

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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and

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INDIVIDUAL FACILITY MONITORING REPORT:**Finger Lakes Residential Center****Lansing, NY****I. INTRODUCTION**

This is the twenty-first 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 (Finger Lakes) on November 4-6, 2014. 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 4, 2014 there were 53 residents at Finger Lakes on six generic units. The 53 youth ranged in age from 13 to 18 (13-2, 14-4; 15-16; 16-19; 17-11, 18-1); the age of the population was similar to the previous site visit with 59% age 16 and older as compared to 58% in June, 2014, 58% in November, 2013, 66% in May, 2013 and 50% in November 2012). The 53 youth had been at Finger Lakes from two days to 410 days (12 had been there for about a month or less, 19 for one to about three months, 11 for 4-5 months, and 11 for six months or more). In November, 2014, 42% had been at Finger Lakes four months or more, as compared to 30% in June, 2014. Half the residents had been at Finger Lakes less than three months (49%), as compared to 62% in June, 2014, 57% in November 2013 and 42% in May 2013. Seventeen residents were at Finger Lakes at the time of the last site visit five before, at least two of whom left and returned during that time. The 53 youth were committed for: Petit Larceny (9), Assault (8), Weapon Possession (7), Robbery (6), Criminal Mischief (5), Grand Larceny (4), Stolen Vehicle (3), Endangering Child (2), Menacing (2), Trespassing (2), Manslaughter (1), Burglary (1), Stolen Property (1), Marijuana Possession (1), and Reckless Endangerment (1).

Sixteen of the 53 residents at Finger Lakes are prescribed psychiatric medication (30%, compared to 32% in June, 2014, 27% in November, 2013 and 34% in May, 2013).

Their diagnoses are PTSD (5), ADHD (4), Cannabis/Alcohol/K2 Use Disorder (4), Depression (1), Disruptive Mood Dysregulation Disorder (1), Generalized Anxiety Disorder (1), Oppositional Defiant Disorder (1), Circadian Rhythm Sleep Disorder (1), Antisocial with Narcissistic traits (1), Personality Disorder(1) and Conduct Disorder (13). They are prescribed the following psychiatric medications: Clonidine (5), Risperidone/Risperdal (4), Prazosin (2), Abilify (1), Intuniv (1), Olanzapine (1), Prozac (1), Quetiapine (1), Remeron (1), Seroquel (1), Trazodone (1), Vistaril (1), and Zoloft (1).

The 10/14 draft Finger Lakes QAI report commended the facility's enhancement programs including the acting group, debate team, yoga classes, and dog training.

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 for the regular collection and dissemination of facility data to the Monitors. The Monitors were given OCFS' seventh Six-Month Progress Report on the Master Action Plan (MAP) on June 13, 2014.

3. Entrance Interview

The entrance interview occurred on November 4, 2014 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; Deb Bacinelli; Sandra Carrk; Diane Deacon; Todd Etchison; Kathy Fitzgerald; Scot Lamphier; Amy Vent; and Edgardo Lopez.

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 18 interviews with Finger Lakes staff. In addition to group meetings with staff, the MH Monitor interviewed seven staff. The PH Monitor conducted

interviews with one Facility Director, one Youth Division Aide (YDA), one Trainer, one Training Coordinator/ACA Coordinator, two (2) Assistant Directors for Programs, two (2) Youth Counselors (YC) 1, three (3) Youth Counselors 2, and three (3) nurses.

