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

Facility Monitoring Report:
Finger Lakes Residential Center
Lansing, NY

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INDIVIDUAL FACILITY MONITORING REPORT:

FINGER LAKES RESIDENTIAL CENTER

Lansing, NY

I. INTRODUCTION

This is the thirteenth 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 May 20-23, 2013. As noted in the first monitoring report, the Monitoring Team consists of two Monitors, Dr. Marty Beyer, who is responsible for the Mental Health paragraphs of the Settlement Agreement, (hereafter referred to as the MH Monitor) and Dr. David Roush, who is responsible for the Protection from Harm paragraphs (hereafter referred to as the PH Monitor).

This report evaluates numbered Paragraphs 40-57 and 68 in the Settlement Agreement. Specific headings within these groups of paragraphs include Use of Restraints, Use of Force, Emergency Response, Reporting, Evaluation of Mental Health Needs, Use of Psychotropics, Staff Training on Psychotropic Medications and Psychiatric Disabilities, Psychotropic Medication Refusals, Informed Consent, Treatment Planning, Substance Abuse Treatment, Transition Planning, Document Development and Revision, and Quality Assurance Programs.

A. Facility Background Information

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

On May 20, 2013 there were 61 boys at Finger Lakes on six generic units. The 61 boys ranged in age from 12 to 18 (12-1, 13-2, 14-6; 15-12; 16-32; 17-6, 18-2); the population was older than during the previous site visit with 66% age 16 and older as compared to 50% in November 2012. They had been at Finger Lakes from 10 days to 430 days (7 had been there for about a month or less, 19 for one to about three months, 18 for 4-5 months, and 17 for six months or more). The 61 boys were committed for: Robbery (14), Assault (9), Petit Larceny (6), Criminal Mischief (5), Weapon Possession (5), Grand Larceny (4), Criminal Possession (4), Burglary (3), Menacing (3), Trespassing (2), Stolen Vehicle (1), Fleeing from Police (1), Arson (1), Reckless Endangerment (1), Criminal Impersonation (1) and False Fire Report (1); at least 14 were at Finger Lakes for Violation of Probation.

An unknown number of the Finger Lakes residents have psychiatric diagnoses. Twenty-one of the 61 boys at Finger Lakes are prescribed psychiatric medication. Their diagnoses are ADHD (7), Conduct Disorder (5), Anxiety (3), Depression (2), Mood Dysregulation (2), Mood Disorder (1), PTSD (1), Hypomania (1), and Insomnia (1). They are prescribed the following psychiatric medications: Risperdal (6), Clonidine (4), Abilify

(3), Depakote (3), Seroquel (3), Prozac (2), Tenex (2), Zoloft (2), Adderall (1), Concerta (1), Lithium (1), Remeron (1), Thorazine (1), Trazodone (1), and Melatonin (1).

Several residents were at Finger Lakes at the time of the last site visit six months ago. [redacted] has been at Finger Lakes more than 14 months because he was given an original placement of six months followed by a six-month placement on a second offense and he had a 60-day hold for his behavior at the facility. [redacted] has been at Finger Lakes almost a year because his team worked with his mother on an RTF placement, but while he was awaiting admission, his mother changed her mind to a plan of returning to her; she then became uninvolved in his treatment, during which time his aggression at the facility increased. [redacted] has been at Finger Lakes more than nine months because of problems with Interstate Compact, followed by a change of placement plan to his other parent which was delayed by his aftercare worker leaving, and a 30-day hold after he was involved in a group disturbance.

Between 10/15/12 and 4/30/13, 54 Finger Lakes residents were released (one was released, returned and was released again during that time). The high rate of returns to Finger Lakes after release is a concern requiring further investigation and coaching support teams in how to enhance transfer of gains made in the facility to the community.

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 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

The Office of Children and Family Services (OCFS) has a good management information system with access to a wide range of data. A further review of the system and its capabilities allowed for the development of Excel spreadsheets that were provided to the Home Office for the regular collection and dissemination of facility data to the Monitors, including the semi-annual Performance-based Standards (PbS) data. The Monitors received the OCFS fifth Six-Month Progress Report on the Settlement Agreement on June 13, 2013.

3. Entrance Interview

The entrance interview occurred on May 20, 2013 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; Deborah Bacinelli, Asst. Dir.

Treatment; Sheryl Benedict, Nurse Administrator; Sandra Carrk, Project Manager; Diane Deacon, OCFS Legal; Todd Etchison, Assistant Director for Program; Scot Lamphier, Assistant Director for Program; Edgardo L. Lopez, Settlement Agreement Coordinator; Tom Murphy, Voc. Spec. II (Acting Ed. Supervisor); and Monique Thomas, OCFS Legal.

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.

6. Staff Interviews

The Monitors interviewed 23 FLRC staff. In addition to group meetings with staff, the MH Monitor interviewed a nurse, a psychiatrist, a NPP, two clinicians, a Youth Counselor (YC), the Assistant Director for Treatment and the Facility Director. The PH Monitor interviewed four (4) Youth Division Aides (YDAs), six (6) Youth Counselors I and II (YCI and YCII), one Facility Director, one Assistant Facility Director, one (1) nurse administrator, two (2) nurses, and one (1) AOD.

7. Resident Interviews

The Monitors interviewed 13 boys; the MH Monitor interviewed three (3) boys individually and the PH Monitor interviewed 10 boys with an average age of 15.3 years old. Interviews occurred in areas with reasonable privacy from staff. The Monitors selected the youth for interviews.

8. Exit Interview

The exit meeting occurred on May 23, 2013. The Monitors expressed their appreciation for the cooperation and hospitality of the FLRC and other OCFS staff. The Monitors then highlighted areas of importance and concern, but not findings. The exit meeting was a time for questions, clarifications, and explanations of events and impressions before the draft report goes to both Parties. Those in attendance included: Brenda Aulbach, Facility Director; Debby Bacinellli, Asst. Director TX; Katie Beard, Calc Clerk II; Sheryl Benedict, NA I; JoAnn Carlson, Teacher IV; Sandra Carrk, Project Manager; Dan Comins, Fac. Manager; Jay Cook, Voc Instructor; Ken Cordon, Stores Clerk II; Diane Deacon, Legal; Monique Thomas, OCFS Legal; Anjeanette Donovan, LMSW II; Shannon Drake, NPP; Todd Etchison, A.D.; Annie Febles, Teacher IV; Bettie Fedrizzi, RN II; Kelly Gilfus, YDA 3; Adiel Gonzeles, Social Worker; Mike Gravel, YDAIII; Steve Kubarek, Teacher IV; Scot Lamphier, A.D; Barham Lashley, Voc.Spec. I; Michelle Ford, Res. Service; Edgardo Lopez, Settlement Agreement Coordinator; Brittney Mainville, YDA; Kristen Kercyk, Voc. Instructor III; Tom Murphy, Vocational Specialist; Haya Novak, Psychologist II; Susan Pionteck, KBS I – BD Dept.; Debbie Preston, Secretary 1; Nancie Saphara, Teacher IV; Bonnie Sherman, Sr. B.M.A; Sean Williams, YDA; John Wilson, Trainer, BOT; Patricia Zosh,

YDA II. Those who participated by telephone included: Augustine Amissah, QAI Specialist; David Bach, QAI Director; Matt Carpenter, Executive Assistant to DJJOY Deputy Commissioner; Lori Clark, QAI Specialist; Regina Jansen, DOJ Legal; Bianca Martinez, QAI Secretary; Ines Nieves, DJJOY Assoc. Comm.; Denise Passarello, QAI Specialist; Sheila Poole, OCFS Executive Deputy Commissioner; and Jenne Utting, QAI Specialist.

C. Preface to Protection from Harm and Mental Health Findings

The New York Model has been implemented at Finger Lakes. Staff are actively involved in support teams and Mental Health Rounds and the DAS and phase system are in place. Finger Lakes is proud of its implementation of intact teams, as reflected in comments the leadership team made at the entrance interview (quoted below), although "Change is difficult for residents and staff. When it went into place in January, 2013, there were many negative reactions by residents to changing staff schedules and assignments of staff." They began with a facility-wide bid for a new schedule, and there was a dramatic increase in restraints after the changed staff schedule in early January. Since the intact team meetings started at the end of January, restraints have decreased. They worked hard to have "staff and residents feel part of the process." They have a 2-hour intact team meeting every other week across shift change; morning staff stay and afternoon staff arrive early. The first hour, other staff manage their unit while the whole unit staff, with YDAs, school, YCs, clinicians, medical and ADs meet to discuss new residents, issues during the two weeks, and DAS and incentives. The second hour, all the staff meet with residents in a group to get and give feedback and make unit plans. Everyone has been trained to lead an intact team meeting; the YDAs convene the second part of the meeting, with the support of clinicians and YCs. "We are closing gaps in communication. Intact teams have enhanced morale among YDAs. We have treatment through the whole program, including dialogues we are having with each other."

In the next six months, the Finger Lakes leadership team hopes most staff will have refresher New York Model training in order to improve their group facilitation skills, support teams, and Mental Health Rounds. The BBHS Chief of Treatment Services will be assisting Finger Lakes in improving how goals are written with residents. They plan to improve their support plans by clinicians taking a primary role in writing them.

Since the site visit six months previously, "staffing has been challenging. One Assistant Director for Treatment and the Education Coordinator retired; 7 YCs and an AOD left, a senior counselor left, a YC was out for surgery, another YC was out on paternity leave, and a clinician was out on medical leave. There are 10 YDA vacancies. We've done a lot of recruiting and hiring. A full-time NPP started two weeks ago, a second substance abuse clinician will begin this week, and we hope to get another psychiatrist for 10 hours a week." Youth turnover has also been challenging—in December 2012, 19 new residents arrived and in the first five months of 2013, there have been 45 admissions so far. At the same time that the YCs departed several challenging residents arrived. There were group disturbances in January, which have decreased, with two units now being able to eat and participate in gym together.

Going to school is being enforced as a requirement for all residents and attendance and grades have improved. Many program enhancements are occurring at Finger Lakes

with a pool of funds to bring in individuals and events, especially on the weekends, including mentoring from the colleges, a poetry class, the Cornell debate team, a Spanish language teacher, pet therapy, African drumming, yoga, meditation, a life skills class, donated seeds for the horticulture program with a new instructor, and an energy conservation class. The recreation specialist from Lansing moved to Finger Lakes and has arranged more recreation and trips, including residents working in a local food pantry; she helped make an incentive room to upgrade phase rewards. "Learning and fun throughout the program with more coming this summer, welding grills for state parks and careers in construction." They are pleased that in some of these activities residents from different units are participating together without conflict. They put an article in the paper to thank the community for their help and there has been interest by other programs to go statewide with some of the Finger Lakes activities.

Before this site visit, the DJJOY Quality Assurance and Improvement (QAI) Bureau completed an in-depth review at Finger Lakes, which the Monitors discussed with them. The QAI team noted the strong beginnings of the intact team model with an agenda that reflects the New York Model and relies on coaching. The QAI Review commended two YDAs for their relationships with youth, a YC for strong leadership in Mental Health Rounds and support teams, and the psychiatrist for developing thorough psychiatric histories of residents. The QAI Review commended Finger Lakes for bringing in individuals from the community and taking youth out of the facility.

II. PROTECTION FROM HARM MONITORING

There are several topics that warrant comment at the outset, including the progress that FLRC has made since the previous monitoring visit. These issues affect Protection from Harm outcomes, even though they are not identified specifically within the text of the Settlement Agreement. In many ways, the topics discussed as a preface to compliance findings exercise substantial influence over the progress toward compliance.

As mentioned previously and consistent with the long-standing assumptions in juvenile corrections that the way a facility is organized affects strategic outcomes, several organizational changes continue to contribute to an improved climate at FLRC, particularly the improved administrative stability. Also, there appeared to be improved continuity through the leadership of Facility Director Brenda Aulbach. 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. Thus far, reports are optimistic about the Intact Team.

The biweekly Intact Team meeting promotes a cohesive unit where staff work with the same coworkers and youth on an ongoing basis. The concept has nearly universal appeal among practitioners and treatment providers in juvenile correctional facilities, so it was an appropriate change in operations. The Intact Team addresses the process of implementing the New York Model. In other words, it focuses more on how the model is

implemented as opposed to looking at what the model intends to do. Process factors are important in the full implementation of a new program.

Information from youth and staff indicated that the Intact Team has been beneficial. Despite initial problems that administration described as difficulties by youth in the changing of some staff from one work assignment to another, reports indicated that there were improved interactions between youth and staff, that youth had greater input into the treatment process, and that youth were able to review the outcomes of the Intact Team so that there was greater understanding of any changes in the youth's plan.

The implementation of the Intact 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 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.

The Intact Team has advanced program development on two fronts, the total number of activities and the integration of New York Model concepts into these activities. First, programs and activities appeared to have increased. The Facility Director provided a summary of the activities that have been provided by volunteers in the community. The list represented a solid foundation for continued program development. Next, the long-standing assumption has been that the intervention and activities that occur within the treatment environment (the sessions with the clinicians, individual counseling with YCs, and group counseling) must also translate into the rest of the waking hour programs that make up daily life in the facility. The total integration of the New York Model into every aspect of waking hour programming is essential, and the Intact Team may be the best vehicle to achieve this integration.

Safety was a strength from the perspective of youth. However, youth were very clear that safety was a function of location in facility. Youth rated on-unit safety highly, whereas off-unit safety was considerably less. Staff perceptions concurred that off-unit safety was a problem. It is important to normalize the institutional routine as much as possible and in concert with the implementation of the New York Model. Decisions to have more than one unit in the cafeteria was a step in the right direction, even though there were some major disruptions.

Youth Counselors (YCs) are a good source of information. The monitoring included a focus group with Youth Counselors; six (6) were in attendance: Lerue Culmer, YCII/Unit 5 & 6; Amanda Derby, YC I/Unit 4; Greg Hall, YC I/Unit 3; Riccarda Jarvis, YC I/Central Control; Robert Nicholas, YC I/ Unit 5; Josh Stash, YC I/Unit 4; and Rod White, YC II/Units 3 & 4. 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. From the Protection from Harm perspectives, the YC may be the most important position due to the responsibility for coordinating program implementation, establishing a unit culture of consistency and fairness as it relates to disciplinary practices, and

supervising YDA staff in the proper implementation of program principles. In most institutions, as unit management goes, so goes the facility.

As key informants about Protection from Harm and program development, the YC perspectives on safety raised some concerns. On a scale 1 to 10, with 10 being the highest, the YCs rated staff safety at 4.3 (a decrease from a rating of 6.7 at the previous monitoring visit) and youth safety at 3.8. The youth safety rating was of note because the 10 youth involved in interviews rated their personal safety at 7.2 on the same scale. The youth responses suggested a discrepancy between the perspectives of youth and staff regarding safety.

Similar to the previous monitoring report, a common theme among staff was that there had been progress but not enough, maybe even some digression. So what has changed?

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. During this visit, the pace of change continued to be a challenge with staff complaining primarily about "new models" that turned out to be adaptations or adjustments to the New York Model concepts based on implementation feedback. Nonetheless, the concern was the instability associated with these modifications.

2. 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. During this visit staff confirmed their confidence in their ability to use the New York Model to address successfully the needs of this population of youth. The distinction was the identification of the current population of youth as containing a higher concentration of challenging youth and some substantial problems surrounding the inexperience and poor decision-making of the new staff.

Youth also described the programs at FLRC as always changing. As a result, staff were described as inconsistent, but youth made exceptions for them because of the numerous changes or modifications to the program. The key for most youth was the relationship with staff, and all youth could identify at least one staff member who they felt was trustworthy and a role model.

A. Use of Restraints

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

41. Use of Restraints. The State shall require that youth must not be subjected to undue restraints. The State shall create or modify policies, procedures, and practices to require that the use of restraints be limited to exceptional circumstances, as set forth below, where all other appropriate pro-active, non-physical behavioral management

techniques have been tried and failed and a youth poses a danger to himself/herself or others. Restraints shall never be used to punish youth. Accordingly, restraints shall be used only in the following circumstances:

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

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

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

PARTIAL COMPLIANCE

COMMENT: Multiple aspects of restraints apply here. They are undue 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.

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 contribute to the partial compliance determination. The QAI Report cited instances where an appropriate use of 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 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.

YCs were asked if today's FLRC population was different. There was some initial disagreement, and the majority of the YCs indicated "yes" there was a difference. Then one veteran YC put the answer into a different context. He started by noting that the problems staff encounter on a daily basis are no different or no worse than they were years ago. Instead, there is a greater concentration of youth with serious, aggressive, and acting out problems. In addition to increasing the likelihood of problem behaviors, the greater concentration of difficulties predicts a higher than expected rate of restraints until the New York Model gains improved effectiveness with the continued enhancement of staff skills.

