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 sixteenth monitoring report for the Settlement Agreement between the United States and the State of New York in the matter of *United States v. the State of New York and the New York State Office of Children and Family Services* (U.S.D.C. Northern District of New York), and it describes the monitoring visit to the Finger Lakes Residential Center (FLRC) on November 18-20, 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 November 18, 2013 there were 59 boys at Finger Lakes on six generic units. The 59 boys ranged in age from 14 to 18 (14-7; 15-18; 16-21; 17-11, 18-2); the population was younger than during the previous site visit with 58% age 16 and older as compared to 66% age 16 and older in May, 2013 (but 50% in November 2012); however, during this site visit there were no 12- or 13-year olds at Finger Lakes as there were in May, 2013. The 59 boys had been at Finger Lakes from five (5) days to 453 days (9 had been there for about a month or less, 25 for one to about three months, 16 for 4-5 months, and nine (9) for six months or more). One of the challenges faced at Finger Lakes is that more than half the residents had been there less than three months (57%), as compared to 42% in May 2013. The 59 boys were committed for: Assault (9), Weapon Possession (8), Robbery (8), Burglary (5), Petit Larceny (5), Criminal Mischief (4), Grand Larceny (4), Criminal Possession (4), Stolen Property (3), Resisting Arrest (2), Stolen Vehicle (2), Manslaughter (1), Arson (1), Menacing (1), Trespassing (1), and Reckless Endangerment (1); at least 13 had violated probation.

An unknown number of the Finger Lakes residents have psychiatric diagnoses. Sixteen of the 59 boys at Finger Lakes are prescribed psychiatric medication (27%, compared to 34% in May, 2013). Their diagnoses are Acute Stress Disorder (1), ADHD (4),

Adjustment Disorder (1), Conduct Disorder (4), Anxiety (2), Depression (4), Disruptive Behavior Disorder (1), Mood Disorder (2), Oppositional Behavior (1), PTSD (1), and Insomnia (4). They are prescribed the following psychiatric medications: Clonidine (5), Seroquel (4), Trazodone (2), Abilify (2), Melatonin (2), Prozac (1), Remeron (1), Prazosin (1), and Intuniv (1). Neither Risperdal nor Depakote, both prescribed in May 2013 to several residents, were prescribed at this site visit.

Eleven residents were at Finger Lakes at the time of the last site visit six months ago at least three of whom left and returned during that time. The high rate of returns to Finger Lakes after release is a concern.

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. 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 November 18, 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, Assistant Director for Treatment; Sandra Carrk, Project Manager; Diane Deacon, Assistant Deputy Counsel; Todd Etchison, Assistant Director for Program; Kathy Fitzgerald, Assistant Director for Treatment; Scot Lamphier, Assistant Director for Program; Edgardo L. Lopez, Settlement Agreement Coordinator; Gary Skinner, Physician Assistant; and Amy Vent, Chief of Treatment Services.

4. 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.

5. Staff Interviews

The Monitors conducted 26 interviews with FLRC staff. In addition to group meetings with staff, the MH Monitor interviewed a psychiatrist, two (2) clinicians and two (2) Youth Counselors (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), two (2) Trainers, one Recreation Specialist, one Facility Director, one Assistant Facility Director, one (1) Nurse Administrator, three (3) Nurses, and one (1) Physician's Assistant.

6. Resident Interviews

The Monitors interviewed 12 boys; the MH Monitor interviewed three (3) boys individually and the PH Monitor interviewed nine (9) boys with an average age of 15.4 years old. Interviews occurred in areas with reasonable privacy from staff. The Monitors selected the youth for interviews.

7. Exit Interview

The exit meeting occurred on November 20, 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, Assistant Director for Treatment; Mel R. Barvinchak, LWSWII; Sheryl Benedict, NA I; Jason Cobb, YC2; Dan Comins, Facilities Manager; Doll Baby Cooper, YRSII; Lerue Culmer, YC2; Kathy, Fitzgerald, Assistant Director for Treatment; Melissa Fuka, LMSWII; Linda Gaydushek, Education Director; Mary Beth Gebczyk, YC1; Adiel Gonzalez, LMYWII; Greg Hall, YC1; Kristy Kennedy, YC1; Rebecca Levin, Licensed Psychologist; Brittney Mainville, YDAII; Dan Manti, YC1; Ines Nieves, Associate Commissioner; Haya Novak, Psychologist II; Josh Stash, YC1; Rod White, YC2; and John Wilson, Bureau of Training (BOT). Those who participated by telephone included: Jim Barron, Director, Labor Relations & Acting Deputy for Administration; Matt Carpenter, Executive Assistant to Division of Juvenile Justice and Opportunities for Youth (DJJOY) Deputy Commissioner; Erin Cassidy, Executive Assistant to Executive Deputy Commissioner; Michael Cohen, MD, Director of Medical Services; Myra DeLuke, QAI Specialist; Felipe Franco, DJJOY Deputy Commissioner; Larry Gravett, Director, SIU; Pam Kelly, Director, BOT; Rob MacGiffert, Assistant Director, QAI; Kristen Northrup, Attorney; Sheila Poole, Executive Deputy Commissioner; Lee Prochera, Acting General Counsel; Jill Sprotbury, Deputy Counsel; Monique Thomas, Attorney; Jenne Utting, QAI Specialist; Amy Vent, Chief of Treatment Services; Lisa Vasnani, Legal Fellow; and Serena Joyce White, Attorney.

C. Preface to Protection from Harm and Mental Health Findings

As part of their implementation of the New York Model Finger Lakes staff are actively involved in support teams and Mental Health Rounds, individual and group

treatment are provided, and the DAS and phase system are in place. Finger Lakes is proud of its implementation of Intact Teams[1] (an unchanging team of YDAs, YCs and a clinician for each unit providing consistency and stability for the residents). The phase system is being strengthened, Bureau of Behavioral Health Services (BBHS) has provided training on improved support plans, and additional DBT training has been provided for staff. Program enhancements include: a guest speaker series, pet therapy, university students meeting with residents on units, community service projects including preparing meals for seniors, graphic arts, and off-grounds trips to learn about construction and Cornell.

Even with outstanding communication and cooperation among all staff in Intact Teams, providing adequate support to meet residents' underlying needs continues to be challenging at Finger Lakes. Understaffing, new staff, a high admissions and discharge rate, and scheduling problems interfere with staff applying the New York Model. At the site visit six month previously, the Finger Lakes leadership team hoped staff teams would be strengthened by New York Model training and improved Mental Health Rounds, support teams and groups. The support teams and groups observed in this site visit were strong.

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 Review commended Finger Lakes for having a safe and respectful environment, with strengths-based relationships with youth. The QAI Review commended Scot Lamphier, Assistant Director for Program, for being accessible and ready to assist in providing solutions and Joseph Murphy, a new YDA, for staying calm in crisis and in tune with the dynamics of the unit, developing relationships with youth, and understanding the importance of developing a team built on consistency. The QAI Review also commended an outstanding support team observed by the reviewer, with each team member specifying their responsibility to help the youth achieve his goals. The QAI Review also noted that having 31 staff out on Worker's Compensation and a staff recruitment and retention problem, staff being mandated to work two shifts was common; the infusion of staff after the closing of Lansing was smaller than anticipated.

II. PROTECTION FROM HARM MONITORING

Several topics warrant comment at the outset, including an explanation of the challenges that FLRC has experienced since the previous monitoring visit. These challenges have affected Protection from Harm outcomes, even though they were not identified in the Settlement Agreement. In many ways, the topics discussed in this preface

[1] As described in the previous FLRC Report: "Intact Teams went into place in January 2013, following a facility-wide bid for a new schedule so that members of the team could be assigned to the team consistently. Intact Teams have a 2-hour 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. Intact Teams increase communications, build morale among YDAs and infuse the New York Model treatment throughout the whole program."

have exerted a considerable impediment to maintaining the previous progress toward compliance.

The May 21-23, 2013 FLRC monitoring visit was replete with enthusiastic and optimistic perspectives from staff about progress in each of the Settlement Agreement areas. They identified the implementation of Intact Teams and the stability in staffing as the prerequisites for continued improvements and progress over the next six (6) months. The tone of staff at this monitoring visit was more subdued, perhaps frustrated, as they explained how hard they have worked to prevent additional deterioration to the progress they had achieved in May. The majority of key informants at all levels seemed to express the same perspective: FLRC was only now returning to levels of the May visit and has worked through many of the disruptions to programs caused by recent destabilizing events related to staffing.

FLRC has a strong leadership team. The continuity in leadership provided stability, which was particularly important as FLRC went through a staff scheduling upheaval as a result of the closure of the Lansing Residential Center (LRC) and the recent hiring of new staff members. The leadership team demonstrated good decision-making based on its understanding of program and treatment issues.

At the Juncture level, which includes Youth Counselors 1, Youth Counselors 2, and Unit Coaches, a strong group of unit leaders existed. Each individual brought different skills to the Intact Teams, and many of these skill sets have been important in the development of the YDA staff members, especially the new hires. Youth care work is difficult enough to learn how to do well without the specialized skills associated with the New York Model. As a result, staff development from the date of hire to the point of working a shift within the expectations of the New York Model may require more time than needed in other facilities. If this is the case, as the Monitors perceive it to be, then the full development of new New York Model staff members may take longer to accomplish. Another staff development challenge was the transfer of YDA staff members with experience working with girls. While it was expected that the LRC staff transitions to the FLRC programs would have been much shorter, their adjustment has been different and variable for each LRC transferee. Finally, veteran FLRC staff members have found themselves with additional stress as they have continued to work very hard on their own adaptations and integrations of New York Model principles into the daily FLRC routines. These responsibilities should have been enough, but veteran FLRC staff members were also expected to take the lead in running the unit on those shifts when there were new staff and Off-Unit staff. To a large extent, the Juncture staff and the YDA staff have mitigated much of the destabilizing and stressful effects on staffing continuity and staffing adequacy since early September.

Another mitigating factor has been the relative stability in the number of youth at FLRC. The average daily population has permitted a distribution of youth in each unit so that the total numbers have ranged between 8-11 youth. Smaller unit populations helped to reduce problems.

Intake patterns appear to have aggravated the stress on inexperienced YDAs. While outside of the control of OCFS, the pace at which youth have been released and new youth have been admitted seems to have had a disruptive effect.

The Monitors were also concerned about the high rate of absent staff and, as described by the MH Monitor, clinical staff vacancies. These problems have elicited widespread agreement among Home Office staff, regional supervisors, and facility leaders. Even though staffing is not directly a part of the Settlement Agreement paragraphs, its adverse impacts on Protection from Harm and Mental Health outcomes have been a concern for Home Office as well as the Monitors. The staffing struggles require attention on at least two fronts:

1. Off-Unit Staffing. There is a need to address and reduce the amount of call-offs (unscheduled absences from work) which result in mandated overtime (mandate) for those YDA staff members who are at work, thus requiring one or more of them to work the next shift to fill-in for an absent YDA staff member. The staff attendance information in the CSU indicated that there have been 5.3 mandates per day over the past 6.5 weeks. While these mandates could have been distributed over any of the three (3) shifts, CSU staff indicated that the majority of the mandates occurred during the waking hour shifts. To the extent that this was the case, then a single mandate meant two disruptions for youth and for the Intact Team. The first disruption was the absence of the regular YDA team member, and the second disruption was the presence of an Off-Unit YDA staff member who might also be a new worker. According to several YC2s, these disruptions to the continuity of the Intact Team have been linked to emotional dysregulation of many of the more volatile and troubled youth on the units. For example, a sample of five (5) restraints of youth with multiple restraints indicated that four (4) of the five (5) restraints occurred on a shift where the regular staffing pattern was disrupted, and three (3) of those restraints directly involved an Off-Unit staff member.

Off-Unit staffing means that a YDA staff, often someone from a different Juncture, has been assigned as a replacement YDA on the unit for that particular shift. Leadership staff uniformly described this phenomenon as problematic because it reduced the consistency in the operations of the shift, which also meant that the unit structure was diminished, and consistency and structure have been critical protective factors for youth in maintaining a sense of safety and emotional regulation. The OCFS restraint data indicated increases in the rates in September and October, the months with the greatest staffing challenges and the greatest occurrences of Off-Unit staffing. Paralleling these increased restraints has been an increase in the number of YDA staff members on the Restricted Contact List due to allegations by youth about staff uses of excessive force, which required investigation and a restricted contact status. The results have been another contributor to the increased use of Off-Unit staff.

2. Leave. The updated list of staff members on leave status, particularly Workers Comp and FMLA, included 40 staff members. This high number suggested problems both in the areas of reducing the work-related factors that led to the need for extended leave and reducing the procedural obstacles sometimes facing administrators regarding how to appropriately expedite the return of these individuals to work. Regarding work-related issues, the challenges of Off-Unit staff and large amounts of leave combine with

inexperienced staff to increase the likelihood that, on many evening shifts, there is no experienced YDA on a unit, and often one of the YDAs is working a double. This mix of factors can have a negative impact on the safety of youth and staff. Facility administrators have been working with OCFS' Bureau of Labor Relations on the reduction of staff leave with efforts such as contacting staff who are on Workers Compensation, identifying potential Workers Compensation abusers for investigation, and enforcing time and attendance rules. Recently, three (3) staff have returned to work as a result of these efforts. Because it is not uncommon that facility administrators do not understand fully the options available under the law, statutes, policies, and collective bargaining agreements about how to ensure that the agency's rights are fully and appropriately exercised, it is recommended that this process be continued.

Much to the credit of FLRC staff, many of the positive program elements remained in place and appeared to be regaining continuity and effectiveness despite these staffing problems. 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.

The biweekly Intact Team meetings were intended to promote 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 Teams also provide an effective vehicle for implementing the New York Model. In other words, the Intact Teams focus 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.

The implementation of the Intact Teams should move FLRC closer to a unit management strategy. Already, YCs have reported a restored consistency and uniformity within and between units. The largest challenge still appeared to be developing new staff to the point that they can effectively run a shift. This requires continued training in skill development, and YCs believed that the Unit Coach concept was working.

Safety was a strength from the perspective of youth. Youth again rated on-unit safety highly, whereas off-unit safety was considerably less. On a scale of 1 to 10, with 10 being the highest, the nine (9) youth interviewees rated their personal safety at 8.7. These ratings represent a 21% increase in perceptions of safety by youth since the previous monitoring visit, and they lend credibility to staff assertions that FLRC has reestablished stability in the units.

Youth expressed a concern about what they described as the always-changing nature of FLRC programs. As a result, youth described staff as inconsistent, but youth made exceptions for them because of the numerous Off-Unit staff working the shifts and an abundance of new staff. The key for most youth was the relationship with staff, and all youth identified at least one staff member who they felt was trustworthy and a role model.

A. Use of Restraints

The Monitors endorsed the QAI strategy for addressing variations in the rates of restraints at the DOJ facilities through the establishment of rate thresholds and a system of graduated responses and plans of action. Once this innovative Home Office-designed quality assurance system is fully implemented and verified, it will serve as a primary safeguard for Protection from Harm issues related to restraints. In the interim, compliance determinations rely on other means of evaluating restraints practices consistent with the language of the Settlement Agreement.