6. Resident Interviews

The Monitors interviewed 16 residents. The MH Monitor interviewed 5 residents individually and the PH Monitor interviewed 11 residents with an average age of 15.6 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 6, 2014. The Monitors expressed their appreciation for the cooperation and hospitality of the Finger Lakes 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: Jason Allen, YC 1; Denise Arriaza, Associate Psychologist; Brenda Aulbach, Facility Director; Ronald Bardo, YDA III; Sarah Bargene, YC 2; Deb Bacinelli, Assistant Facility Director of Treatment; Sharon Bell, YC 1; Nicole Bowen, YCI; Alexa Cleveland, RN 2; Dan Comins, Facilities Manager; Dollbaby Cooper, YRS 2; Todd Etchison, Assistant Facility Director; Kathy Fitzgerald, Assistant Facility Director of Treatment; Cindy Furman, RN 2; Linda Gaydushek, Education Director; Adiel Gonzelez, Clinician; Greg Hall, YC 1; Kristen Keryk, Vocational Instructor; Scot Lamphier, Assistant Facility Director; Edgardo Lopez, Settlement Coordinator; Dan Manti, YC 1; Justin Mott, YDA III; Gary Pendergast-Clark, YDA III; Curtis Williams, YC 1; and on the phone; David Bach, Q/A Director; Lori Clark, Q/A Specialist; Matthew Carpenter, Executive Assistant to the Deputy Commissioner; Michael Cohen, Medical Director; Diane Deacon, Assistant Deputy Counsel; Larry Gravett, Director, SIU; Regina Jansen, DOJ Litigation Attorney; Carol McClellan, Director Labor Relations; Lee Prochera, Acting Deputy Commissioner and General Counsel; Amy Vent, Regional Coordinator MH; Jenne Utting, Q/A Specialist; John Wilson, ATT.

C. Preface to Protection from Harm and Mental Health Findings

In this site visit, the Intact Teams struggled with the uncertainty of impending personnel changes and the introduction of several youth associated with a greater number restraints. Home Office attributed the spike in restraints in October, 2014 to increased admissions and challenging youth being placed at Finger Lakes because of assaults in other programs: four residents, two of whom were new, accounted for 43% of October restraints. The increased admissions were described as an annual occurrence in October, yet no advance preparations appeared to have been made. Deeper analysis showed that the units with the highest number of restraints in September and October 2014 did not have the largest number of new residents.

The Monitors encountered conditions different than those described in the October 31 teleconference reviewing the findings of the October 2014 QAI Report. The changed conditions could be seen in the following:

- Graduated Response System (GRS) classified October uses of force as problematic or in the “red” zone. For example, when comparing August and October data, there had been a 92% increase in the number of unique use of force incidents and a 57% increase in the percentage of youth involved in a use of force.
- The results of the June 2014 administration of the Youth Counselor Civil Service exam, an event outside Home Office control, would alter the composition of stable Intact Teams at Finger Lakes when implemented on November 19, 2014.

The immediate concerns were what Finger Lakes planned to do about the anticipated harm to residents from what they perceived as a loss of important relationships and how to provide extra support to Intact Teams, YCs and clinicians to prevent destabilization.

II. PROTECTION FROM HARM MONITORING

Continuity in leadership provides stability, which was particularly important as Finger Lakes went through a staff scheduling upheaval with the closure of the Lansing Residential Center (LRC) and the hiring of new staff members. The FLRC leadership team had demonstrated good decision-making based on its understanding of program and treatment issues.

The Intact Teams and the new continuity in staffing led to productive stability and consistency at Finger Lakes, which contributed substantially to the June 2014 compliance findings. At the Juncture level, which includes Youth Counselors 1, Youth Counselors 2, plus Unit Coaches and clinicians, a strong group of unit leaders existed. Each individual brought different skills to the Intact Teams, and many of these skill sets were important in the development of the YDA staff members, especially the new hires. To a large extent, the June 2014 Juncture staff and the YDA staff teams had mitigated much of the destabilizing and stressful effects on staffing continuity and staffing adequacy from 2013.

The Monitors observed several substantial improvements following the November 2013 monitoring visit. First, enhanced organizational and social structures produced improvements in order, structure, and consistency among staff that had a positive impact on the social climate, which was more calm and relaxed with staff and youth commenting about a variety of reinforcers for appropriate behaviors. In the June 2014 site visit, youth and staff appeared more relaxed, and more people were smiling. Second, the Graduated Response System appeared to be working, and Finger Lakes plans for reducing restraints resulted in two consecutive months in the “green” zone. Third, the PH Monitor observed two Code Yellow situations where staff effectively de-escalated a youth and returned him to participation with his scheduled activity. These circumstances were not present at the same levels during the November 2014 monitoring visit.

