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

Facility Monitoring Report:
Columbia Girls Secure Center
Claverack, NY

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Mental Health Monitor

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INDIVIDUAL FACILITY MONITORING REPORT:
COLUMBIA GIRLS SECURE CENTER
Claverack, NY

I. INTRODUCTION

This is the seventeenth monitoring report for the Settlement Agreement between the United States and the State of New York in the matter of *United States v. the State of New York and the New York State Office of Children and Family Services* (U.S.D.C. Northern District of New York), and it describes the monitoring visit to the Columbia Girls Secure Center (Columbia) on March 5 and 6, 2014. The Monitoring Team for the Settlement Agreement 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).

Pursuant to the Monitors' recommendation in the Columbia report dated November 11, 2013, the Department of Justice approved the petition by the Office of Children and Family Services (OCFS) that Columbia be found in compliance with the Protection from Harm paragraphs of the Settlement Agreement (Paragraphs 40-44, excluding subparagraphs 44b (first sentence), d, e, and h).

Since the Protection from Harm monitoring at Columbia was terminated after the last 2013 site visit, it was anticipated that Dr. Roush would not be involved in the March, 2014 Columbia site visit. Due to Dr. Beyer's medical problem, Dr. Beyer participated in the March 5 and 6, 2014 by videoconference, teleconference and receiving documents by mail and electronically. Dr. Roush was on site at Columbia on March 5, 2014 in order to conduct interviews and review documents at Dr. Beyer's request to provide information to Dr. Beyer about particular Mental Health subparagraphs of the Settlement Agreement

This report evaluates numbered Paragraphs 45-55 in the Settlement Agreement. Specific headings within these groups of paragraphs include Behavioral Treatment Program, Mental Health Crises, 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, and Transition Planning.

A. Facility Background Information

Columbia is a 16-bed secure girls facility consisting of two living units, each with a capacity of eight, in a building that also has the school and dining hall and another building with the gym, library, and a classroom. Columbia serves three types of offenders: (1) juvenile offenders/youth offenders who have committed specified serious felonies who are placed by criminal court and who must remain in a secure facility for their confinement. These youth are transferred to the New York State Department of Correctional and Community Services if they must continue to be confined when they reach age 21; (2) juvenile delinquents placed restrictively by the family court who have committed specified

serious felonies; and (3) juvenile delinquents placed by the family court whose placement in a secure facility has been authorized by the court or who have been transferred from a limited secure facility through an administrative action referred to as being "fennered." Residents at Columbia may remain involuntarily in OCFS up to age 18. At least one of the residents at Columbia at the time of the site visit who has a 15-life sentence is likely to transfer to an adult prison at age 21. None of the residents at Columbia at the time of this site visit had been fennered there.

On March 4, 2014, there were 10 girls at Columbia: all were juvenile offenders/youth offenders. Only three girls remained from the monitoring visit six months previously. Four girls who had been at one or more previous site visits had been discharged after very long stays: two went home, one went to an RTF and one went to a halfway house.

The 10 girls ranged in age from 15½ to 20½; nine were 16 or older. They had been at Columbia (or Tryon) from 12 days to 1,168 days (three had been at Columbia less than three months; four had been there four-six months). The 12 girls were committed for: Murder (1), Manslaughter (2), Assault (2), Robbery (4), and Burglary (1).

On March 5, 2014, all the girls at Columbia had psychiatric diagnoses: PTSD (2), Generalized Anxiety Disorder (1), Anxiety (1) Major Depression (1), Depression (1), Dysthymic Disorder (1), ADHD (1), Bereavement (1), Cannabis Use (1), and Insomnia (1); all of the girls were diagnosed with Conduct Disorder. Four of the girls were prescribed psychiatric medication: Zoloft (1), Adderall (1), and Benadryl (3).

B. Assessment Protocols

The assessments used the following format:

1. Pre-Visit Document Review

The MH Monitor discussed with OCFS the documents necessary for the Columbia monitoring and received the documents. The Monitors also received the *Pilot Program Review: Columbia Girls Secure Center for Girls* (Draft; 2/4/14), 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.

3. Entrance Interview

The entrance interview occurred on March 5, 2014 and included Dr. Roush (in person to support Dr. Beyer's review) and OCFS representatives, including key staff members from the facility (Dr. Beyer joined late by teleconference). The meeting provided an opportunity for introductions, informal discussion of institutional goals, an overview of the assessment process, and the scheduling of the remaining assessment activities. Those in attendance included: Sandra Carrk, Project Manager; Patricia Fernandez, Assistant Director for Treatment; Edgardo L. Lopez, Settlement Agreement Coordinator; Anne Pascale, Bureau of Behavioral Health Services (BBHS) Chief of Treatment Services; and

Anita Sapio, Facility Director. (Note: The Assistant Director for Program position was vacant).

4. On-Site Review

Most of the documents that would have been reviewed on-site were sent electronically to the MH Monitor. While at Columbia, Dr. Roush reviewed documents not sent to the MH Monitor including medical records. The MH Monitor observed two support team meetings, Mental Health Rounds, and met with the clinicians by videoconference and reviewed six girls' records. The MH Monitor (by teleconference) and Dr. Roush met with the Columbia Therapeutic Intervention Committee (TIC).

5. Staff Interviews

On the MH Monitor's behalf, Dr. Roush interviewed four Columbia YDAs; he structured the interviews around questions the MH Monitor requested.

In addition to group meetings with staff, the MH Monitor interviewed the Assistant Director for Treatment and a clinician by phone.