There is agreement that non-compliance (or partial compliance) with Paragraph 41 (Use of Restraints) and Paragraph 42 (Use of Force) should not be determined by increases or decreases in the number of restraints; but the PH Monitor should review existing data on the number and rate of restraints, considering that such information could serve as a "red flag" that undue restraints are occurring. (We make a distinction between the "red flag" situation in this new restraint monitoring approach and the "Red Flag" meeting used in the New York Model to gather staff to discuss urgent concerns about a resident or unit. Even though both may focus on similar restraint activities, the "red flag" monitoring status is a term of the Parties that initiates the shift in the monitoring of restraints.) The determination of a "red flag" situation would prompt a closer inquiry by the PH Monitor in his evaluation of this paragraph and Paragraph 42 (Use of Force). The "red flag" approach shifts the monitoring logic more toward an inductive versus a deductive approach. The "red flag" restraint monitoring will start with specific observations to detect patterns and regularities that would support broader generalizations and general conclusions related to compliance. The inductive approach involves an accumulation of individual level data elements where the PH Monitor begins with a specific restraint incident and thoroughly reviews the Restraint Packet (the documentation and the video) using each component in each sentence of the Settlement Agreement paragraph as points of analysis along with the restraint evaluation factors articulated in the QAI Report. Once a "red flag" designation is triggered, acquiring a sufficient amount of individual data to reliably establish patterns and regularities in the absence of aggregate data analyses means that a greater number of restraint incidents will need to be included in the monitoring. In other words, to move confidently to a general conclusion under this approach will require an appropriate sampling of restraint events over a designated time, usually the period between monitoring visits. FLRC's restraint frequency and rate data justify a "red flag" designation.

The "red flag" review of FLRC restraint activities included a stratified, non-random sample of Restraint Packets based on the complexity of the restraint (for example, notation of multiple restraint techniques and multiple staff members involved), the length of the restraint, preliminary indications of injuries to youth or staff or referrals of staff for investigation, and the date of the incident with dates closer to the monitoring visit having a higher priority. The sample of 20 Restraint Packets contained multiple problems, which provided an opportunity to evaluate the systemic responses to the correction and remediation of difficult circumstances. The mark of a competent protection from harm strategy is the ability to resolve appropriately the majority of the most difficult and challenging use of force situations since it is unrealistic to expect a facility to eliminate all

inappropriate uses a force. Nonetheless, a competent facility should be able to demonstrate effectiveness in the majority of these situations.

Special attention was given to the reason for the restraint (Paragraph 41), the use of the IIP (Paragraph 41b), the use of CPM techniques (Paragraph 42b), the nature and extent of documentation (Paragraph 42c), the use of Documented Instruction as a teaching and coaching tool (Paragraph 42e), and the nature and extent of supervision of staff (Paragraph 44g). The Restraint Packets provided to the PH Monitor routinely contained the documentation surrounding the physical restraint and the necessary video to substantiate the written documentation. Two questions were part of the assessment process. First, did the documentation describe a restraint event that was consistent with the policy, procedure, and practice required by the Settlement Agreement? Second, did the video affirm and corroborate the descriptions of the uses of force contained in the documentation?

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

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

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

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

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

PARTIAL COMPLIANCE

COMMENT: The numerous aspects that must be considered by staff in determining the reasons that justify a physical restraint 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, compliance concerns existed regarding the use of restraints that did not meet the reasons-to-restrain definitions.

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 contributed 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 a better integration of the New York Model.

The reason listed for initiating physical restraint in all 20 Restraint Packets was for the safety of any person (Paragraph 41i). The documentation in the 20 Restraint Packets supported the safety justification. The video review was not uniformly consistent with the documentation. Acknowledging that there was no audio available, only seven (7) (35%) of the 20 Restraint Packets contained video that confirmed the documentation, while five (5) (25%) had video that did not correspond to the justification listed in the documentation. The remainder of the Restraint Packets did not have sufficient video evidence to support or refute the designated justification in the documentation. Even with the most difficult physical restraints, the expectation was that there would be a majority of the reviews that had clear evidence in support of a justifiable reason for using physical restraint.

In Restraint Packet 503101, there was nothing in the videos (V1 CS 120 Unit 5C and V2 CS 124 Unit 5A) that indicated that the youth was an imminent danger to self or others. This raised the question as to whether noncompliance and verbal abuse toward staff constitute an imminent threat to the safety of others (Paragraph 41i) versus a perceived threat to the order and safety of the facility.

In Restraint Packet 502205, the Incident Report indicated that the staff member initiated a two-person escort with another staff member while the youth was sitting in a chair. The video (V1 CS 133 Unit 6A, at 09:40) matched the documentation with the youth moving around, sitting down, and possibly agitating. However, the youth was clearly seated when the restraint was initiated. Sitting in a chair, not cooperating, and being verbally abusive does not automatically constitute an imminent danger to safety. Likewise, the video did not create a link between the allegations that the youth may have been inciting others. The camera angle provided views of the other youth in the dayroom, and their behaviors did not support an allegation of inciting negative behaviors by the youth who was restrained.

In Restraint Packet 500501 (V8 CS 120 Unit 5C3, At 00:28), it appeared as if staff had the youth cornered. At 00:30, the youth sat down. At 00:31, a two-person standing restraint was initiated. The justification for the youth restraint was not consistent with Paragraph 41i; the youth was sitting down when the restraint was initiated.

In Restraint Packet 507303 (V1 CS 36 Visiting Room A, at 03:40), the youth banged his head against the wall and was interrupted by the Youth Counselor, who took a secondary role in the de-escalation attempts. By 05:54, there were three (3) staff members in the room blocking egress; the youth was trapped. It is recommended that some level of study or analysis is needed regarding restraints in the visiting rooms, particularly the tendency on the part of YDA staff to block egress from the room thereby giving the youth the impression that he is trapped.

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 of staff 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 bases for this finding were examples where the inappropriate or inefficient use of available techniques for moderating the need for uses of force resulted in more physical control and time than would have been necessary. These examples included (a) the problems with a justifiable restraint cited above (Paragraph 41) where an unjustified restraint is more than the minimum amount necessary, (b) failures to know and use those de-escalation techniques recommended through the behavioral treatment system (Paragraph 41b), and (c) circumstances where staff behaviors were so seriously unacceptable that, in one case, led to an immediate and substantial escalation of the youth's behavior (Paragraph 42b).

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 PH Monitor's review of data, including multiple Restraint Packets, combines with direct observations, youth and staff interviews, and the conclusions from the FLRC QAI Report to support this finding. The policy and procedures exist; the training on the policies and procedures has occurred; and staff and resident interviews were consistent with the policy and procedures. The IIP appears to be a Home Office-generated resource to help staff reduce the risk of harm from the use of force by identifying individual risk factors for each youth. Interviews with direct care and health care staff revealed a working knowledge of physical conditions and circumstances that limit the restraints to youth due to heightened risk of physical or psychological harm. However, YDA staff members appeared to pay greater attention to the physical limitations that modify or restrict CPM than to a specific youth's emotional risks from restraint. This seems to be a partial application of the guidance contained in the IIP. Further investigation revealed a frequent and noticeable gap between what the IIP recommended staff should do and the

behavioral descriptions of what staff actually did in the Restraint Packets' Incident Reports. An unreasonable expectation would be an absolute adherence to the IIP, but greater coherence between the IIP and actual staff behaviors seems to be a reasonable expectation of this Settlement Agreement Paragraph.

Of the 20 Restraint Packets, four (4) situations (20%) were described as requiring immediate action by staff such that the ability to use the de-escalation strategies in the IIP was not practical. Of the 16 remaining Restraint Packets, the documentation by staff indicated that the IIP was used during the intervention in 10 (63%) of the situations. Of these 16 Restraint Packets where the IIP materials could have been used or were used, all of the staff documentation rated the value of the IIP materials as ineffective.

There is agreement with Home Office that the IIPs should demonstrate value, but the Settlement Agreement does not require absolute adherence to the IIP by YDA staff. Granted, this sample is representative of the most troublesome restraint circumstances, but the IIP is the way OCFS chose to define the information required to safeguard youth at risk of psychological harm due to restraints. Similarly, the Justice Center has included under "significant incidents" the conduct of a direct care worker that is inconsistent with a youth's treatment plan. Therefore, a 63% usage rate of the support team's recommended interventions reflects considerable room for improvement before approaching absolute adherence. The concern in these Restraint Packets was the unanimous staff assessment of the IIP value as ineffective.

If the IIP is supposed to represent the best thinking of the support team and is supposed to have value for the YDAs through de-escalation tailored specifically to the individual youth, the assumption is that the IIP information will be current or specific to the youth's changing progress in the New York Model. The following Restraint Packets contained outdated IIPs (more than 120 days old): 503101 and 502205; and 484400 contained only the initial IIP, dated five months before this restraint event. During a discussion about the value of the IIP and whether that value was more powerful if the IIP were reasonably current, one YC exclaimed that efforts by administration to update IIPs were "Utterly absurd!" in light of the volume of restraints, staffing problems, and existing documentation requirements. The notion of up-to-date IIPs diverts attention from the larger IIP problem in these Restraint Packets: Staff sometimes did not know the youth's IIP, rarely used the de-escalation strategies recommended in the IIP, and regularly described these behavioral treatment recommendations as ineffective.

For example: In Restraint Packet 503101, one Incident Report read that the AOD "*gave* this youth several de-escalation techniques." This was an interesting choice of words and warrants some further inquiry. In Restraint Packet 500501, the Restraint Monitor Report under "Adherence to the IIP" stated, "I didn't know his IIP." In Restraint Packet 500500, the Use of Physical Restraint Staff Debriefing Report regarding the IIP stated that staff used Validation and Direct Appeal, which they evaluated as not working "at all." Under the suggestions for improvement to avoid recurrence, staff wrote, "use IIP," which seemed to be an acknowledgment that the IIP was not used. In Restraint Packet 507209, the IIP techniques were reported as Hurdle Help, Eye Contact, and Positioning; and none of these were rated by staff as effective. The IIP, however, listed 1) undivided attention, 2) limit the audience, and 3) time away. In Restraint Packet 507303, the de-escalation

technique was Direct Appeal; the IIP listed 1) humor, 2) ventilation, and 3) one-on-one staff time. And, in Restraint Packet 519800, the Staff Debriefing Report indicated that staff used the IIP techniques of Positioning, Eye Contact, and Direct Appeal; but the youth's IIP called for 1) listening, 2) time away, and 3) tends to respond better to female staff.

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.

COMPLIANCE

COMMENT: The PH Monitor's review of data, including multiple Restraint Packets, combines with direct observations, youth and staff interviews, and the conclusions from the FLRC QAI Report to support this finding. 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. There has been an elimination of facedown or prone restraints in the DOJ facilities. Isolated instances continue to occur as a result of unusual circumstances or concerns about individual staff members.

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

COMPLIANCE

COMMENT: FLRC has sustained its compliance with this paragraph. The PH Monitor's direct observations, youth and staff interviews, and the findings from the FLRC QAI Report support this finding. Policy and procedure clearly prohibit the use of chemical agents such as pepper spray. Resident and staff interviews and direct observations provided no evidence of the use of pepper spray.

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

COMPLIANCE

COMMENT: FLRC has sustained its compliance with this paragraph. The PH Monitor's review, including multiple Restraint Packets, combines with direct observations, youth and staff interviews, and the conclusions from the FLRC QAI Report to support this finding. Policy and procedure regarding physical restraint clearly prohibit the use of psychotropic medication solely for restraint purposes. Resident and staff interviews and

direct observations provided no evidence of the use of psychotropic medication solely for restraint purposes.

41. f. Create or modify and implement policies, procedures, and practices to require that staff are adequately trained in appropriate restraint techniques, procedures to monitor the safety and health of youth while restrained, first aid, and cardiopulmonary resuscitation ("CPR"). The State shall require that only those staff with current training on the appropriate use of restraints are authorized to utilize restraints.

COMPLIANCE

COMMENT: Training continued to be in compliance. The review of the STARS training records with John Wilson and Deb Peete revealed that there were six (6) YDA staff members who did not qualify for participation in physical restraints due to a training deficit. Two (2) of the six (6) were on extended leave and will attend the next scheduled training following their return to work. Three (3) of the individuals were new hires and were attending the Academy training at the time of the monitoring visit. Therefore, only one YDA staff member qualified for notification and identification of the restriction on participation in physical restraints. Notification to the employee occurred through a memo, and the notification to all staff members occurred through the posting of an up-to-date list of restricted employees in the Central Services Unit (CSU). A problem occurred with the updating of this CSU list, but it was resolved immediately. Problems of this nature should not happen during monitoring visits.

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: The New York Model (as is common with most behavioral treatment systems for juvenile correctional facilities) is the application of principles and techniques by youth and staff designed to increase emotional regulation in the face of problems and crises and, thereby, mitigate the accompanying practices governing uses of force. This does not imply that the New York Model will eliminate the need for an occasional use of force or physical restraint, and the Monitors have never suggested that it should. Instead, if this "accompanying practice" were an effective use of New York Model principles by YDAs, the "amount of force necessary" would be lower.

From the PH Monitor's reviews of Restraint Packets, the following uses of force did not appear to make adequate use of available New York Model concepts; and more force was used than may have been necessary if staff had used the principles of the New York Model: Staff did not use or did not document de-escalation techniques (500501, 507303, 519800); de-escalation techniques were used, but they were not the techniques recommended by the support team (507209, 507303, 519800); IIP recommendations used but were ineffective (505699); and de-escalation techniques were used inappropriately or ineffectively (500500).

In nine (9) (45%) of the 20 Restraint Packets, there were no indications in the documentation or the video regarding improper or inappropriate uses of CPM techniques. However, more than half of the Restraint Packets contained video evidence of identifiable CPM technique problems and concerns linked to correctable issues regarding the amount of force required (484400, 488298, 492013, 499198, 500398, 500500, 500501, 501798, 507303).

Two Restraint Packets contained examples of highly unacceptable staff behaviors that have the potential to escalate the behavior of youth and, in one case, did just that. In Restraint Packet 500500 (V2 CS 091 Unit 1C), the YDA staff member who passed out the treats approached the youth who was in a one-person seated restraint, knelt down in front of him, held out a piece of fruit (an apple or perhaps a pear), and took a big bite out of it (at 02:41) as if taunting the youth by eating a snack that was perhaps the youth's or eating a snack because the youth had now forfeited his snack. In this YDA's Incident Report, he described his actions as "I tried *humor*, Hurdle Help & before I could try to talk more he spit on me (emphasis added)." The youth responded violently, spit on the staff, and was then put into a two-person seated restraint with the taunting staff member in the secondary position. As a result of the escalation in the youth's struggling, the primary staff member turned the youth to his left; and the youth went facedown to the floor. Facility Administration agreed that the staff member did taunt the youth, which escalated the situation and caused the need for additional force to control the youth, i.e., more force and more time than the least amount necessary. During the monitoring visit, Facility Administration provided assurances that corrective action would be taken, especially since taunting should never be considered humor and is inconsistent with Hurdle Help.

Secondly, in Restraint Packet #484400 (V1 CS 124 Unit 5 A, At 14:28), a YDA was moving toward the exit door of the Unit and apparently verbally engaging a youth, who was in his room. The conversation prompted the female staff member to turn and look in the same direction as the male staff member. At 14:30, the staff member made an obscene gesture toward the youth with both hands. All other staff members had their backs toward him, and the female staff member had her head down doing paperwork. At 14:32, he could be seen skipping backwards toward the exit with both gestures in plain view. Staff behaviors of this nature are often a function of the relationship between youth and staff, but they are always unprofessional and inappropriate because, in part, of the potential to be misinterpreted and inflammatory. During the monitoring visit, Facility Administration provided assurances that corrective action had been taken.

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 contributor to the documentation problem was the volume of restraints. As mentioned earlier, the amount of time required for the documentation of these restraints was substantial, and the frequency of the restraints placed staff in situations accommodating quicker and less thorough reviews. Issues were the tardiness and incompleteness of staff reports.