A. Safety

One indicator of change was the reduction in youth perceptions of safety. The PH Monitor interviewed 10 FLRC youth who had been recently restrained. Another source of information was the Youth Interview. Beginning with the October 2012 monitoring visit, the PH Monitor asked Finger Lakes youth questions from the Performance-Based

Standards (PbS) Project's Youth Climate Survey regarding their perceptions of the climate¹ in the facility. All youth responded to the survey questions. Their responses are compared below to the responses from the June 2014 monitoring visit:

- One indicator of structure and consistency is the response to the question "Do you understand the facility rules?" In June 2014, 100% of youth said "yes," whereas 70% said "yes" in November 2014.
- Regarding safety, only 10% (1 youth) in June 2014 indicated that he had feared for his safety within the past six months at the facility, whereas 50% indicated that he had feared for his safety in November 2014.
- In response to the question "On a scale of 1 to 10 with 10 being the highest, how safe do you feel in this facility?" the June 2014 average response was 8.2, and the November 2014 average dropped to 7.1.
- Regarding relationships with staff, 80% of youth in June 2014 indicated that staff members show them respect, that staff members are good role models, and that staff members use force only when they really need to. In November 2014, responses of dropped to 40%, 40%, and 60%, respectively.
- Regarding uses of force, all interviewees in June and November 2014 had been restrained within the past six (6) months. Only 30% of youth in June 2014 thought that staff tried to hurt them during the restraint, but the perception that staff were trying to hurt them during a restraint increased to 70% in November 2014.
- Likewise, in response to the question if youth had ever made a complaint against a staff member as the result of a physical restraint, the rate jumped from 10% in June 2014 to 60% in November 2014

B. Paragraph 57

The present gateway to compliance determinations regarding use of force is Paragraph 57 and the Graduated Response System (GRS), a quality assurance mechanism that followed the Home Office/DOJ agreement about restraint numbers. A factor in compliance determinations, the GRS provides information that complements the QAI periodic on-site assessments of uses of force using the DOJ- and Monitor-approved QAI standards. Essential elements of GRS are identifying, tracking, and resolving use of force problems using action thresholds that correspond to three different color zones.

Home Office staff, in particular QAI and the Settlement Coordinator, did an excellent job of building a GRS prototype presented to the Monitors on August 2013. Home Office selected a color-coding system to reflect various quality assurance action indicators for use of force activities reflected by physical restraint rates and the percentage of youth involved in physical restraint events. Home Office established three-color coding system thresholds.

¹ Drs. Ken Dodge, Tom Dishion, and Jennifer Lansford edited a book of readings on the iatrogenic effects of congregate living conditions with incarcerated youth entitled, *Deviant peer influences in programs for youth: Problems and solutions* (2006). The book summarizes research on what the authors called "peer deviance contagion." The primary challenge in addressing this phenomenon is the absence of regular and systematic feedback from youth in the facility about safety and other conditions of confinement.

The GRS parallels the latest, best peer-reviewed statement of generally accepted professional standards for quality assurance as described in the recent joint publication of the National Institute of Corrections (NIC), the Office of Juvenile Justice and Delinquency Prevention (OJJDP), and the National Partnership for Juvenile Services (NPJS). Dedel² describes quality assurance elements and strategies that include key concepts of performance-based assessments of policy and procedure using clear performance ratings, identifying underlying causes using data, changing the causes through measured outcomes, assessing effectiveness related to the measurement of the size and scope of change, and the construction of at least three levels of program quality. Her recommended three levels include first a level for exceptional, a middle level for satisfactory or in need of minor improvements, and a third level for in need for substantial or major improvements. The GRS green, yellow, and red levels are consistent with her recommendations.