6. Resident Interviews

On the MH Monitor's behalf, Dr. Roush interviewed four Columbia residents, two from each unit who had been at Columbia from 12 days-5 months and were 15, 16, 17 and 19 years old; he structured the interviews around questions the MH Monitor requested. Interviews occurred in areas with reasonable privacy from staff. The Monitors selected the youth for interviews.

7. Exit Interview

The exit meeting occurred on March 6, 2014. The Monitors expressed their appreciation for the cooperation and hospitality of the Columbia and OCFS staff. The MH Monitor described successes at Columbia. The Monitors described their meetings at Home Office earlier in the week. The exit meeting was a time for questions and impressions before the draft report is sent to both Parties. Those in attendance included: Sandra Carrk, Project Manager; Nancy Copenen, Secretary; Marvin Curry, YDA IV; Nikita Dickerson, YC1; Patricia Fernandez, Assistant Director for Treatment; Floyd Harkless, YDA IV; Tanya Harrison, YDA IV; Cory Jackson, Youth Counselor II; Crystal Jones, Youth Counselor; Chris Latino, Psychologist 2; Edgardo Lopez, Settlement Agreement Coordinator; Deborah Mulligan-Timer, NPP; Anne Pascale, BBHS Chief of Treatment Services; Jamie Romero, YCI; Melissa Ross; Anita Sapio, Facility Director; Ann Saxe, YDA IV; Betsy Subik, YDA IV; Kim VonWedel, LMSW; and Ron Williams, YC1. Participating by teleconference were David C. Bach, QAI Director; Jim Barron, Associate Commissioner for Human Resources; Marty Beyer, MH Monitor; Merle Brandwene, Director, Office of Management and Program Support; Matt Carpenter, Executive Assistant to the Deputy Commissioner; Erin Cassidy, Executive Assistant to the Executive Deputy Commissioner; Diane Deacon, Legal; Larry Gravett, Director, SIU; Robert MacGiffert, QAI Assistant Director; David Nasner, BBHS Special Projects Coordinator; Ines Nieves, Acting Deputy Commissioner DJJOY; Sheila Poole, Acting Commissioner; Lee Prochera, Deputy Counsel; Erin Purdy, Supervisor of Facility Security; David Roush, PH Monitor; Monique Thomas, OCFS Legal; and Iren Valentine, Director, Bureau of Behavioral Health Services.

II. MENTAL HEALTH MONITORING

The Monitors find the Mental Health Paragraphs 45-55 in substantial compliance with the Settlement Agreement at Columbia. Pursuant to Paragraph 77, Subsection d regarding "compliance with a portion of the agreement with respect to one or more facilities," the Monitors support a request by Home Office to DOJ for the end of the Mental Health monitoring at Columbia.

Columbia is an exemplary facility. The collaborative work among staff is outstanding. Relationships between staff and girls continue to be the key to the residents' progress. Increasingly sophisticated implementation of the New York Model has been evident over the past year, which is particularly noteworthy in a facility with unusually immature girls in combination with many residents being 18 or older and some girls who have been in custody for years with girls who are released in a few months.

As noted in this report, there are several Mental Health subparagraphs that were not found in compliance 12 months ago because policies, and/or guidelines had not been completed by Home Office. However, even without final policies and guidelines, Columbia practices have complied with the requirements of those subparagraphs for 12 months or longer.

Before this site visit, QAI completed a thoughtful review at Columbia that recognized Columbia for strong team meetings and groups and found that "most of the youth were able to clearly state their goals and how they would achieve them." The QAI review commended the Columbia Assistant Director for Treatment for establishing a clear treatment philosophy and the two Columbia YCs for their strong case management skills. The Monitors discussed the report with QAI staff members by conference call on February 28, 2014. The call included David L. Bach, Director QAI; Sandra Carrk, Project Manager; Lori Clark, Quality Assurance Specialist; Diane Deacon, Asst. Deputy Counsel OCFS; Myra DeLuke, Quality Assurance Specialist; Norine Durkin, Quality Assurance Analyst; Edgardo L. Lopez, Settlement/Agreement Coordinator; Robert MacGiffert, Assistant Director QAI; Jennifer Mack, Quality Assurance Analyst; Denise Passarello, Quality Assurance Specialist; Michael Rotolo, Quality Assurance Analyst; Hilda Saltos, Quality Assurance Analyst; and Jennifer Utting, Quality Assurance Specialist.

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 Columbia.

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 concluded that the New York Model is implemented at Columbia as evidenced by their examination of residents' records for integrated assessments, psychiatric evaluations, support plans, psychiatric contact notes, medication, suicide response, substance abuse services and release planning, interviews of staff and residents, and observations of support teams, Mental Health Rounds and groups.

46b. Create or modify and implement policies, procedures, and practices to require that mental health staff provide regular consultation regarding behavior management to direct care staff and other staff involved in the behavioral treatment program.

COMPLIANCE

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

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.

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

COMPLIANCE

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

Through support teams and Mental Health Rounds, Columbia staff are complying with 46c on an individual basis. Columbia staff discuss the effectiveness of interventions facility-wide and make adjustments to their practices during Mental Health Rounds, the Columbia TIC meetings, and change of shift meetings in compliance with 46c.

The MH Monitor reviewed informative monthly BBHS site visit reports by Anne Pascale, Chief of Treatment Services which showed another approach to program refinement at Columbia.

The Columbia Integrated Assessment, IIP, Support Plan, and contact notes by the psychiatrist, NPP, clinicians, YCs and CMSO were all accessible on JJIS and comply with 46c. JJIS is designed to capture how a strengths-based, trauma-responsive approach is being implemented with each resident and tracks the diverse interventions of the New York Model. JJIS makes it possible to document practice according to the procedures that comply with several mental health paragraphs in the Settlement Agreement and allows for the regular assessment of the effectiveness of interventions required by 46c.

