behaviors to the unmet needs driving them and designing ways each staff can help the resident meet those needs with more acceptable behaviors; (b) incorporating the Integrated Assessment findings into the team discussion and support plan; and (c) making connections between the resident's goals at Finger Lakes and success in the community. Finger Lakes staff are making progress at learning how to write specific treatment goals and orchestrate the support team meeting around the resident's goals. Figuring out the unmet needs behind their behaviors to make sure each resident is actively working on getting his needs met requires a specific, needs-driven support plan explicitly connected to the skill building of the New York Model. An integrated support plan states needs that can be met by staff in different ways, many of which will not be therapy. A youth worksheet has been developed to help residents state their goal, the steps to their goal, and what adults can do to help them with each step. It will helpful both in the development of the support plan with the resident and to assist the resident in preparing to speak up at the support team meeting.

"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." The Finger Lakes psychiatrist is prescribing medication for nearly a third of the residents in the facility. It seems likely that, in addition to discussing one resident per month in depth at Mental Health Rounds, the psychiatrist would find it informative and it would be helpful for other staff to participate in another resident's support team monthly. This resident might have symptoms that are enigmatic, acute or cause divergent staff reactions. Having one support team a month (or more, depending on need) rescheduled during the psychiatrist's hours would seem preferable to conveying his views of the high needs resident solely through contact notes and discussions with the therapist.

The scarcity of psychiatric resources noted by Dr. Glindmeyer when she was at Finger Lakes in March 2012 continues with the new psychiatrist being available for only 12 hours a week so he cannot meet with support teams and can only participate in one Mental Health Rounds per week. 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 may be necessary. 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 support team meetings) and from the estimated time required, a full time equivalency level should guide recruitment.

FUTURE MONITORING

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

The MH Monitor will continue to review psychiatric 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

OCFS has indicated that there is no plan to add the NY Model to the section of PPM 3243.33 entitled "Substance abuse interventions and treatment." Instead, an OCFS Substance Abuse Manual is in the process of being drafted that will provide clarity about the OCFS substance abuse services in the four DOJ facilities as part of the New York Model, including the applicability of DBT and Sanctuary skills.

The MH Monitor reviewed the curriculum for the DBT for Substance Abuse training, which demonstrates 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 support team and Mental Health Rounds among the therapist, substance abuse clinician, YCs, YDAs and the rest of the team on how to support each resident's individual progress in self-calming at Finger Lakes and how he can use these skills to avoid substance use in the community. Hopefully these concerns will be addressed in the Substance Abuse Manual.

The MH Monitor had reviewed POSIT (Problem Oriented Screening Instrument for Teenagers) when it was implemented by OCFS, but OCFS has decided not to use POSIT. Instead, the Adolescent Alcohol and Drug Involvement Scale (ADDIS) will be used at the four facilities to screen youth for drug and alcohol use. The MH Monitor reviewed the ADDIS and it is shorter and uses terminology more understandable to youth than the POSIT; in addition, the ADDIS can be administered by any clinician as part of the Integrated Assessment and offers the flexibility of collecting more detailed information from youth under each question.

The MH Monitor reviewed descriptions of Innervisions and Triad provided by OCFS. Although OCFS acknowledges that Innervisions is outdated, it will continue to be used. OCFS indicates that at Columbia, Taberg, and Lansing all residents are involved in both Innervisions (a prevention program) and Triad (a treatment program). At Finger Lakes Innervisions is used as well as groups led by the substance abuse clinician. OCFS is

working with a consultant to develop a DBT-based substance abuse curriculum and plans to implement a health-awareness curriculum (including substance abuse prevention).

Once the substance abuse manual is completed, OCFS indicated clinicians will be trained to administer and interpret the ADDIS so that the results of substance abuse screening can be included in the Integrated Assessment and to incorporate substance abuse into treatment in the New York Model.

The MH Monitor is waiting to review the Substance Abuse Manual detailing how individual and group chemical dependency treatment will be integrated into 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 (11/12)*

Because of a change in schedule necessitated by a fire drill, it was not possible to observe the scheduled substance abuse group during the site visit.