In June 2014, Finger Lakes' GRS had demonstrated the capacity to achieve compliance with the Protection from Harm paragraphs in the Settlement Agreement and to provide an excellent mechanism at the facility and Home Office levels to monitor and alter variations in use of force activities. The Intact Teams (by more than their Red Flag meetings for their unit) had become an essential element in the use of the GRS, serving as a primary agent for problem-solving and stability regarding Protection from Harm and Mental Health programs in the living units.

Reducing the time between the discovery of a problem and its resolution also increased the likelihood of successful outcomes. Empowering the Intact Teams strengthened GRS, particularly with real time week-by-week data analysis for each Intact Team meeting so (a) the Intact Teams recognized when the unit was in the green and (b) the Intact Teams could immediately generate new interventions if the weekly data go into yellow. Looking at data from the previous month can be a delay for initiating a corrective intervention. The Intact Teams in June 2014 were sensitive to the individual youth variables (a new youth has arrived, a youth gets bad news, a conflict from the street emerges) and develop immediate strategies such as one-on-one, intensified mentoring, etc. to fit the youth. This aspect of GRS had largely disappeared during the November 2014 monitoring visit, and Monitors recommend a restoration and a renewed emphasis on Intact Team access to real-time restraint data.

Many variables exist in operating a multi-unit facility that may sometimes create temporary circumstances where uses of force move into a GRS "red" level. Because GRS yellow levels are associated with special activity and involvement by the Intact Teams and the facility and Home Office TICs, movement to a GRS "red" level signals the need for additional problem solving actions through the leadership of Home Office. Previously, this arrangement has demonstrated the ability to move a GRS "red" level back to yellow or green. Therefore, while a GRS "red" level reflects urgency for additional immediate Home Office and facility intervention, it does not, in and of itself, signify a loss of compliance.

² Dedel, K. (2014). Quality Assurance (Chapter 17). In *Desktop Guide to Quality Practice for Working with Youth in Confinement*. Lexington, KY: National Partnership for Juvenile Services and Office of Juvenile Justice and Delinquency Prevention. Download: <http://www.desktopguide.info/?q=node/5>.

Moving a GRS “red” level to yellow or green within 60 days would sustain compliance findings. The GRS “red” level 60-day parameter means no more than two consecutive a GRS “red” levels before moving to yellow or green. In the event of a “red” GRS level for more than 60 days, Home Office would be expected to explain the circumstances contributing to the “red” level for the Monitors’ consideration in making compliance determinations.

C. Use of Restraints

The Finger Lakes GRS level was “red” at the time of this monitoring visit, signifying a substantial concern. Expecting the Finger Lakes GRS to return to a “yellow” level within 60 days, the Monitors offered to extend the compliance determinations for 60 days while the Home Office TIC and the facility TIC addressed the youth and staff transition issues affecting the Intact Teams. The State rejected the offer on November 26, 2014 with an additional request that no further QAI review occur for FLRC. For this reason, several paragraphs have been classified as “Compliance Pending” under the assumption that the October and November GRS levels could be circumstantial, making a loss of compliance under these circumstances unfair. The intent will be to review thoroughly the GRS data from November 2014 through April 2015 at the next monitoring visit.

The “Red Flag” Restraint Review of FLRC restraint activities included a stratified, non-random sample of 15 Restraint Packets containing multiple problems, which provided an opportunity to evaluate the systemic responses to the correction and remediation of difficult circumstances. 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).

Two questions remained as 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? The 15 Finger Lakes Use of Force Packets provided to the PH Monitor contained the documentation surrounding the physical restraint, but the amount and quality of the necessary video had a few inadvertent difficulties due to the location and circumstances of the restraints that made determinations problematic.