Legibility is another important factor in appropriate documentation. In Restraint Packet 502205, the Incident Report by YC Stash was thorough, typed, and easy-to-read. Another Incident Report in the same packet was also typed and much easier to read. In Restraint Packet 492013, one Incident Report provided an excellent behavioral description of what occurred in the visitation room. Any initiatives to have YDA staff members file incident reports on computers should be encouraged.

Several Restraint Packets were problematic because key information was not legible. In Restraint Packet 507209, the Restraint Monitor Report Indicated that the youth was offered Time Away; but regarding adherence to the IIP, the yes box was checked but the entry was illegible. In Restraint Packet 500398, the Use of Physical Restraint Staff Debriefing Report regarding staffs' response to the IIP de-escalation techniques indicated "unable due to (illegible)." Regarding the effectiveness of the interventions, the report indicated that they were unable to determine. The signature and printed name of the debriefer was also illegible.

In some Restraint Packets, the documentation contained words or phrases that did not meet the generally accepted report writing standard that all entries should be in a language that can be understood by anyone who reads them. For example: In Restraint Packet 502301, one Incident Report was difficult to read; the initial sentence indicated that the youth was "sangin an tusle," whatever that means. In Restraint Packet 507209, the Incident Report by YDA Jones indicated that the youth started saying, "I going to start throwing bricks if that code is on me;" and nowhere in the report was there an explanation of the term "throwing bricks."

In Restraint Packet 502205, the Use of Physical Restraint Staff Debriefing Report regarding the youth's behavior before the restraint indicated "safety issues during

searches." When safety issues exist before the restraint, appropriate documentation requires adequate explanation as to how this notation related to the restraint event. If it is important enough to document in an Incident Report, it also requires explanation so that the reader understands its relevance.

The most difficult restraint events require the greatest precision in documentation, particularly the level of coherence between the documentation and the restraint video. Two (2) Restraint Packets contained examples of noteworthy discrepancies between the documentation and the video:

1. In Restraint Packet 501798, the video did not match the documentation, which indicated that the incident began approximately 45 minutes before the images on the video. This leaves the reader to question what happened prior to the youth and staff behaviors on the video and how this information may have affected the outcomes regarding use of force.

2. In Restraint Packet 518988, a substantial discrepancy existed between the video and the documentation provided by the AOD. The AOD made special reference to "the above noted time of the 3:14 PM" as the starting point of the restraint event, whereas he later noted that mechanical restraints were initiated at 3:22 PM and ended 3:32 PM. The video began with the application of mechanical restraints less than one (1) minute into the video, so there were at least 13 minutes of interactions that were not covered by the video. Before the use of mechanical restraints, the Incident Report stated that the AOD entered the youth's room; the youth became physically aggressive; and the AOD initiated "a physical restraint." There was no video of this physical restraint. Furthermore, the VRF contained no mention of the discrepancy between the documentation and the video, instead confirming that the video was consistent with the documentation. The VRF occurred four (4) days after the incident.

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: FLRC has sustained compliance with this paragraph. The PH Monitor's review of multiple Restraint Packets combines with staff interviews and the conclusions from the FLRC QAI Report to support this finding. The Therapeutic Intervention Committee (TIC) is the "review by senior management." 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. The TIC will be an important part of the new Graduated Response protocols tied to the new restraint metrics. Home Office should carefully monitor the TIC to help it reach its full potential within this new system.

The relationship between Off-Unit staff and uses of force warrants additional evaluation, and it is recommended that this relationship be part of the weekly analysis of restraints by each FLRC Intact Team, with a monthly report back to the TIC.

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 PH Monitor's review of multiple Restraint Packets, including the Video Review Forms (VRF), combines with administrative interviews and the conclusions from the FLRC QAI Report to support this finding. The policy and procedures exist, and there is a practice in place. An SG-18 or above facility administrator completes a review and logs the information and recommendation on the OCFS 2091 form, which is reviewed by the Facility Director.

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 has become a critical part of the feedback needed to enhance the effectiveness of CPM within the New York Model. With the advent of Quality Assurance, it has provided another perspective on the types of staff behaviors that are exemplary or in need of improvement. A few VRFs in these Restraint Packets appeared to have been rushed and, in some instances, incomplete.

The Home Office expansion and adaptation of the Documented Instruction as a teaching tool for staff as opposed to a disciplinary or corrective action has been commendable. The use of Documented Instruction is the entrée to coaching, mentoring, and constructive supervision of staff to improve their CPM abilities, particularly de-escalation strategies. Still, there are noticeable differences between the DOJ facilities regarding the approach to the role and function of Documented Instruction. This variation implies that some facilities are making greater use of Documented Instruction, and the following are examples of circumstances where Home Office should consider some type of expansion of the Facility Administrator's review of "proper techniques" as part of Paragraph 42e

The FLRC approach to the Facility Administrator's Review of physical restraints seems to underutilize Documented Instruction as an approach to misuses and problems with CPM. There were zero requests by Facility Administration for Documented Instruction in the 20 Restraint Packets. The concern here was on the existence of situations or circumstances or staff behaviors that provided an opportunity for constructive discussion, coaching, and reevaluation of daily practices for the overall improvement of use of force decisions. From the PH Monitor's perspective, only two of these Restraint Packets did not require some form of Documented Instruction. It is recommended that Home Office conduct an analysis of the amount of time required at the facility-level to conduct the large volume of physical restraint reviews required in Paragraph 42e. Additionally, the quality of the reviews and documentation in these 20 Restraint Packets suggested that many were completed too hurriedly.

In Restraint Packet 501798, (V9 CS 40 Infirmary Room 1, At 02:06), there was a violent shift by the youth and staff, resulting in the youth hitting his head or face against the

wall. What followed at 02:19 was the transition to a one-person seated restraint. At 2:51, the restraint became a two-person seated restraint as one staff member assumed the secondary position on his legs. Staff struggled to maintain the youth in a seated position. While the video was not clear because only the lower two thirds of the youth's torso was visible on the camera, it appeared as if restraint moved into a three-person supine restraint at 03:25. At 20:34, the release process begins, ending at 21:22, or nearly 18 minutes in a supine position. Documented Instruction should have been requested to address better ways of resolving use of force situations in small rooms or confined areas.

In Restraint Packet 500501, the Use of Physical Restraint Staff Debriefing Report read, "During the struggle of restraint, staff and youth fell to the floor." There should have been Documented Instruction, but none was requested. This is not meant to imply that that Documented Instruction should be required in every case when a restraint does not occur in a "textbook" way. For example, some would make a case that a fall to the floor does not necessarily mean staff did not do the best they could do in the situation. However, from a Protection from Harm perspective it must be noted that the Post-Physical Restraint Health Report indicated a "possible dislocation" after the youth complained about pain in his shoulder resulting from the fall. The nurse, a mandated reporter, also made a referral to SCR. These circumstances suggest that even restraint techniques applied consistent with CPM training but which result in injury should be reevaluated, and Documented Instruction appears to be an appropriate way to conduct that evaluation.

In Restraint Packet 500500 (V3 CS 130 Unit 6B), the camera showed three (3) staff members attempting to restrain the youth. The techniques used did not appear to be those of CPM. There should have been Documented Instruction, but none was requested. Further, V2 CS 091 Unit 1C, at 00:56, showed the staff member attempting a takedown where he did not have control and ending up with the youth on the floor and the staff member on top of the youth. There should have been Documented Instruction, but none was requested.

In Restraint Packet 492013 regarding the PRE, the youth complained of injuries. In explaining the injury, the youth stated, "During the restraint, he didn't do it right. My leg hit the table. My face hit the floor. I feel dizzy." The nurse noted and treated abrasions on the face and leg, and made a SCR contact. There should have been Documented Instruction, but none was requested.

In Restraint Packet 492013 (V1 CS 37 Visiting Room), the youth was left unsupervised in a visiting room. The youth tore up pages in a staff notebook or file, and four (4) staff entered the room. The youth was trapped and turned his back to the staff, facing into a corner. The female YDA moved very close to the youth while talking in an animated fashion, invading his personal space and putting herself at a high risk of physical assault. Fortunately, a male YDA intervened immediately, moving in between the youth and the female YDA. As staff shifted spaces, the youth moved to the opposite corner of the room and tried to pick up a chair, presumably to throw at the female YDA, which precipitated the restraint. In the process, a table was tipped over and the legs on it broken. The restraint could not follow CPM due to the restricted amount of space. Staff finally got the youth in a two (2) person standing restraint and moved the youth out of the visitation room. There should have been Documented Instruction for the restraint in a small and

confined area and, more importantly, for a comprehensive retraining of the female YDA on all aspects of the proper use of de-escalation strategies, but none was requested.

Continuing with Restraint Packet 492013 (V9 CS 40 Infirmary, at 08:34), it appeared as if one of the male staff members in the Infirmary room asked the same female YDA described in the previous paragraph to leave the room. Both videos suggested a justification for Documented Instruction about how to maintain a professional demeanor and emotional neutrality in conflict situations, and how to know when to handoff responsibility to a coworker who may not be as emotionally involved in the restraint or may not be a stimulus for anger on the youth's part at that particular time; but none was requested.

In Restraint Packet #488298, the first staff member was out of place with regard to direct and continuous supervision. This was an issue for Documented Instruction as opposed to the issue regarding the restraining staff member ending up on top of the youth.

In Restraint Packet #499198 (V2 CS 102 Unit 2 Classroom Camera A, at 00:25), the Youth Counselor initiated the restraint of the youth who weakly threw a chair in the direction of the other youth. The youth broke free of a one-person standing restraint, and the female staff member intervened and all three (3) fell to the floor. It appeared as if the youth went to the floor face first. There should have been Documented Instruction, but none was requested.

In Restraint Packet #507209, V1 CS 122 Unit 5D, for a substantial portion of the restraint, a staff member in a purple hooded sweatshirt stood directly in the line of sight for this camera. There should have been Documented Instruction about the importance of the video documentation to staff as a way to resolve allegations of excessive force, but none was requested.

In Restraint Packet #519800, there was a concern about the youth kneeing a staff member intentionally as he attempted to secure the youth's legs in a secondary position in the restraint. Even though the documentation indicated that the youth deliberately kneed the staff member, there was nothing in the documentation regarding whether this type of behavior was possible if the primary staff member had sufficient control and was using CPM as taught. There should have been Documented Instruction due to the potential for staff injury, but none was requested.

The review of Restraint Packet #484400 was an example of how the demands upon Facility Administration to conduct the Administrator's Review of restraints may have led to some oversights and omissions on the VRFs. The inappropriate behavior of one staff member was not detected during the Facility Administrator's Review. While the video was part of the Administrator's Review of the restraint, the reviewer used the fast-forward function of the video software to move more quickly through a somewhat lengthy restraint. With the PH Monitor, the Assistant Facility Director reviewed the video at both regular speed and fast-forward, confirming that the inappropriate behavior was not visible on the fast-forward setting.

Four (4) (20%) of the Restraint Packets contained entries in the documentation stating, "Correction to (staff member's name here)." The PH monitor assumed this entry referred to some type of impending disciplinary or corrective action. Home Office provided

clarification that some YCs put that phrase in their report so that if there are questions about the packet or something was incomplete, the person doing the Restraint Packet review would know the name of the AOD to go to for answers. However, given the information in the documentation and the images on the video, the names of the staff members in these Restraint Packets warrant monitoring follow-up for the next visit under the expectations outlined in Settlement Agreement Paragraph 44e.

The relationship between Off-Unit staff and uses of force warrants additional attention in the Facility Administrator's Review, and it is recommended that information about Off-Unit staff derived from Restraint Packets be communicated to the Intact Teams along with a monthly summary to Home Office.

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

The formalization and standardization of new staff development requires attention. For example, FLRC was just recently completing a resident handbook for the New York Model. By articulating the rights and expectations of FLRC youth, administration has indirectly helped to define for veteran and especially new staff members a clearer understanding of their role. Role ambiguity has a long history in organizations as an obstacle to effectiveness. As the New York Model implementation continues, various job responsibilities will ebb and flow in importance or criticality. With the number of new staff members, transferred staff members, and staff members still improving their New York Model skills, the reduction of role ambiguity is an important factor in strengthening Protection from Harm elements. Two examples where role clarity could prove beneficial

were guidelines, checklists, and explanations for the "job shadowing" experience and guidelines, expectations, and supervised practice related to supervisory follow-ups and coaching.

C. Emergency Response

The levels of emergency response seemed good, and the policy and procedure regarding response teams and codes were 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: FLRC has sustained its compliance with this paragraph. The PH Monitor's review of the Restraint Log in CSU combines with youth and staff interviews and the conclusions from the FLRC QAI Report to support this finding. The policy and procedures exist (PPM 3246.02 and PPM 3247.12); the training on the policies and procedures has occurred; and staff and resident reports are consistent with the policy and procedures. All staff confirmed with acceptable accuracy the call for assistance procedures based on the color code indicators, where Code Yellow = security emergency, Code Blue = medical, Code Gray = mental health issues, Code Green = Fire/Safety Emergency; and Code White = restraint in progress.

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 six (6) months (March 15, 2013 through September 15, 2013) that QAI looked at these numbers, the frequency of Code Whites was considerably less than Code Yellows each month with August and September representing a 71% and 77% reduction, respectively.

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

COMPLIANCE

COMMENT: FLRC has sustained its compliance with this paragraph. The PH Monitor's review of data, including multiple Restraint Packets and the Restraint Log from CSU, combined with the conclusions from the FLRC QAI Report to support this finding. The policy and procedures exist (PPM 3246.02); the training on the policies and procedures has occurred; and staff reports were consistent with the policy and procedures. The PH Monitor verified the existence of the response team chart in the CSU booth and the log entry of response descriptions in the CSU logbook.

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

COMPLIANCE

COMMENT: Home Office has addressed the requirement for an emergency plan through the development of the Crisis Response and Radio Communications Policy (PPM 3246.02). The policy complies with the intent of this paragraph. Further, Local Practice, which interpreted the policy for implementation at FLRC, was expressed in the FLRC Operating Practice (3246.02). The Local Policy complied with the intent of the paragraph.

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

COMPLIANCE

COMMENT: FLRC has sustained its compliance with this paragraph. The PH Monitor's review of training records combined with staff interviews and the conclusions from the FLRC QAI Report to support this finding. The policies and procedures referenced in Paragraphs 41-43 are addressed primarily in policies 3247.12 and 3246.02. These policies are part of the CPM training, and the STARS system confirms the FLRC staff's successful completion of the training.

D. Reporting and Investigation of Incidents

These paragraphs refer largely to the activities of the Special Investigations Unit (SIU) and the new Justice Center, officially implemented as of June 30, 2013. The Monitors appreciate the information provided by Home Office on the development and responsibilities of the Justice Center, but questions remain about its relationship to certain Settlement Agreement paragraphs. The Monitors recommended that any implications for monitoring be resolved first by the Parties (Home Office and DOJ). As such, the Parties have agreed to the following:

> In light of the fact that some of the responsibilities described in Agreement portion Section III.A, paragraph 44 have been reassigned from facility control to centralized state control (SIU and/or the Justice Center), the parties agree that Paragraph 77d termination shall not be conditioned on compliance with those subsections. Specifically, the subsections that are outside of facility control include: 44b, first sentence only, and 44d, e and h. This understanding in no way removes the requirements of paragraphs 44b (first sentence), or 44d, e or h from the Agreement, and substantial compliance with these paragraphs is still required for Termination pursuant to paragraph 77a and 77b.

The findings in this section take into account the Parties agreement regarding Paragraph 44.

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 and youth yielded similar results. No one commented about a reluctance or fear of retaliation when faced with the need to report another worker regarding an alleged incident of an inappropriate use of force or suspected abuse.