Finger Lakes still has only one substance abuse clinician. She cannot provide sufficient substance abuse services for six units nor can she assess every resident at admission. She reviews previous information about every resident and based on that contributes to the Integrated Assessment. She participates in most support teams, both to coach staff and guide the inclusion of substance abuse in planning. She runs one group per day—one on each of four units and an AA group; she does not have time to run a group on every unit. She also counsels some residents individually. She has a large office she described wanting at the previous site visit so she could convene groups with privacy, but because cameras have not been installed she is still holding groups on the units. Her weekly groups include all the residents on the unit even those who are not substance users—the location and over-inclusiveness of these groups are a problem, but she also has seen some non-users learn a lot that might keep them from using. She is offering an AA group weekly with a leader from the community with residents from different units together. In at least one recent discharge, a resident's experience with AA at Finger Lakes helped him get involved with AA in the community when he relapsed.

At the time of the site visit, 35 of the 62 residents at Finger Lakes had a substance abuse diagnosis, and the facility requires an additional substance abuse clinician so all the residents who need treatment can have a substance abuse group that fits their level of use, some with no substance experience can have a prevention group, and all the residents who need individualized assistance to prevent relapse can receive it. OCFS indicated there is no plan to hire an additional substance abuse clinician at Finger Lakes. OCFS argued that several other Finger Lakes clinicians have substance abuse treatment experience and can also provide individual treatment for residents with substance abuse diagnoses. While it would be desirable for them to incorporate substance abuse treatment into their individual therapy with residents, their caseloads are too large for them to also facilitate group treatment for residents with substance problems. Even if (a) other clinicians administer the ADDIS to all new residents and interpret their findings on the Integrated Assessment; (b) every resident requiring individual substance abuse treatment receives it either from the substance abuse clinician or their therapist who helps insure this work is reflected in their support plan; and (c) the substance abuse clinician and/or their therapist report their progress in support team, it is doubtful that the plan for the new Lansing substance abuse clinician to work at Finger Lakes 1-2 days weekly will be sufficient to extend the group and individual treatment capacity of the Finger Lakes substance abuse clinician for the size of the facility.

[redacted] He wants to go to a group home and independent living, get his GED, and go to community college. His support plan goals are: #1 Impulsivity for which he is to use DBT skills and #2 Relapse Prevention skills through substance abuse counseling, DBT skills, and help to develop a relapse prevention plan. His mother is supportive of his staying sober and living wherever he can be safe and succeed. He needs a lot of individual time with the substance abuse clinician to identify specifically the skills that will help him avoid relapse in the community and practice those skills at Finger Lakes.

FUTURE MONITORING

The MH Monitor will review the substance abuse manual and the incorporation of chemical dependency services in the New York Model utilizing DBT and Sanctuary and in the context of the integrated assessment, support plan and support team process.

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

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.

*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, which 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

As discussed below, there is not yet full compliance with this paragraph as the transition plan only meets some of the requirements of the Settlement Agreement.

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. 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 (11/12)*

The MH Monitor reviewed the one-page Mental Health Continuity of Care Plan and the Transition Plan for [redacted] His diagnosis is Conduct Disorder and Cannabis Abuse. His Mental Health Continuity of Care Plan indicated the outpatient provider he was scheduled to see for mental health counseling, psychiatry, family therapy, and substance abuse treatment, with an appointment a week after discharge. His transition plan called for return to adoptive parents, electronic monitoring, YMCA and B2H services. In addition, his aftercare worker referred him to BEAM, an engineering program in his community where he can get OJT (to encourage his interest in studying engineering in college). His safety plan was mentioned (taking deep breaths, time away and pleasant imagery) but how it would be applicable to return to the community and an adoptive home where he has not lived for more than two years was not described.