Avoidable restraints sometimes occur as a result of inappropriate staff behaviors including the inability to maintain an adequate level of supervision such that minor misbehaviors, including horseplay, do not escalate to the point where staff perceive the situation as out-of-control or threatening safety, thereby justifying the use of force. Those situations in which staff clearly are not doing their job appropriately contribute to instances where the restraint was avoidable even if staff apply the CPM restraints correctly.

Several concerns existed about the use of physical restraints that were not consistent with the extraordinary circumstances clause in Paragraph 41, and these instances did not appear to be mere technicalities or temporary failures. For example, in Restraint Packets 426500 and 434206, it appeared as if the restraints followed or resulted

from the staff members' inability to control youth horseplay. Before the restraint, the youths' behaviors could have been described as inappropriate and disrespectful as opposed to meeting either criteria (i) and (ii) listed above.

Regarding Restraint Packet 426500, one Activity/Incident Report discussed pre-engagement activities and described a situation where youth were involved in horseplay with staff, and the staff did not appear able to resolve the situation. As a result, the inappropriate behavior escalated. The situation warranted Documented Instruction and coaching and represented an avoidable restraint.

In Restraint Packet 426500, the YDA was in the center of the room, and youth moved behind her back without her knowledge (incorrect positioning). For this reason, one youth was able to "push the pin" on her radio. Youth continued to violate minor rules including sitting on furniture in the presence of two staff. AOD Murphy arrived and began to direct staff action. Within minutes there were five staff members on the unit. Based on what the documentation referred to as AOD Murphy's direction, one staff member put the youth in a standing restraint. The Use of Physical Restraint Staff Debriefing Report stated that the youth's behavior prior to restraint was "physically aggressive." From a review of the video, there did not appear to be clear evidence of physical behaviors indicating a threat to safety other than noncompliance with staff directives. Home Office indicated that the youth was threatening to incite other youth on the unit; and this verbal behavior, which was described in the documentation, represented the policy justification for restraint, i.e., "Safety." If a general justification, such as "safety," was intended to include the staff need to make the environment safe, then the justification can easily be confused as a threat to the "safety and order of the Facility," which is not a part of policy on exceptional circumstances. If "safety" means the protection of "any person," the documentation should make that link more directly.

According to the Activity/Incident Report for Restraint Packet 434206, the staff member described the youth as having been engaged persistently throughout the day in horseplay with staff. The report also described multiple efforts by the staff member to get the youth to cease horseplay. There was nothing in the Restraint Packet documentation to indicate that the staff member requested or received assistance or coaching from a supervisor regarding how to handle horseplay.

Restraint and Injury Data

Regarding the injury and restraint data provided by Home Office, there has been a stabilization of the injury data, which argues for the appropriate use of the CPM techniques and an amount of force that does not exceed the amount necessary to control the situation. The concern is the restraint data. The pattern was unstable and volatile, and while the response was that the volatility in the rate of restraints was a function of changes in the resident population, mechanisms are needed to moderate these variations.

There were 208 physical restraints in April 2013. It is difficult to know how many staff hours of activity and documentation are associated with a single restraint. That does not mean that there cannot be an estimate. Consider the time spent on writing the activity or incident reports by two (2) or three (3) staff members, a Restraint Monitor's report, a Youth Debrief Report, and Egregious Behavior Protocol, an Administrative Review of

restraint, the Video Restraint Form, the Post-Restraint Examination, to name a few. If one conservatively estimates that 10 hours of staff time go into one restraint, then April accounted for 2080 hours of staff time, which was the equivalent of one full-time employee. If this use of staff time and program disruption was acceptable and appropriate, then coverage and assignment issues factor back into the equation of avoidable restraints and create a need to re-think the amount of staff assigned to FLRC.

Gangs

Youth gangs contributed 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. Gang activities remained a problem even though there was a lack of clarity about the gang activities. The information provided by different staff indicated a lack of consistency about how the gangs form and the reason for the violence. Some staff described the gangs as a "pack" activity and others described affiliation as a means of feeling safe. As with other institutional gang activities, an attack on a rival gang member or independent (non-gang involved) youth was a way to gain prestige and status.

One YDA's Strategy

One staff conversation provided a wealth of information about a line staff-generated strategy for addressing unnecessary restraints. During the conversation about use of force, the staff member indicated that the number of restraints on his unit were less than other units. At that point, the PH Monitor got the Restraint Log from CSU, and we counted the number of restraints for April for all the living units. The assertion that his unit's restraints were lower proved to be true. In fact, the rate of restraints was 42% lower than the rate for the total facility, and the rate was the lowest among all living units.

Much of the success was attributed to Intact Teams, but the issues about how to work as a team and work with youth preceded the implementation of the Intact Team and are worth noting. The following were the key components of the staff member's approach to working with youth and avoiding unnecessary restraints:

1. Consistency. The staff member stressed a focus on mentoring and relationships such that the entire team and residents held each other accountable to behave according to agreed upon expectations. Staff members held each other accountable through gentle confrontations about commitments to behave in a certain way as opposed to a "gotcha" strategy.

2. Relationships. Staff took time to do one-on-one interactions with youth. The schedule was difficult and full of activities, so it was important to find as many of these opportunities as possible. One-on-one relationships were based on sincerity and genuineness. These factors permitted staff to hold multiple groups where youth participation was high and respect for one another's feelings was also very high. This produced a safe environment for groups.

3. Mentoring. As much as anything else, mentoring translated into staff behaving as a role model. The important factor was that actions speak louder than words, so it was important to show youth how to behave. It was also important to avoid situations where staff say to youth "Do as I say and not as I do."

4. Communications. Communications were constant. The staff member indicated that he talks to youth all the time. Much of this communication was describing what was happening and telling youth what will happen next. These advanced organizers were important to help youth transition smoothly from one event to another and one activity to another. The communication began with a pre-shift briefing and continued through the writing of good entries in the logs.

5. Assimilation of new staff. It was important to set the same expectations of new staff or substitute staff when they worked the shift. This included an initial, brief conversation about the expectations that staff were to be genuine and honest with the youth and each other. There was a clarification that the level of effort required to make the team concept work was often times more than staff experienced on other living units. Therefore, it was important to keep the effort level consistent with other staff. The staff member also indicated that the new staff members were expected to observe the unit routine, watch how problem solving occurs, and ask for explanations of how and why staff members behaved accordingly.

Recommendation: This information should be formalized as part of new staff training and inserted into some aspect of the annual training expectations for veteran staff.

Further, the State shall:

41. a. Create or modify and implement policies, procedures, and practices to require that in the limited circumstances when the use of restraints is necessary, staff shall employ only the minimum amount of physical control and time in restraints necessary to stabilize the situation.

PARTIAL COMPLIANCE

COMMENT: The policy and procedures are established; the training on the policies and procedures has occurred; and evidence of a corresponding practice includes documentation (written and video), staff reports, and resident reports that are consistent with the policy and procedures. 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 noted, but there are still too many examples of uses of force where the amount of force needs to be re-examined. The QAI Report cited several examples of restraints outside compliance with its standards. Restraint Packet 434206 represents an example of a staff member's use of excessive force. The case remains under investigation by IAB.

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.

The QAI Report cited instances of noncompliance in Restraint Packets where there was no evidence of an IIP available for the youth involved in the restraint so the restraint lacked evidence that de-escalation techniques were a viable part of the physical intervention. In the review of Restraint Packets included in this monitoring visit, there were multiple instances where staff described the restraint as happening so fast that IIP materials, especially those related to youth safety plans, went largely unused. The purpose of these materials is to assist staff in the de-escalation of problems and to reduce avoidable restraints. Even if a YDA forgets what was in a youth's IIP (and individual IIPs for 12 residents on unit might be difficult to keep in mind and time might not permit checking the written IIP), teamwork and coaching by clinicians and YCs hopefully include sensing before a youth escalates and when he requires immediate help in calming himself. If YDAs confidently calm youth before escalation begins, restraints can be avoided

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. Concerns remained about facedown restraints, even though none of the Restraint Packets in the PH Monitor's review involve a facedown restraint. However, the QAI Report indicated that approximately 28% of the youth in its survey reported having been placed on their stomach at some point during restraint. This could have been due to the accidental movement to a facedown position, which the QAI Report documented thoroughly and found only one restraint that appeared to be a purposeful facedown

restraint. The concern was that QAI Report indicated that 57% of the youth who had been in a facedown position said that they had been placed in handcuffs.

The accidental use of a facedown restraint calls attention to staff competencies when restraining adolescent males. So far, there has been no evidence that indicated that a facedown restraint was anything more than a failure on the part of staff to implement a CPM technique effectively or an accidental circumstance. The issue of handcuffings warrants Home Office follow-up regarding safety, especially since a new and safer handcuffing technique has only recently been approved and implemented.

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

COMPLIANCE

COMMENT: The policies, procedures, and practices remain unchanged since the last monitoring visit and the last finding of compliance. This paragraph should be considered for transfer to QAI for continued monitoring.

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

COMPLIANCE

COMMENT: The policies, procedures, and practices remain unchanged since the last monitoring visit and the last finding of compliance. This paragraph should be considered for transfer to QAI for continued monitoring.

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 Debora Peet and John Wilson, FLRC BOT Field Instructors, and reviewed with them line-by-line. Despite a change in the presentation of the information, which made the review more complicated than necessary, all staff members were up-to-date with the exception of three (3) YDAs, but two (2) were at training during the monitoring visit and the other had a legitimate excuse. 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.

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 policies, procedures, and practices remain unchanged since the last monitoring visit and the last finding of compliance.

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.

Multiple staff members acknowledged that there have been three (3) broken noses among staff recently. One staff member maintained that the reason for so many injuries to staff was that youth did not take CPM seriously. The staff member emphasized that CPM was "not as painful" to youth as the previous restraint strategy. As a result, the staff member claimed that youth did not care if they are restrained.

Staff still talked about the lack of accountability as another reason why youth violence persists. The definitions of accountability include making sure that there was a consequence for each incident of misbehavior by youth. Regarding accountability for youth-on-staff assaults, administration noted that two (2) youth were in jail on felony assault charges as a result of behavior at FLRC.

One staff member was very clear that youth and staff relationships needed to improve because the relationship element improves de-escalation and results in a quicker ending of restraint events.

42. c. Create or modify and implement policies, procedures, and practices to require that staff adequately and promptly document and report all uses of force.

PARTIAL COMPLIANCE

COMMENT: The policy and procedures exist; the training on the policies and procedures has occurred; and evidence of a corresponding practice includes documentation (written and video), staff reports, and resident reports that are consistent with the policy and procedures. The QAI Report cited multiple instances of restraint documentation that did not meet its standards. A consequence of the Settlement Agreement has been 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 volume of restraints. As mentioned earlier, the amount of time required for the documentation of the restraints was substantial, and the frequency of the restraints placed staff in situations where it is easy to cut corners and do a quick and superficial report. Issues are the tardiness and incompleteness of staff reports, which need to be resolved as conditions for compliance.

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.

COMPLIANCE

COMMENT: The Therapeutic Intervention Committee (TIC) seems to be the system of review by senior management outlined in this paragraph according to Home Office. The TIC has mandatory attendees that include the Facility Director or designee, Clinical, Assistant Director, AOD, YDA, YC, Medical, Kitchen, Maintenance, Recreation, Spiritual (if on staff), Education, and youth (for last agenda items only). Additionally, the documentation provided by Home Office included minutes from several TIC meetings.

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 was 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. Therefore, much of the narrative for Paragraph 42e 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, including de-escalation.

The timeliness of the administrative reviews of restraints was a problem noted by QAI and timeliness issues were part of the concerns raised in the monitoring visit. Staff indicated that the number of restraints created a burden regarding the timely completion of the documentation.

1. Documented Instruction

Case # 241957

From camera angle (V2 CS 26 W. Spine Camera 1), Youth A punched Youth B in the face while Youth B was in a standing restraint. Youth B was defenseless due to being in a restraint. There was no explanation in the documentation about how the cafeteria door got opened with the two youth were on opposite sides of the door. Neither was there any notation of it in the Restraint Monitor report. Because the event occurred during the monitoring visit, the Video Review Form had not been completed at the time the materials were provided to the PH Monitor.

Case # 225449

At question was the discrepancy between the video and the Activity/Incident Report filed by the lead staff member. The report stated, "I saw the resident getting punched by Youth A. Youth A was being restrained by another YDA and I placed Youth B in restraint before he could punch Youth A back." As stated above, the video seemed to show that Youth B was in some type of restraint so that he could not move his arms to defend himself when Youth A punched him.

Restraint Packet 434206

The Crisis Prevention and Management (CPM) Request for Documented Instruction form under the Deficiency Observed section stated, "Supervisory follow-up–the YDA is seen shoving youth away to gain space not appropriate." Under the section Describe Instruction Provided, "Discussed calling for assistance sooner and backing away himself–not pushing youth."

The date of the documented instruction was May 22, 2013, nearly 60 days following the event and during the monitoring visit. In fact, the materials for this Restraint Packet were prepared on May 22, 2013. Therefore, this was not a timely response to an observed deficiency for CPM.

2. Notation of Appropriate Behaviors

In Restraint Packet 394301, unlike other examples of an in-room restraint, the staff moved the youth in a standing restraint to the day room so that the youth was out of his room. The behavior warrants special recognition given the perspectives of the PH Monitor where this type of behavior was not a routine occurrence.

Regarding Case # 241957, staff did a good job of the separating youth during the food fight. The staff responses appeared to be quick with numerous staff members responding to the cafeteria. The staff responses minimized the amount of disruption that resulted.

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. Similar to the New York Model chain analysis (a sequential analysis to help youth realize that they can change their thoughts and feelings and as a result their behaviors), this administrative review process could enhance its current effectiveness by expanding the analysis of de-escalation or the ability of staff to change the context or the situation in ways that the youth has an increased likelihood of regaining emotional regulation and thus avoiding a physical intervention. When a pre-restraint problem results from staff escalation and a restraint follows, the restraint was 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.

Questions remained about CPM. One staff member pointed out that there was still a lot of change in the way that staff were supposed to implement CPM techniques. Some of this change in CPM was attributable to the fact that many staff are simply not strong enough to handle the adrenaline rush and strength of FLRC youth during the restraint, according to the staff member. As a result, the suggestion was that the administration should address those staff who are not in shape and who have been on workers comp or disability as a result of physical fitness problems. An additional recommendation was that the facility should create and provide staff access to a work out facility or room as part of the Employee Assistance Program (EAP). The video review process as a part of the Facility Administrator's review provides an opportunity for internal monitoring of this concern.

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 seemed to have occurred regularly, and the evidence of a corresponding practice from the STARS system was consistent with the requirements of this paragraph. Training records showed that 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.

Staff, however, expressed disappointment about the pace of change noting that many of the problems stemmed from too much indecision by new staff. The indecision was described as staff waiting too long before confronting the misbehavior, even if it meant setting limits. There are enough staff if everyone comes to work, but the use of leave time creates periodic and temporary shortages that require overtime.

The low safety rating by YCs for the YDA staff tended to support feedback from youth and staff that new staff created numerous problems that eroded staff safety. The chief concern was that inexperienced staff allowed misbehavior to go too long, and by the time they intervened or by the time veteran staff were aware of the situation, the behavior had escalated. The YCs agreed with other veteran staff who were part of the interview process that the inexperience of many of the new staff, while a temporary problem as they gain knowledge and experience, contributed to a substantial number of avoidable restraints.

As the key staff for the implementation of the Settlement Agreement reforms, YCs expressed concern about the current status of the New York Model. The discussion started with consistency and immediately turned to the concern about too many models, meaning too many re-interpretations of DBT, sanctuary, DAS etc. YCs were confident that the New York Model could create a safe system, but the problem expressed by YCs was the ongoing lack of understanding on the part of direct care staff about how to implement it. The New York Model was described as too complicated, too complex, and too cumbersome for line staff. When pressed for more explanation, the YCs focus turned away from the New York Model complexities and onto training. YCs described training as piecemeal and incomplete. These are the types of issues that should be important to trainers as elements in maintaining compliance. The key to the training experience is building the skill set among the staff so that they can work successfully with youth within the framework of the New York Model and CPM.

C. Emergency Response

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

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

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

COMPLIANCE

COMMENT: The policies, procedures, and practices remain unchanged since the last monitoring visit and the last finding of compliance. This paragraph should be considered for transfer to QAI for continued monitoring.