Columbia staff have been in compliance with 46c for 12 months by refining their program's effectiveness, particularly through Red Flag meetings and Mental Health Rounds, although tracking through JJIS and the consistent use of the TIC for program improvements were not finalized by Home Office until fall, 2013.

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.

Columbia staff provide orientation to new residents in compliance with 46d. Records indicated that all of the new arrivals had an orientation that explained the program to them, and this was verified by the interviews conducted by Dr. Roush on behalf of the MH Monitor. Both living units have New York Model (DBT/Sanctuary) principles on the bulletin boards near the bathrooms.

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

Columbia staff have been in compliance with 46d for 12 months with the orientation of youth to their program, although policies regarding orientation were not finalized by Home Office until mid-2013.

On Site Observations Regarding Paragraph 46a-d (3/14)

Paragraph 46 of the Settlement Agreement requires an effective program to meet the needs of residents. OCFS is implementing the New York Model, and the policies and training to support it, to build on the strengths of OCFS services and address limitations of past programming. OCFS does not have to implement the New York Model to comply with Paragraph 46, but OCFS is choosing to comply with Paragraph 46 with the New York Model.

The New York Model has been fully implemented at Columbia. The Daily Achievement System (DAS) and phase system are in place, each resident has a mentor, and each phase requires a certain number of mentoring contacts. Staff members, including YDAs, the school and AODs, are actively involved in support teams and Mental Health Rounds. Program enhancements include individuals from the community providing a variety of activities at Columbia including music therapy, pet therapy, Zumba, arts and crafts, the Sister-to-Sister faith-based program on Sundays, incentive trips, hair styling, and Columbia cash earned for buying yarn and hygiene products. Columbia continues to sponsor regular Family Days where families and CMSOs visit. Several girls enjoy attending a wood shop at Brookwood Secure for vocational education. Staff consistency continues to be a strength at Columbia—even though many staff commute an hour or more each way, car pools have been supported by flexible scheduling.

Columbia staff described the purposeful use of the orientation in the first days after a resident arrives, when she is not participating in the regular schedule immediately, and staff and residents teach the new arrival about the program. In the interviews, a resident explained the orientation process:

> "I had a 3 day orientation that included a medical exam, books on life skills, 2 girls who came and explained the program to me, and a welcoming group on the 3rd day where everyone introduced themselves, shared their goals, and talked about the program."

The four interviewed residents each named one or more staff who have helped them change:

> "They show me a lot of acceptance; they check me on things all the time, but they're not judgmental."
>
> "The thing that has helped the most is sessions that include role-play and practice."
>
> "He talks to me everyday, he says good things, he talks about what I need to do to get out and what I need to do when I'm released; he makes sense; he puts me on the right track; he uses the New York Model language."

In the month before the site visit, clinical contacts notes at Columbia indicated that one clinician saw 6 residents 1-4 times each for individual therapy; another clinician saw 4 residents 8-9 times each for individual therapy; and another clinician saw 1 resident 5 times for individual therapy.

The MH Monitor observed exceptional Mental Health Rounds at Columbia (by videoconference). Participants included the psychiatrist, the Assistant Director of Treatment, two clinicians, two YCs, the nurse, the PNP, two teachers, a YDA and the BBHS Director of Treatment Services. They collaborated on a detailed discussion of two residents with intellectual disabilities (particularly speech and language deficits). Both are special education students who have difficulty with comprehension, in part because their vocabularies are so limited. All staff have learned to explain limits and activities using understandable words, with repetition and help for these residents not to get overwhelmed by too much information (while at the same time avoiding making them feel they are "slow"). Teaching mindfulness and awareness of emotions in simple terms has been especially challenging. Columbia's adjustment of the New York Model for residents with intellectual disabilities would be a valuable approach for other facilities to learn.

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, rather than simply a clinical service. The Columbia coaching team convened for a discussion with the MH Monitor by videoconference and described their ongoing efforts to provide guidance to staff who are always improving in their teaching of self-regulation to residents. Girls have been helped to learn not to be afraid of strong emotions and to become confident they can manage them. The focus has been on continually enhancing the tone of Columbia: teaching self-soothing through a calm tone on each unit is emphasized. This has included coaching in not seeing interactions with residents as disciplinary and instead as teaching moments. Coaching has led to important improvements in the supervision of YDAs: instead of a time and attendance focus, supervision is about each staff person's use of their relationships with residents for teaching. There is open discussion among staff about the emotions evoked by residents in staff and how to manage them. "We

could not have done any of these refinements without a strong working team." The coaching team has turned the phase system into a powerful tool, both for residents and staff. As one coach described, a staff member was surprised at the depth of a discussion abut a resident asking for phase advancement, and previously thought phases were "'just about behavior.' It takes time to understand how what we do here is about what is behind the behavior." As Columbia adjusts to the discharge of its long-stay residents, the coaches are reminding staff that "it takes time to change. With the newest girls we have to be patient and not move them to a higher phase if they are not ready." Ongoing training at Columbia on the New York Model, DAS and how to apply mental health information to individual girls has also provided opportunities for coaching.