The MH Monitor reviewed the one-page Mental Health Continuity of Care Plan for LF who was released from Finger Lakes shortly after the site visit; the MH Monitor had the opportunity to observe LF's last support team meeting and interview him at length. [redacted] Although he has experienced significant trauma (including the shooting death of a relative at home after he arrived at Finger Lakes) and worries about an adult criminal charge he is facing, he avoids treatment saying, "I do not have a mental problem." His use of marijuana while on probation was not discussed as his way of managing his trauma-related feelings. He is college bound, is in 11th grade, reads at the college level, does math at the 10th grade level and has taken many Regents. The clinical treatment needs in his Integrated Assessment included "individual therapy focused on developing coping skills to begin to address trauma." His support plan was weak, making it sound like he had nothing to change. Goal #1 was Go home for which he had to "practice skills, make academic progress and arrange aftercare." His Goal #2 was Go to college and the program was to "support current studies and guide his college steps." There were no family treatment goals. Between 10/11-10/23 his therapist wrote four clinical contact notes trying to engage him; of four DBT groups during the same period, he had good participation twice and refused twice. His aftercare worker was not videoconferenced into the support team even though release was being planned in a few weeks. The support team was exemplary in the good interaction among the staff, youth and his mother. His mother expressed strong support for him to be successful. She is concerned about his choice of friends. She wants him to attend drug treatment everyday after school. By the end of November 2012 after he had been discharged from Finger Lakes, LF still had no Transition Plan. His Continuity of Care Plan called only for substance abuse treatment in a program in his home town, but mental health counseling (despite the

effects of trauma on his behavior) and family counseling were described as "not indicated," so there was no referral for those services.

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 his needs and how each of them can support his distress tolerance, self-calming and interpersonal effectiveness skills (including how, specifically, he can make use of his Safety Plan and other New York Model skills in the community); and (2) Identifying his team in the community to help the young person reach his goals and giving each team member (youth, family, OCFS staff, service providers) 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 support 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 his team at the facility use his support plan to assess progress and refine supports, OCFS should help the youth, his family and community services be able to rely on his transition plan. Through the New York Model OCFS has implemented the integrated assessment and integrated support plan, but OCFS does not yet have an *integrated* transition plan that includes all elements of a youth's successful re-entry to the community without violating HIPAA.

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*

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

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

PENDING REVIEW

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

*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 has been the creation and implementation of the Quality Assurance and Improvement (QAI) Bureau. The Monitors received the *Pilot Program Review: Finger Lakes Residential Center* (Draft) or the QAI Report for FLRC before the monitoring visit and then had an opportunity to discuss its contents and findings before the FLRC monitoring visit. Again, the Quality Assurance and Improvement (QAI) Bureau has produced an excellent report, identifying many of the same issues observed by the Monitors.

The Monitors met with QAI staff members to discuss the FLRC report. Attendees included David L. Bach, QAI Director; Sandra Carrk, Project Manager; Diane Deacon, Assistant Deputy Counsel; Edgardo Lopez, Settlement Agreement Coordinator; Denis Passarello, QA Specialist; David Sagaties, QAI Assistant Director; Beverly Sowersby, Facilities Manager; and Dr. Joe Tomassone, via video. The MH Monitor also had a follow-up conference call with the QAI team after the Finger Lakes site visit. The quality of QAI products has become an important component of compliance decisions for various Settlement Agreement paragraphs. The quality of the QAI pilot reports has been excellent. The reports have been thorough and informative.

The critical and yet-to-be developed aspect of QAI 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: Various issues, voiced primarily by staff during confidential monitoring interviews, may prove to be of concern to quality assurance efforts at some later point, but presently they do not appear to have been communicated to QAI nor they currently have not risen to the level of an implementation problem. Two include work with Home Office and facility administration at all DOJ facilities to streamline paperwork demands, and the need to address the stress placed on middle managers in their supervision of new staff in new programs and veteran staff adapting to new programs.

*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 FLRC visit.

## V. SUMMARY

The Finger Lakes monitoring visit revealed numerous positives that predict continued improvement and progress toward compliance. The QAI Report described systems improvements at Finger Lakes that allowed administration to focus on strengthening services and building teams to carry out their vision. A strong administrative team exists with a range of complementary persons that supply the kind of balance needed to address the changes required by the Settlement Agreement reforms. To the extent that this staff and Home Office can better manage the pace of change, substantial improvement can be expected over time.

Because FLRC has experienced an inconsistent continuity in programs and services due to changes in the resident population, the problems surrounding a large influx of new staff, and the variations in the rates of restraints (measures of harm and threats of harm), Finger Lakes has had to struggle to make temporary progress toward compliance and to sustain an acceptable level of services that would constitute substantial compliance. Finger Lakes has a good staff with improved continuity, so the challenge is, with time, to grow, achieve, and maintain levels of compliance that withstand mere technicalities and temporary failures to comply.