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

COMPLIANCE

COMMENT: The policies, procedures, and practices remain unchanged since the last monitoring visit and the last finding of compliance. This paragraph should be considered for transfer to QAI for continued monitoring.

QAI looked at different variables as new ways to demonstrate staff effectiveness in the use of CPM and, ultimately, the reduction in the number of physical restraints. One strategy was to compare the monthly number of Code Yellows with the number of Code Whites. The rationale was that a Code Yellow identified a problem where a restraint was possible if de-escalation did not work. If the de-escalation were effective, there would be no need for a Code White, so the number of Code Whites should be fewer than the number of Code Yellows. Even though the method cannot qualify all times when de-escalation is successful, for the five (5) months (October 2012 through February 2013) that QAI looked at these numbers, the frequency of Code Whites was considerably less than Code Yellows each month.

43. c. Create or modify policies and procedures regarding the appropriateness of the response to the situation presented.

COMPLIANCE

COMMENT: The policies, procedures, and practices remain unchanged since the last monitoring visit and the last finding of compliance. This paragraph should be considered for transfer to QAI for continued monitoring.

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 policies, procedures, and practices remain unchanged since the last monitoring visit and the last finding of compliance. This paragraph should be considered for transfer to QAI for continued monitoring.

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

COMPLIANCE

COMMENT: The policies, procedures, and practices remain unchanged since the last monitoring visit and the last finding of compliance. This paragraph should be considered for transfer to QAI for continued monitoring.

D. Reporting and Investigation of Incidents

These paragraphs refer largely to the activities of the Special Investigations Unit (SIU). The opening of the Justice Center on June 30, 2013 represents a statewide initiative to address many of the reporting and investigation issues contained in the Settlement Agreement. There is some uncertainty about the exact responsibility that the Justice Center will assume, and there has not been a discussion between the parties as to how the Justice Center affects these Settlement Agreement Paragraphs. Therefore, some of the compliance findings and narrative comments may be different in future monitoring reports based on a clearer definition of the role of the Justice Center.

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. The policies, procedures, and practices remain unchanged since the last monitoring visit and the last finding of compliance. This paragraph should be considered for transfer to QAI for continued monitoring.

44. b. Create or modify and implement policies, procedures, and practices providing that such incidents or allegations are promptly screened and which establish criteria for prioritizing facility investigations based on the seriousness and other aspects of the allegation. There shall be a prompt determination of the appropriate level of contact between the staff and youth, if any, in light of the nature of the allegation and/or a preliminary investigation of the credibility of the allegation. The determination shall be consistent with the safety of all youth. The determination must be documented.

COMPLIANCE

COMMENT: The policies, procedures, and practices remain unchanged since the last monitoring visit and the last finding of compliance. This paragraph should be considered for transfer to QAI for continued monitoring. 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 policies, procedures, and practices remain unchanged since the last monitoring visit and the last finding of compliance. This paragraph should be considered for transfer to QAI for continued monitoring.

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. The monitoring visit to the health clinic revealed no changes in the strategy for conducting post-restraint examinations with sufficient confidentiality that youth feel free to discuss issues of excessive use of force with the nursing staff. In response to the QAI report that noted several instances where the PRE occurred past the one-hour policy requirement, the nursing staff indicated that the problem was a function of the number of restraints and how frequently multiple restraints occurred. In situations like these, the clinic staff noted that there were often no YDA staff members available to bring the youth to the clinic.

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. All 10 youth interviewed stated that youth receive a confidential examination in the clinic following a restraint. The health clinic staff was prepared to discuss other PRE issues. 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. 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.

Monthly clinic data showed an increase in youth restraints, which prompted a request for additional information about the nature and type of injuries coming to the clinic. The nurses indicated that there was an increase in youth-on-youth assaults resulting in injuries to the face, eyes, lips and mouth, and hands. As the nursing staff went over the Monthly Summary sheets, they also noted the youth who had been injured due to self-harm behaviors while in his room. These injuries were to the hands and feet from punching and kicking the walls in the room.

A specific review was conducted on the April data, particularly the number of youth that were taken to the emergency room at the local hospital. Of the six (6) youth cases reviewed, only one resulted from youth-on-youth violence. In May, however, two (2) youth were injured by youth-on-youth assault requiring medical attention to their mouths, one requiring stitches at the hospital.

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 (SIU) 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 74 open FLRC investigations for child abuse and maltreatment, 15 (20%) have exceeded 90 days before finding a conclusion. The Justice Center is supposed to begin operations as of June 30, 2013, so QAI has not conducted reviews of the SIU. Unresolved is whether the functions described in this paragraph will be all or partially assumed by the Justice Center.

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 that there is 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.

Document #17 Staff Discipline from the documents supplied by Home Office revealed no substantial differences regarding the timeliness of discipline and the transfer

where Labor Relations receives the file from the materials from the previous monitoring visit.

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.

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.

The problems continued regarding the role of the Restraint Monitor. In several of the Restraint Packets under review for this monitoring visit, a Restraint Monitor Report was not completed because of multiple restraints. It was understandable that multiple restraints would result in this type of situation, but it speaks to two larger problems. If there were no staff available to serve in the role of Restraint Monitor, then the supervision required by the Settlement Agreement cannot be fulfilled, especially during a use of force event. Similarly, the failure to have a designated Restraint Monitor violates CPM policy. These critical program disruptions indicated that there are either too many restraints or not enough staff.

The QAI Report requested an action plan regarding the role of the Restraint Monitor, specifically requesting a means for accounting for staff performing the role of the Restraint Monitor. In response, home office recently modified the Restraint Monitor form to allow for primary staff involved to fill out appropriate sections even when a designated monitor is not present for all or part of a restraint. A revision of the restraint monitor training also included new instruction on signs of distress among youth in restraints. 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.

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.

NOT APPLICABLE

COMMENT: These factors are mostly systemic and apply to Home Office. One measure of determining and appropriate level of fitness to work in a juvenile justice facility is to develop a common set of characteristics of those staff who demonstrate a high level of competency working with youth as indicated by both youth and staff and to identify characteristics of those who do not work well with youth, again, basing this on the perspectives of youth and staff. The State has not implemented reasonable measures to make this determination. The assumption has been that concerns about the effectiveness of staff will become a greater priority as concerns about the excessive use of force subside and as the effectiveness of the therapeutic effects of the New York Model increase.

III. MENTAL HEALTH MONITORING

This site visit at Finger Lakes revealed continued progress in implementing the New York Model. 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 "Youth Rules" in the New York Model) and Juvenile Justice Information System (JJIS) instructions for the new mental health sections, additional psychiatry guidelines, and the OCFS substance abuse manual are being completed. The MH Monitor cannot fully assess compliance until the policies and procedures are finalized and staff demonstration of consistent application of training and adherence to practices 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:

46a. 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.

COMPLIANCE

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

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" which complies with 46a.

The QAI review of the New York Model implementation is being refined with guidance from BBHS staff, and the QAI report is now organized to reflect a youth's progress through the program. The QAI review examined residents' records for integrated assessments, psychiatric evaluations, support plans, diagnoses, psychiatric contact notes, medication, family outreach, suicide response, substance abuse services and transition plans.

46b. 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.

COMPLIANCE

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

46c. Create or modify and implement policies, procedures, and practices to regularly assess the effectiveness of the interventions utilized.

PARTIAL COMPLIANCE

Through support teams and Mental Health Rounds, Finger Lakes staff are complying with 46c on an individual basis. Full compliance requires regularly assessing the effectiveness of interventions facility-wide which is not the current practice.

The Finger Lakes Integrated Assessment, IIP, Integrated Support Plan, and contact notes by the psychiatrist, NPP, clinicians, YCs and CMSO were all accessible on JJIS and comply with 46c, although all the revisions of the forms are not yet in place. The MH Monitor was provided with an impressive JJIS demonstration at Home Office on February 5, 2013. JJIS is the OCFS Juvenile Justice Information System, a comprehensive automated system tracking youth in OCFS custody, including but not limited to case management, movement histories, legal histories, and administrative/billing. Reception diagnostic information, Integrated Assessment, IIP (Individual Intervention Plan), Facility Initial Mental Health Assessment (which includes mental status exam and results of suicide risk assessment), contact notes (by psychiatrists and other clinicians, as well as facility and CMSO case managers), Integrated Support Plan (with updated diagnosis), and Transition Plan are all included on JJIS. JJIS is designed to capture how a strengths-based, trauma-responsive approach is being implemented with each resident and tracks the diverse interventions of the New York Model. JJIS makes it possible to document practice according to the procedures that comply with several mental health paragraphs in the Settlement Agreement and allows for the regular assessment of the effectiveness of interventions required by 46c.

Now that these sections of the JJIS are developed, forms are being revised to fit emerging best practice as the New York Model evolves: the IIP is being reduced to a more effective single page document, the Integrated Assessment is being simplified, the support plan is being strengthened (monthly clinical updates will reflect notes from Mental Health Rounds), and a discharge summary is being developed. JJIS not only provides current information on each resident's progress and efforts being made to enhance interventions, but also offers the opportunity for stronger clinical supervision of staff and can serve as the basis for Quality Assurance monitoring.

The Assistant Directors for Treatment of the four DOJ facilities and social work supervisors saw the JJIS demonstration. The BBHS Director of Treatment Services and the JJIS clinical coach are in the process of meeting with each facility to instruct in the use of the JJIS and also provide examples of writing goals that reflect the resident's aspirations and the staff's assistance in clarifying the steps to achieve them. Finger Lakes has begun the BBHS coaching process on JJIS. A crucial next step will be to ensure that this documentation system includes all the non-clinical staff involved in the resident's progress and fully reflects the teamwork necessary for his/her success. Positive illustrations of educational services outside this Settlement Agreement but nonetheless important include educational testing results that are reflected in the Integrated Assessment and in JJIS as monthly updates in the academic progress of the residents, including new assessment results, recent achievement scores, passing Regents, and new IEPs, and what educational and other staff are doing to support that progress.. OCFS is in the process of finalizing two manuals and training programs for JJIS, one for case managers, and a separate one for clinicians. BBHS is doing in-person coaching on use of JJIS for clinicians and the Bureau of Training is producing the technical manual and training class for case managers (to be completed by the end of summer, 2013). The MH Monitor reviewed the draft BBHS Facility Clinical Procedures for using JJIS. It is a thorough explanation of the expectations for integrated assessments and support plans, among other clinical activities. However, like the BBHS "Goal Writing and Support Plans in the New York Model," it is not being practiced by clinicians at Finger Lakes. Examples of alternative best practice integrated assessments and support plans should be used in coaching sessions with clinicians to move them from forms to be filled out to detailed, motivating plans of the youth and family with specific interventions tailored for the youth (different for each youth).

How the facility uses the QAI, TIC, pre-shift briefings and information from residents' progress to regularly assess facility-wide effectiveness of interventions for all residents will continue to be monitored to determine full compliance.

46d. 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

OCFS released the Facility Admission and Orientation policy and PPM 3443.00 "Resident Rules" (renamed "Youth Rules") to be consistent with the New York Model and they are in the final stages of revision. 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.

On Site Observations Regarding Paragraph 46a-d (5/13)

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 MH Monitor observed one intact team meeting that included 7 YDAs, the YC, clinician, teacher, Assistant Director for Program, and Assistant Director for Treatment. The first hour was Mental Health Rounds (discussed below). YDAs were active and often took leadership of the meeting. The discussion of individual residents led to collaborative decisions about what topics would be discussed with residents. Then the team joined nine residents for the second part of the intact team meeting, in which 7 YDAs participated with a YC, clinician, teacher, and Assistant Director for Program. Two YDAs effectively led the group, announcing at the beginning that staff wanted help from residents about how to deal with three unit issues: horseplay, regression after achieving phase, and uniforms. It was an open discussion, with residents being attentive and positively involved. They had good ideas to contribute, taking responsibility for their behavior and asking staff for changes. They said the major contributor to horseplay was boredom, requested more activities and brainstormed some ideas; the Assistant Director for Program told them steps he would take to initiate these activities. It was an upbeat meeting, residents were praised, and the feeling was one of pride and belonging to a strong community. In the debrief of the intact team meeting, staff comments included: "We feel proud of ourselves and the residents. We worked so hard to get to this point. Our first intact team meetings were awful. We talked honestly about trust and coming together as a team. Now it is really worthwhile to share ideas about each resident and make decisions together." Both the staff portion and the meeting with residents were impressive.

The MH Monitor observed a second intact team meeting that included 8 YDAs, 2YCs, 2 clinicians, a teacher, the Assistant Director for Program and the Assistant Director for Treatment. A YC and clinician led the intact team meeting. The clinician presented a DBT concept in the first 15 minutes. Because of the compressed time, it was didactic and would have been more effective had it been applied to residents on their unit; the pressure to complete it quickly meant there was no role play or practical example. It seemed artificial to use SELF to organize the discussion during the remainder of the first hour. Mental Health Rounds about each resident would have made more sense instead of discussing some residents under Safety and some under Emotions. Under Loss, the loss of a staff person who moved off the unit was mentioned. After the first section of the meeting, the YDAs were going to lead a community meeting with the residents to discuss some of the topics covered by staff (the MH Monitor was unable to observe the second part of the intact team meeting or to do a debrief with participants).

The MH Monitor observed two Mental Health Rounds at Finger Lakes. Both reviewed current issues with the residents on the units. At both, their determination to improve their teamwork to intervene more effectively with residents was impressive.

The MH Monitor observed Mental Health Rounds with one unit that was not conducted during the intact team meeting. Convened by a YC, the unit clinician, a YDA, two other YCs, the substance abuse clinician, the NPP, nurse, teacher, and the Assistant Director for Treatment participated. The problem behaviors of residents on the unit dominating the discussion (including one youth who was characterized as the unit's Buffalo gang leader, "a rough kid who stirs up a lot. This won't be his last time here."). Staff said they were worn out and expressed dread of the impending arrival of a new resident. All 10 residents were discussed: three were described as fighting a lot, three were struggling with being released

soon and two were dealing with family issues; two out of ten were making progress; several residents were described as unwilling to talk in therapy. They reported on a medication change; four of the residents are prescribed psychiatric medication and one was referred for a psychiatric evaluation because of anger and sleep problems. The BBHS Director of Treatment Services, who also observed, encouraged the participants in Mental Health Rounds to begin with each resident's goal with the discussion focusing on what else staff could be doing to support him to meet his goal.

The MH Monitor observed Mental Health Rounds with another unit that was embedded in the intact team meeting and occurs on alternating weeks. It included the most YDAs in Mental Health Rounds the MH Monitor has seen at any DOJ facility; discussion was animated and focused on how the team could respond more effectively to each of the nine residents on the unit. One resident was described as doing well in school, having his first contact with his mother, and working hard to move up to the next phase, then deteriorating. As staff discussed what they could do to motivate him, they noticed that this was a pattern with several residents. The discussion did not focus on mental health issues, but for one resident his clinician described his significant trauma history and how sad he is that he cannot live with his mother because of her substance abuse problem. His increased problems since he decided to stop medication were mentioned, but neither the NPP nor psychiatrist were present to help strategize. Another resident does not have consent from ACS yet for medication (he had been at Finger Lakes for six weeks). One resident is doing well despite a court hearing that changed his release date and directed that he go to a step-down placement instead of his grandparent's home. For one resident who was doing well, the staff quickly went through the phase checklist and agreed he should advance his phase. The MH Monitor suggests that the intact teams at Finger Lakes consider adopting Lansing's approach to phase advancement. Instead of staff reviewing the phase accomplishments checklist to decide on phase advancement and then announcing it to the youth, Lansing staff go through the checklist with the resident asking her whether she thinks she has met each expectation; when staff disagree with her, they say so and unless the resident persuades them otherwise, the staff view prevails. This process empowers the resident to award herself a phase advancement or acknowledge she is not ready yet. Lansing does this phase advancement process as part of each support team meeting, and if the resident is ready between support teams, her YC, therapist, and YDA meet with her in a special phase advancement meeting using the same process.

Neither of the Mental Health Rounds had substantial discussion of mental health issues. The psychiatrist was not involved in either and the newly hired NPP only attended one and did not participate. A clinician actively participated in each meeting, but not to clarify mental health issues. The in-depth discussion of behavior and interventions by the whole team, with active participation of YDAs, YCs, clinicians and teachers, is a crucial part of the New York Model. Now that Mental Health Rounds is a valued team process at Finger Lakes, clinicians and the NPP will have to weave their understanding of the effects of trauma on behavior, effective responses by all unit staff to symptoms of depression, anxiety and mood dysregulation, and medication into the discussion.