The MH Monitor met with the Columbia TIC by teleconference, and Dr. Roush was in the meeting on the MH Monitor's behalf. The TIC demonstrated the continuing refinement of the New York Model to enhance the effectiveness of the Columbia program. They have used the TIC to problem solve concerns about the DAS. They have collaborated to change the environment for the new residents at Columbia who required more consistent structure than residents who had been at the facility for a long time. In emphasizing the message of safety plans that "You can do these things for yourself," staff are learning how to teach residents "to rescue themselves" but also be able to ask for help. Staff ask residents, "What can you use from your safety plan to calm yourself down?" This has led to clarity about room time as a self-calming method in which residents getting time for themselves (whether reading, journaling, or thinking) is a new way to soothe themselves. Staff said that before the New York Model, room time was seen as a punishment and staff worried what residents would do if they were not constantly observed, so well-managed "Time Away" as a teaching tool has taken time for staff to adjust to. The Columbia TIC seems to be a place for staff from throughout the facility to "discuss new ideas for how to look at what we are trying to accomplish. Using our own self-evaluation in order to be purposeful about what we are teaching." TIC meeting notes from previous months reflected special training for YDAs in the Seven Challenges substance abuse curriculum and a 3-day Sanctuary training for staff (including a real Red Flag meeting as a demonstration). Since the last site visit, Columbia made progress on one of their important program improvement objectives: continuing to expand the YDAs' role in the TIC, support teams, and Mental Health Rounds.

DBT groups, Sanctuary groups and Girls Circle meet consistently once a week on each unit at Columbia and are reflected in the clinical contact notes for residents. In the month before the site visit, clinical contacts notes at Columbia indicated that one clinician saw 13 residents in DBT group, most of them 4 times.

The Columbia DAS is a skill-based approach to safety, emotion management, loss and future consistent with the New York Model. The Columbia DAS scores a different individual treatment goal for each girl, and there is a clear connection between their most recent support plan and the treatment goal listed on the DAS. Columbia staff recently improved their system for staff collaboration on the DAS and discussions of scores with residents.

On the MH Monitor's behalf, Dr. Roush interviewed four Columbia YDAs; he structured the interviews around questions the MH Monitor requested. All four said they feel that they are a valued member of the team. They said they are skilled at helping girls

calm themselves down, including: "I have a calming presence. I'm very consistent; I don't change my affect; I give a lot of reminders in a calm way that uses program language." "Everything I do is based on the relationship; I use humor a lot." They emphasized staff communication so that staff effectively "use New York Model skills to help them do their job." Staff interviews reflected continuing work at making the DAS a useful tool for residents. Staff interviews indicated the importance YDAs give to getting information from clinicians and YCs about "the issues surrounding the youth, anything to make the job easier and to help us help the youth."

47. Mental health crises. The State shall provide any youth experiencing a mental health crisis with prompt and adequate mental health services appropriate to the situation. To this end, the State shall:

47a. Train all appropriate staff, including direct care staff, on appropriate positive strategies to address a youth's immediate mental health crisis, including a crisis manifesting in self-injurious behavior or other destructive behavior. Such strategies should be utilized in an effort to stabilize and calm the youth, to the extent possible, while awaiting the arrival of a qualified mental health professional. Staff shall not resort to uses of force, including restraints, except as provided in paragraphs 41 and 42 [of the Settlement Agreement].

COMPLIANCE

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

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

Mental health staff members at Columbia were observed complying with 47a.

47b. Create or modify and implement policies, procedures, and practices for contacting a qualified mental health professional outside of regular working hours in the event of a youth's mental health crisis or other emergency situation.

COMPLIANCE

A 3/12 memorandum entitled "Contacting Mental Health Professionals Outside of Regular Work Hours" (linked to the Behavioral Health Services policy (PPM 3243.33) finalized in 5/12) complies with 47b and indicates that "each of the facilities reports having an established procedure in place." Updates regarding the staff person to be contacted for mental health crises after hours at Columbia are decided at the facility level and are maintained at the Central Services Unit (CSU), which complies with 47b. The telephone number (emergency contact) of Dr. Fernandez as the mental health crisis person to contact after-hours is posted in CSU, as confirmed Dr. Roush on behalf of the MH Monitor.

47c. Require that any youth who experiences a mental health crisis and resorts to maladaptive coping strategies, such as self-injurious behavior, is referred for mental health services following the resolution of the immediate crisis. A qualified mental health professional shall develop a crisis management plan in conjunction with the youth and his or her other mental health service providers. The crisis management plan shall specify methods to reduce the potential for recurrence through psychiatric

treatment, treatment planning, behavioral modification and environmental changes, as well as a strategy to help the youth develop and practice positive coping skills. Such services shall continue throughout the duration of the youth's commitment to the Facility.

COMPLIANCE

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

On Site Observations Regarding Paragraph 47a-c (3/14)

Completed ISO 30s were observed in Columbia residents' records.

In the six months before this site visit, two residents were placed on Suicide Watch at Columbia (█ twice, 10/11/13 (for less than a day) and 10/23/13 (for one day) and █ 11/21/13 (for one day). █ a 16-year old, was admitted to Columbia on 11/20/13 for a robbery; she had previously spent months at █ She had been hospitalized for depression and suicidal thoughts. Her father is incarcerated and she was removed from her substance-abusing parents and raised by her █ since age 3. Her diagnosis was Dysthymic Disorder, Generalized Anxiety Disorder, PTSD, Conduct Disorder and Cannabis Abuse and she was prescribed Prozac. Her goals in her 1/14 support plan were: To learn how to manage her emotions, To stop smoking marijuana in the community, and To earn her high school diploma. In the month before that support team, █ had been restrained twice as a result of peer disputes which were de-escalated but she had difficulty managing her emotions and began throwing things which led to the restraints. During her three months at Columbia, she worked in therapy, used mindfulness, and completed diary cards to identify and manage her emotions. Clinical contacts notes revealed skilled handling of her suicidal thoughts soon after her arrival: the clinician met with █ at 1 PM the day after she arrived at Columbia and she completed the ISO 30. At 5 PM the same day, the Columbia NPP met with █ who was prescribed Zoloft and Risperdal at her prior placement). The NPP told the clinician she was concerned that █ was suicidal; the clinician learned from the record that █ had been on suicide watch 10 days prior to admission; her ISO 30 placed her at high risk for suicide. The clinician met with █ at 6 PM, discussed her thoughts and feelings and placed her on Suicide Watch. The clinician met with her the next morning and several times during the day. She was able to contract for safety and her suicide watch was discontinued; the clinician met with her the next day.