Many of these factors along with other Protection from Harm indicators have direct positive relationships with primary use of force indicators, and the knowledge of these relationships has been part of the conventional juvenile corrections wisdom for some time. Additional data analysis revealed information that could be helpful to the Home Office and facility TICs in developing additional strategies to reduce uses of force. For example, direct relationships exist between several categories of OCFS data, meaning that additional alternative strategies may exist for reducing uses of force. By creating action plans that reduce other variables with a strong direct relationship to uses force, TIC action plans could be strengthened. There are powerful relationships between rate of physical restraints and several other important variables, such as the percentage of youth involved

in a physical restraint, facility population as measured by total days care, injury, and suicidal gestures. The first two maybe particularly important in reducing use of force rates.

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.*

COMPLIANCE PENDING

COMMENT: The numerous aspects that must be considered by staff in determining the reasons that justify a physical restraint apply here. They include 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. Several findings from the Restraint Packet reviews could put compliance with this paragraph at risk if continued.

The PH Monitor reviewed 15 Restraint Packets of youth who were housed at the facility during the November 4-6 monitoring visit. The justifications listed for initiating a physical restraint in all 15 Use of Force Packets was for "the safety of any person" (Paragraph 41i). Of these, only 43% had sufficient evidence that the use of restraints was within the three parameters listed in this paragraph. Acknowledging that there was no audio available, documentation in four Use of Force Packets supported the safety justification, while five had insufficient video to make a determination regarding the safety justification. This is a reduction of 34% from the June 2014 monitoring visit and puts the facility below the preponderance level established at the previous monitoring visit.

Most of the five insufficient-evidence-to-determine packets were the result of restraints occurring off-camera. This is another changed circumstance considering that none of the Use of Force Packets reviewed in June were off-camera. The video, however, was largely consistent with the documentation. Two restraint packets contained visual evidence of the restraint occurring while the youth was seated. In neither packet was this noted in the documentation. While it is important to the order, organization, and security that youth are in their rooms at the designated bedtime, it is the role of an adequate behavior management system to address compliance with these minor misbehaviors. What was visible in these restraint packets was a substantial use of force to get youth to

comply with staff directives, in the absence of any visible behavior indicators of a threat to staff or youth safety. No generally accepted professional standards recommend the use of physical restraint tactics to get resident compliance staff directives. In most instances, generally accepted professional standards define this type of unnecessary use of force as punitive, and the use of restraints as punishment is consistently denounced. Home Office concurs and initiated investigations into these events.

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.*

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. Finger Lakes 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.

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

COMPLIANCE

COMMENT: The PH Monitor's review of data, including multiple Use of Force Packets, combines with direct observations, youth and staff interviews, and the conclusions from the Finger Lakes 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 helps 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. While YDA staff members appear to pay greater attention to the physical limitations that modify or restrict CPM than to a specific youth's emotional risks from restraint, there is a growing reliance on the IIP as an effective intervention strategy. The recurring obstacle with the IIP is that it continues to be rated as ineffective with the most challenging youth. One observation was that providing "time away" during a crisis situation rarely works. Again, the recommendation is that YDA staff continue to have greater input through the Intact Teams about circumstances where IIP recommendations have been effective.

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 Use of Force Packets, combines with direct observations, youth and staff interviews, and the conclusions from the Finger Lakes 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. Isolated instances continue to occur as a result of unusual circumstances or concerns about individual staff members, but these are mostly technical failures or accidental circumstances as in Restraint Packet 640804 and do not represent systematic failures.

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

SUBSTANTIAL COMPLIANCE

COMMENT: Finger Lakes has achieved sustained compliance with this paragraph. The PH Monitor's direct observations, document reviews, youth and staff interviews, and the findings from the Finger Lakes QAI Report support this finding.

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

SUBSTANTIAL COMPLIANCE

COMMENT: Finger Lakes has achieved sustained compliance with this paragraph. The PH Monitor's direct observations, document reviews, youth and staff interviews, and the findings from the Finger Lakes QAI Report support this finding.

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.*

SUBSTANTIAL COMPLIANCE

COMMENT: Finger Lakes has achieved sustained compliance with this paragraph. The PH Monitor's direct observations, document reviews, youth and staff interviews, and the findings from the Finger Lakes QAI Report support this finding.