Mental health staff lead DBT groups twice weekly. It is recognized that YDAs and YCs need to be trained in DBT. As one clinician commented, "You don't learn DBT to impart

it to someone, but because it works for you, for me, for everyone." The DBT trainer is teaching DBT skills, and staff observed him lead a DBT group, participate in an intact team meeting and do a chain analysis with a resident. The clinicians are spending 15 minutes at every intact team meeting teaching a new DBT skill. Instead of providing these brief exposures to DBT, it might be more effective to put skill-building in the context of the Finger Lakes leadership team's plans to provide New York Model implementation training for all staff, including how to improve support plans and support teams. Ideally the training would be in intact teams, but even for a series of half-day trainings, intact team sessions would require rescheduling for the facility. For both New York Model and DBT training, is essential that it is applied training using specific examples and role plays about how to apply it to everyday life on units, in the facility school and in the community.

The MH Monitor observed an inspired DBT group at Finger Lakes, facilitated by a clinician and YC-Unit Manager. All six residents participated, guided through ACCEPTS by the specific, practical examples of how to say, "I don't like this situation—it's unfair, it makes me angry—but I don't want to make things worse by acting out so to tolerate it I will think about something else." They did an activity of writing a personal example of how they would apply this lesson. Then they proudly performed a DBT rap that they had prepared.

The MH Monitor observed a Risks and Decisions group at Finger Lakes, skillfully led by a YC. All seven residents participated in a discussion of peer pressure. This is a 30-day curriculum from Phoenix that one of the Assistant Directors for Program identified as a successful gang intervention approach. The YC commented that the curriculum fits well with DBT and is easier for residents because it relies on practical examples and their own experience.

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. Since the last site visit, Finger Lakes has been without one Assistant Director for Treatment, a clinician was on medical leave, and several YCs were out or left. The MH Monitor met with 14 Finger Lakes coaches and they were enthusiastic, despite being overloaded with their responsibilities for individual residents on large units, leading the intact team change process, and supporting staff who require more New York Model training. One approach to coaching is the formal monthly coaching meeting using the form developed by the Assistant Director for Program. The coaches emphasized their "in-the-moment" coaching successes. Coaching was described as "constant empowerment of YDAs." They called coaching "raising the emotional intelligence of all staff." One YC described the coaching he is able to do in the intact team. One clinician commented on much improved relationships with YDAs. Another agreed and described being on "a cohesive team where there is no longer contention between YDAs and mental health." Another clinician was positive about co-leading DBT groups with a YDA. Two YCs worked YDA shifts to give YDAs time off, and it gave them "a fresh perspective for coaching." One clinician said coaching was explaining the "why" behind a resident's behavior. One YC described not intervening as a coach immediately all the time, but doing it later by asking, "How could you have done that differently?" On one unit there were three suicide watches at one time, and the clinician

and YC coached staff on suicide watch practices to "restabilize the unit." The Finger Lakes coaches were pleased that Red Flag meetings, another New York Model element, are so helpful. If a resident has three restraints in one week, a Red Flag meeting automatically occurs, but "anyone can ask for a Red Flag meeting, and they are becoming a good place for staff to talk things over." The clinicians and YCs help staff use Red Flag meetings to "bring everyone together to problem-solve," most recently in coping with a challenging 12-year old. They describe their focus as "self-calming. As a team we help each other with emotional dysregulation. We call each other on it." A YC commented, "Since we were YDAs, we can sense something building up so self-calming coaching is natural." A challenge for coaches is constantly getting new staff: "Staff here a year or more have gotten a lot better at supporting residents' self-calming. Conflict resolution skills of the newest staff have to be developed quickly. They have to be able to coach kids in distress tolerance, to see they will think less clearly when they are highly anxious. It's a lot to do in a short period of time with a kid. Now that there's a feeling of community, we hope to accomplish a lot in four months." The Finger Lakes coaches are dedicated and have ambitious aspirations for which they require more support from BBHS.

The MH Monitor observed IIPs (Individual Intervention Plans) in the reviewed Finger Lakes records; support plans indicate the IIP has been reviewed each month. Sixty-one youth of 64 placed at Finger Lakes Residential Center had IIPs at the time of the QAI review. "The IIPs contained information that would assist staff in understanding or anticipating a youth's response to physical interventions. The youth-generated safety plans were generally consistent with the Crisis Prevention Management plans, albeit some appeared to be very generic." Of the 18 Finger Lakes staff interviewed by QAI, staff were aware of IIPS and that they were kept in binders on the unit but only eight found them useful and five said they don't use IIPs. "The responses suggested that staff do not have much confidence in the IIPs." Of the six records reviewed by QAI, in most, the IIPs were reviewed every 30 days at support team meetings and the youth's IIPs clearly prescribed de-escalation and intervention techniques to be utilized that were specific to him. For one youth, there was no indication of updates to the IIP following crisis events and there was no evidence that the IIP prescribed intervention techniques to be utilized for the youth.

The Finger Lakes DAS has become a composite of rules that have evolved away from the original intentions of the DAS. The MH Monitor recommends that Finger Lakes consider adapting the Columbia DAS for a skill-based approach more consistent with the New York Model since the Finger Lakes DAS is even more compliance-oriented than it was at the site visit six months previously:

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

- Wearing appropriate uniform and proper line movement
- Bedroom is clean and complies with room contents. Completes assigned unit chores.
- No touching others (staff or residents). Seeks help from staff to remain safe and accepts feedback. No lending, borrowing, trading, or gambling.
- No participating/demonstration of unauthorized organizational/gang activities
- No verbal threats and no inappropriate violent language/body language

Manages Emotions: Uses skills to avoid conflict or problems
- Makes attempt to use safety plan
- Uses skills to manage emotions (ART, problem solving, DBT skills)
- No verbal threats, use of racial slurs ("N" word) or swearing, inappropriate sexual language (SMD)/acts, unauthorized organizational/gang activities
- Participates in community meetings and safety planning. Responds to coaching from staff

Deals with Loss: Accepts circumstances
- Accepts responsibility for behavior. Accepts being told "no" and "stop"
- Accepts redirection. Accepts positive feedback from staff

Works toward Future: Plans for the future/follows current program
- Attends school daily and participates in class. Wears uniform correctly (pants up, shirt tucked in, and shoes (not slippers) on
- Attends group counseling, individual counseling, mentoring sessions and community meetings and participates in all
- Is not disruptive in any area of program (line movement, classroom, unit, gym, café)
- Uses proper manners ("Please." "Thank you.")
- No cursing, racial slurs, "war stories," inappropriate conversations—singing, rapping

Shows Effort: Beyond simple compliance with program, shows effort and works towards goals (is active, not passive)
- Positive role modeling
- Improvement in progress toward treatment goals
- Volunteers for assignments

The Finger Lakes DAS is limited by not including an individual goal of the resident. OCFS noted that facilities have successfully implemented DAS when they use Effort as the fifth criterion of achievements, and that incorporating an individual's goal is the highest standard. A separate, and the primary, concern raised by the MH Monitor about the Finger Lakes DAS is that it is rule-oriented as compared to the Columbia skill-based DAS. OCFS notes that "the goal of the DAS was to give staff a clear indication of what being safe and being emotionally regulated looked like. It is a mixture of both seeing skills being used and not seeing problem behaviors. Sometimes the skills being used are not visible, and in fact internal, but become evident in the lack of outward problems." When the DAS reflects a direct connection between New York Model skills and positive behavior, residents are more likely to learn from the DAS. But when the DAS is a list of negative behaviors not organized around the youth's goals or skill development, it appears similar to other disciplinary tools the New York Model rejected as ineffective.

The five elements of the Finger Lakes DAS are supposed to be 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 form is confusing because the shading at the top of page is incomplete, so the 6-10 AM, 10 AM-2 PM and 2-6 PM periods were incorrectly scored twice on the same sheet in the reviewed DAS forms which could allow achieving higher than 25). Since most residents sleep from 10

PM – 6 AM, it weakens the DAS to be scored on these areas overnight—it would make the DAS more valid to make the time periods similar to the DAS at other facilities by including awake times with night times

The DAS for four Finger Lakes residents from different units—several of whom were described as having significant challenges in the program—were reviewed for a day during the site visit. [redacted] achieved 16, [redacted] achieved 20, [redacted] achieved 21, and [redacted] achieved 18. Across units, achievements were not earned primarily during the 2-6 PM timeframe, which suggests reduced late afternoon compliance by residents and/or differential scoring by shift, both of which should be addressed.

The QAI Review found that in several Finger Lakes records, the clinician documented their efforts to engage residents when they were refusing mental health services. The QAI Review found that in several Finger Lakes records there was no documentation that clinicians had sessions with residents at least every 30 days or contact with families every 30 days. In QAI interviews with 18 Finger Lakes staff, 10 did not see a strong relationship between "program" and "mental health." Many staff could only vaguely describe the New York Model, and five said they had gone through training. The majority of staff did not like the DAS, saying it was too "subjective," "complicated" and the incentives did not work. In interviews with 18 staff, 8 said they participate in Mental Health Rounds, depending on coverage and workload. Six of 18 staff interviewed said they do not participate in Mental Health Rounds. The QAI review found that in the four observed Mental Health Rounds at Finger Lakes, all youth on the unit were discussed, usually in depth using a strengths-based approach, but neither YDAs nor the psychiatrist participated (prior to the hiring of the NPP). QAI requested a corrective action plan for the integration of program and mental health in the context of the New York Model.

Finger Lakes does not control intake and cannot limit units to only 9 or 10 residents. (during the QAI review two months before this site visit, Finger Lakes had 72 residents on six units; the facility expected several new admissions immediately after this site visit). Finger Lakes clinicians cannot do all their required activities with 12 residents on a unit. Managing two unit admissions a month (with the Integrated Assessment and Integrated Support Plan within 30 days), three support teams a week, more than three individual therapy sessions a week, conducting family sessions, convening several groups weekly, participating in Mental Health Rounds, supporting intact team functioning and Red Flag meetings, coaching staff, and doing all the contact notes and other paperwork is more than a 40 hour week. This does not include many residents who need to be seen by their clinician more than once a month, suicide assessments and other unscheduled mental health responsibilities. In an effort to have mental health coverage seven days a week, Finger Lakes has decided to have clinicians working weekends, which they object to. If Finger Lakes continues to have units with 11-12 residents much of the time, in order to meet the requirements of the Settlement Agreement, the facility will have to have additional clinicians and develop creative ways to assign residents given the intact teams. Finger Lakes clinicians have requested laptops to simplify their paperwork completion (and they might benefit from voice recognition software that produces written narratives from dictation), but paperwork is not the primary problem with large clinical caseloads. Some Finger Lakes residents have mental health needs that would dictate weekly therapy if

they were in the community; while they do have individual counseling with their YCs and mentoring, to do trauma treatment, family therapy or skill building requires weekly therapy with their clinician. This would only be possible at Finger Lakes for a portion of each clinician's caseload even if they had fewer than 12 residents on their caseload. OCFS argues that a 1:12 ratio of clinicians to residents "compares favorably to OMH outpatient clinics," but that is not a reasonable comparison. Finger Lakes is a residential facility with many youth with complex mental health needs (and those needs are compounded by being placed away from family and in a living situation that increases anxiety), many of whom require weekly therapy.

FUTURE MONITORING

When they are available, the MH Monitor will review:

- New policy on Facility Admission and Orientation
- Revised PPM 3443.00 "Youth Rules"

The MH Monitor will review the New York Model update training for Finger Lakes staff.

The MH Monitor will review the adequacy of clinical staffing and coaching capacity at Finger Lakes.

The MH Monitor will observe the facility's use of information to regularly assess the effectiveness of interventions for all residents.

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

The MH Monitor will observe coaching and the continued implementation of successful Mental Health Rounds and the Daily Achievement System and consistent New York Model practice; the MH Monitor will review BBHS support for coaching.

The MH Monitor will observe how the NPP and clinicians weave their understanding of the effects of trauma on behavior, as well as diagnostic and medication issues, into Mental Health Rounds at Finger Lakes.

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:

47a. 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].

COMPLIANCE

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

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

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

47b. 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.

COMPLIANCE

A 3/12 memorandum entitled "Contacting Mental Health Professionals Outside of Regular Work Hours" (linked to the Behavioral Health Services policy (PPM 3243.33) finalized in 5/12) complies with 47b and indicates that "each of the facilities reports 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.

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

On Site Observations Regarding Paragraph 47a-c (5/13)

The MH Monitor observed completed ISO 30s in Finger Lakes residents' records.

Between 12/1/12 and 4/30/13, 17 Finger Lakes residents were on 30 Suicide Watches or Personal Safety Watches. This is a substantially higher incidence of Suicide or Personal Safety Watch than the other DOJ facilities, and an analysis of the conditions that contribute to this high rate of suicidal ideas and actions should be done in order to initiate changes through the intact teams and the clinicians to reduce these pressures on residents. A third of the watches were for a day or less and another third for two days (Range=less than 24 hours-12 days, including two residents on longer watches while waiting for transfer to MHUs).

Between 12/1/12 and 4/30/13, one Finger Lakes resident was sent to the hospital for a psychiatric evaluation; he was placed in a psychiatric hospital ([redacted]) for six days, returned to the facility on Suicide Watch and transferred to Highland MHU. A week later another resident was transferred to Industry MHU.

A concern was raised at Finger Lakes that sometimes residents are unwilling to go through the 30 questions on the ISO again when they just completed it at Reception. It was proposed that when the Reception ISO accompanies the resident, a suicide evaluation is not recommended by Reception, and the clinician evaluates the resident during the initial assessment, there is no need to complete an ISO at Finger Lakes.

The QAI Review found that for one of the six youth, there were indicators for suicide risks that were not assessed. Eleven out of 15 Finger Lakes staff interviewed by QAI indicated that they felt competent in their abilities to perform the skills learned in the Suicide Reduction training; four had not attended the training. Nine indicated they do not receive enough training on dealing with youth with mental health issues.

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 discuss the Finger Lakes analysis of the conditions behind a high rate of suicidal ideas and actions and the effectiveness of interventions designed to reduce it.

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:

48a. 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.

COMPLIANCE

Finger Lakes records reflect that residents are seen soon after admission by a mental health professional who completes the ISO-30 and begins the Integrated Assessment. Youth who arrive on psychiatric medication or who are referred to the psychiatrist by facility staff are seen, documented in a psychiatric evaluation or psychiatric contact note. The Finger Lakes psychiatrist has had a waiting list, but the newly hired NPP can interview new admissions on the four 10-hour days she is in the facility. The MH Monitor observed completed and timely Integrated Assessments in the Finger Lakes records that demonstrated compliance with 48a.

48b. 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.

COMPLIANCE

The procedure for referring a youth for evaluation to a qualified mental health professional was completed. A 2/12 memo described (linked to the Behavioral Health Services policy (PPM 3243.33) finalized in 5/12) the procedure for referral of youth to a committee for a mental health placement and complies with 48b. The procedure was revised in a Memo on DJJOY Referrals send to BBHS and facility clinicians in 12/12, including a change in the name of the committee to the BBHS Youth Team, also in compliance with 48b. As indicated above, during the six months since the previous site visit, Finger Lakes staff had referred two residents who were accepted on mental health units.

48c. 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.

PARTIAL COMPLIANCE

The Integrated Assessment form complies with 48c.

Remaining concerns about the Integrated Assessment are that it should include:

(a) a thorough trauma history, symptoms of trauma and how trauma appears to be affecting the resident's behavior,

(b) evidence of learning disabilities and how they appear to be affecting the resident's behavior,

(c) history of substance use and how it may be related to behavior, including results of the Adolescent Alcohol and Drug Involvement Scale (ADDIS) when it has been completed with the resident.

In addition, the MH Monitor recommends that as JJIS and support plan coaching is occurring, clinicians and educators be encouraged to avoid jargon so the Integrated Assessment serves as a way for all staff to understand the resident and can be used to design interventions of all team members in the support plan.

48d. 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.