In the six months before this site visit, no Columbia residents were admitted to a psychiatric facility.

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 BBHS Facility Clinical Procedures described the Integrated Assessment, which complies with 48a.

Columbia records reflect that residents are seen soon after admission by a mental health professional who completes the ISO-30 and begins the Integrated Assessment. Youth who arrive on psychiatric medication or who are referred to the psychiatrist by facility staff are seen, documented in a psychiatric evaluation or psychiatric contact note. The MH Monitor observed completed and timely Integrated Assessments in the Columbia records that demonstrated compliance with 48a.

48b. Require that any youth whose mental health screening identifies an issue that places the youth at immediate risk is immediately referred to a qualified mental health professional. The qualified mental health professional shall determine whether assessment or treatment is necessary. A determination to transfer a youth to a more appropriate setting on other than an emergency basis shall require consultation with a committee designated by OCFS' Deputy Commissioner for Juvenile Justice and Opportunities for Youth (DJJOY) or his or her designee or successor. Such committee may include qualified mental health professionals at OCFS' central office. If a determination is made that the youth should be transferred to a more appropriate setting, the State shall immediately initiate procedures to transfer the youth to such a setting.

COMPLIANCE

The procedure for referring a youth for evaluation to a qualified mental health professional was completed. A 2/12 memo described (linked to the Behavioral Health Services policy (PPM 3243.33) finalized in 5/12) the procedure for referral of youth to a committee for a mental health placement and complies with 48b. The procedure was revised in a memo on DJJOY Referrals send to BBHS and facility clinicians in 12/12, including a change in the name of the committee to the BBHS Youth Team, also in compliance with 48b.

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.

COMPLIANCE

The Integrated Assessment form complies with 48c.

The OCFS Psychiatry Manual (3/14) complies with the requirements of 48c.

Efficacy of interventions is discussed in Mental Health Rounds and psychiatric contact notes, and the psychiatrist, Assistant Director for Treatment and others bring research findings or treatment information to the attention of staff.

Columbia staff have been in compliance with 48c for 12 months with their Integrated Assessments, although the OCFS Psychiatry Manual was not finalized by Home Office until 2014.

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.

COMPLIANCE

The OCFS Psychiatry Manual (3/14) complies with the requirements of 48d. Columbia staff have been in compliance with 48d for 12 months with clinical contact notes, particularly the Psychiatric Contact Notes, that discuss residents' symptoms and diagnoses, although the OCFS Psychiatry Manual was not finalized by Home Office until 2014.

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 Columbia records reviewed by the MH Monitor.

The OCFS Psychiatry Manual (3/14) complies with the requirements of 48e.

On Site Observations Regarding Paragraph 48a-e (3/14)

On March 5, 2014, the Columbia residents had the following diagnoses:

Depression, Anxiety, Conduct Disorder
PTSD, Conduct Disorder
Dysthymic Disorder, Conduct Disorder, Bereavement
Major Depression, Conduct Disorder, Rule Out Mild Mental Retardation
Insomnia, PTSD (by history), Conduct Disorder
ADHD, Conduct Disorder
Generalized Anxiety Disorder, Conduct Disorder, Cannabis Abuse
Conduct Disorder (2)

The MH Monitor reviewed the OCFS Psychiatry Manual completed in March 2014. It is a thorough presentation of psychiatry standards in DJJOY facilities (for psychiatrists and psychiatric nurse practitioners), including: psychiatric evaluations, diagnosis and symptom

identification, therapy in the facilities, family engagement, prescription and monitoring of psychotropic medications, and clinical connections to OCFS staff (as well as consent procedures, initial mental health screen and intake assessment, psychiatric hospitalizations, relationship with CMSO offices, OMH Mental Health Units, and documentation). The Appendix contains ten DJJOY policies applicable to mental health: behavioral health services; child abuse and neglect; crisis prevention and management; initial mental health screening; lesbian, gay, bisexual, transgender and questioning youth; psychiatric hospitalizations; psychiatric medicines; suicide risk reduction therapeutic management; youth rules; and prevention, detection and response to sexual abuse, assault and harassment. The manual begins by noting that about half the youth in DJJOY facilities have mental health issues who are the focus of the psychiatrists.

The MH Monitor had a productive meeting with the consulting supervising psychiatrists (Dr. Shashi Elangovan and Dr. Andrea Faulkner), Dr. Michael Cohen, Medical Director, Ines Nieves, Acting Deputy Commissioner, Dr. Iren Valentine, Director, BBHS, Dr. Joe Tomassone, Anne Pascale and Dr. Amy Vent (three BBHS Chiefs of Treatment Services) David Nasner, BBHS Special Projects Coordinator, and other Home Office representatives by teleconference on March 4, 2014. The requirement of 48d is to "develop a consistent working diagnosis(es)." OCFS provides clinical guidelines in the BBHS Facility Clinical Procedures and the new Psychiatry Manual (3/14). On 1/29/14 the Director of BBHS sent a memo to all OCFS psychiatrists indicating that "OCFS has committed to having a uniform working diagnosis for each youth receiving mental health services. Changes in a youth's diagnosis should result from an updated evaluation or as a result of the support/treatment team discussion."