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.

First Sentence: The Parties agree that this part of Paragraph 44b is outside the control of FLRC staff and is not included in the compliance findings for this facility.

Second through Fourth Sentences: PARTIAL COMPLIANCE

COMMENT: In those instances where there were allegations, the Facility Director made the initial determination in conjunction with her supervisor (the Facilities Manager) and with OCFS regional staff supervised by another arm of OCFS that oversees the creation of safety plans. Normally, this arrangement has worked effectively. However, below is an example that raised a "red flag" and justifies a review of this an entire process.

In Restraint Packet 518988, which occurred on a Thursday at 3:22 PM, the AOD was on a NO UNSUPERVISED CONTACT status with this youth, which suggested this was not the first incident where there were questions or concerns about the level of force used. There was no indication that any other staff member accompanied the AOD during the time when

the documentation indicated that he entered the youth's room or before he entered the youth's room a second time, which appeared on the video. His Incident Report gave the impression that there was a repetition of his actions; the youth kicked and banged his room door; the AOD entered the room and a restraint followed; the youth calmed down enough to be put back into his room but restarted kicking the door; the AOD re-entered the room second time, initiated another restraint, and then called for handcuffs.

The Incident Report also began with a description of how the AOD had been involved in counseling the youth for several hours before the uses of force began. There was an implicit acknowledgment of the ineffectiveness of the counseling intervention, but there was nothing in the documentation to explain the counseling outcomes or to recommend a handoff or transition of de-escalation efforts to another staff member given the AOD's pattern of ineffectiveness with this youth at this time.

The AOD engaged in all of these activities while on a NO UNSUPERVISED CONTACT status with this youth. He stated in his Incident Report, "I engaged in the physical restraints due to the youth's unsafe behavior for himself and others area at all times, other staff were present and the cameras were operational so at no time was I unsupervised during these physical restraints." The distinction between supervision and "the presence of others" seemed to have been lost on the AOD in this instance. The level of contact status seemed to be clear, and "no unsupervised contact" is distinct from no unobserved or unaccompanied contact. As the lead supervisor on the shift, subordinates can observe; but it is problematic and may even have collective bargaining implications to require subordinates to supervise supervisors. As a supervisor (AOD) on duty when other administrative staff presumably were present, the failure to acquire proper supervision during a NO UNSUPERVISED CONTACT level of contact appeared entirely unacceptable as a responsible safeguard for Protection from Harm. Additionally, the NO UNSUPERVISED CONTACT status within the New York Model context suggested a previously conflicted relationship between this staff member and this youth, so even if the AOD did nothing inappropriate toward the youth in this situation, the youth's past feelings of anger or having been unfairly treated could have triggered the youth. If the youth has a history of trauma, particularly domestic or community violence, he could have felt unsafe any time this AOD was around and had difficulty regulating his emotions, even if the AOD was doing nothing provocative. Both perspectives underscore the importance of following level of contact policy and procedure and knowing when to hand off primary responsibility to a coworker during crisis prevention.

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 Clinic remained in compliance, and the procedures to conduct Post Restraint Examinations (PRE) were consistent with the intent of the Settlement Agreement paragraph. Discussions with the clinic staff affirmed these findings. Additionally, every youth in the youth interviews reported that all youth are transported to medical for a PRE following a restraint. Of the youth interviewees who had been restrained, every one indicated that they had an opportunity to talk to a nurse privately about the restraint. The number of PRE as noted in the Monthly Summaries corresponded to the number of restraints in the CSU Restraint Log. The initial review of the data for October 2013 revealed discrepancies, which were later attributed to reporting errors as opposed to situations where the PRE did not occur. An identification of the errors and corrective actions occurred immediately.

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 interviewees 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 were related to the timing of the restraints. When multiple restraints occurred, especially with a large group of youth, additional time was required for processing, and OCFS recently revised its policy to address the practical reality of the one-hour expectation when where there have been multiple restraints. Another concern regarding the PRE was the documentation of the name of the YDA who brought the youth to the clinic. The FLRC 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.

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.*

The Parties agree that Paragraph 44d is outside the control of FLRC staff and is not included in the compliance findings for this facility.

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.

The Parties agree that Paragraph 44e is outside the control of FLRC staff and is not included in the compliance findings for this facility.

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: The level of staff supervision at FLRC was not yet consistent with generally accepted professional practices based on concerns about reoccurring problems with the distribution of staff and with consistent approaches to confront and resolve minor problems. Three examples from the Restraint Packet reviews were illustrative.

1. In Restraint Packet 502205 (V1 CS 133 Unit 6A), the video began with two staff members (both transfers from Lansing) sitting at a table some distance from the group. This positioning of staff in a direct supervision model was unacceptable as an adequate supervisory safeguard for Protection from Harm. There should have been Documented Instruction, but none was requested.

2. In Restraint Packet 500398, Restraint Monitor Report indicated that the Restraint Monitor was not present at the beginning of the restraint and entered once the restraint was in progress. Therefore, the Restraint Monitor Report did not contain essential information about how the restraint took place.

3. In Restraint Packet #488298 (V1 CS 133 Unit 6A, at 00:05), there was only one YDA visible from the camera angle, and there were four youth sitting behind the staff member, outside of his line of sight. This positioning of staff in a direct supervision model was unacceptable as an adequate supervisory safeguard for Protection from Harm. There should have been Documented Instruction, but none was requested.

The issue here is the "adequate supervision of staff." The multiple restraints explain the problems regarding the Restraint Monitor. However, if there were insufficient staff available to serve as a Restraint Monitor during multiple restraint events, then the question remains about how the adequate supervision of staff during a use of force event required by this paragraph is fulfilled.

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.

The Parties agree that Paragraph 44h is outside the control of FLRC staff and is not included in the compliance findings for this facility.

III. MENTAL HEALTH MONITORING

This site visit at Finger Lakes showed that staff are working hard to continue implementing the New York Model. Regarding the ten mental health paragraphs of the Settlement Agreement, OCFS completed two policies, Juvenile Justice Information System (JJIS) instructions, and the substance abuse manual. The MH Monitor is focusing on staff demonstration of consistent New York Model practices to determine compliance.

The observed support teams demonstrated strong teamwork, rapport with residents, communication with families, and collaboration with CMSO. Intact teams demonstrated effective communication among all members of the team. The biggest obstacles to New York Model implementation at Finger Lakes are: staff are "greener than ever," too few clinicians given the high rate of mental health needs, and scheduling that continues to keep YDAs from participating in Mental Health Rounds and support teams. Clinicians and YCs do not have sufficient time to coach YDAs in guiding residents' use of self-calming and other skills.

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 at Finger Lakes examined residents' records for integrated assessments, psychiatric evaluations, support plans,

diagnoses, psychiatric contact notes, medication, family outreach, suicide response, substance abuse services and release planning, staff and residents were interviewed, and support teams, Mental Health Rounds, groups and change of shift meetings were observed, which showed progress in these practices.

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

The New York Model and BBHS procedures regarding Mental Health Rounds, support teams, and the coaching role of mental health staff, comply with the requirements of 46b.

Mental health staff at Finger Lakes were observed complying with 46b. As discussed below, because Mental Health Rounds are not offering sufficient mental health guidance for staff and the facility has too few clinicians, it is difficult for Finger Lakes to maintain compliance with this paragraph.

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

PARTIAL COMPLIANCE

The New York Model and BBHS procedures regarding Mental Health Rounds, and support teams comply with the requirements of 46c.

Through support teams and Mental Health Rounds, Finger Lakes staff are complying with 46c on an individual basis. 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. The Finger Lakes Integrated Assessment, IIP, Support Plan, and contact notes by the psychiatrists, clinicians, YCs and CMSO were all accessible on JJIS. 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 with individuals required by 46c. There are many factors outside the facility contributing to a youth's success in the community, and a resident may be helped to commit to a re-entry plan and still fail. Nevertheless, Finger Lakes has a high rate of return, and the facility would benefit from assistance in examining the factors for lack of re-entry success and how the program could be strengthened so youth are better prepared.

The MH Monitor observed that Finger Lakes is using the TIC to assess facility-wide effectiveness of interventions for residents in compliance with 46c. Disseminating findings from QAI reviews and monthly restraint data in unit meetings and the TIC are also ways to enhance the effectiveness of interventions facility-wide, and will continue to be monitored.

The facility's use of monthly restraint data and QAI reviews to regularly assess the effectiveness of interventions for all residents will continued to be monitored to determine 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.

COMPLIANCE

OCFS released the Facility Admission and Orientation policy (PPM 3402.00 Limited Secure and Non-Secure Facilities Admission and Orientation and PPM 3402.01 Secure Facilities Admission and Orientation with the Admission Checklist, Orientation Checklist and Facility Classification forms) and PPM 3443.00 "Resident Rules" (renamed "Youth Rules") to be consistent with the New York Model and comply with 46d.

Finger Lakes staff provide orientation to new residents in compliance with 46d.

The QAI Review at Finger Lakes found that although many of the youth records reviewed did not contain evidence that the youth had been oriented to the behavioral treatment program, when interviewed the majority of the youth indicated that they had been oriented to the facility and 93% of survey respondents answered that they understood the facility rules. The QAI Review concluded that probably the orientation process is occurring and documentation of the orientation must be improved and recommended that additional verification of the completion of OCFS Orientation Checklist be provided in a contact note or other documentation.

On Site Observations Regarding Paragraph 46a-d (11/13)

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.

Finger Lakes staff continue to strive to achieve trauma-responsive, relationship-driven, culturally competent, and strengths-based teamwork to meet residents' complex needs. Many of the residents at Finger Lakes have long histories of trauma and troubled behavior, and staff work hard to figure out how each resident can improve his emotional regulation. Implementing the New York Model continues to be a challenge for staff who work effectively with youth and want to improve practice throughout the facility but are overextended because of insufficient staff.

The MH Monitor observed Mental Health Rounds on three units at Finger Lakes, all of which were detailed discussions of the residents led by the YC. Although Finger Lakes YCs and clinicians describe the residents as having "high mental health needs," the observed Rounds did not have an emphasis on understanding the underlying mental health needs of residents—they were unit team updates on residents without a psychiatrist, and for two out of the three, without YDAs. The nurse responded to infrequent medication questions and the clinicians contributed insights from the youth's therapy a few times, but discussion focused on behavior and intervention that was valuable but did not appear to deepen staff understanding of the effects of trauma or other mental health issues. In one Rounds, there was strong YDA and teacher involvement. The following observations about

individual residents were helpful in pulling the team together around an effective intervention: "This resident was born crack addicted with a lot of trauma and has extreme difficulty processing even simple instructions." "This resident is very redirectable; he gets upset if he feels slighted; he is easily frustrated." "We are encouraging this resident to go to college; other youth are picking on him for being a good guy; he is isolated because he doesn't want to get provoked into making a mistake." They agreed to schedule a Red Flag for one resident. In another Rounds that included two clinicians and an Assistant Director for Treatment, few observations about trauma-related or other needs behind their behaviors were made, although the discussion about the residents' problems was thoughtful. One resident had just passed the GED, three were Finger Lakes returnees, several older residents were seen as having great potential, three residents were getting ready to leave (one was described as very anxious about discharge), one resident is worried about an upcoming court date, and four residents' parents have not responded to weeks of requests for psychiatric medication approval. One resident "feels stuck here with no plan. He has a whole life of rejection. He's 17 and wants [redacted]." In the unit that is missing a clinician, five clinicians and an Assistant Director for Treatment (who are each providing therapy to one or two residents on the unit) participated in Rounds in addition to three YCs, a nurse and a teacher. One resident has pending immigration issues and the clinician explained that he was abandoned in the U.S. by his father and is afraid to be deported; the teacher said he is working hard in school despite language barriers and the vocational teacher connected with him. Another resident on the unit was also struggling in school and in groups because of language barriers. No resolution was reached about a resident who is deteriorating, despite his potential. Another resident made Honor Roll but is struggling with his shock over his serious offense, long sentence and recognition that his family will have to move out of their community because of what he was involved in. A clinician commented on another resident that he has been in placement since age 10, has institutionalized behaviors, experienced a lot of trauma, and wants to go home but cannot connect his explosive behavior with his home problems.

Finger Lakes staff commented that the new schedule for clinicians on weekends results in YCs and clinicians overlapping only a few days a week, which undermines their teamwork. Most would prefer to have Mental Health Rounds during Intact Team so YDAs are included, but they believe there is not enough time (one unit has Rounds during one Intact Team meeting per month). As one participant observed, "Psychiatrists usually cannot attend Mental Health Rounds. So the clinician brings in a clinical perspective. If a youth is really struggling, the team invites the psychiatrist to come to Rounds. Psychiatrists sometimes come to Intact Teams where most YDAs participate."

A key to implementation of the New York Model is a functioning team of coaches. A strong facility coaching team ensures that the New York Model becomes a way of thinking by staff and youth, rather than simply a clinical service. The Finger Lakes coaching team meeting was a large group of YCs, clinicians, one of the psychiatrists and two Assistant Directors. They remain committed to coaching staff and continue their daily efforts to support staff in building strengths-based relationships with each resident. The coaches face major challenges at Finger Lakes. There are more new YDAs than at previous site visits, and staff continue to be mandated in many shifts. As a result clinicians and YCs coach YDAs primarily "when they say they do not know what to do with a resident." They

help staff build on the positive in each resident, which is challenging especially for staff working double shifts. It is frustrating to the coaching team that no matter how much Finger Lakes staff have wanted YDAs to participate in support teams and Mental Health Rounds, scheduling continues to prevent it. They remain proud of their Intact Teams where the YDAs are actively involved, but the YCs and coaches struggle to convey the richness of information from support teams and Rounds back to their units. The Finger Lakes coaches appear depleted and stressed trying to keep up with clinical responsibilities and also guiding staff. They believe they coach and model New York Model practice every opportunity they have. They need more guidance from BBHS, especially with the addition of new clinicians and YCs. The psychiatrist offered to provide more support to the coaches.

Finger Lakes has too few clinicians. At the time of the site visit at Finger Lakes, only three units had a permanent clinician, one unit had a temporary clinician, one unit had an OMH vacancy, and one unit had an OCFS vacancy with a new clinician scheduled to begin in 12/13; in addition, there were two substance abuse clinicians and one part-time clinician. One psychiatrist was working 12 hours and the other 4 hours weekly, and there were no candidates to fill the vacant NPP position. Finger Lakes is budgeted for 16 YCs but not all the positions have been filled. An insufficient number of clinicians will make it difficult for Finger Lakes to consistently demonstrate compliance with Paragraph 46: despite their quality clinical work, they will not be able to provide individual therapy as often as necessary, tailor group therapy to meet residents' needs, do family therapy by telephone or in person as often as necessary, manage suicidal residents, contribute in support teams, coach staff effectively and complete paperwork.