PARTIAL COMPLIANCE

Diagnosis appears to be less important at Finger Lakes than the other DOJ facilities. In the Mental Health Rounds and some of the support teams the MH Monitor observed, diagnosis was not discussed; in one support team meeting, the resident's mother expressed strong views about a diagnosis her son had received years before that she insisted should be what he is prescribed medication for at Finger Lakes; case notes indicated that Finger Lakes staff disagreed with her, but to keep her engaged, the clinician said the psychiatrist would discuss diagnosis and medication with her at another time. This exemplifies diagnostic complexity that all the staff working with the resident would have benefitted from understanding by hearing a brief presentation at intact team meeting on how behavior and symptoms are considered and a medication trial initiated to help confirm or disconfirm the new diagnosis (for example, with another resident the psychiatrist tentatively diagnosed Anxiety Disorder based on symptoms—but noted considerable trauma history—and when an anxiety medication was ineffective, he changed the diagnosis to PTSD and treated hyperarousal and nightmares with a different medication). Just because the other DOJ facilities have diagnostic discussions routinely at Mental Health Rounds does not mean that to comply with 48d Finger Lakes has to do so to arrive at a consensus diagnosis among clinicians since the psychiatrist/NPP and other clinicians have opportunities to discuss diagnosis and the reaching of a consensus diagnosis will be documented in JJIS. However, the current psychiatry guidelines and the New York Model describe this use of Mental Health Rounds. An issue previously raised by the MH Monitor is that it is unknown whether the majority of Finger Lakes residents have a psychiatric diagnosis, as is the case in the other DOJ facilities serving girls. The psychiatrist has a waiting list and is prescribing psychiatric medication for 34% of the Finger Lakes residents (compared to 90% of Taberg residents in 3/13, 80% of Lansing residents in 4/13, and 42% of Columbia residents in 2/13). Perhaps this will change with the hiring of the NPP and the addition of a second part-time psychiatrist in the summer of 2013.

Finger Lakes clinical contact notes, particularly the Psychiatric Contact Notes, discuss residents' symptoms and diagnoses, in compliance with 48d.

As discussed in more detail below, JJIS instructions for the new mental health sections and additional psychiatry guidelines are being developed and will be reviewed by the MH Monitor to determine full compliance.

48e. 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.

COMPLIANCE

Psychiatric Contact Notes comply with 48e and were completed in Finger Lakes records reviewed by the MH Monitor.

On Site Observations Regarding Paragraph 48a-e (5/13)

The Finger Lakes staff are completing the Integrated Assessment for all youth within a few weeks of admission.

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 other clinicians' 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 and in subsequent treatment plans. The target symptoms necessitating treatment with psychiatric medication must be documented in order to determine to efficacy of medication.

Two of the six youth reviewed by QAI had significant mental health symptom histories and because they were not prescribed psychiatric medication and were not seen as needing psychiatric evaluation, they were not seen by the Finger Lakes psychiatrist. These two youth would have been evaluated by the psychiatrists at the other three DOJ facilities because their time is not so limited, and they interview all youth who are admitted or have a mental health history. Now that Finger Lakes has a full-time NPP, it is unknown whether her schedule will permit a psychiatric interview of youth with a mental health history to give a psychiatric diagnosis, if there is one, and prioritize youth needing to seeing her or the psychiatrist, or whether the Finger Lakes clinicians will more readily refer youth to her after doing the initial mental health interview.

The youngest resident at Finger Lakes during this site visit, [redacted], exemplifies the importance of careful multidisciplinary assessment and documenting an evolving diagnostic formulation. His mother was incarcerated for substance abuse, he had no contact with his father, and he was in foster care where his sibling remains. He lived with his grandmother, ran away and at age 9 broke a window in his grandfather's house to get in. He was sent to [redacted] for 14 months, then sent to [redacted] and removed two months later after hitting a staff member, and then sent to [redacted] /12) where he had 1:1 staff in school and the residence. No details of his early trauma were included, but he was described as "easily agitated," and his diagnosis was ADHD and Conduct Disorder and was prescribed Zyprexa and Clonidine. He was sent to OCFS for violating probation (apparently for his original charge at age 9). The Reception psychological evaluation concluded with a diagnosis of Depression, Neglect, ADHD (by history), Rule Out Cognitive Disorder, Conduct Disorder (by history). The Reception psychiatrist diagnosed Depressive Disorder and recommended a neurological evaluation. He arrived at Finger Lakes on 4/4/13 and the Integrated Assessment noted that he had injured a teacher previously, no DSS records were available, his mother may have used substances during pregnancy and he was not cooperative with educational testing. The Finger Lakes psychiatrist saw him within a week of his arrival,

noted in utero drug exposure, lead poisoning treatment at age 4, a seizure disorder, and also maybe tics and pica and possibly a Pervasive Developmental Disorder with "further records and assessment necessary." Finger Lakes listed his diagnosis as ADHD and he was prescribed Risperdal (an antipsychotic), Depakote (an anticonvulsant), and Clonidine (an ADHD medication).

The MH Monitor has been expecting what has been referred to as a protocol for mental health professionals on developing uniform working diagnoses or standards for treating clinicians regarding consistent diagnostic practices. Recently OCFS responded to the MH Monitor's inquiry about when the protocol or standards would be completed, that a "separate protocol" is not going to be developed "because the topic is clearly addressed in the BBHS policy, is discussed during the NY Model implementation training, and will be part of the procedural manual being developed for clinical documentation in JJIS." The relevant sections of the BBHS policy are:

Mental health rounds occur weekly, the purpose is to identify and address acute treatment-related issues for particular youth in a team format. In addition to the review of acute issues, rounds will be used to discuss both the progress and challenges for individual youth. The rounds will include members of the mental health team: the psychiatrist, the psychiatric nurse practitioner (if applicable), the clinician, the case manager, a representative of the direct care staff, and representatives from education and medical. The clinician will write a short summary note of the discussion on each youth presented and record this note in the youth's mental health chart. Mental health rounds will assist in integrating the psychiatric and behavioral health services of each youth into a broader holistic understanding of the youth and the family. (Page 3)

The psychiatrist and nurse practitioner participate in the weekly mental health rounds and contribute information about diagnosis(es), medication, benefits, and side effects. Consensus of team members is achieved during these meetings, with resultant modification of treatment parameters by all participants according to the team discussions. The Axis I primary diagnosis may change as treatment progresses and more information about the youth becomes available. (Page 7)

If the clinician does not participate (in the psychiatric visit with the youth], they will meet with the psychiatrist prior to the youth's session to communicate regarding treatment issues and progress. The treating clinician and the psychiatrist (with input from the mental health rounds team) will develop a single working diagnosis, which is reflected in JJIS and in the Treatment Plan. The treating clinician is also responsible for communicating any and all changes to the youth's treatment (including medication changes, expected outcomes of medication changes, potential side effects, etc.) to the treatment team following the youth's psychiatric visit. (Page 8).

Compliance regarding consensus diagnosis cannot be determined until the MH Monitor is provided the procedural manual being developed for clinical documentation in JJIS. The BBHS policy only addresses discussions of the diagnosis among the psychiatrist and other clinicians at Mental Health Rounds. How the psychiatrist's initial diagnosis, the diagnosis from Reception, and other clinicians' initial diagnostic impressions are combined in the Integrated Assessment and then how refinements in the diagnosis in the psychiatric

and other clinical contact notes result in an updated consensus diagnosis in each support plan is crucial. While it is true that adolescents' diagnoses can be expected to change, the Settlement Agreement requires that the psychiatrist treat symptoms of an identified diagnosis with medication appropriate for that diagnosis and that the other staff working with the youth agree about that diagnosis, which is reflected in the support plan.

The MH Monitor examined the diagnoses of all 44 youth prescribed psychiatric medication by five psychiatrists at Columbia, Finger Lakes, Lansing and Taberg in early January, 2013. This analysis revealed considerable range among psychiatrists about diagnosis:

DEPRESSION 27% of youth prescribed medication (12)
(Including Depression NOS, Major Depressive Disorder, and Dysthymic Disorder)

Columbia	67% (4)
Finger Lakes	22% (4)
Lansing	25% (2)
Taberg	17% (2)

MOOD 27% of youth prescribed medication (12)
(Including Mood Disorder, Mood Disorder NOS, and Mood Dysregulation)

Columbia	
Finger Lakes	33% (6)
Lansing	
Taberg	50% (6)

ANXIETY 23% of youth prescribed medication (10)
(Including Anxiety Disorder, Anxiety NOS, and Generalized Anxiety Disorder)

Columbia	33% (2)
Finger Lakes	17% (3)
Lansing	50% (4)
Taberg	8% (1)

INSOMNIA 32% of youth prescribed medication (14)

Columbia	17% (1)
Finger Lakes	11% (2)
Lansing	75% (6)
Taberg	42% (5)

ADHD 23% of youth prescribed medication (10)

Columbia	33% (2)
Finger Lakes	17% (3)
Lansing	13% (1)
Taberg	33% (4)

Many more youth were diagnosed with depression at Columbia (67%), Mood Disorder at Taberg (50%) and Finger Lakes (33%), and Anxiety Disorder (50%) at Lansing, as compared to the other facilities. Although divergent diagnoses among the individual youth in the four facilities are expected, these discrepancies appear to be larger than likely would be accounted for by population variation. The former Chief Psychiatrist indicated that depression, mood problems and anxiety are within the same cluster of diagnoses and that what is necessary is diagnostic consensus among the facility clinicians where the

resident is being treated. Nevertheless, the differences above reflect diversity in interpreting symptoms that is likely to play a significant role in achieving diagnostic agreement.

This analysis appeared to show movement away from Conduct Disorder being diagnosed in OCFS, in recognition that trauma-related depression, anxiety and emotional dysregulation are primary in residents. An email to the Assistant Directors for Treatment from the BBHS Chief of Treatment Services expressed this concern about the value of diagnoses other than Conduct Disorder in guiding interventions: "Our total statewide population (including secure) is below 550 youth. Every youth who has any other possible service option is being served elsewhere. The remaining youth are the most complex, multi-challenge youth (and families) in the State of New York. They have extremely high levels of substance abuse, trauma, attachment problems, mood disorder, self-regulation issues, etc. Their diagnoses should facilitate a deeper understanding of their behavior based on their developmental experiences as well as their current presentation. It is difficult to imagine that Conduct Disorder would be the primary focus of intervention for our youth. To reduce their diagnostic complexity to Conduct Disorder can actually impede their recovery. Our diagnoses should clearly reflect the mental health issues of our kids."

The New York Model is a strengths/needs-based trauma responsive approach that is not a traditional medical model, and symptoms of depression, anxiety, emotional dysregulation, and substance abuse associated with trauma are addressed without being driven by diagnosis. If traumatized adolescents typically have a mixture of anxiety and depression, diagnosis may be less informative than tracking of symptoms by the psychiatrist and other clinicians and noting the efficacy of medication and other interventions in reducing the symptoms presented by each resident. OCFS wants to avoid pathologizing youth (which can occur when there is an emphasis on diagnoses), but to clarify the extent of serious emotional problems across facilities requires the capacity to analyze the symptoms of all youth, not just the diagnoses of youth who are prescribed medication by the psychiatrist. This would necessitate psychiatrists contributing to symptom clarification for youth not being prescribed medication and an effective process of discussing diagnoses and symptom reduction not just at Mental Health Rounds but also as refinements are made in support plans and during teams.

The QAI Review commended Finger Lakes for a clinician assessing youth within 72 hours of admission and completing ISO 30s at initial screening. The QAI Review found that in several Finger Lakes records, the psychiatric evaluations contained information about the youth's psychiatric history and symptoms were thoroughly documented. The QAI Review found that in several Finger Lakes records, the Integrated Assessments did not have a comprehensive history and were missing information, and they were completed after the resident's first 21 days.

FUTURE MONITORING

The MH Monitor will continue to review Integrated Assessments, particularly for the inclusion of (a) a thorough trauma history and how trauma appears to be affecting the resident's behavior, (b) cognitive impairments (including language and executive function

difficulties) and how they appear to be affecting the resident's behavior, and (c) substance abuse history and how it appears to be affecting the resident's behavior.

The MH Monitor will review JJIS instructions for the new mental health sections.

The MH Monitor will review additional psychiatry guidelines.

The MH Monitor will continue to discuss consistency in diagnostic practices with psychiatrists and other clinicians.

49. Use of psychotropic medications. The State shall require that the prescription and monitoring of the safety, efficacy, and appropriateness of all psychotropic medication use is consistent with generally accepted professional standards. To this end, the State shall:

49a. 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.

PARTIAL COMPLIANCE

Policy PPM 3243.32 entitled "Psychiatric Medications" complies with 49a.

In practice, the Psychiatric Contact Note links diagnosis with the medication prescribed, followed by a current symptom checklist. The requirement of 49a is stating "the target symptoms intended to be treated by each medication." Each psychiatrist has a rationale for prescribing particular medication(s) for the resident but there appears to be no consistent practice of sharing that rationale (sometimes it is obvious, such as Benadryl for Insomnia, but often it may not be understood even by staff who completed training, such as prescribing the combination of a stimulant and antidepressant for a youth not diagnosed with either ADHD or depression, but Severe Mood Dysregulation). Consistency of tracking diagnosis, symptoms and efficacy and side effects of psychiatric medications at Finger Lakes is being monitored to determine full compliance.

49b. 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.

PARTIAL COMPLIANCE

Policy PPM 3243.32 entitled "Psychiatric Medications" complies with 49b.

Psychiatrists complete a Psychiatric Evaluation form and enter a Psychiatric Contact Note in JJIS indicating diagnosis, efficacy, symptoms, side effects, and the rationale for continuing, changing or discontinuing each medication in compliance with 49b.

The QAI review alerted the facility that two interviewed youth prescribed psychiatric medication appeared sedated. The QAI review found that not all Finger Lakes youth received a face-to-face psychiatric follow up every 30 days for 60 days after the initial exam although one youth had been seen more frequently. After the QAI review, Finger Lakes hired a psychiatric nurse practitioner who will monitor youth prescribed psychiatric medication and review lab results and side effects. To determine full compliance, the MH Monitor will review whether follow-up medication management by the NPP and psychiatrist occur at least monthly and medication side effects are responded to immediately.

49c. 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.

COMPLIANCE

Policy PPM 3243.32 entitled "Psychiatric Medications" complies with 49c.

Forms to track laboratory findings and side effects comply with 49c and were completed in Finger Lakes records.

On Site Observations Regarding Paragraph 49a-c (5/13)

On May 20, 2013, 21 of the 61 boys at Finger Lakes were prescribed psychiatric medication:

ADHD	Risperdal
ADHD	Abilify, Depakote, Lithium
ADHD	Risperdal, Depakote, Concerta
ADHD	Risperdal, Depakote, Clonidine
ADHD	Prozac, Clonidine, Adderall
ADHD	Tenex (2)
Conduct Disorder	Abilify
Conduct Disorder	Risperdal (2)
Conduct Disorder	Risperdal, Prozac
Mood Dysregulation, Conduct Disorder	Zoloft, Abilify
Mood Dysregulation, Depression	Zoloft, Seroquel
Depression	Trazodone, Remeron
Anxiety	Clonidine (2)
PTSD	Seroquel
Mood Disorder	Seroquel

Hypomania	Thorazine
Insomnia	Melatonin

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

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." Four Finger Lakes residents are prescribed three psychiatric medications.

The MH Monitor observed completed forms for laboratory and clinical monitoring of residents prescribed psychiatric medication (Weight and Vital Signs Flow Sheet and Psychiatric Medicine Monitoring Flow Sheet) in the Finger Lakes records.

An unknown number of Finger Lakes residents have sleep problems. A contact note by the Finger Lakes NPP indicated that she discussed sleep hygiene with a resident having difficulty falling asleep. Has the evening shift been coached in the concept of sleep hygiene? Have clinicians, YCs and YDAs incorporated sleep-enhancing skill building into groups and individually, supported by the youth's team? Traumatized youth have to learn how to put themselves to sleep without substances, which requires feeling safe and trusting that staff will take care of them. Not only may bedtime remind them of night fears, but also they miss home and the familiarity of sleeping with family members so going to bed may accentuate their loneliness. Given the importance of sleep to emotional regulation, more attention to self-soothing strategies for sleep is a priority. OCFS responded to this concern with a 1/13 BBHS memo to clinicians encouraging them to assist their teams in increasing staff awareness and competency around the issue of sleep hygiene, with follow-up discussion planned during regular clinical meetings.