The MH Monitor examined the diagnoses of all 35 youth prescribed psychiatric medication by four psychiatrists and one NPP at Columbia, Finger Lakes, and Taberg in January, 2014. This analysis revealed considerable range among psychiatrists about diagnosis, with the most common diagnoses across the three facilities being sleep disorders, Depression, PTSD, Mood Disorder, and ADHD:

SLEEP DISORDERS 35% of youth prescribed medication (12)
(including Insomnia, Sleep Disorder, and Circadian Rhythm Sleep Disorder)

Columbia	57% (4)
Finger Lakes	13% (2)
Taberg	46% (6)

DEPRESSION 31% of youth prescribed medication (11)
(including Depression, Major Depressive Disorder, and Dysthymia)

Columbia	57% (4)
Finger Lakes	20% (3)
Taberg	31% (4)

PTSD 23% of youth prescribed medication (8)

Columbia	
Finger Lakes	
Taberg	62% (8)

MOOD DISORDER 20% of youth prescribed medication (7)

Columbia		
Finger Lakes	33%	(5)
Taberg	15%	(2)

ADHD 17% of youth prescribed medication (6)

Columbia		
Finger Lakes	40%	(6)
Taberg		

In January, 2014, more youth were diagnosed with depression and sleep disorders at Columbia (57%) and PTSD (62%) and sleep disorders (46%) at Taberg while 40% of youth at Finger Lakes were diagnosed with ADHD and 33% with Mood Disorder.

The diagnosis of PTSD increased and of Anxiety decreased across the three facilities:

	1/13	7/13	1/14
Depression	27%	9%	31%
PTSD	9%	9%	23%
Mood	27%	21%	20%
ADHD	23%	23%	17%
Anxiety	23%	9%	3%

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 Chief Psychiatrist indicated 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.

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.

The OCFS Psychiatry Manual (3/14) complies with the requirements of 49a.

The Psychiatric Contact Note links diagnosis with the medication prescribed, followed by a current symptom checklist. The MH Monitor observed the Columbia psychiatrist explaining the rationale for prescribing particular medication to treat a resident's symptoms.

Columbia staff have been in compliance with 49a for 12 months with their Psychiatric Contact Notes, although the OCFS Psychiatry Manual was not finalized by Home Office until 2014.

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.

The OCFS Psychiatry Manual (3/14) complies with the requirements of 49b.

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

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.

The OCFS Psychiatry Manual (3/14) complies with the requirements of 49c.

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

On Site Observations Regarding Paragraph 49a-c (3/14)

On March 5, 2014, four of the Columbia residents were prescribed psychiatric medication:

Zoloft
Adderall
Benadryl (3)

In the month before the site visit, clinical contacts notes at Columbia indicated that the Columbia psychiatrist saw 2 residents once each for medication review and the Columbia Psychiatric Nurse Practitioner saw 7 residents once each for medication review (one was also seen again a week later).

Completed forms for laboratory and clinical monitoring of residents prescribed psychiatric medication (Weight and Vital Signs Flow Sheet and Psychiatric Medicine Monitoring Flow Sheet) and documentation of diagnosis, symptoms, dosages, and administration of psychiatric medication are in the individual records at Columbia.

The requirement of 49a is to state "the target symptoms intended to be treated by each medication." OCFS provides clinical guidelines in the BBHS Facility Clinical Procedures and the new Psychiatry Manual (3/14). The Director of BBHS sent a memo to all psychiatrists on 1/29/14 reminding them of the expectation that they clearly identify in their contact notes the target symptoms and rationale for each medication being prescribed.

The MH Monitor examined the diagnoses of all 35 youth prescribed psychiatric medication by four psychiatrists and one NPP at Columbia, Finger Lakes, and Taberg in January 2014. Overall 43% of the residents of the three facilities were prescribed psychiatric medication (35 of 82) as compared to 49% (43 of 87) in July 2013 and 43% (36 of 83) in January 2013. In this third analysis, the MH Monitor again found divergent medication practices among the five psychiatrists and one NPP at Columbia, Finger Lakes, and Taberg. Finger Lakes continued to have a much lower percentage of prescription of psychiatric medications (31%) in comparison to Columbia (50%), and Taberg (68%). All the facilities had lower rates of psychiatric medications than previously (Finger Lakes, 36%, Columbia, 67% and Taberg, 75% in July, 2013).

The most frequently prescribed psychiatric medications in January 2014 were Trazodone (26%, 9 residents at Finger Lakes and Taberg) and Clonidine (20%, 7 residents at Finger Lakes and Taberg). Even given the small numbers analyzed, there are noteworthy different rates of prescribing medications. The most common psychiatric medications by facility were:

Columbia-Benadryl (57% of those prescribed medication; four girls were prescribed Lexapro, Remeron, Zoloft and Melatonin; in contrast, in July 2013, Columbia-Remeron (25%) and Adderall (25%)

Finger Lakes- Trazodone (27%) and Clonidine (27%); in contrast, in July, 2013, Finger Lakes-Seroquel (25%) and Clonidine (20%)

Taberg-Trazone (39%) and Clonidine (23%); in contrast, in July 2013, Taberg-Seroquel (33%) and Trazodone (27%).

There has been a decrease in Seroquel in the three facilities to 14% of prescribed psychiatric medication in January 2014 (3 residents at Finger Lakes and 2 at Taberg); in January 2013 and July 2013, Seroquel was 23% of psychiatric prescriptions—10 residents. There has been national attention to reducing the prescription of Seroquel in facilities because of the dangers of abuse after return to the community.