Clinician #1 had sessions with 18 residents in October 2013: five for individual therapy, six for individual therapy and group, six for group only, and one for a mental health crisis; this clinician saw one resident twice and ten residents once for individual therapy during the month. Clinician #2 had sessions with 15 residents in October, 2013: five for individual therapy, six for individual therapy and group, and four for group only; this clinician saw eight residents three (3) or more times, two residents twice and one resident once for individual therapy during the month. Clinician #3 had sessions with 15 residents in October, 2013: four for individual therapy, nine for individual therapy and group, and two for group only; this clinician saw seven residents three (3) or more times, three residents twice and three residents once for individual therapy during the month. Clinician #4 (a substance abuse clinician) had sessions with 31 residents in October, 2013: one for individual therapy, six for individual therapy and group, 23 for group only, and one for a mental health crisis; this clinician saw four residents three (3) or more times, one resident twice and two residents once for individual therapy during the month. Clinician #5 (a new substance abuse clinician) met with 30 residents in groups in October, 2013:15 residents in two groups and 15 residents in one group during the month; he has also been translating for support teams and IEPs, and while having a bilingual clinician is valuable, Finger Lakes would benefit from a part-time interpreter to free this clinician to do clinical work. Clinician #6 (part-time) met with 19 residents in groups in October, 2013: 11 residents in two groups and eight (8) residents in one group during the month. One Assistant Director for Treatment had clinical sessions with nine (9) residents in October, 2013: six for individual therapy, two for their initial mental health assessment and then for individual therapy, and one for individual therapy and a family session; she saw two

residents three (3) or more times, five residents twice and two residents once during the month. The other Assistant Director for Treatment had clinical sessions with three (3) residents in October 2013: two for individual therapy and one for crisis; she saw one resident five times and one resident twice for individual therapy during the month. Family sessions were not noted in the contact notes for the majority of Finger Lakes residents. At the time of the site visit five clinicians and an Assistant Director for Treatment were working with the eight residents on the unit missing the OMH clinician, which meant that each of them had individual therapy caseloads larger than ten. Despite their efforts to support staff, the Intact Team cannot function as effectively when the unit does not have its own clinician.

In November 2013, Finger Lakes had 1753 care days and had 2 Assistant Directors for Treatment, 6.5 clinicians, two psychiatrists who work at total of 16 hours/week and 14 YCs. By comparison, in August 2013, Columbia had 367 care days and had an Assistant Director for Treatment and two other clinicians, a psychiatrist who works 7.5 hours per week, an NPP who works 20 hours/week in psychiatry, and 2 YCs. In August 2013, Taberg had 627 care days and had four clinicians, one psychiatrist who works 12 hours/week and another psychiatrist who works 9-10 hours/week, and 2 YCs. The allocated number of clinicians may not be sufficient for the size and needs of the Finger Lakes population. In October, 2013 19 youth were admitted to Finger Lakes, requiring that five clinicians each completed on average one new integrated assessment and one new support plan per week. In October 2013, 11 youth were discharged from Finger Lakes, requiring that five clinicians each complete on average the transitional arrangements for two residents in the month. Moreover, responsibilities for substance abuse treatment, special watch evaluations, staff coaching, and JJIS documentation have continued to increase. It is impossible for the clinicians to provide therapy for each resident on their caseload once a week. Residents receiving individual therapy once a month are unlikely to recover from trauma and learn to regulate their emotions, especially if they are at Finger Lakes four (4) or five (5) months. YCs and mentors play an important role in listening to residents and guiding skill building, but they want training to become more proficient in individual counseling.

An example of the need for more coaching and a stronger shared response by clinicians and YDAs is exemplified by [redacted] a resident staff have worked hard to support. [redacted] is a 17-year old who arrived in 9/13 from [redacted] for possession of stolen property after years in a residential program for repeatedly running away from home in 2007; he was diagnosed there with Bipolar Disorder, and he stopped taking medication when he returned home. He lived with his grandmother and older sisters; his mother is bedridden with MS in their home. He felt abandoned by his [redacted] who was out of his life until age [redacted] then he lived with him briefly, then he was sent to live with his aunt. His marijuana use started at age 11. He had several psychiatric hospitalizations due to angry outbursts. He violated probation, was remanded to [redacted], and then sent to Finger Lakes. Trauma history including witnessing his [redacted] physically abused by their [redacted] being hit by a car and losing consciousness and having a broken leg, and witnessing people in the community being killed. Watching his mother's deterioration from [redacted] was not mentioned as a trauma, nor was separation from family for years as a child in placement. He has rapid mood changes and escalates unpredictably; he gets in a lot of fights because he feels he is the target of peers. His Reception Diagnosis was Mood Disorder, Conduct Disorder,

Cannabis and Alcohol Abuse, Borderline Intellectual Functioning. "[redacted] is a young man with a complex history, and requires intense skill building, therapy, and support to manage his emotions and his mistrust of adults. Family therapy and individual therapy should be utilized to explore his feelings related to parental involvement." In the month before the site visit, after being involved in multiple restraints, there were two Red Flag meetings with [redacted] On 10/21/13, the meeting noted he did not feel safe on his unit and was frustrated and angry that no one was listening to him. The Red Flag on 11/14/13 followed several more restraints after he had been moved to another unit at his request: "He says he is frustrated with youth and staff and does not have enough to do. He is worried he may lose the opportunity to go home early, and knows a fenner hearing request has been submitted. The team has tried one-to-one, short-term goals, building relationships with staff, keeping away from peers. Time away and allowing him to write in an isolated area helps him escape what was making him angry so he can calm down." On 10/3 he met with the psychiatrist "He fits the diagnosis of Mood Disorder (rule out PTSD) and Learning Disability. He is unwilling to take any medications but will benefit from CBT and rapport building with a therapist that can help address the triggers for his aggression. Multiple restraints since he came here a week ago. Hope that he will agree to take medications to get him through difficult times and avoid worsening of symptoms." On 10/22 he met with his therapist and realizes that he cannot return to his grandmother given all the help his mother needs and he does not think it is a good idea to return to his father's home (who also has a pending [redacted] case)." These realizations must have been devastating for [redacted] who may have required an intensification of support as he faced past and future losses. In the observed Rounds, staff expressed their difficulty tolerating his rapid mood swings, especially when neither staff nor [redacted] understand what triggers them. His needs may require an increase in individual therapy sessions to help [redacted] identify what is behind his behavior and more coaching for staff on how to help [redacted] calm himself before he escalates, for which the clinician does not have time.

Finger Lakes Intact Team meetings are exemplary. The MH Monitor observed three Intact Team meetings, in which 5-7 YDAs actively participated, along with 2-3 YCs, 1-2 clinicians, a teacher and Assistant Director for Treatment. The Intact Teams began with achievements of their units, recognizing that with teamwork they were able to make positive changes in their unit environment as they planned. YDAs and YCs were recognized for their effective efforts. In one Intact Team meeting, two YDAs were commended: "You took on school attendance and it made a huge difference! No one is sleeping in." A teacher-YC collaboration was commended with another resident: "At his support team he said sitting in class was too much, his teachers listened and changed his schedule. Being listened to helped him do it his way." It was surprising that the part of the intact meeting where residents joined did not begin by celebrating improvements in chores and line movement and that four out of eight students at Finger Lakes who had just made the Honor Roll were on this unit. Residents were asked to participate in decision-making about unit problems. At another Intact Team meeting, staff were recognized for being proactive, "so we don't get to restraints like other units. But our unit is slipping, new kids, new staff, we have to get safety back. We have a lot of young, developmentally delayed residents with processing issues. They are lost in a maze. We have to team together to help them out."

The Finger Lakes DAS remains the same rule oriented checklist as it was at the previous two site visits, and the MH Monitor again encourages staff to consider adopting the Columbia skill-based DAS. It is a learning process for Finger Lakes staff to become skilled at using the DAS as a shaping tool for residents. The MH Monitor reviewed the DAS for [redacted] (whose support team is described below)—he received an A for 24 achievements for both days before he advanced to Future Phase. The MH Monitor reviewed the DAS for [redacted] (whose support team is described below)—he received 25 achievements for one day and 23 for the other day just before his support team meeting. The MH Monitor reviewed the DAS for [redacted] who received 14 achievements on one day (the reasons were only noted in two boxes for horseplay and arguing) and 15 on the next day (for horseplay, being rude, being defiant, and talking back). Staff are aware the residents want more motivating DAS incentives and are in the process of improving them (see below for residents' suggestions from the Resident Council and QAI interviews).

The MH Monitor observed IIPs in the reviewed Finger Lakes records; support plans indicated the IIP has been reviewed monthly. In July 2013, OCFS revised the IIP form to make it clearer. It is a simpler form, focusing on what staff will do to calm the youth, as well as the prohibited and approved physical interventions for the youth. The BBHS Facility Clinical Procedures described the process of arriving at the IIP: "The clinician will work with the youth to determine what de-escalation techniques used by staff will be most helpful to the youth given the possibility of difficulty with emotion regulation."

The PH Monitor and MH Monitor observed a meeting of the Finger Lakes TIC where the Director presented a Graduated Response Plan to Monthly Restraint Data that included "Each unit will be responsible for developing their unit-specific response plan for their Intact Team, led by the YC-2s with assistance from Director and both Assistant Directors for Program. On 11/6/13 Graduated Response was reviewed at facility-wide staff meeting." For the Intact Teams to have ownership over testing their own interventions to increase self-soothing in residents (before de-escalation is necessary) and to see that they can reduce avoidable restraints will require (a) administration providing unit-based restraint data analyzed by time of day and day of week and (b) YCs who are coached on how to help staff look at these analyses and develop team strategies. For example, at the Monitors' request, Home Office analyzed the previous month of Finger Lakes' restraints and found clusters at 10-11 AM, 2-3 PM, 6-7 PM, 8-9 PM; there was no time in the TIC meeting to discuss possible explanations for higher restraints during these time periods and how an Intact Team could reduce stressors then, but these are the actions steps the YC2s will be leading. The plan presented by the Director also included (1) completing year-long in house training with YCs, led by the Director and Assistant Directors. So far, these monthly YC training sessions have covered case files, extension of placement, and admission screening. Hopefully technique training, such as how to guide self-soothing in residents or how to use DBT skills during regular daily activities, will be included. (2) Recruitment and retention, including new YDAs having two weeks of job shadowing, led by the Director and Assistant Directors. (3) Engaging youth through improved incentives and program enhancements through the Resident Council, led by the Director and Assistant Directors. (4) Engaging families by arranging that each month a different CMSO office will bring families to visit, led by YCs; this would result in most residents having at least one visit with their family and CMSO during their stay at Finger Lakes. (5) Using restraint

incidents as a training/support tool by (a) support teams conducting Red Flag Reviews on residents involved in three or more restraints in a week, led by the Assistant Director of Treatment and (b) review selected incidents during the monthly TIC. At the end of the Finger Lakes TIC, the Director reviewed a video of a restraint and led a discussion of how the intervention could have been improved, which was an effective way to coach.

The MH Monitor also observed a meeting of the Resident Council which consisted of six residents from different units, each with a YDA, and five YCs, recreation, cook, school, the Assistant Directors and the Director. Recommendations made by the residents were: longer phone calls; more recreation activities other than basketball, including going outside and unit teams playing against each other; better incentives; the time between brunch and dinner on weekends being too long and requiring bigger snacks; computers on the units; jobs for residents with GEDs. There was discussion of healthy versus sweet snacks for commissary. The residents were asked to go back to their units and get ideas for specific incentives.

Although not discussed during the site visit, unit meetings would also be a place to present highlights of QAI findings as another way to regularly assess facility-wide effectiveness of interventions; because QAI reports are long, it is doubtful most facility staff read them, but it would be beneficial for staff to hear their unit team members and themselves commended by QAI for good practice and also to develop unified approaches to improvements recommended by QAI. The MH Monitor recommends that QAI prepare a single page summary of highlights of good practice and recommended improvements after each QAI review to encourage consistent discussion of their findings at unit meetings.

QAI reviewers observed Mental Health Rounds at Finger Lakes in which the psychiatrist, clinicians, and Assistant Director for Treatment were present, but there was no YDA participation. "Rounds were a general overview of each youth's behaviors. A more in-depth discussion with greater clinical feedback could allow for strategies to address these behaviors. In one, the team generated hypotheses about how a resident's current behavior might be a manifestation of trauma symptoms. Most staff reported that they have never participated in Mental Health Rounds." In the QAI Review in Finger Lakes staff interviews, "few respondents were able to adequately provide a definition or description of the New York Model. Two respondents correlated it to a trauma-informed approach for working with OCFS youth and a few respondents described it as a therapeutic model that integrates mental health treatment into facility programming. In contrast, almost all respondents were familiar with the Daily Achievement System (DAS), referring to it as a point system from which the residents can earn privileges and incentives. However, much of the feedback obtained from staff interviews discussed the lack of diverse and motivating incentives and perceived ineffectiveness of the DAS as a behavior modification system…Few, if any [youth] indicated that the ability to earn the incentives sufficiently motivated them to comply with the behavioral and program expectations of the facility. When asked what incentives would be motivating, many of them were able to list at least one idea including extra phone calls, time to work out in the weight room, music, swimming, home visits, and the ability to purchase snacks from the commissary…During QAI's review of Finger Lakes, administrative staff reported that they are collaboratively working on revising the facility's incentive and phase system." The QAI Review

recommended improvements in the Finger Lakes DAS including achievements in discrete time segments and wording that reinforces desired behaviors (rather than what residents should not do). In the QAI Review at Finger Lakes, none of the five records scored in the meeting standards range for core programming because of generalized treatment responses and system-wide challenges with identifying a comprehensive set of measurable and attainable goals and objectives. Continued improvement is necessary in the overall content and quality of support plans, especially goals being transferable to the community and team members' roles in interventions. In response to these findings, the Assistant Director for Treatment provided training to YCs, medical, educational and clinical staff regarding the development of the support plans. Clinicians are required to submit weekly counseling schedules to the Assistant Directors for Treatment.

FUTURE MONITORING

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—particularly using monthly restraint data and the QAI—to regularly assess the effectiveness of interventions for all residents, with attention to teaching self-calming to residents who escalate quickly and changing support plans, interventions and support team meetings to reduce the rate of post-discharge returns to Finger Lakes.

The MH Monitor will observe coaching, strengthening Mental Health Rounds, improvements in support plans, more motivating DAS incentives, all staff learning how to teach residents to use skills to regulate emotions in the moment, and continued implementation of effective New York Model practices (including additional training in DBT, Sanctuary, and individual and group counseling desired by staff).

The MH Monitor will review Finger Lakes scheduling efforts to make it possible for YDAs and psychiatrists to participate in Mental Health Rounds.

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.

Staff at Finger Lakes were observed complying with 47a (see above for the PH Monitor's discussion of use of force).

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, and staff report these arrangements are effective.

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. Finger Lakes staff are aware of the importance of improving their consistency in the clinician meeting with the resident after a Suicide Watch to help him develop coping skills to avoid future self-harming thoughts or behaviors and following up with staff to figure out what they can do to prevent self-harming.

On Site Observations Regarding Paragraph 47a-c (11/13)

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

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

Finger Lakes had 41 Suicide and Personal Safety Watches for 27 residents between 5/1-10/31/13. Most Suicide Watches (SW) were 1 day, and about half were followed by a Personal Safety Watch for 1-3 additional days. The longest Suicide Watch was eight (8) days for a resident who was transferred to a Mental Health Unit. One resident had a 3 day Suicide Watch followed by an eight (8) day Personal Safety Watch, and another had had a 3 day Suicide Watch followed by a seven (7) day Personal Safety Watch. One resident had five Suicide Watches (some followed by Personal Safety Watch), two in May, one in August and two in September. Two other residents had three Suicide Watches each. During the six

month period, there were 12 Suicide and Personal Safety Watches in May 2013 and 12 in October 2013, with 3-6 in the other four months. Intact teams could consider steps to reduce factors accounting for higher rates in May and October (since they were not accounted for by particular residents having repeated watches in a month). Completing several mental health assessments for suicide a week, and then re-evaluating, is a major time commitment for clinical staff who were already overextended at Finger Lakes.

Although the QAI Review at Finger Lakes found some youth whose IIPs were reviewed and updated and who were seen by a clinician immediately, were assessed following a suicidal threat, and were seen again until stable, the review raised concerns about the lack of consistency of these practices. The Assistant Director for Treatment has since met with the clinicians to review suicide assessment and documentation requirements and verified that there is one suicide log per unit. The Assistant Director for Treatment also met with the YCs to review the IIP protocols and the requirements for Suicide Watch and Personal Watch, and the YCs were scheduled to present this information in their Intact Team meetings.