In the review of the 44 youth prescribed psychiatric medications at the four DOJ facilities on January 1, 2013 described above, the MH Monitor found divergent medication practices among the five psychiatrists at Columbia, Finger Lakes, Lansing and Taberg. Finger Lakes, the facility with the least amount of psychiatric coverage and the only boys facility, had a much lower percentage of prescription of psychiatric medications (32%) in comparison to Columbia (55%), Lansing (67%) and Taberg (75%). Even given the small numbers analyzed, there are different rates of prescribing the three most common psychiatric medications (Note: the antidepressant Trazodone has the highest rate of prescription at the three girls facilities (Columbia and Lansing (50%) and Taberg (25%)), but is seldom prescribed at Finger Lakes because of a side effect experienced by boys):

- 8% use of Seroquel (antipsychotic) at Taberg compared to much higher use at Lansing (38%), Finger Lakes (28%) and Columbia (17%)
- 25% use of Clonidine (ADHD medication) at Finger Lakes and Taberg and none at Columbia and Lansing

- 25% use of Risperidal (antipsychotic) at Taberg and 17% at Finger Lakes and none at Columbia and Lansing

In the DOJ facilities in January 2013, Trazodone was being prescribed for Anxiety Disorder, Dysthymic Disorder, Major Depressive Disorder, Depression, and Insomnia. Seroquel was being prescribed for Mood Disorder, PTSD, Mood Dysregulation, Generalized Anxiety Disorder, Anxiety Disorder, Dissociative Disorder, and Conduct Disorder. Clonidine was being prescribed for Anxiety Disorder, ADHD, Bipolar Disorder, Mood Disorder, and Impulsivity. Risperidal was being prescribed for ADHD, Conduct Disorder, and Mood Disorder.

The QAI review at Finger Lakes found that of four youth records reviewed of youth prescribed psychiatric medication, all had evidence that the psychiatric medication prescribed was tied to the diagnostic formulation from the evaluation and the rationale of that medication for addressing symptoms; psychiatric contact notes were consistently completed. In the youth survey, several youth knew the medication they were taking, why, had the side effects explained to them, and thought the medication was helpful.

FUTURE MONITORING

The MH Monitor will review additional psychiatry guidelines.

The MH Monitor will review consistency of tracking diagnosis, symptoms and efficacy and side effects of psychiatric medications at Finger Lakes.

The MH Monitor will observe discussions of efficacy of medication at Finger Lakes.

The MH Monitor will discuss with psychiatrists how "the target symptoms intended to be treated by each medication" can be noted.

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.

50a. 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.

COMPLIANCE

The training curriculum entitled "Introduction to Psychiatric Medicine" complies with 50a.

50b. 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

Staff are provided with an orientation on the Psychiatric Medication policy and a 7-hour training on Mental Health and Psychiatric Medication that complies with 50b.

On Site Observations Regarding Paragraph 50a-b (5/13)

The MH Monitor did not observe Finger Lakes staff discussing medication and diagnoses except at a support team meeting.

In the QAI review, only 5 of 15 staff surveyed indicated that they receive enough training on dealing with youth with mental health issues; of 14 staff interviewed, they were divided between those who said medical staff or clinicians shared informed about residents' medications with them and those who felt uninformed.

FUTURE MONITORING

The MH Monitor will continue to observe Mental Health Rounds and support teams, review records and interview staff regarding psychiatric medication at Finger Lakes and steps Fingers Lakes leadership take to ensure that staff feel adequately trained (and coached) about mental health and informed about residents' medications.

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:

51a. 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.

COMPLIANCE

Policy PPM 3243.32 entitled "Psychiatric Medications" and Policy PPM 3243.15 entitled "Refusal of Medical or Dental Care by Youth" comply with 51a.

The curriculum for the one-hour training for nurses entitled "Refusal of Psychiatric Medication" complies with 51a.

Nursing staff at Finger Lakes described practices that comply with 51a.

51b. 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.

COMPLIANCE

Policy PPM 3243.32 entitled "Psychiatric Medications" and Policy PPM 3243.15 entitled "Refusal of Medical or Dental Care by Youth" comply with 51b.

The training for nurses entitled "Refusal of Psychiatric Medication" complies with 51b.

Nursing staff at Finger Lakes described practices that comply with 51b.

51c. 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.

COMPLIANCE

The training for nurses entitled "Refusal of Psychiatric Medication" complies with 51c.

The MH Monitor observed signed medication refusal forms in Finger Lakes residents' records that complied with 51c.

51d. The youth's psychiatrist shall receive, review, and sign all medication refusal forms prior to meeting with the youth.

COMPLIANCE

The MH Monitor observed signed medication refusal forms in Finger Lakes residents' records that comply with 51d.

51e. The youth's treatment team shall address his or her medication refusals.

COMPLIANCE

The MH Monitor observed documentation that medication refusal had been discussed in Finger Lakes residents' support teams that complies with 51e.

On Site Observations Regarding Paragraph 51a-e (5/13)

The nursing staff at Finger Lakes maintain a notebook of every resident prescribed psychiatric medication with a daily record of the administration of their medication. The MH Monitor observed documentation in a Finger Lakes record when a resident refused psychiatric medication. A few residents periodically refuse their medication, typically because they do not want to get up in the morning; usually within the hour the nurse will return to the resident and they may be willing to take their medication. For every refusal, the psychiatrist and clinician are notified; if the refusal occurs for a few days, the nurse also emails the resident's team. There was understanding that if a resident refuses psychiatric medication, the NPP and/or 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) and these issues are discussed in support team.

The QAI review found that at Finger Lakes medication refusals were documented in residents' records, but that parents were not made aware of the refusals; for one youth, there was no indication that his medication refusals had been discussed in support team.

FUTURE MONITORING

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

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

Staff receive orientation on the Psychiatric Medications policy, which includes informed consent procedures, and a 7-hour training on Mental Health and Psychiatric Medications, which comply with 52.

On Site Observations Regarding Paragraph 52 (5/13)

Completed 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:

53a. 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.

PARTIAL COMPLIANCE

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" complies with 53a. BBHS has revised the support plan and the integrated assessment and these will be presented to staff in facility JJIS demonstrations, along with guidance to strengthen staff skills in identifying needs and writing goals with residents.

Support teams at Finger Lakes inconsistently comply with New York Model implementation guidelines. These practices will be further coached by BBHS and monitored to determine full compliance.

53b. Require that treatment teams focus on the youth's treatment plan, not collateral documents such as the "Resident Behavior Assessment."

COMPLIANCE

Mental health staff at Finger Lakes were observed complying with 53b and the support team meetings observed by the MH Monitor complied with 53b.

53c. 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.

COMPLIANCE

Support team meetings at Finger Lakes comply with 53c.

The Parties interpret 53c to mean (a) the psychiatrist has input at support team meetings through their contact notes and communication between the psychiatrist and clinicians during Mental Health Rounds and informally and (b) the psychiatrist will attend support team meetings when their participation is clinically indicated for a specific resident. The new NPP at Finger Lakes will participate in support teams. Since MH Rounds are not focused on mental health issues at Finger Lakes, it will be particularly important for the NPP to discuss diagnostic and medication concerns prior to and at support team meetings.

The psychiatric coverage issue is more than attending support teams. If more residents required psychiatric medication than currently and/or the consensus diagnosis process included all the residents in a facility (not just those prescribed psychiatric medication), more psychiatry hours would be necessary. OCFS does not have a formula to calculate number of necessary psychiatry hours based on population.

53d. 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.

PARTIAL COMPLIANCE

Some Finger Lakes Integrated Assessments and clinical evaluations describe the effects of trauma on residents' thinking and behavior and are part of planning interventions.. But typically the resident's support plan, a key aspect of the New York Model, does not include trauma. The Mental Health Rounds observed by the MH Monitor did not discuss the effects of trauma on most residents' behavior. For some residents, the clinical contact notes indicate trauma work by the resident. This may be considered private between the resident and one or two clinicians and not something they want discussed with their team and/or family. To meet the Settlement Agreement's requirement for "a strategy for developing coping skills [for trauma] by the youth," the effects of trauma on the resident's behavior must be part of staff assistance in the youth's development of

goals. Hopefully, the more support plans reflect both the resident's views and the staff's understanding, trauma will become a safer topic in the process of residents changing their thinking and behavior.

53e. 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 or 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.

PARTIAL COMPLIANCE

Mental health staff at Finger Lakes were observed complying with 53e and the support team meetings observed by the MH Monitor are working at complying with 53e.

"Goal Writing and Support Plans in the New York Model" (4/12/13) provides helpful and specific guidance for goal writing to maximize the motivation and engagement of youth by "starting where they are" and beginning services with their goals. Strengths to build on to achieve their goals is stressed as an important part of writing support plans. This document guides staff in how to help youth develop goals by validating and breaking goals into components they can achieve. Staff are encouraged to ask the youth about outcomes they want to identify the reward for them for working toward their goal. Utilizing the examples of goals, objectives, supports/services/interventions in these guidelines will improve support plans. The one-page document Support Team Staff Notes walks staff through an analysis of their role in assisting a youth to his/her goal. The one-page Goals Worksheet is for staff to help youth identify their goals and break them down into achievable component and can assist in the development of the support plan with the resident and prepare the resident to speak up at the support team meeting. Guidelines for safe ways for youth to include trauma-related goals would be helpful, such as "Understand anger from the past that I can't control" or "Figure out why someone telling me 'No' reminds me of things in the past."

At the time of the site visit, these guidelines for writing effective goals did not appear to be implemented yet at Finger Lakes. Consistently strong support plans—including building from the Integrated Assessment, clear goals based on the resident's aspirations with the addition of staff expertise, and all team members' interventions (not just clinicians) stated specifically--is being monitored to determine full compliance.

53f. 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 53f.

Consistency in support plans and support team meetings complying with 53f at Finger Lakes are being monitored to determine full compliance.

On Site Observations Regarding Paragraph 53a-f (5/13)

The MH Monitor observed three Finger Lakes support team meetings that demonstrated strong engagement of residents and their families. Concerns about the support team meetings included the typical inclusion of the resident from the beginning of the meeting (in contrast to the New York Model approach) and the apparent lack of New York Model philosophy among CMSOs.

The MH Monitor observed [redacted] 120-day support team. [redacted] is a 16-year old at Finger Lakes for burglarizing a [redacted]. His Integrated Assessment described a history of school suspensions, alcohol and marijuana abuse, stealing, fighting and gang involvement. The trauma section noted that in [redacted] his father died in car accident: "His feelings are very raw." His parents were separated and he lived with both of them; his father's girlfriend was "like a stepmom." Before coming to Finger Lakes he lived [redacted] with his mother. His father had a history of incarceration, substance offenses, and attempted sex abuse. Vulnerabilities included head trauma twice with loss of consciousness once. He was described as fidgety and restless, with processing issues; he had a borderline IQ and was reading at the third grade level and wanted to play basketball at college. His Reception diagnosis was ADHD, Conduct Disorder, Cannabis Dependence, Bereavement. His IIP indicated that his safety plan includes pacing back and forth—"staff should not touch him, but give him space and time to pace." The Integrated Assessment concluded, "Habitual use of physical acts to solve issues without thought to consequences," refer to psychiatrist for medication for poor impulse control, frustration tolerance, decision-making (but he does not want medication). The support team meeting the month before discussed a Red Flag meeting held because of his continued fighting, and he was described as "aggressive to staff, poor understanding of boundaries, poor social skills. Does well 1-to-1. It is exhausting to staff to help him stay on track." Other than the current functioning paragraph, [redacted]'s 4/13 support plan was identical to the one a month before. Goal #1 Go home: Avoid Level 3s, fights and restraints to earn way home. He was to meet with his clinician weekly to develop distress tolerance skills, see his YC weekly to develop skills, get help staying focused in school from education, and his YDA's responsibility was listed as "Youth will reach out to staff for support and be able to hear feedback." Goal #2 Learn anger control: learn anger control skills—not doing so has resulted in being locked up: pro-social ways to deal with frustration (the list of staff support was the same as Goal #1 except education was to use intervention skills when he seemed upset). His family goals were to return home by "navigating way through program to earn home" and graduate from high school, with no mention of learning problems, head injury, low IQ, ADHD or an achievable goal in future. The support plan did not acknowledge family issues related to parent separation, delinquency and school problems prior to his father's death (this arrest was more than a month before his father's death) On 2/20/13 he was placed on the waitlist for the psychiatrist and he was seen 3/19/13: "Grief over father contributes to anger—

uncomfortable expressing emotions—no thoughts of suicide--close to mother. No other depression, anxiety symptoms. Wants to improve behavior. Clinician says he is impulsive, invades people's space, has difficulty interpreting group behavior, socially awkward, no friends, conflicts with peers. Past diagnoses of ADHD, ODD, CD. No evidence of mood or anxiety disorders. Past ADHD diagnosis, but probably cognitive limitations and impulsivity leads to appearance of poor attention. Has shown improvement in the past with stimulants and Seroquel, but heavy cannabis use so medication is contraindicated." The psychiatrist diagnosed Conduct Disorder, Cannabis Abuse, Bereavement and prescribed Risperdal for disruptive, aggressive, impulsive behavior. The Psychiatric Contact Note on 5/13/13 by the NPP indicated that [redacted] said "I'm too hyperactive and impulsive," "I'm tired and aggravated," and "People make me mad." He had numerous restraints, fights, boundary violations, and exposing himself and did not seem to understand consequences of his behavior. She asked the teachers to complete a Vanderbilt and wanted to review the results of a scheduled WISC. [redacted] asked for Seroquel and Adderall, the NPP said she would confirm their past effectiveness with his mother, but explained to him the side effects when Seroquel is combined with marijuana. Between 2/20/13 and 5/10/13, his clinician saw him for individual therapy 12 times (four of which he refused). Between 2/202/13 and 4/24/13, his YC saw him for individual counseling 11 times, several of which included phone discussions with his mother. Between 3/13/13 and 5/1/13, he attended five substance abuse groups and 13 DBT groups. [redacted]'s support team was convened by his YC with his clinician, teacher, nurse, NPP, and the psychologist who completed cognitive testing. His mother and aftercare worker's supervisor were on the phone. His mother immediately said she is angry that he has ADHD and Reception did not accept the ADHD medications that she offered. She is angry that the psychiatrist called her and said he did not see ADHD. She is angry that Finger Lakes has taken so long to get the evaluation done. "He is very smart. He is entirely different when he takes his medications. Adderall works for him." She reiterated several times her insistence that he has ADHD and must be medicated for it. She said the problem is that Finger Lakes does not have enough psychiatric coverage. The NPP responded that Risperdal is effective for impulsivity. Then his mother described the side of effects of poor appetite and sleep problems for which he was prescribed Seroquel for almost a year. The team was able to calm his mother in order to present the results of cognitive testing. The psychologist had developed a relationship with his mother and described his ability to pay attention and use his memory: "but he has a very limited vocabulary and gets frustrated having so much trouble making sense out of things. He has difficulty solving problems because of his verbal skill deficits." The testing psychologist was not allowed the time to guide the team in how to help him with his cognitive limitations. His mother complained that she did not sign a consent for Risperdal and that the psychiatrist told her the medication would be for sleep (the NPP found a verbal consent in the record). The psychiatrist will see him this week and will talk to his mother. [redacted] arrived at the support team and was asked what his goals are. "Going home." "What are you doing to go home?" "Not falling into negativity." "Stop getting restrained." "Managing my emotions." "Getting phase." His mother asked him whether Adderall would help him with his behavior, and he answered that it would. He is thinking about going to school for barbering and wants to open his own barbershop. He said to do that he would have to "stop getting arrested." He told his mother "I go to school everyday now." His YC went through each element of his safety plan asking if each still works. He said that his

tapping script helps make him calm (EFT-Emotional Freedom Technique). He said staff still touch him and he wants not touching him to stay on his IIP. Then he said, "I need a drug treatment program at home." His mother asked, "Why?" He said, "Because I smoke too much weed." His mother countered, "You're not doing that now. Why are you thinking about that at home? Think about positive activities." [redacted] maintained himself and said, "But I panic and think I need weed." His mother expressed irritation that "You just chose to do bad things and not what you should." The substance abuse clinician suggested she start individual sessions with him because he finds groups difficult. The aftercare supervisor suggested MST for substance abuse. His YC told him, "I will send out the PRA if you go for a week with no restraints and no codes." Everyone said, "You can do it." His YDA and YC came up with a phase chart with stickers on a calendar. They ask him to explain it—"Every day I get no codes and no write-ups and no restraints, I get a sticker." His YC said, "You can do it, but you have so many excuses. You do it when you want to." In a very caring way, his YDA brought up his loss of his father: "one of your goals should be to find someone—a YDA, your YC, your MH counselor to start to talk to about your loss." The psychologist who tested him commended him for how well he was participating in the meeting. She asked if there is anyone at Finger Lakes he can talk to about his loss. He said "No" with his eyes filling with tears. His YDA said, "I'm here for you." His clinician talked about how his YDAs are "going over and above. You have lots of mentors giving time to support you to meet your goals." His YDA said he was doing very well in vocational class and his other class, doing his work and asking for homework that he does at night. His teacher said, "Every grade has improved." The teacher reminded him that he does well in classes until the last minute and then throws a chair or threatens a teacher on the way out. The nurse was positive, saying he had improved a lot, not cursing or pushing the medical cart. The NPP promised to talk to him about Adderall before he sees the psychiatrist. His YC remained calm and supportive throughout the meeting, talking directly to him. A thorough review of [redacted]'s record suggests a developmental disorder with the following telltale characteristics: does not understand social cues, violates others' personal space, constantly talks, cannot wait his turn, repeatedly asks for the same thing, cannot ignore peers, cannot listen. A diagnosis of ADHD or Conduct Disorder does not account for this mixture of characteristics of a developmental disorder. For example, he annoys staff by disagreeing with shift summaries and complaining about being picked on by staff—this can be seen as a conduct disorder (minimizing his role and not taking responsibility) or it can be seen as a developmental disorder interfering with his comprehending instructions, understanding that the rules are the same for everyone. If it is viewed as conduct disorder, consistent consequences will be prescribed and are unlikely to help him learn how to compensate for his impaired comprehension. If viewed as a developmental disorder, staff repeating simpler instructions, helping him with checklists, praising when he correctly reads others' cues, and treating him as if he is younger than his chronological age will result in compensatory skill-building. He may also feel picked on as a reaction to trauma since he witnessed domestic violence and his father was physically abusive; Finger Lakes contact notes indicate he is being "targeted by bullies because he is highly reactive." These difficulties require trauma-responsive practices, but no recommended staff interventions were included in the plan. In addition, his support plan ignores his sexualized behaviors. His clinician told [redacted] in the team meeting, "Exposing yourself has to stop. It's a big problem." His inappropriate behavior toward female staff could be the result of not

understanding why these behaviors are offensive and/or the result of being exposed to sexual behaviors at an early age. A developmental disorder combined with behaviors resulting from trauma require a combination of coordinated interventions by all staff, and simple or generic goals common in support plans are unlikely to guide staff in how to respond to him.