In the three DOJ facilities in January 2014, Trazodone was being prescribed for Depression, ADHD and sleep at Finger Lakes and Insomnia for five Taberg residents. Clonidine was being prescribed for ADHD, Mood Disorder, and Impulsive Aggression at Finger Lakes and Depression, Anxiety and Conduct Disorder at Taberg. Seroquel was being prescribed for Mood Disorder, ADHD, and Oppositional Defiant Disorder at Finger Lakes and PTSD and Depression at Taberg.

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

On Site Observations Regarding Paragraph 50a-b (3/14)

The MH Monitor observed Columbia staff discussing medication and diagnosis at Mental Health Rounds.

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 Columbia 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 Columbia 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.

Dr. Roush, on behalf of the MH Monitor, reported that there were signed medication refusal forms in Columbia 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

Dr. Roush, on behalf of the MH Monitor, reported that there were signed medication refusal forms in Columbia residents' records that complied 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 Columbia residents' support teams that complies with 51e.

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

The OCFS Psychiatry Manual (3/14) complies with the requirements of 52.

Staff members 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.

Dr. Roush's review on the MH Monitor's behalf of the STARS records for the Mental Health and Psychiatric Medications Overview Training Course indicated that there were 8 Columbia staff members who had not completed the training course, but these 8 individuals were scheduled for the next course on March 18, 2014.

Completed informed consent forms were in the Columbia records.

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

53a. Create or modify and implement policies, procedures and practices regarding treatment planning which address, among other elements, the required content of treatment plans and appropriate participants of a youth's treatment team.

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.

Support teams at Columbia exemplify New York Model implementation.

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 members at Columbia 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 Columbia comply with 53c.

The NPP participated in the observed support teams at Columbia, which complied with 53c.

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.

COMPLIANCE

Columbia Integrated Assessments and clinical evaluations describe the effects of trauma on residents' thinking and behavior and are part of planning interventions and the residents' support plans. The effects of trauma on the resident's behavior are an important aspect of staff teaching of Columbia residents.

Columbia staff have been in compliance with 53d for 12 months with Integrated Assessments and support plans that address the effects of trauma, although guidelines for incorporating trauma into goals and interventions were not finalized by Home Office until mid-2013.

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.

COMPLIANCE

Mental health staff members at Columbia were observed complying with 53e and the support team meetings observed by the MH Monitor complied with 53e.

Columbia staff have been in compliance with 53e for 12 months with refining their approach to developing goals with residents, although guidelines for writing goals and support plans were not finalized by Home Office until mid-2013.

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.

COMPLIANCE

Mental health staff at Columbia were observed complying with 53f.

On Site Observations Regarding Paragraph 53a-f (3/14)

Columbia staff have completed IIPs for more than 12 months. Columbia staff have used the revised IIP form in JJIS since September 2013.

The MH Monitor observed two exemplary support team meetings at Columbia. Both were collaborative, with active involvement of YDAs, teachers, clinicians, YCs, AOD, medical staff and the Assistant Director. Both engaged family members: one was an out-of-state family who had visited at Columbia and were preparing for the resident's discharge to their home; the other was a mother who, during the meeting, the YC skillfully taught about mindfulness and how she might use it with her daughter. In one support team the CMSO on videoconference had been to Columbia and talked directly to the resident about how he could assist her although she will be released (on a fixed sentence) out of OCFS custody.

The first observed support team with █ a 16 year old placed at Columbia in 11/13 for a robbery, was her last meeting before discharge. A YDA described how much █ had improved in accepting feedback and her YC said she now can see the effect her behavior has on others. Although it was noted that in four months she had not changed as much as residents at Columbia for longer, her new skill of respectfully talking through pros and cons with her mother on the phone is much different from her verbal aggression in response to every directive when she arrived. There was a discussion with the CMSO that Columbia will recommend individual and family counseling, continued Adderall for ADHD and a structured school setting, but █ and her mother will have to seek the services voluntarily because she will not be in OCFS custody. She described her goals as "working on being patient and being mindful of consequences and people's feelings." The team went around the table telling █ what each could do to help her achieve her goals. One person commented, "You are a solid Regents students. Keep on developing your emotional intelligence so your feelings don't get in the way of using your school smarts." Someone else said to her mother, "You should be very proud of your daughter," and her mother thanked everyone for "all their good work." The CMSO told █ "What I heard is awesome. You are ready to come out and be successful." █ ended the meeting by saying, "I learned the problems I had to work on. When I came here, I didn't know I had to improve. I've learned skills."

The second observed support team was with [redacted] who at 19 is the longest stay resident, having been placed at Tryon in 12/10 and moved to Columbia when it opened. She did not want to be discharged to her former neighborhood, but Interstate Compact for placement with relatives out-of-state may not be finalized before her release. [redacted] has many talents and is a hard worker, both in school and her OJT job. She did all of high school while at Tryon and Columbia and passed all her Regents; she has two electives to complete to graduate from high school. Staff are working on discharge to both places (a halfway house in [redacted] and her [redacted] relatives). She is anxious about how to avoid get pulled into negative situations in her neighborhood and learning how to take care of herself as an adult, having been told what to do for four years. She had a long history low self-esteem and being brought down by enmeshed relationships. The team described her significant progress. [redacted] articulated her goals as finishing high school and learning how to handle her future relationships. She said she plans to help her mother and siblings. Staff told her they "believe she has what it takes to be successful." She said, "I learned how to put my anger aside. I thought arguing was the best way and you taught me a different way. I learned I'm not a bad person. I didn't have good relationships—you've taught me how to. I will miss a lot of people here."