FUTURE MONITORING

The MH Monitor will observe coaching of staff on teaching youth self-calming, de-escalation, and chain analysis to prevent mental health crises at Finger Lakes.

The MH Monitor will review documentation of suicide assessments at Finger Lakes.

The MH Monitor will discuss the rate of special watches with Finger Lakes staff, and what additional interventions could be effective.

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

The recently-released BBHS Facility Clinical Procedures summarized the Integrated Assessment in compliance with 48a: "While several different support team members enter information into this shared assessment, the clinician will review this multidisciplinary report for accuracy and completeness, ensuring that the information presented provides for a solid conceptualization of the youth and their family strengths and support needs."

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 soon thereafter, documented in a psychiatric evaluation or psychiatric contact note.

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 (linked to the Behavioral Health Services policy (PPM 3243.33) finalized in 5/12) described 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. Finger Lakes staff request that clinicians complete mental health evaluations as necessary, and if more intensive services are required, referral is made to a mental health unit.

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. Finger Lakes staff are entering an Integrated Assessment for every resident, but with varying amount of completeness.

The quality of Finger Lakes Integrated Assessments are uneven, with some being thorough and others having incomplete sections. Improvements needed are that every Integrated Assessment should include:

(a) integrating information from a complete review of past records, including mental health, hospital, residential, school, substance abuse and other community assessments and reports

(b) a thorough trauma history, symptoms of trauma and how trauma appears to be affecting the resident's behavior (unless there has not been trauma),

(c) evidence of learning disabilities and how they appear to be affecting the resident's behavior (unless there are no learning problems),

(d) history of substance use and how it may be related to behavior and trauma (unless there has been no history of substance use).

If a resident's Integrated Assessment does not explain how trauma, learning disabilities, and substance use affect his behavior, his support plan goals and interventions will be incomplete. Thorough Integrated Assessments take time, and an insufficient number of clinicians will make it difficult for Finger Lakes to consistently demonstrate compliance with Paragraph 48.

Although Finger Lakes staff want to improve their effectiveness with each resident, Mental Health Rounds and clinical (including psychiatric) contact notes are not being used consistently by the Assistant Directors for Treatment, psychiatrists and other clinicians to discuss diagnostic and treatment information and efficacy of interventions.

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. Other than residents seeing the psychiatrists (most of whom are prescribed psychiatric medications), it is unknown how many Finger Lakes residents have psychiatric diagnoses, how they were rendered for the first support plan, and the process for consensus about their diagnoses during their stay at the facility. In the Mental Health Rounds and support teams the MH Monitor observed, diagnosis was not discussed. All staff would benefit from having more understanding of residents' complex symptom combinations, including possibly brief presentations by psychiatrists and other clinicians about how behavior and symptoms are considered and a medication trial initiated to help confirm or disconfirm a new diagnosis. The other DOJ facilities have diagnostic discussions routinely at Mental Health Rounds, but to comply with 48d Finger Lakes does not have to do so to arrive at a consensus diagnosis among clinicians since the psychiatrist 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. If psychiatrists and other clinicians are discussing diagnoses outside of Mental Health Rounds, the evolution of the diagnosis and symptoms being treated should be described in a note, shared at support team and reflected in the support plan.

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 (11/13)

BBHS policy requires that "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 policy continues: 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 support plan (Page 8). The BBHS Facility Clinical Procedures expand on the policy: the clinician updates the youth's current diagnosis in the support plan, but "only if changes are agreed upon between the clinician and psychiatrist. The assistant facility director for treatment should be consulted when the facility clinician and psychiatrist are unable to reach an agreement about the youth's diagnosis. The regional social work supervisor and chief of treatment services should also be consulted in instances where the primary treatment team is unable to reach consensus surrounding the youth's diagnosis." The BBHS Facility Clinical Procedures define a process that ensures that all support team members "are providing interventions to assist the youth and family in effectively managing or reducing symptoms associated with the current diagnosis." When a diagnosis is given at reception or secure facilities, in the facility diagnostic evaluation, the integrated assessment, and the support plan, the uniform working diagnosis screen in JJIS is automatically updated to keep track of the diagnostic history of the youth.

This system for updating diagnoses may be undermined by two discrepancies the MH Monitor has observed in the DOJ facilities: (1) it appears that in each psychiatric contact note, the psychiatrist renders the diagnosis of the youth at that session—these notes can be written 1-4 times monthly and a range of diagnoses may be given; if the psychiatrist and clinician do not discuss current diagnosis immediately before the support team, the support plan may carry over the diagnosis from the previous support team without regard to changing interpretation of symptoms by the psychiatrist; and (2) the diagnosis and medication list prepared by facilities for monitoring visits are different from

the diagnosis in the most recent support plan and/or most recent psychiatric contact note (medications are also often not up-to-date on those lists).

The August 2013 version of the Scope of Work of OCFS Psychiatrists was reviewed by the MH Monitor; it is being finalized by the newly-appointed consulting Chief Psychiatrists. It briefly lists the ten duties of OCFS psychiatrists, including medication management, attending weekly Mental Health Rounds, attending support teams as directed by the facility administrator, restrictions on number of medications, required laboratory studies, informed consent, and psychiatric emergency evaluations. It does not provide guidance for psychiatrists about their role consistent with the New York Model requirement of integrated care among all staff in the facility and community. It does not describe the role of the psychiatrist in reaching a uniform consensus diagnosis with others on the youth's support team, nor how the psychiatrist's changing diagnostic interpretation of symptoms will benefit the work of other team members with the youth. 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. A Home Office next step is for the practice guidelines in the BBHS Facility Clinical Procedures to be re-framed by a New York Model-experienced psychiatrist for psychiatrists, with particular attention to diagnosis, helping staff make use of information about symptoms and medication, and the role of the psychiatrist in Mental Health Rounds and support teams.

The MH Monitor examined the diagnoses of all 43 youth prescribed psychiatric medication by four psychiatrists and one NPP at Columbia, Finger Lakes, and Taberg in July 2013. This analysis revealed considerable range among psychiatrists about diagnosis, with the most common diagnoses across the three facilities being ADHD, mood disorders, insomnia, depression, and anxiety in July 2013:

ADHD 23% of youth prescribed medication (10)
- Columbia 25% (2)
- Finger Lakes 35% (7)
- Taberg 7% (1)

MOOD 21% of youth prescribed medication (9)
(including Mood Disorder and Mood Dysregulation)
- Columbia
- Finger Lakes 10% (2)
- Taberg 47% (7)

INSOMNIA 16% of youth prescribed medication (7)
- Columbia 25% (2)
- Finger Lakes
- Taberg 33% (5)

DEPRESSION 9% of youth prescribed medication (4)
(including Depression, Major Depressive Disorder, and Dysthymic Disorder)
- Columbia 39% (3)
- Finger Lakes 5% (1)
- Taberg

ANXIETY 9% of youth prescribed medication (4)
(including Anxiety Disorder and Generalized Anxiety Disorder)

Columbia	13% (1)
Finger Lakes	5% (1)
Taberg	13% (2)

In July 2013, more youth were diagnosed with depression at Columbia (39%) and Mood Disorder at Taberg (47%) while 35% of youth at Finger Lakes and 25% of youth at Columbia were diagnosed with ADHD. There was a large reduction of diagnosing depression (27% in January, 2013 to 9% in July, 2013), anxiety (23% in January, 2013 to 9% in July, 2013), and insomnia (32% in January, 2013 to 16% in July, 2013) across the three facilities. Diagnosis of ADHD was the same between January and July, 2013 (23% of youth) and similar for Mood Disorders (27% in January, 2013 and 21% in July, 2013).

Although divergent diagnoses among the individual youth in the three 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.

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.

An example of the importance of staff understanding of an evolving formulation of a resident's symptoms and what it means for their role in assisting him is [redacted] a 16 ½ year old sent to Finger Lakes for burglarizing a liquor store in 1/13. His parents had joint custody of him when his father died [redacted]. His Integrated Assessment (2/13) described him as acting out long before father's death. He had a history of head trauma with loss of consciousness; his [redacted] was arrested for sex abuse, and [redacted] had one incident of fire setting. His reception diagnosis included ruling out borderline IQ. The Finger Lakes psychologist completed testing in 5/13, finding an FS IQ 72, with impaired comprehension and that he was reading at the 3rd grade level and doing math at the 6th grade level: staff were encouraged to repeat instructions and break them into smaller tasks. His most recent support plan indicated that he "continues to struggle in program daily. We set a small goal of trying to go one week with no codes in order to have PRA sent, but he has been unable to do it. We have attempted to use calendars with small goals to help him, but that has been unsuccessful. His mentor meets with him five (5) days per week two (2) times per day in an attempt to give him additional support. He continues to meet with his clinician weekly and we work on SLTs, but he has difficulty remembering and applying them in program. We have attempted to adjust his medications, which has helped for periods of time, but he has been inconsistent taking medication. We have had

multiple Red Flags and he has made commitments each time that he is unable to keep. He is extremely impulsive and dysregulated. He has gone over problem solving skills and expressing his feelings, but has difficulty retaining the knowledge. He reports he tries to use skills when he is upset, but sometimes he is too angry. He tends to be disruptive and has difficulty with physical boundaries with staff. He is socially inappropriate and fails to recognize social cues and mores and thus is often ostracized by his peers and adults alike. He is energetic, persistent, and loves the attention he receives. His stepmother reported that his mother was unable to teach him social skills and would send him to his father when she had difficulty with him; now his father is deceased." Surprisingly, his 9/19 support plan indicated his diagnosis was simply ADHD, Conduct Disorder, Cannabis Dependence, and Bereavement for which he was prescribed Clonidine and Abilify. His Goal #1 was to graduate from high school so he can transition back into college (which is unrealistic given his reading level and IQ). His Goal #2 was to learn skills that will help him with a goal of running his own [redacted] shop and his YC and mentor were to work with him on skills of problem-solving and expressing feelings. These were the only interventions listed. In the month of October 2013, [redacted] attended five substance abuse groups, four Sanctuary groups and had four counseling sessions with his YC (in one session she went over the log book with him because he did not remember all the things staff reported about his being disruptive, violating personal boundaries, and being disrespectful). In November, he started individual therapy with the new therapist and in the first session talked about grief over the loss of his father and coping skills. At his next therapy session, he said he "couldn't take it anymore" in a discussion of his disruptive behaviors, then he exposed himself to the clinician. Ten days later he had therapy with a male therapist and talked about being ashamed and very sorry for what he did. Meanwhile, he had been taken all the way to Long Island for court for his new charge with his YC, who reported that they had "good long discussions about reaching his goals and DBT skills." [redacted] was the second longest stay resident at Finger Lakes at the time of the site visit and the reason given for his 10-month stay was that "he has had over 70 restraints since his arrival. We have tried on multiple occasions to begin his release process, but as soon as he gets close to the possibility of release he assaults staff/peers, which results in a hold. He has expressed that he does not want to return home on numerous occasions, but mom is adamant that the only place he can go is home. His paternal grandmother tried to talk his mother into letting him come home to her and while his mother was deciding [redacted] did well. As soon as his mother said no, he assaulted someone. The Support Team feels that he may be avoiding returning home in order to deal with the fact that his father has passed. He has yet to be out of a facility since his passing. He refuses to engage in any grief counseling while he is here." The MH Monitor observed [redacted] support team meeting at the previous site visit (5/13) where staff were exhausted trying to manage his behavior and his mother insisted that Finger Lakes was not treating his primary problem of ADHD. At that time the MH Monitor wrote "A thorough review of [redacted] 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." Six months later, it is not apparent that staff considered treating this youth's developmental disorder combined with behaviors resulting from trauma. Before this site visit, the psychiatrist saw [redacted] three times between 10/10 and 11/5/13. In contrast to the diagnosis in the support plan, in all three contacts the psychiatrist gave a diagnosis of Mood Disorder, Disruptive Behavior Disorder, ADHD (by history), Conduct Disorder and *Rule Out Pervasive Developmental Disorder* (emphasis added), but there is no reference to discussion of developmental disorder and the relevance of the testing results. The psychiatrist's contact notes did not mention the diagnosis of Bereavement although it was given at Reception and was in his current support plan. The meaning of his continuing sexual behavior is not recognized in either his support plan or contact notes. [redacted] is an extremely complex resident with multiple determinants for his frustrating behaviors. A clinical discussion including all staff is essential to recognize the effects of unresolved (perhaps sexual) trauma and a developmental disorder so that agreement about his specific trauma-related and developmental needs results in more sophisticated, coordinated, intensive interventions than have occurred to date. It is not consistent with the New York Model for staff to conclude simply that a resident's behavior is mystifying or that a resident's behavior is unacceptable because neither will lead to a resident learning what he has to change for his behavior to improve.

In the QAI Review at Finger Lakes, the psychiatric evaluation in all five records met standards, a substantial improvement from the previous QAI review. QAI reviewed several records where there was evidence of a consensus on diagnosis and that diagnoses were utilized to inform treatment goals and that behaviors necessary to achieve goals were transferable to the community. In the QAI Review at Finger Lakes, one Integrated Assessment that was reviewed lacked information about trauma, diagnostic formulation or clinical treatment needs. In the QAI Review, two out of five initial support teams were not conducted within 30 days of youth's admission. In the QAI Review, one Integrated Assessment described part of youth's trauma history but did not include Reception's

recommendation of a referral to neurology because of head trauma when he was hit by a car and assaulted in the community; another IA did not include a complete history of trauma. In the QAI Review, two IA's were not completed within 30 days of admission. Finger Lakes administration had a meeting on 10/31/13 with clinicians to discuss improvements necessary in the IAs.

FUTURE MONITORING

The MH Monitor will continue to review Integrated Assessments, particularly for the inclusion of (a) integrating information from a complete review of past records, including mental health, hospital, residential, school, substance abuse and other community assessments and reports, (b) a thorough trauma history and how trauma appears to be affecting the resident's behavior, (c) cognitive impairments (including language and executive function difficulties) and how they appear to be affecting the resident's behavior, and (d) substance abuse history and how it appears to be affecting the resident's behavior.

The MH Monitor will continue to discuss consistency in diagnostic practices with psychiatrists and other clinicians and ongoing efforts to routinely arrive at agreement about what is behind a resident's behavior and how staff should respond.

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.

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 to state, "The target symptoms intended to be treated by each medication." The Finger Lakes psychiatrists often do not check any symptoms on the symptom checklist on the psychiatric contact notes, which suggests that the form might require modification by either (a) improving the symptom checklist so all psychiatrists and NPPs complete it consistently or (b) requiring that psychiatrists and NPPs state explicitly the symptom each psychiatric medication is being prescribed to treat.

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.

COMPLIANCE

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

Finger Lakes psychiatrists complete 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.

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 (11/13)

On November 18, 2013, 16 of the 59 residents at Finger Lakes in November 2013 were prescribed psychiatric medication:

Acute Stress Disorder	Prazosin
ADHD	Clonidine (3)
ADHD	Intuniv
Adjustment Disorder, Insomnia	Melatonin
Conduct Disorder	Abilify
Depression	Prozac
Depression	Seroquel
Depression, Anxiety	Remeron
Depression, Anxiety	Trazodone
Depression, Insomnia	Trazodone
Disruptive Behavior Disorder	Clonidine
Insomnia	Melatonin
Mood Disorder, Conduct Disorder	Abilify, Clonidine
Mood Disorder, Conduct Disorder	Seroquel
Oppositional Behavior, Conduct Disorder	Seroquel

PTSD, Insomnia Seroquel

A substantially smaller percentage of Finger Lakes residents are prescribed psychiatric medication as compared to the other DOJ facilities (Finger Lakes 27% in 11/13, Taberg 74% in 9/13, and Columbia 58% in 8/13). Finger Lakes is a male facility and has fewer contracted psychiatry hours (by population) in comparison to Taberg and Columbia.