D. 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.

SUBSTANTIAL COMPLIANCE

COMMENT: Finger Lakes has achieved sustained compliance with this paragraph. The PH Monitor's direct observations, document reviews, youth and staff interviews, and the findings from the Finger Lakes QAI Report support this finding.

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.

COMPLIANCE PENDING

COMMENT: Another area that reflected the disruption of effective operations at FLRC was the increased percentage of restraints that did not adhere to CPM guidelines. The PH Monitor reviewed 15 Restraint Packets of youth who were housed at the facility during the November 4-6 monitoring visit. If a staff member does not use CPM techniques in the manner taught in training, the assumption is that the staff member is not using the least amount of force necessary since the CPM training focuses on teaching staff how to use only the minimum amount of physical control and time necessary to stabilize the youth. The November 2014 packets revealed some slippage in the level of CPM technique usage that is consistent with how CPM is trained. For example, there was roughly a 34% increase in the proportion of November 2014 Restraint Packets with one or more of these CPM techniques.

Of the Restraint Packets that showed discrepant applications of CPM techniques, five contained examples of staff behaviors that could be characterized as unapproved, prohibited, or excessive force techniques, approximating headlocks and chokeholds. Several of these restraint behaviors have already resulted in referrals to the Justice Center and are pending investigations. This represents an unacceptable increase in the kinds of use of force behaviors by staff that increase substantially the probability of a return of serious injury to youth by staff.

In Restraint Packet 642700, the staff member powerfully applies what looks like an inappropriate restraint technique, some type of headlock. As the youth stood up, the staff member rushed him, placed him in a headlock while talking to him, and then continued to talk once additional staff members had taken the youth to the floor. Staff member's report indicates that he was attempting to prevent the youth from biting him. The youth ended up in handcuffs for 22 minutes. Beyond the alleged headlock-looking-bite-prevention technique, the youth was restrained twice and most of the restraints occurred off-camera.

In Restraint Packet 645600, the video shows the staff member using a front facing headlock on the youth to lift him and move him. A report was made to the Justice Center (VPCR: 301-93684116) by medical after the youth complained of pain in his neck because of the restraint.

In Restraint Packet 631605, the video shows one staff member rushing past the two primary YDAs who had control of the restraint situation and pinning the youth to the wall. The video shows the staff member using a headlock and pulling the youth's hair during the restraint. Once other staff had the youth under control, the staff member walked around talking to the youth until the youth spit at him. The documentation said the reason for restraint was that the youth had assaulted the staff member, giving the impression that there was a physical altercation initiated by the youth. A witnessing staff member's Incident Report stated that the "assault" was actually the youth "threatening to throw cheese and crackers" on the staff member. While doing so, the report indicated that the youth was telling the staff member that he, the youth, was not "a pussy" suggesting that there was an existing tension between the youth and staff. An interview with the youth in question during the monitoring visit (and prior to the review of the Restraint Packet) revealed the youth's complaints about the staff member's behaviors toward him, accusing the staff member of making demeaning, humiliating, and racial comments about him.

Because the individuals in Restraint Packets 642700, 645600, and 631605 currently occupy supervisory positions, this factor substantially threatens compliance.

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.

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 met its standards. A consequence of the Settlement Agreement has been an increased amount of paperwork associated with programs and documentation, so fewer restraints mean less documentation; and when restraints have been low, there has been a noticeable improvement in the quantity and quality of the documentation. Regarding this paragraph, Finger Lakes is now experiencing the somewhat never ending challenge of administration and trainers to maintain acceptable documentation quality. Documentation problems continue to exist, but fewer physical restraints also allow staff more time to complete reports. This "Red Flag" Restraint Review contained two Activity Reports from the same YDA, and both were illegible. Consideration should be given to the identification of staff members who must type their Activity Reports.