Asked what they were proudest of changing (in interviews with Dr. Roush on the MH Monitor's behalf), residents responded:

> "Learning how to express myself verbally; I used to keep stuff inside, now willing to meet staff halfway. Staff are willing to do the same. Improved relationships with other youth and staff."
>
> "I am now staying away from negativity."
>
> "My attitude; I used to be vulgar, curse a lot, took things too personally, and could be very rude. I haven't done this in a month or so."
>
> "My anger is much better; I used to be evil, mean, and rude; this has to do with all the people who have wronged me in the past, but two wrongs don't make a right. I don't have to be that way; I won't get anywhere acting like that."

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.

Columbia 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 54b.

Columbia is providing a Seven Challenges group for residents who have used substances.

The Columbia clinicians provide individual therapy, including relapse prevention assistance, for residents with a substance abuse diagnosis.

On Site Observations Regarding Paragraph 54a-b (3/14)

Columbia has implemented Seven Challenges, an evidence-based adolescent drug and alcohol treatment approach with successful outcomes in juvenile justice in other states. Seven Challenges fits with DBT, supporting residents in making thoughtful choices and recognizing the consequences of their actions. It is also compatible with a trauma focus, helping residents examine what is behind their substance use. Journaling is an important part of Seven Challenges, and YCs and clinicians write notes to residents in their journals to guide their self-discovery and decision-making process. Columbia has undertaken training all the staff in the facility in Seven Challenges especially because it departs from adult-oriented 12-step programs: it does not tell residents to stop using and it recognizes that they received some benefits from using.

The substance abuse clinician is actively involved on the Columbia units and in support teams. In the month before the site visit, clinical contacts notes at Columbia indicated that the substance abuse clinician saw 13 residents in clinical groups, most of them 5-9 times. If a resident has substance abuse problems, her need for treatment is documented in the Integrated Assessment and included in her support plan.

Although the QAI Review at Columbia raised concerns about the scheduling of Innervisions groups and the documentation of substance abuse treatment in individual therapy, at this site visit, impressive substance abuse treatment integrated in the New York Model was evident to the MH Monitor at Columbia.

Columbia has been providing substance abuse services for 12 months, although the final version of the OCFS Substance Abuse Services Training and Procedure Manual was not completed by Home Office until mid-2013.

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;

COMPLIANCE

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

Columbia staff have been in compliance with 55b for 12 months with refining their approach to developing re-entry goals with residents, although guidelines for writing goals and support plans were not finalized by Home Office until mid-2013.

Columbia staff have been completing Discharge Summaries for more than 12 months. They will shift to the new Community Re-Entry Plan which Home Office expects to deploy in JJIS in March or April 2014, with training occurring through June/July 2014 in the facilities.

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

COMPLIANCE

The one-hour training for nurses entitled "Psychiatric Medications at the Time of Release" explains release plans for youth with a 30 days dose of psychiatric medication, an appointment with a community-based mental health program, and the involvement of the parent and CMSO case manager in compliance with 55c.

On Site Observations Regarding Paragraph 55a-c (3/14)

Between 8/1/13-2/15/14 eight residents were released from Columbia (not including a girl who was admitted for three days). Of the eight residents, six were released to their parent, one to RTF and one to DSS. One had been at the facility more than two years and another almost a year; the other six were at Columbia from two months to eight months.

The MH Monitor reviewed the excellent Discharge Summary for ███ a 19-year old discharged a week before the site visit after 16 months at Columbia. ███ was admitted to Columbia at age 18 (10/12) with a sentence of 1-4 years for a robbery committed when she was 16. She had a history of school suspensions due to group violence and stealing. ███ struggled with managing her emotions and accepting responsibility for her behaviors. She was denied parole in 4/13. Her goals in her last support plan were passing the TASK (GED) exam and applying for employment before leaving. She worked on both despite struggling with anxiety about leaving. Her support plan indicated she would be discharged to her mother, but hoped to move as soon as she could. Her mother wanted little involvement in her treatment and encouraged ███ to live independently. Her Discharge Summary reported "███ has received at least eight or more Role Model incentive awards and has been Student of the Week five or more times. She has been selected several times to go on trips and attend events at our central office. She continues to attend all individual therapy sessions, engage with her counselor, be a leader and role model for her peers and is an excellent participant in groups. She has attained the second highest phase in the New York Model. She accepts responsibility for tasks that need to be done and no longer blames others or complains about what others do not do for her. She demonstrates maturity and insight into her past behaviors and can make connections between them and her current placement. ███ is actively planning for her return to the community. She uses the computer to research programs and job opportunities; she has applied for employment and will be participating in the C.A.S.E.S program. She has chosen to live with her uncle who she believes will be a positive role model for her and offer support and motivation. She wants to separate herself from her old peers in the community and make safe, healthy choices." ███ Continuity of

Care Plan indicated that she was not discharged on psychiatric medication and did not want mental health or substance abuse services in the community, but would be participating in parole and the C.A.S.E.S. program for employment and education (contact information included). The name and contact information for community mental health services if she wants them was also provided on her Continuity of Care Plan.

III. SUMMARY

Columbia is an exemplary facility. The Monitors find the Mental Health Paragraphs 45-55 in substantial compliance with the Settlement Agreement at Columbia. Pursuant to Paragraph 77, Subsection d regarding "compliance with a portion of the agreement with respect to one or more facilities," the Monitors support a petition by Home Office to DOJ for the end of the Mental Health monitoring at Columbia.