One of the psychiatrists met with 18 different residents during his once or twice weekly visits to Finger Lakes in October (10/2, 10/9, 10/28, 10/30); eight (8) of these residents were seen twice and one was seen three times in October; four of these residents were not prescribed psychiatric medication but were being seen by the psychiatrist. The other psychiatrist met with nine (9) different residents during his days at Finger Lakes in October (10/1, 10/2, 10/8, 10/10, 10/17, 10/29, and 10/31); 1 of these residents was seen twice in October.

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 [and] no more than one medicine per class, i.e., one antipsychotic, antidepressant, mood stabilizer in his/her treatment of a youth." In November 2013, no Finger Lakes residents were prescribed three or more 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.

In the MH Monitor's review of the 43 youth prescribed psychiatric medications in July, 2013 described above, overall 49% of the residents of the three facilities were prescribed psychiatric medication (43 of 87) as compared to 43% (36 of 83) in January 2013. In July 2013, there were divergent medication practices among the four psychiatrists and one NPP at Columbia, Finger Lakes, and Taberg. In July 2013, the most commonly prescribed psychiatric medications by facility were: Finger Lakes-Seroquel (25%) and Clonidine (20%); Taberg-Seroquel (33%) and Trazodone (27%); and Columbia-Remeron (25%) and Adderall (25%). At Finger Lakes, the use of Seroquel remained the same from January 2013 to July 2013. There has been national attention to reducing the prescription of Seroquel in facilities because of the dangers of side effects and abuse after return to the community. In this site visit four Finger Lakes residents were prescribed Seroquel (25% of those prescribed psychiatric medication), an increase from three residents (14%, of those prescribed psychiatric medication) at the previous site visit.

In the DOJ facilities in July 2013, Seroquel was being prescribed for Mood Disorder, PTSD, Mood Dysregulation, Anxiety Disorder, Adjustment Disorder, and Conduct Disorder. Trazodone was being prescribed for Insomnia, Major Depressive Disorder, Depression and PTSD Clonidine was being prescribed for Anxiety Disorder, ADHD, PTSD, Depression, Insomnia, and Conduct Disorder Risperdal was being prescribed for ADHD, Mood Disorder, Disruptive Behavior Disorder, and Conduct Disorder.

The QAI Review at Finger Lakes found documentation in psychiatrist's progress notes of reasons for use of medication and symptoms targeted, discussed with youth by the

psychiatrist. The QAI Review at Finger Lakes found residents prescribed psychiatric medications were seen monthly or more often by the psychiatrist, they were not prescribed three or more medications, labs were done according to schedule, effectiveness was monitored in relation to the target symptoms, and side effects checked and responded to.

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 Mental Health Rounds and support teams.

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.

FUTURE MONITORING

The MH Monitor will continue to review documentation that Finger Lakes staff are adequately trained 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 (11/13)

The QAI Review at Finger Lakes found that when residents refused psychiatric medication, it was documented and the psychiatrist signed the refusal form. The QAI Review found that in one record psychiatric medication refusals were not discussed in the support team, and for two there was not evidence the parent was notified when the youth refused. Finger Lakes now has a procedure for the nurse to email the clinician regarding a youth's psychiatric medication refusal, and the clinician is responsible for notifying his family.

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 person(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 (11/13)

Completed informed consent forms were in the Finger Lakes records reviewed by the MH Monitor.

The QAI Review at Finger Lakes found documentation of diligent efforts to obtain written consent for psychiatric medication.

FUTURE MONITORING

The MH Monitor will continue to review documentation of informed consent for psychiatric medications at Finger Lakes.

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.

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 guidance is being provided to strengthen staff skills in identifying needs and writing goals with residents.

The support team practices at Finger Lakes comply with 53a.

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. Finger Lakes staff indicated that having the NPP participate in support teams was helpful, and this practice will resume when a new NPP is hired. Neither psychiatrist participated in the support teams observed by the MH Monitor during the site visit. In the interim before an NPP is hired and becomes a support team member, it is expected that a psychiatrist will participate in any support team meeting when it is clinically indicated (and the support team meeting will be scheduled to fit the psychiatrist's time on site).

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, clinical evaluations, and Mental Health Rounds 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. For some residents, the clinical contact notes indicate trauma work by the resident. This may be considered private between the resident and clinician and not something he wants discussed with his 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 complied with 53e. Consistently strong support plans—including building from the Integrated Assessment, stating clear goals based on the resident's aspirations with the addition of staff expertise, and all team members' interventions (not just clinicians or just case managers) stated specifically--is being monitored to determine full compliance. Helping a resident articulate his goals and encouraging each staff person on his team to identify what he/she will do to support the resident's daily steps to achieve his goal is time-consuming, and an insufficient number of clinicians will make it difficult for Finger Lakes to comply with Paragraph 53.

"Goal Writing and Support Plans in the New York Model" (4/12/13) provides helpful, specific guidance for goal writing to maximize the motivation and engagement of youth by "starting where they are" and validating them as they talk about the outcomes they want, building on strengths to build on to achieve their goals is stressed as an important part of writing support plans. The one-page Goals Worksheet is for staff to help youth identify their goals 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. The one-page

Support Team Staff Notes walks staff through an analysis of their role in assisting a youth achieve goals. 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 were not being implemented consistently yet at Finger Lakes, but they were working at improving support plans. Finger Lakes staff have strong relationships with residents, but support plans often do not reflect the unique ways different staff use their relationships with a resident to meet his needs.

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 is being monitored to determine full compliance. For example, when a resident returns to Finger Lakes, his new support plan should address specifically what has to change during his time at the facility and the preparation for his second re-entry to reduce the likelihood of another return to custody.

On Site Observations Regarding Paragraph 53a-f (11/13)

The MH Monitor observed two outstanding support team meetings, both of which demonstrated Finger Lakes staff with supportive relationships with residents and communicating effectively with family and CMSO.

[redacted] is a 15-year old from [redacted] at Finger Lakes more than four months for VOP on a robbery. He lived with his mother and [redacted]; he was traumatized by his [redacted] death in 2010 from an illness and his father's absence due lengthy incarceration and living out-of-state. Based on a Finger Lakes assessment, his verbal abilities are a significant weakness, causing him to misunderstand verbal communication and be easily manipulated. Yet, his diagnosis is Adjustment Disorder with Depressed Mood, Conduct Disorder, Cannabis Abuse, and Personality Disorder, which does not reflect his significant comprehension problems. The psychiatrist saw him, but he is not prescribed psychiatric medication. His support plan noted that on 9/28 he was placed on Suicide Watch. He was often distracted by his inability to regulate emotions. He met with his clinician consistently; he enjoyed vocational class but struggled in other classes. He is close to his family and his mother is working with his support team. His Goal #1 was to return and stay at home, which his support plan indicated included addressing loss and introducing the concept of trauma and its impact. No other interventions were listed. His Goal #2 was to be on the fast track for release by meeting all program and treatment areas, and his case manager was providing help with prosocial skills and learning to trust and build relationships with adults; no interventions by other staff were listed. His Goal #3 was to go to school consistently in the community, by stopping using marijuana for which his case manager was going to refer him to APT; no interventions by other staff were listed. In the

month prior to the site visit, his clinician came to the facility on a Saturday for family counseling when his mother visited, arranged for him to have cognitive testing at Ella McQueen with family visits there, explained to his CMSO the results of testing that indicated he has a pervasive difficulty tolerating uncertainty and is unable to perceive who he can trust, and met with [redacted] to talk with him about his distrust regarding arrangements for his release. His support team was co-led by his clinician and YC (with the YC2, nurse, teacher, both Assistant Directors for Treatment, and BBHS Director of Treatment Services and CMSO, B2H, APT, and his mother on videoconference). His YC skillfully began with, "The goal of this support team meeting is to transfer [redacted] goals to the community." The team included everyone on screen in the community meeting and throughout. His clinician described how important it is for providers to explain things clearly and repeat because of [redacted] comprehension problem; she also described his worries that make it difficult for him to trust and confide. His clinician has a strong relationship with his mother, and they expressed mutual appreciation for each other's efforts. When [redacted] arrived, his YC said, "This is your last support team meeting here at Finger Lakes, so we want to pass your goals on to everyone on the screen for you to work on when you get home." His team was very supportive of him, talking directly to him and saying, "I am really proud of you." [redacted] said his goals at Finger Lakes were to go home and to say what he feels in a positive way. His YC asked him, " What is your goal at home?" [redacted] answered, "To go to school, get into a sport." His YC responded, "Do you have something you want to ask your aftercare worker, B2H, and APT?" [redacted] responded, "Help me be occupied so I don't do bad stuff. Get better in math." His B2H worker promised to go to his school to help him get math tutoring, as well as helping him look for a job and on weekends taking him to games and movies. His APT worker said they would help him with his goal to abstain from marijuana. His aftercare worker said he will see [redacted] once a week. His Finger Lakes teacher said his transcript will be sent to the CMSO; she explained to the participants on the screen that he had not previously been in special education, and his IEP from Finger Lakes will be used by his new school. It was an impressive, truly integrated team of Finger Lakes and community and family, and an effective transfer of his goals.

[redacted] is a 16-year old who lived with his mother and sister in [redacted] and was revoked to Finger Lakes in 9/13 for assault and daily marijuana use. He was born in [redacted] but had to move to [redacted] at age [redacted] after he was shot at by a gang. Then they moved to [redacted] and his mother reported that his gang burglarized her home and she had to move twice. ACS placed him at [redacted] in 5/11 after he said his mother kicked him out. He had frequent AWOLs, was placed at [redacted], was AWOL and was placed at the Highland Substance Abuse Unit for seven months. He was on aftercare for months before being revoked to Finger Lakes. He has a strained relationship with his mother and has decided not to be discharged home. His integrated assessment described him as mature, articulate, goal-oriented, and able to calm himself. His trauma history was summarized as loss of his father at a young age, loss of his relationship with his mother, and exposure to severe community violence. His most recent support plan reported his progress: he was fully engaged in GED, therapy, and groups and was working on his [redacted] application. His diagnosis was Conduct Disorder and Cannabis Abuse. His Goal #1 was to get his GED, and the clinician was listed as supporting his efforts in taking the GED exam. His Goal #2 was to go to [redacted] to become a nurse, and his clinician was

described as helping him identify triggers for substance use, as well as coping skills, and develop his portfolio for [redacted]. No other staff were listed with activities to help him achieve his goals. His clinician has done exemplary work with [redacted] She took him to an AA meeting in the community: "On the way back he asked to drive through the Cornell campus as he had never seen a university. He never believed he would have the opportunity to attend college. We discussed how his personal story would make for a very good college admissions essay and how his experiences and perseverance would make him a strong candidate for college admission." Subsequently, his clinician took him to visit the local community college to learn about their nursing program; he met with the nursing admissions coordinator and visited classrooms. In therapy he worked on his mother's early rejection, and learning not to react angrily to her now. His YC convened his 60-day support team, which included two other YCs, his clinician, nurse, teacher, Assistant Director for Treatment, and BBHS Director of Treatment Services with the CMSO on videoconference. [redacted] was described as a model resident in the facility: he goes to school, took the GED exam, avoids negative peers, identifies feelings, is involved in therapy, goes on off campus trips, and is planning his future. There was cooperative, open communication with the CMSO, and the Finger Lakes staff were appreciative of his aftercare worker's advocacy of [redacted] and help with getting his mother's permission. [redacted] arrived for his goals review and said he was waiting to hear his GED results and has a [redacted] interview this week. Staff said they will prepare him for the interview and get clothes. He and his teacher agreed to work on his resume to have his portfolio completed. He said he had a new goal for the meeting: Future Phase-- "I think I'm a leader. My anger is under control. I'm learning to accept constructive criticism. I wrote a letter to Ms. Nieves asking for OCFS financial support in college." His CMSO said, " I'm so proud of how well you are doing. I'm hussling hard for you because you are working hard. If you want to go to college, you will be able to do it. You will be able to sell yourself to [redacted]." [redacted] responded, "When I was out on aftercare, I hung with the same kids. I never had goals before." The team reviewed the phase advancement checklist with him, and he was pleased to get his phase. In the debrief, team members expressed satisfaction that "he has relationships with and is getting something specific from everyone on team. Sometimes we feel like the YCs and clinician are the only ones in the meeting the resident is working with. But this youth has engaged everyone." The team was encouraged to teach other staff to have team meetings like this one. Ideas for residents who are afraid to speak up in team meetings included making it a project they prepare to present at support team. They suggested challenging residents to build a relationship with one staff person on their team before their next meeting. The team wants more YDA involvement in team meetings; in this meeting a YDA brought the resident to the meeting, but did not contribute. It was suggested that the mentor or YDA involved with the resident participate from the beginning of the meeting, with someone else moving the resident, and asking the YDA to be prepared to talk about the resident. The MH Monitor suggested that team meetings begin with the appreciating of strengths after the resident arrived (not just among the adults). The MH Monitor asked why the team did not celebrate the resident's phase achievement—he is the only Future Phase at Finger Lakes and there was no applause. A former Lansing staff said that at Lansing phase advancement was announced on the loudspeaker, and they talked about broadcasting his achievement on their radios at Finger Lakes.

"The New York Model: Youth Support Team Implementation Guidelines, BBHS" includes functions of the support team meeting, support team documents, process of and procedure for support teams, and integrated assessment instructions. "The Support Plan is the answer to this question: "How will we help this youth (what resources or supports can we offer?) progress from where s/he is currently (assessments, strengths, motivations, 'potential'), to where they hope to be (goals), given their current circumstances (needs, vulnerabilities, obstacles)?" The Guidelines clarify the reason for a two-part support team meeting, and the importance of beginning the second part of the meeting with the youth and family present with strengths and "a sense of hopefulness and capability." The Guidelines continue, "When progress does not occur, the entire team takes responsibility for the plan and rewrites the plan in an effort to assist the youth in moving toward their goal." The Youth Support Team Implementation Guidelines example of interventions for a youth with attention difficulties could be strengthened by including interventions of team members other than the psychiatrist, clinician and educator; guided by those team members, the youth's mentor and other YDAs play key roles in assisting with building attention skills individually and in groups, the recreation specialist could do so in games and exercise, and the vocational instructor could help find a work activity where the youth excels even with attention limitations. The Finger Lakes support teams require more guidance from BBHS in writing goals with residents and including in their plans specific ways each team member will use their relationship with the resident to help him achieve his goals.

The BBHS Facility Clinical Procedures emphasize how to write goals and objectives, interventions including substance abuse, and a narrative of the youth's progress each review period. "All clinicians are expected to provide individual therapy, group facilitation and regular family contacts to assist youth and families in making progress toward their objectives and goals." The revised Integrated Support Plan format on JJIS includes a clearer way of writing each goal and interventions to support the young person in meeting that goal as well as sections on the youth's current functioning and progress made toward goals, family strengths and family goals.

The BBHS Facility Clinical Procedures (with instructions for clinical documentation in JJIS) include: accessing reception assessments in JJIS, mental status exam (including ISO-30), IIP, safety plan, integrated assessment, support plan, psychiatric diagnostic assessment and psychiatric contact notes, uniform working diagnosis, clinical contact notes (for individual and family sessions), group contact notes (DBT and psychoeducation groups), referral forms to discrete treatment units, discharge planning and Continuity of Care plan. The BBHS Facility Clinical Procedures clearly present both clinical practice expectations and instructions for documenting clinical services. The BBHS Facility Clinical Procedures could be strengthened by describing the special role of the clinician in Red Flag meetings and Mental Health Rounds where the clinician models examining what contributed to a youth's behavior and integrating information from assessment and trauma history to support other staff in adjusting their actions to meet the youth's needs, especially to prevent escalation.