The MH Monitor observed [redacted]'s six-month support team. He is a 16-year old sent to a limited secure facility for a 2009 petit larceny (after a probation violation and being sent to a residential program) and modified to Finger Lakes after an AWOL, aggression and destruction of property. CPS reported physical abuse by his mother; he moved back and forth between his parents due to conflicts with both. He had a history of loss of consciousness from a bike accident and school failure and truancy. His Reception diagnosis was ADHD, Mood Disorder, Conduct Disorder, Borderline Intellectual Functioning (provisional). His Finger Lakes Integrated Assessment listed his needs as: gain skills to regulate emotions; impulse control; improve ability to tolerate frustration; and increase social skills. Between 2/1 and 5/14, [redacted] had individual therapy eight times (plus the first two scheduled sessions when he was not interested) and participated in three DBT groups and five substance abuse groups; he was not receiving medication, so there were no psychiatric contacts and the Finger Lakes psychiatrist apparently did not give an opinion about the diagnostic questions. His 4/13 support plan lacked specificity, was not motivating, and was not realistic about his family. There was some effort to tailor what staff would do, but not specifically enough connected to his goals and needs. Goal #1 Return home (unclear whether this is to his father's home): Increase self-motivation. Mental health planned to teach DBT and positive self-talk. His YC planned to set short and long-term goals and steps to reach goals. Education would encourage him to follow classroom norms, and his YDA would mentor weekly and give positive reinforcement. Goal #2 Be a mechanic: Increase school effort. Mental health would teach DBT skills and mindfulness, his YC would make step-by-step plans to reach his goal, education would encourage class participation (no vocational class or anything related to car mechanics is mentioned). His Family Goal #1 Get him home (no indication if it is his father's or mother's home): Increase communication. Mental health planned to update family and his YC would provide youth with counseling calls to family. His diagnosis was ADHD (by history), Mood Disorder, Conduct Disorder, Rule Out Bipolar Disorder, Rule Out Parent-Child Relationship Problem, Rule Out Communication Disorder, Borderline Intellectual Functioning (provisional), but after six months at Finger Lakes his intellectual function and whether he has a communication disorder should have been determined and the possible diagnoses ruled out or not. [redacted]'s support team was convened by his YC with a YDA, two other YCs, his clinician, teacher and nurse. His father, CMSO and B2H were on videoconference. The support team meeting had a rough beginning because when the nurse arrived he announced that the dentist had decided [redacted]'s wisdom teeth had to be extracted and an appointment was being set up with a specialist; this was new information for the team which they wished had been shared before the meeting—the teacher was concerned that he has two Regents in June and does not want the schedule of the surgery or recovery to affect his performance. Other team members suggested the surgery could be done in the community. [redacted] seemed discouraged and said he was not doing well in the program, not going to school consistently. Staff affirmed him, "It was a good decision you made to stay

here to take the Regents and we want to support you to study for them." He said he wants to go the next grade and to do so he has to pass the Regents. He did not respond to their question, "What can we do to support you in achieving your goal?" This is an important reason for having a support team, and staff should have pursued this question (maybe even writing it on the board so he could generate a list of things that could change so he would get ready for the Regents). The meeting followed different participants' priorities, with B2H asking if they could come to Finger Lakes to interview [redacted] about the skill-building they could help him with when he is released in mid-June. His clinician said he needs family counseling. His CMSO recommended an anger management program that [redacted] was obviously not pleased about. Then his father asked questions about electronic monitoring and the CMSO said she would be explaining that to him and his father. [redacted] said, "I'm not playing basketball or going to work with an ankle bracelet." The CMSO brushed his concerns off and said, "Lots of kids do and just cover the bracelet with their sock or pants. [redacted] asked for a 9 PM curfew, saying, "I can't do 6 PM." He said he is not taking any medication, and that he is not ADHD. Although this is his last team meeting at Finger Lakes before he leaves, there was no discussion of the specific supports he needs to be successful in his father's home. In the debrief the participants had regrets about the meeting, starting with the surprise announcement at the beginning. They said it was not a typical team meeting. Their biggest concern was that the meeting was too much question and answer with the resident and did not focus on his going home goals. Had Finger Lakes and the CMSO agreed first about his goals in the community and the services that would support him to be successful with his father, then the meeting could have been about his view of his goals and a description of possible services, including B2H, electronic monitoring, and curfew. His father had to catch up on his goals and proposed services because he has only been intermittently involved while his son has been at Finger Lakes. For this resident, who is a Finger Lakes returnee, the unasked question was asked, "What was it that made you come back here and how can your team help you prevent that from happening again?" His last release he went home to his mother in a gang neighborhood. Everyone hopes that living with his father this time will make a difference, but little attention was given to what it would take for him to be successful in his father's home. Finger Lakes staff have talked with [redacted] about staying away from his mother's neighborhood, away from gangs, but it was not discussed in this support team: "This meeting is the tip of the iceberg. He's come a long way, but he is facing a lot out there."

The MH Monitor observed [redacted]'s 30 day Support Team meeting. He is a 14-year old sent to Finger Lakes for taking and totaling his mother's car and damaging police cars. Both his parents and stepfather were involved with drugs and incarcerated. He started mental health services when he was 5—he was described as inattentive with mood dysregulation and explosive anger. At age 9 he was admitted to [redacted] Psychiatric Center for three weeks for threatening his mother. His mother was incarcerated when he was 5-8, and he lived with a friend of his mother's, then with his paternal grandmother and father. In 2011, he was in and out of detention and [redacted], running away and stealing cars four times to get back home; he was then placed in a group home, [redacted] Psychiatric Center and returned to the group home. Testing found borderline intellectual ability and he was diagnosed with Bipolar Disorder and ADHD and prescribed Abilify, Lithium and Depakote. The Reception psychological evaluation described "very chaotic traumatic childhood with

multiple long separations from both parents at an early age repeatedly due to their incarceration, exposure to domestic violence and his parents' drug activity." His Reception diagnosis was Conduct Disorder, ADHD, Intermittent Explosive Disorder, Borderline Intellectual Functioning. His Finger Lakes Integrated Assessment was completed the day he arrived, and he said he wanted to improve his relationship with his mother and stepfather. Under risk factors, his early disruptive behavior was linked to his mother's incarceration. The clinician's review of psychological testing showed average intelligence with grade level skills. He said he wants to be an auto mechanic and had started a BOCES program. In a 5/1/13 Psychiatric Contact Note, the Finger Lakes psychiatrist reported a prior diagnosis of Bipolar Disorder, two years of Lithium, but no evidence of manic or hypomanic behavior: "doing well, no sign of psychopathology, no symptoms, maybe he had lithium toxicity. Continue Lithium for now-repeat labs, re-evaluate, maybe discontinue; continue VPA for now; decrease Abilify—no clear benefit." His support team meeting was convened by his YC and included the other YC, clinician, teacher, nurse, and his mother, stepfather and aftercare worker who came to the facility from [redacted]. His YC opened the meeting by using his IIP to effectively teach him and his parents about his physical cues when he is angry and then how to employ his skills. She asked the resident, "What do you want to learn here?" He responded, "What to do when I get mad." His clinician helped him articulate that he wants to learn how not to argue back and wants a better relationship with his family. His mother said she wants him to deal with his anger and not lash out at her when she says "No." She said he is materialistic and wants too many things. She added that he wants acceptance from the gang and she hopes he can improve his self-esteem. Then without asking what he wanted, the CMSO insisted, "I want you to get a diploma. I will enroll you in high school." He talked about not wanting to go back to his old school, but "it's hard to move to a new place," which probably reflected his anxiety about his relationship with his mother and stepfather as well as a new school and neighborhood. The CMSO continued giving [redacted] advice, and the meeting deteriorated. It is evident that he has trouble with comprehension, but only some team members were careful to use easily understood words. His medication changes were discussed: his mother said he was shaking on the high doses at Reception, Lithium and Abilify were reduced, but he feels very tired and wants them reduced more. He will see the psychiatrist or NPP soon. Because his family lives [redacted] his clinician offered family therapy. The clinician described his needs as improving self-esteem, connecting his feelings to actions and problem-solving, some of which [redacted] appeared not to understand. His science teacher gave him positive feedback for doing his work and passing everything. He reassured [redacted] he can make up his missing credits to pass 8th grade this summer. The origins of his anger in domestic violence and separation from his mother were not mentioned, nor was his marijuana and alcohol use. The CMSO told him he would probably leave in October (undermining the idea of earning his release, and his YC reacted with, "You have to show you want to go home"), said he would have electronic monitoring, outpatient mental health and B2H (which were one-size-fits-all aftercare services not generated by his evolving support plan, thus undermining New York Model at the facility). The unidentified attendee at the support team meeting apparently was a DSS worker who insisted that his mother and stepfather move out of [redacted]; the CMSO agreed this was imperative for him to return home because "They will find you in [redacted]" (whether this was a reference to gang members who were after [redacted] and/or to his mother and her past substance abuse was

unknown). In the debrief, the BBHS Director of Treatment said the meeting demonstrated good engagement with the resident and family but was not a New York Model support team. The YC who convened it said they could not do a two-part support team meeting because his family and CMSO were here, movement could take 20 minutes, and this was not the usual day scheduled for support teams. Participants commented on the need for training on support plans and support teams.

The three observed support teams at Finger Lakes showed staff with strong relationships with residents communicating effectively with family. At Finger Lakes residents often are in the support team meeting from the beginning because it takes so long to move residents from their units. The New York Model approach to two-part support team meetings encourages discussion before the resident arrives. Aspects of Finger Lakes support teams requiring improvement are (a) continuing to strengthen individualized goals and specifying ways each staff can help the resident meet their goals; (b) incorporating he Integrated Assessment findings into the team discussion and support plan; (c) making arrangements for residents to move from their unit to the support team in a timely way so the two-part New York Model support team can occur; and (d) making connections between the resident's goals at Finger Lakes and success in the community. In addition, it is essential the CMSOs understand the New York Model and continue what residents learned in the facility in the community, starting with the CMSO's involvement in support teams.

The importance of strong support plans is exemplified by [redacted] a Finger Lakes returnee with a significant trauma history who was at Finger Lakes for a few months (1/13/13-4/5/13), was released to the [redacted] CMSO, and returned a month later (5/9/13) at age 15 for fighting in school. In his support plan just before release, his Goal #1 was "Accepting Constructive Criticism: Learn to accept feedback as helpful and listen to what is being told to him without debating and/or becoming upset. He understands he is quick to anger" and his Goal #2 was "Respect authority figures/Make better choices: Youth needs to respect adult figures and stop acting as though he's untouchable. When he does not like what is being said, he will challenge staff and become very disrespectful. This has been a concern while out in the community." The intervention was his clinician "meeting with him to work through past issues and trauma." His one-page Continuity of Care plan indicated his mother would make appointments for counseling and family therapy and the address and phone of the counseling center was listed. When [redacted] returned to Finger Lakes, his integrated assessment reported that in 2009 his father (who had not be previously much involved in his life) was sent to prison for murder. Reportedly his behavior escalated when his mother's boyfriend moved into their home in 2010. He had two group home placements, from which he went AWOL. At his third placement there was a founded charge of forcible touching, which he continued to deny, and he was sent to a sex offender program in 3/12 (although no reports on his progress there were reviewed). Mental health concerns were not included in the integrated assessment, nor was the Rule Out Cannabis Abuse diagnosis from Reception noted. His current support plan gives a diagnosis of Conduct Disorder, Mood DO, Victim of physical abuse as child, Perpetrator of sexual abuse (by history), Rule Out ADHD, Rule Out Cannabis Abuse, Borderline Intellectual Functioning. In his current support plan, his Goal #1 is "Increase skills to use in community" and his Goal #2 is "Interpersonal effectiveness, stay on task in school." The support plan does not

reflect what [redacted], Finger Lakes staff, his mother, or CMSO will do differently during his second placement in the facility and transition to the community than they did earlier in 2013.

Insufficient psychiatry involvement in the support plan and support team are a problem for [redacted], a youth whose record was reviewed by QA. [redacted] is an 18-year old who has been at Finger Lakes almost seven months for a violation of probation. At age 5 he was diagnosed with ADHD and prescribed Adderall and Clonidine. At age 10, he was hospitalized, diagnosed with ADHD and Psychotic Disorder. At age 15 he was hospitalized again when he experienced command hallucinations and was prescribed Olanzapine. Concerned that his hallucinations were a side effect of high doses of stimulant, his community psychiatrist attempted to reduce his medication, but his aggressive behavior at home increased. His diagnosis in his 12/7/12 Finger Lakes Integrated Assessment was ADHD, Psychotic Disorder, Cannabis Abuse. In his most recent support plan, his Goal #1 was "Go home: Increase program participation" and his Goal #2 was "Get GED: Increase school participation." The interventions were generic, with his clinician to teach DBT, emotional regulation, and Pros and Cons and his YC to set short term and long term goals and steps to reach them. The support plan contained no details about psychiatric intervention (he is prescribed Prozac, Clonidine, and Adderall) or his psychotic disorder, even though his probation violation was reportedly the result of aggression toward his mother after he stopped taking his medication. The QAI Review raised concerns about [redacted]'s treatment including: there was no evidence that his support team took into consideration the youth's history of trauma, its impact, and a strategy for developing appropriate coping skills; in four support plans, the goals remained the same, with minimal progress; plans were not individualized, specific to youth's needs, or focused on the youth's treatment; treatment goals did not provide an understanding for how this youth was being prepared for a successful return home; and [redacted] had a diagnosis of Cannabis Abuse which was not being addressed in any of the ISPs.

The QAI Review commended Finger Lakes for having service plans that had goals transferable to the community. The QAI Review found that in several Finger Lakes records, the Integrated Assessments did not inform service plans. Although the QAI Review found that in several Finger Lakes records, service plans were "driven by input from the youth, his family, and all treatment providers," other service plans had inadequate goals, did not address trauma, were not individualized, had generic treatment interventions, and did not address the youth's diagnosis. The QAI survey of 51 youth found that 30 said they had a support plan, 26 said they helped develop their goals, 27 said their attended all their support team meetings, 15 said their parent participated in support team meetings, 22 said their CST participated, 29 knew there was a phase system and 24 knew there was a DAS. In interviews with 12 youth, nine knew whom they were being released to, but could not describe the services they would be receiving after release; only four youth could describe the phase system and none knew how to move up the phases. In a staff survey of 15 staff, 9 responded they are not an active and contributing member to youth support teams, 7 said CST contributed at support teams, 4 said family contributed, and 13 said they were familiar with IIPs. QAI requested a corrective action plan for support team members providing specificity around what their role will be in assisting youth in achieving their goals and objectives.

FUTURE MONITORING

The MH Monitor will continue to review Finger Lakes support plans, especially for building from the Integrated Assessment, clear goals based on the resident's aspirations as well as staff expertise, and all team members' interventions being included.