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: Home Office has worked hard to sustain FLRC's compliance with this paragraph. The PH Monitor's review of multiple Use of Force Packets combines with staff interviews and the conclusions from the Finger Lakes 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 is the mechanism by which GRS "red zone" status is a change to "yellow" or "green" status.

These factors explain the Monitors specific questioning of the Finger Lakes TIC on November 5, 2014 about how the TIC planned to reverse the increases in rates of uses of force. What did not make sense was that TIC members knew that there would be substantial upheaval to the Intact Teams because of major personnel changes, and they even predicted that it would have an adverse effect on uses of force, meaning that they predicted an increase in restraints. Consensus existed among the Monitors, Home Office, and the Finger Lakes TIC that the Intact Teams had been the best defense against problem situations resulting in the use of force. Therefore, knowing that the primary preventative of uses of force would be compromised for several weeks, at a minimum, the Monitors expected that greater considerations would have been given to new specific action strategies to mitigate the anticipated reduced impact of Intact Teams.

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).*

COMPLIANCE

COMMENT: The PH Monitor's review of multiple Use of Force Packets, including the Video Review Forms (VRF), combines with administrative interviews and the conclusions from the Finger Lakes QAI Report to support this finding. The policy and procedures exist, and there is a practice in place. Perhaps one of the most significant staff development decisions was moving the review of physical restraints to the YC2 level by Finger Lakes administration. This produced an immediate increase in the requests for constructive corrective actions outside the disciplinary system but thoroughly targeting improved staff skill development. The shift of Restraint Packet reviews from Facility Administration to Juncture Team Administration resulted in an immediate increase in the use of coaching, supervisory follow-up, and Documented Instruction (DI). Consistent with good practice, Finger Lakes reinforces the premise that the best way to improve the skills of staff is to scrutinize constantly and carefully actual behaviors in a manner that helps staff improve their skills and abilities while learning new techniques. It also indicates a transition has occurred from defensive and reactive to positive and proactive regarding use of force problem-solving.

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.

SUBSTANTIAL COMPLIANCE

COMMENT: Finger Lakes has achieved sustained compliance with this paragraph. The PH Monitor's direct observations, document reviews, youth and staff interviews, and the findings from the Finger Lakes QAI Report support this finding.

E. 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."*

SUBSTANTIAL COMPLIANCE

COMMENT: Finger Lakes has achieved sustained compliance with this paragraph. The PH Monitor's direct observations, document reviews, youth and staff interviews, and the findings from the Finger Lakes QAI Report support this finding.

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

SUBSTANTIAL COMPLIANCE

COMMENT: Finger Lakes has achieved sustained compliance with this paragraph. The PH Monitor's direct observations, document reviews, youth and staff interviews, and the findings from the Finger Lakes QAI Report support this finding.

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

SUBSTANTIAL COMPLIANCE

COMMENT: Finger Lakes has achieved sustained compliance with this paragraph. The PH Monitor's direct observations, document reviews, youth and staff interviews, and the findings from the Finger Lakes QAI Report support this finding.

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

SUBSTANTIAL COMPLIANCE

COMMENT: Finger Lakes has achieved sustained compliance with this paragraph. The PH Monitor's direct observations, document reviews, youth and staff interviews, and the findings from the Finger Lakes QAI Report support this finding.

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

SUBSTANTIAL COMPLIANCE

COMMENT: Finger Lakes has achieved sustained compliance with this paragraph. The PH Monitor's direct observations, document reviews, youth and staff interviews, and the findings from the Finger Lakes QAI Report support this finding.

F. 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.

SUBSTANTIAL COMPLIANCE

COMMENT: Finger Lakes has achieved sustained compliance with this paragraph. The PH Monitor's direct observations, document reviews, youth and staff interviews, and the findings from the Finger Lakes QAI Report support this finding.

- 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 Finger Lakes staff and is not included in the compliance findings for this facility.