The QAI reviewer at Finger Lakes observed a support team meeting that was thorough, positive, and supportive of the youth and family. All attendees were engaged and

participated fully. The team was validating and solution-focused with the youth. The youth articulated his goals and his feedback was used to change his IIP. The support team members connected the youth's current goals and strategies to his future and the community. The support team was trying to develop reinforcements to help motivate this youth. The QAI Review reported that Finger Lakes support plans did not include team members' roles in assisting the youth in achieving objectives, including types and frequency of interventions. Support plans did not include evidence that trauma history was considered in designing interventions or development of coping strategies. In staff interviews, the QAI Review found that many staff were unable to participate in support team meetings because the facility was short-staffed. In the QAI Review at Finger Lakes, one record had no reference to the different diagnoses listed from Integrated Assessment, psychiatric, psychological evaluation and ISPs, a psychological evaluation done in June 2013, was not referenced in the support plan, and there was no evidence the diagnosis informed the treatment plan.

FUTURE MONITORING

The MH Monitor will continue to review Finger Lakes support plans for specific needs unique to that resident, building from the Integrated Assessment with clear goals based on the resident's aspirations as well as staff expertise about trauma and other challenges for him, and all team members' interventions being specified.

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

The MH Monitor will review Finger Lakes scheduling efforts to ensure that YDAs participate in support teams.

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;

COMPLIANCE

The OCFS substance abuse manual defines practices that comply with 54a.

Finger Lakes is providing InnerVisions groups for residents.

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.

COMPLIANCE

The OCFS substance abuse manual defines practices that comply with 54a.

Finger Lakes is providing substance abuse groups for residents.

Finger Lakes clinicians, as noted in support plans, provide individual therapy regarding substance abuse for residents with a substance abuse diagnosis. The MH Monitor did not see any records in which a clinician assisted a resident in completing a relapse prevention plan.

On Site Observations Regarding Paragraph 54a-b (11/13)

The final version of the OCFS substance abuse manual was reviewed and integrates substance abuse prevention education and treatment into the New York Model. The Substance Abuse Services Training and Procedure Manual is thorough and includes chapters on Adolescent Substance Abuse, the Continuum of OCFS Substance Abuse Services, New York Model Phases and Substance Abuse Treatment, and Transition Planning and Community Care. The progressive self-awareness, response to mentoring, and use of skills listed for each phase is particularly helpful and has an emphasis on relapse prevention.

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 therapy and DBT and Sanctuary groups. Strong communication in support teams and Mental Health Rounds among the clinicians, YCs, and YDAs and the rest of the team is necessary to support each Finger Lakes resident's individual progress in self-calming and relying on these skills to avoid substance use in the community.

Finger Lakes has hired a second substance abuse clinician.

The MH Monitor observed two strong substance abuse groups at Finger Lakes. The InnerVisions leader made an excellent use of role-playing to examine peer pressure to get involved in substances. Several staff participated actively, including playing roles in the skits the residents developed with them. In the substance abuse group with another unit, the clinician got group members' attention by talking about the dangers of Krokodil, a potent flesh-eating opiate gaining in popularity. The group had such a range of maturity and cognitive levels that it was challenging to discuss a topic—some residents did not understand basic ideas until the clinician had given several repetitions.

Most Finger Lakes residents had a history of substance abuse. Substance abuse was noted in Integrated Assessments, but not reflected in some support plans. When substance abuse treatment is specified as an individual therapy objective, subsequent support plans do not reflect the resident's learning. Applying skills being learned in the facility to prepare the resident to successfully avoid returning to substances in the community should be an ongoing goal of services documented in contact notes and support plans. Relapse prevention plans should be included in re-entry planning and be part of the resident's work with community supports in the last support team meeting and presentation of his portfolio to the Director.

The QAI Review at Finger Lakes found that youth with documented substance abuse problems received weekly group therapy for substance abuse and youth without a substance abuse diagnosis received InnerVisions, both of which were an improvement since the previous review. Following the QAI Review, the Assistant Directors for Treatment met with clinicians to review the necessity of including substance abuse specific counseling in individual sessions for youth who have a substance abuse diagnosis.

FUTURE MONITORING

The MH Monitor will continue to review documentation of 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 and support teams, including the preparation of 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 new Community Re-Entry Plan complies with 55b.

Finger Lakes staff were not doing Discharge Summaries, but will be trained in completing Community Re-Entry Plans which are designed to include referrals to mental health or other services.

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 (11/13)

Community Re-Entry Plans should define how a resident's support plan and gains in the facility will continue in the community. The resident's goals should be transferable to the community, and that is a major purpose of the last support team meeting before transition and of the Community Re-Entry Plans, so supporters in the community understand their role in helping the youth regulate emotions, tolerate distress and avoid relapsing. Through the New York Model OCFS has implemented the integrated assessment and integrated support plan, and information transmitted before discharge should result in an integrated transition that includes all elements of a youth's successful re-entry to the community.

During this site visit at Finger Lakes, OCFS staff reviewed the new JJIS screens for the Community Re-Entry Plan with the MH Monitor. The Community Re-Entry Plan will be finalized on JJIS in April 2014, and staff will be trained on its use in June/July, 2014. Like support plans, each discipline will submit their part of the Community Re-Entry Plan: clinician, case manager, medical, education, and CMSO. The needs and goals of the youth and family during the transition to the community will be entered, with the services to be provided in the community, including the ACS/DSS-permanency plan regarding where the youth will live and who is legally responsible. The Community Re-Entry Plan is designed to consolidate information from the Integrated Assessment, support plan, and other sources (plus the current IEP, transcript, and other school and vocational information to be provided to the youth's next school).

Finger Lakes has an exemplary process that helps residents focus on what it will take for them to successfully return to the community: they are required to present their Release Plan formally to the Director, with their YC and Assistant Directors asking them questions about their re-entry goals. [redacted] a 17-year old who violated probation on a robbery when he was 15, spent 10 months at [redacted] and was sent to Finger Lakes for having marijuana in his room, was preparing to leave after three months. His hard work with his YC and others to put together his portfolio was an important process for readiness for release. He reported that he had no rule violations in four weeks: "My unit is not mature. Sometimes I fall in the trap of getting on their level. Being silly, horseplaying. I have been stepping up to be a role model." Asked about his accomplishments at Finger Lakes, he responded, "I've set goals for myself. That's what life is. Setting goals. Accomplishing goals. My aunt said I should go to placement to learn something. It has been a learning experience." He reviewed his resume with the Director. He is returning to 12th grade in his old school, and his transcript was in his portfolio. His [redacted] goes to college in [redacted] and he said he wants to go there. "In my household I'll be the first to graduate from high school." Finger Lakes leadership taking the time to show so much interest in each resident and his future is commendable, and the release plan presentation is an outstanding re-entry preparation process that fits well with support teams.

Three residents' re-entry problems demonstrate the urgency of strengthening the connection between progress at the facility with services and family supports in the community. These youth were at Finger Lakes at the previous site visit, were discharged, returned and were at Finger Lakes this site visit:

[redacted] was placed at age 15 at Finger Lakes in 11/12 for Reckless Endangerment; he had a history since age 12 of running away, polysubstance use and repeated stealing and had been in several residential placements. He was discharged home in 6/13 after more than six months at Finger Lakes, with a Continuity of Care Plan referring him to substance abuse treatment and psychiatric services, but neither mental health counseling nor family therapy. He was returned to Finger Lakes four months later (10/13) after smoking marijuana, being late for school and curfew, and taking a laptop. Trauma and other contributors to his behaviors were not explored in his 11/13 Integrated Assessment. He was described in Mental Health Rounds, as "knowing the system. He says 'this place has nothing to offer me.'" His current support plan reported that he is an intelligent youth with good social skills who wants to be a math teacher. Both parents visit, and his mother is

involved in his treatment, but she cannot have him living with her due to his lack of commitment to follow up treatment; he will go to a step down program. His diagnosis is Depressive Disorder, Anxiety Disorder, Conduct Disorder, Cannabis Abuse and he is prescribed Trazodone, but he "refuses to meet with clinician." There was no description of trauma or other contributors to his depression, anxiety, or substance abuse, nor whether any efforts had been made by another clinician to gain his trust; there was no indication of what had been effective in his previous stay at Finger Lakes. His goal #1 was to work towards achieving a higher level of functioning to accept he has a drug problem, and no interventions were listed. His goal #2 was to acquire an employment position in the facility, and his YC, clinician, and teacher will assist him in advancing in the phase system. His goal #3 was to acquire his GED and his YC, clinician, and teacher will assist him. Basically, despite his intelligence and high aspirations, it appeared that Finger Lakes staff were hoping he would make changes when he got to the step-down program. His current support plan did not address what has to change while he is at Finger Lakes and after leaving for him not to return.

[redacted] was a 14-year old sent to Finger Lakes in 8/12 for violation of probation for criminal mischief. He was released after more than nine (9) months (6/13) to his father in the Bronx and returned to Finger Lakes in 10/13 as a revocator. He had been AWOL from aftercare and was arrested for concealing an imitation weapon. His current support plan reported that he "has the ability to quickly learn and utilize social skills; he has the ability to be respectful, demonstrate leadership, and be a positive role model." His goal #1 was to learn skills to remain in the community successfully and his YC and clinician planned to build on his Distress Tolerance, Emotional Regulation, and prosocial skills. His goal #2 was to re-establish and maintain positive relationships with peers and staff, and his YC and clinician were going to support use of Interpersonal Effectiveness skills. [redacted] parents are separated and both are involved on his support team, but there had been no contact with his CMSO since his return. His current support plan did not appear to contain anything that will ensure improved re-entry success from this Finger Lakes stay than the last.

[redacted] was 16 when he was sent to Finger Lakes for assault in 3/13; he was released after four months (7/13). He was returned to Finger Lakes two months later (9/13) for violating aftercare after missing appointments for substance abuse counseling and cutting off his electronic monitoring bracelet. He was released in 11/13. His Integrated Assessment was superficial, indicating he lived with his mother, her boyfriend (with whom he has conflict), and [redacted] siblings in [redacted]; his father was incarcerated. A history of concussion and loss of consciousness from a bike accident was noted, but no recommendations were made for follow-up assessment. His support plan just before his release in 11/13 is also superficial, with almost no interventions, including none for several family goals that appeared necessary for successful re-entry. His goal #1 was to attend a Division 1 college and play sports, and the only intervention was to work with recreation staff to identify training programs. His goal #2 was to finish high school, with no interventions. His goal #3 was to process parenting concerns and identify services in the community (he is a father), with no interventions. His goal #4 was to work on substance abuse issues by "setting boundaries, new friends, follow rules of substance program," but with no Finger Lakes staff interventions specified. His goal #5 was to work on controlling his anger by finding appropriate outlets for anger (e.g. boxing, reading, drawing), but with

no interventions. Surprisingly in his Continuity of Care Plan for his discharge in 11/13, although there was a referral for B2H, family therapy and substance abuse treatment, it listed mental health counseling as not indicated. If his primary problem at home was conflict with his stepfather and in the community was substance abuse and taking responsibility for his child, by not including interventions to assist him with progress in the facility with these difficult challenges, his re-entry success relies on the effectiveness of B2H and family therapy, where trust will have to be built and he may feel he is "starting over" since they may not use the skills he learned in the New York Model.

No analysis was evident in these three Finger Lakes returnees' support plans of why specifically their gains at the facility had not continued in the community. Finger Lakes emphasizes preparation of a portfolio before release, and a similar level of effort to support the resident in learning how specifically his second re-entry must be different is essential. Despite the individual progress these three residents made during their four, six and nine month stays, it was not apparent that B2H and community substance abuse treatment supported them sufficiently to maintain their gains at home. The trauma that may have contributed to their substance, family and peer problems was not incorporated in their support plans, and trauma-responsive treatment at Finger Lakes and the community may have been central to successful re-entry. Unsuccessful discharges are harmful for residents and discouraging for staff. It is important that the Assistant Directors for Treatment, clinicians, and YCs to develop ways to determine what will reduce unsuccessful discharges and implement those steps with staff and residents.

The QAI Review at Finger Lakes found that one resident's release planning began when he first arrived; he came from a one-year residential placement and will be stepped down to a residential placement. The CST worker and YC have discussed his step-down plan with the youth in support team meetings and individual counseling. The QAI Review found that another resident spent eight months at Finger Lakes before his first release home with aftercare services and placement on electronic monitoring. He spent four months in the community when he absconded from home, so his release was revoked and he was returned to Finger Lakes. During this second stay at Finger Lakes, there were many contact notes by the CST worker demonstrating engagement with the youth. After the court denied an extension and ordered his release, there was no evidence of a support team meeting held to discuss the youth and family's plan, the services they would be receiving, or the school the youth would be attending.

FUTURE MONITORING

The MH Monitor will review documentation that Finger Lakes produces thorough Community Re-Entry Plans and that, along with Continuity of Care plans, support the continuation of the resident's progress in the facility in the community, and for those residents who are returnees to Finger Lakes, address specifically what will make the next re-entry successful.

IV. DOCUMENT DEVELOPMENT AND QUALITY ASSURANCE

56. Document Development and Revision. Consistent with paragraph 68[2] 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.

COMPLIANCE

COMMENT: This and the previous monitoring visit generated no concerns about Paragraph 56.

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

PARTIAL COMPLIANCE

COMMENT: A positive element of the monitoring process 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 been implementing a quality assurance strategy that could lead to an expedited finding of compliance for the Protection from Harm paragraphs when fully implemented. In its efforts to assist the facility in the appropriate use of physical restraint interventions, Home Office developed performance metrics through the efforts of many DJJOY staff members, especially the important assistance of Dr. Rebecca Colman, Director of OCFS' Bureau of Strategic Planning and Policy Development. QAI reviewed with the Monitors the development of these restraint metrics and how they will be linked to graduated response protocols and action plans. More importantly, this QAI initiative recognize that the paradigm shift that occurred in juvenile corrections nearly two decades ago and was consistent with generally accepted professional standards. These critical performance metric/restraints safeguards require more time for implementation and

[2] 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.

verification, but they have the potential to change the monitoring strategies in such a way that expedites agreement among the Parties about compliance.

The Monitors' endorsement of the new protocols was that they satisfied the need for a reasonable, logical, and coherent policy, but there was not yet information about the performance of the new protocols. Evidence that the protocols work is necessary to find compliance with this paragraph.

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 some progress toward compliance. Staff have strong relationships with residents. The observed support teams demonstrated strong teamwork, rapport with residents, communication with families, and collaboration with CMSO. Intact teams demonstrated effective communication among all members of the team.

The QAI Report described improvements at Finger Lakes.

Despite their commitment to improving interventions with residents, Finger Lakes staff are overextended to achieve the structural elements of New York Model and documenting them—IIP, Integrated Assessment, support plans, groups and discharge planning—and cannot give attention to demonstrating DBT and Sanctuary skills consistently every day. Sufficient coaching of staff and intensive therapeutic work with residents is not possible with the shortage of clinicians. Furthermore, staff being mandated to work double shifts undermines effectiveness. The facility continues to have scheduling problems that have lasted two years and make it impossible for YDAs and psychiatrists to consistently participate in Mental Health Rounds and support teams. Finger Lakes staff are dedicated but exhausted.