The MH Monitor will continue to observe Finger Lakes support team meetings.

The MH Monitor will continue to review psychiatry coverage.

54. Substance abuse treatment. The State shall create or modify and implement policies, procedures, and practices to require that:

54a. All youth who have a suspected history of substance abuse are provided with adequate prevention education while residing at a Facility;

PARTIAL COMPLIANCE

The OCFS substance abuse manual will be reviewed. Residents identified as benefitting from substance abuse prevention education and their participation in substance abuse prevention education at Finger Lakes is being monitored to determine full compliance

54b. 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

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 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 teams 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 and how he can use these skills to avoid substance use in the community.

The OCFS substance abuse manual will be reviewed. Residents identified as having substance abuse problems and their participation in substance abuse treatment at Finger Lakes is being monitored to determine full compliance.

On Site Observations Regarding Paragraph 54a-b (5/13)

The substance abuse clinician is actively involved on the Finger Lakes units and in support teams, providing individual therapy for residents as well as substance abuse groups on each unit.

The substance abuse clinician continues to provide a 17-week group curriculum. This curriculum appears to fit the interest level of residents and can be tailored to the cognitive abilities of the participants. She looks forward to the addition of another substance abuse clinician at Finger Lakes. Substance abuse groups are impossible to convene effectively for 10-12 residents on a unit (especially when the maturity levels on one unit range from an 11-year old to an 18-year old), but if the half the residents participate at a time that requires (a) staff able to do something else with the residents who

do not participate and (b) the availability of the substance abuse clinician to do twice as many groups. The substance abuse clinician wants to develop (and have clinicians develop) a substance abuse relapse prevention plan with each resident. She continues to provide an AA meeting for residents. At Mental Health Rounds on one unit, the substance abuse clinician reported on one youth participating in AA meeting with whom she is working on a relapse prevention plan so he can present it at his support team. Unfortunately her large office selected so that groups could be conducted privately still does not have a camera so she is unable to convene groups in it. Furthermore, there continue to be movement issues for groups convened outside the unit.

The MH Monitor observed an outstanding substance abuse group at Finger Lakes. The six residents actively participated and the YC and YDA helped the residents contribute to the discussion on triggers (for both substance use and powerful emotions). After a presentation, a personal triggers worksheet guided residents through the DBT skill of IMPROVE the moment that could help them with their triggers without using substances. Residents then tackled a difficult game to find common triggers hidden in a word puzzle. The residents were bright and engaged in individual work as well as group interactions. In the debrief after the group, the YC was admiring of the substance abuse clinician's effectiveness in groups. He recently attended a 2-day DBT and substance abuse training and is positive about becoming more skilled at using DBT and his new knowledge about substance abuse.

[redacted] is one of the residents the substance abuse clinician sees in individual therapy. He is a 16-year old at Finger Lakes for six months for criminal mischief and probation violation. He has a history of opiate, marijuana, and alcohol abuse. Due to his mother's substance use and both parents' incarceration, he was in foster care. Although the Reception psychological evaluation indicated that he was depressed and his distractibility and impulsivity did not meet ADHD criteria, the Reception diagnosis was ADHD, Disruptive Behavior Disorder, Rule Out Depression Rule Out Substance Abuse. His 1/13 Finger Lakes plan was Goal #1 Emotional Regulation-Increase coping skills #2 Avoid peer negativity and do own program. Prior to his last court appearance in 1/13, he did well at Finger Lakes; after court, his behavior changed dramatically with 12 rule violations in one month, multiple restraints and decreased school participation. His diagnosis was Anxiety for which he was prescribed Clonidine. The MH Monitor reviewed thorough contact notes in [redacted] record. They reveal a careful approach to therapy with a resident who has not talked about his feelings before and struggles with intermittent behavior problems and self-harming thoughts. He appeared to be an example of a young person who would have made more progress if he had been seen for individual therapy once or twice a week, but his overloaded clinician is unable to schedule weekly therapy.

If a resident has substance abuse problems, his need for treatment must be clearly documented in the Integrated Assessment and substance abuse treatment included in his support plan. In addition, applying skills being learned in the facility to preparing him to successfully avoid returning to substances in the community should be an ongoing goal of services documented in contact notes and support plans

The QAI review found that of six youth records reviewed, five had a diagnosis of Cannabis Abuse prior to arriving at Finger Lakes and did not contain a substance abuse

assessment or evidence the residents were being provided with treatment; only one was receiving substance abuse treatment. Finger Lakes indicated it will soon add a second substance abuse clinician.

FUTURE MONITORING

The MH Monitor will review the substance abuse manual (expected in summer, 2013) and the incorporation of its concepts into the integrated assessment, support plan and support team process.

The MH Monitor will observe substance abuse assessment, substance abuse prevention education and substance abuse treatment being provided to Finger Lakes residents and their substance abuse being addressed in support plans, support teams and through coaching of staff.

The MH Monitor will review the effectiveness of this treatment approach in preparing Finger Lakes 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:

55a. Mental health resources available in the youth's home community, including treatment for substance abuse or dependence if appropriate;

COMPLIANCE

The Continuity of Care Plan complies with 55a.

55b. Referrals to mental health or other services when appropriate;

PARTIAL COMPLIANCE

The Continuity of Care Plan complies with 55b for mental health services.

The Discharge Plan (still being developed) will be reviewed for compliance with 55b.

The Transition Plan includes: (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.

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."

55c. Provisions for supplying psychotropic medications, if necessary, upon release from the Facility.

COMPLIANCE

The one-hour training for nurses entitled "Psychiatric Medications at the Time of Release" explains 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 in compliance with 55c.

On Site Observations Regarding Paragraph 55a-c (3/13)

A noteworthy practice at Finger Lakes is that every resident has to present a release plan to the Director.

The MH Monitor reviewed the one-page Mental Health Continuity of Care Plan for [redacted] a 15 year old with a weapon offense who was at Finger Lakes for nine months because of a hold after he was involved in a group disturbance. His Integrated Assessment (8/29/12) described a trauma history that included the violent deaths of his father when he was 3 and his stepfather, to whom he was close, when he was 13, as well as being stabbed himself and witnessing a suicide from the roof of his building that he continued to have flashbacks and bad dreams about. He did not see the Finger Lakes psychiatrist for the first six months of his stay, but finally agreed to see him in 2/13 for help with anger. The psychiatrist diagnosed Anxiety Disorder (PTSD features), Conduct Disorder ("consider trauma-focused therapy referral"). He was prescribed Clonidine, when it was ineffective, the psychiatrist concluded [redacted] had PTSD and commenced a trial of Prazosin for PTSD nightmares and hyperarousal. He saw the NPP weekly and complained the medication was not effective. She educated him about Seroquel and decided to taper and then discontinue Prazosin and begin Seroquel for hyperarousal, anger and sleep problems. His last support plan before leaving (5/12) listed a diagnosis of Anxiety Disorder, Conduct Disorder, ADHD (provisional), and Cannabis Abuse, but the psychiatric medication list gave a diagnosis of PTSD for which he was prescribed Seroquel. Goal #1 Finish school ("Go to school all the time; Increase DBT knowledge). Mental health planned to "work on distress tolerance," his YC was going to "encourage school participation," Education was going to "encourage use of DBT and Sanctuary skills," and his YDA was going to "help to keep focused and avoid negative peers." Goal #2 was "Get home (continue to increase participation and effort in school; Mindfulness.") Mental health planned to help him with "mindfulness to keep focused in school, his YC encouraged school participation, education supported use of skills in the classroom, his YDA supported "use of skills on unit and in program," and Vocational assisted with vocational training. His family goals were return home and help him be successful, and mental health planned to "Help with skills to calm anger" and "Explain DBT skills to Mom." His clinician had a difficult time finding discharge mental health services in the [redacted] for him up to a few days before his discharge, and it seemed unlikely that he would receive trauma treatment necessary to reduce PTSD symptoms underlying his offending.

[redacted] is a Finger Lakes returnee who exemplifies the important of strengthening transition planning. He was at Finger Lakes 4/26/12-10/18/12 and returned 2/26/13 at age 16 for running away from home, not adhering to his aunt's rules, taking her computer and being disruptive at his grandmother's home. When he was 11 his mother died suddenly, he was sent to his maternal grandmother, and then moved to his aunt because of his behavior. He witnessed gang violence and his friend being killed. After five months at Finger Lakes, a few weeks before his release in October 2012, [redacted] was working hard in the program, attending school, helping peers and showing leadership skills; he had been involved in two off-campus programs. He wanted a closer relationship with his brothers and his goal was to control his anger. At release he was not referred to mental health, psychiatric or substance services and his family declined B2H services, despite his trauma history and the likelihood that the loss of his mother would undermine his relationships with family caretakers. [redacted]s current support plan at Finger Lakes is identical to his last one six months ago (during his first placement), except that his aunt may not want him to return so group home placement is being considered. "Will learn the pro-social, emotion management and educational skills to complete program and earn his way home" and "will learn anger control skills in program to help him stay out of trouble when he leaves" were not sufficient goals to be successful in the community the last time he was at Finger Lakes. His current support plan and staff interventions should be geared toward transition to success in the community.

[redacted] is another example of a Finger Lakes returnee whose transition planning was weak. He first went to Finger Lakes at age 14 (4/19/12-12/6/12) and returned a few months later (3/11/13) at age 15 for Grand Larceny. He had been mistreated by his stepfather, witnessed domestic violence, his mother left his stepfather, and WT was placed through Interstate Compact with his mother in her new home in [redacted]. His last service plan before release indicated that his diagnosis remained Conduct Disorder, Rule Out Mood Disorder, and although he was prescribed Abilify, in seven months of treatment Mood Disorder had not been confirmed. His Goal #1 was "Going home: Will learn impulse control skills, prosocial peer relationship skills and the ability to follow directions without the need of a response call or receiving a major rule violation." His Goal #2 was "Finish high school and go to college: Will need to learn interpersonal effectiveness and impulse control skills so he can sit through a class period in school." His Family Goal was "Improve relationships: Impulse control and lack of anger control are getting in the way for family relationships." His one-page Continuity of Care plan referred him for psychiatric services and counseling to a mental health center in [redacted]; he was released prescribed Abilify. When he returned to Finger Lakes, the Integrated Assessment did not indicate he had recently been released. His diagnosis was Mood Disorder, Conduct Disorder, Reading Disorder (provisional). His support plan did not mention that he was a returnee. His goal to "avoid negative peers," was not connected to skills learned in his previous stay, and the interventions listed were generic. This support plan was unlikely to lead to transition planning that would address the unmet needs that resulted in his return.

[redacted] is also an example of a Finger Lakes returnee with poor transition planning. He was at Finger Lakes for five months (7/3/12-12/12/12) and returned less than a month later (3/11/13) at age 16 for violation of probation. [redacted] was born in [redacted] and lived in a violent refugee camp until age 8. He was placed as a PINS in two group homes and

AWOLed from both. He is a resident who benefitted from the structure of the program and excelled in his facility job, but his trauma history affects his expression of anger, family relationships and self-medicating with alcohol and other substances and his learning problems interfere with school—without trauma treatment, intensive culturally-informed home-based services and a strong IEP, he will be set up for failure on every release. The plan for his release in December, 2012, was to return to his parents and attend school in [redacted] although the noted need to "repair relationships with parents before returning home" was not mentioned in transition planning and his one-page 12/12/12 Continuity of Care plan only referred him to a substance abuse program. His Integrated Assessment when he returned to Finger Lakes indicated that he was extremely quiet, anxious and unable to comprehend some words and questions (e.g., he did not seem to understand the terms "therapy" or "counseling"); prior testing found he had low average intelligence but was struggling in 9th grade with reading skills at 3rd grade and math skills at 5th grade levels. His most recent support plan (5/15/13) indicated that he was not engaged in program and not attending school consistently because he was awaiting a criminal court hearing (for attempting to climb the fence at Finger Lakes). His Goal #1 is "Go home: Increase school attendance," his Goal #2 is "Finish high school: Increase class participation" and his Family Goal is "Youth to come home and stay out of trouble." These are vague, not motivating, and do not connect past trauma to his behavior and do not take into account his learning disabilities and family culture. His diagnosis is Conduct Disorder, Alcohol Abuse, Reading Disorder (Provisional), Mathematics Disorder (Provisional), Disorder of Written Expression (Provisional), Rule Out Cannabis Abuse, Rule Out Adjustment Disorder, Rule Out Anxiety Disorder. AR's support plan gives no indication of what assistance is being provided to him and his family, what alcohol and other substance treatment is being provided (his alcohol problem is not mentioned in the plan and the Finger Lakes substance abuse clinician apparently is not on his team). There has been no update of his provisional diagnoses, which suggests that learning disabilities testing, an IEP, and specific school interventions at Finger Lakes and in the community have not been done.

Two important functions of transition planning 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 support 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 service providers be able to rely on his discharge plan as his support plan in the community. All the residents in the four DOJ facilities are receiving individual therapy and individual counseling and are participating in DBT and Sanctuary groups and most are

participating in substance abuse treatment groups. The Settlement Agreement wording does not limit the need for a continuity of care plan to youth prescribed psychiatric medication; it includes all residents with the terms "mental health issues" and "receiving substance abuse treatment" in the facility. The Settlement Agreement wording "referrals to mental health *or other* (emphasis added) services when appropriate" requires continuity of care planning for almost all OCFS residents because most residents receive treatment in the facility to meet their mental health and substance abuse needs. This could include, in addition to referrals to therapy, medication management and substance abuse treatment on the Continuity of Care plan, referrals to B2H services, YAP services, mentoring services, and educational services. Referrals for these services are important for transition plans for all youth, not just those requiring medication management in the community. Some residents have a goal of discontinuing psychiatric medication before they are discharged, and they might be at greater risk of return to the facility than those residents who have a Continuity of Care plan for follow-up by a mental health provider in the community. Through the New York Model OCFS has implemented the integrated assessment and integrated support plan, and hopefully, a revised Discharge Plan format could become 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 Discharge Plans and Continuity of Care plans of recently released residents.

IV. DOCUMENT DEVELOPMENT AND QUALITY ASSURANCE

56. Document Development and Revision. Consistent with paragraph 68[1] of this Agreement, the State shall create or modify policies, procedures, protocols, training curricula, and practices to require that they are consistent with, incorporate, address, and implement all provisions of this agreement. In accordance with paragraph 68 of this Agreement, the state shall create or modify, as necessary, other written documents – such as screening tools, handbooks, manuals, and forms – to effectuate the provisions of this Agreement. The State shall submit all such documents to the United States for review and approval, which shall not be unreasonably withheld.

PENDING REVIEW

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

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

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[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.

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) (also referred to as the QAI Review of 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 quality of QAI products has become an important source of information in the monitoring process. The quality of the QAI pilot reports has been excellent. The reports have been thorough and informative.

QAI has developed a new quality assurance strategy that could lead to an expedited finding of compliance for the Protection from Harm paragraphs. In its efforts to assist the facility in the appropriate use of physical restraint interventions, QAI proposed the development of restraint metrics that would be linked to graduated restraint safeguards and action plans. More importantly, the QAI initiatives recognize the paradigm shift that occurred in juvenile corrections nearly two decades ago and are consistent with generally accepted professional standards. These critical and yet-to-be-implemented performance metric restraints safeguards require more review, but they have the potential to change the monitoring strategies in such a way as to expedite agreement among the parties about compliance with various Settlement Agreement paragraphs.

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: No recommendations exist as a result of the FLRC visit.

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 New York Model has been implemented at FLRC; FLRC is proud of its implementation of Intact Teams; going to school is being enforced as a requirement for all residents and attendance and grades have improved; there have been many program enhancements; and safety was a strength from the perspectives of youth. From the ranks of the YDA staff, an excellent strategy exists for improving youth-staff relationships

The QAI Report described systems improvements at FLRC that allowed administration to focus on strengthening services and building teams to carry out their vision. Despite recent transitions, 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 moderate the pace of change, continued improvement can be expected.

Challenges remained. FLRC still experienced inconsistency in programs and services due to changes in the resident population (a higher concentration of challenging youth), the problems surrounding training and assimilation of a large influx of new staff (and there are still 10 YDA vacancies) and the poor decision-making associated with them, and the fluctuations in uses of force, especially serious assaultive behaviors (three broken noses among staff recently and two youth were injured by youth-on-youth assault requiring medical attention to their mouths, one requiring stitches at the hospital) that could be gang related.

Finger Lakes has a good staff; and with improved continuity of programs and staff, the challenge is to achieve and maintain New York Model consistency that withstands mere technicalities and temporary failures to comply.