Second through Fourth Sentences: SUBSTANTIAL COMPLIANCE

COMMENT: Finger Lakes has achieved sustained compliance with this paragraph. The PH Monitor's direct observations, document reviews, youth and staff interviews, and the findings from the Finger Lakes QAI Report support this finding.

- 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.*

SUBSTANTIAL COMPLIANCE

COMMENT: Finger Lakes has achieved sustained compliance with this paragraph. The PH Monitor's direct observations, document reviews, youth and staff interviews, and the findings from the Finger Lakes QAI Report support this finding.

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. Clinical staff reported no changes in the policy, procedure, or practices of the Post-Restraint Exam (PRE) by medical.

- 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 Finger Lakes 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 Finger Lakes 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.*

SUBSTANTIAL COMPLIANCE

COMMENT: Finger Lakes has achieved sustained compliance with this paragraph. The PH Monitor's direct observations, document reviews, youth and staff interviews, and the findings from the Finger Lakes QAI Report support this finding.

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

COMPLIANCE

COMMENT: At the time of this monitoring visit, the level of staff supervision at Finger Lakes was consistent with generally accepted professional practices. Concern about "adequate supervision of staff" focus on continued strengthening of the role of the Restraint Monitor.

- 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 Finger Lakes staff and is not included in the compliance findings for this facility.

III. MENTAL HEALTH MONITORING

In this site visit at Finger Lakes the MH Monitor observed support teams demonstrating teamwork, rapport with residents, communication with families, and collaboration with CMSOs. The coaching team articulated a shared approach to supporting staff in guiding residents' use of self-calming and other skills and integrating DBT and Sanctuary skills consistently on the units. Although the two new clinicians had not yet assumed their caseloads, by mid-November all six of the units will each have a clinician, which will hopefully result in consistent, thorough Integrated Assessments and support plans with improved individualized goals and interventions reflecting residents' needs to recover from trauma.

In this site visit, the intact teams struggled with destabilization, higher restraints, and residents' reactions to personnel changes. At the time of the site visit, changes in clinicians, YCs and the substance abuse program were affecting all the units. Out of the 8-10 residents on each unit, 1-5 of them were new admissions (unit 3 had 5 residents who arrived less than 45 days before; 1-4 youth on each unit had been at Finger Lakes longer than 5 months), 0-5 were on advanced phases (Unit 1 had 5 residents on Learning, Application and Generalization), and 1-5 were prescribed psychiatric medicine (Unit 4 had 5, and Unit 2 had 4). Unit 1's restraints more than doubled between 9/14-10/14 (11 to 27) and Unit 4's restraints remained the highest in the facility for two months (25 in 9/14 and 28 in 10/14). Only two units (2 and 5) had 2 or fewer restraints per week in both 9/14 and 10/14.

The YC1 exam was given in June, with results at the end of August 2014. Three provisional YCs who had played important roles in the intact teams did not score high enough on the exam to get permanent YC positions, and they will be returning to YDA positions. A fourth is being bumped by a returning YC. Three who were provisional received the YC position permanently. Three newly-appointed YCs were Finger Lakes YDAs. Unfortunately, although this news had not yet been formally announced at the time of the site visit, word was out to the residents that on November 19, 2014 they would be losing some of their YCs. Furthermore, clinician assignments were going to be different and the substance abuse program was changing. Intact teams were reeling from their worries that changes in positions would disrupt unit consistency. The intact teams had not been empowered to handle the transition in ways that would most protect the residents. During the site visit the Monitors expressed this concern to the Deputy Commissioner. The Monitors were concerned that the threat to important relationships perceived by residents in the upcoming change in roles of staff in their teams—changes that were poorly understood by residents but made them feel unsafe—was a major contributor to the continuing increase in restraints. The Finger Lakes changes in staff could have been managed with a focus first on the residents: in order to continue feeling safe it appeared that residents needed assurances that the relationships that mattered most to them would not change (even though some staff roles would change). The MH Monitor likened this process of protecting the residents' closest relationships to termination in therapy in which the therapist supports the client in understanding the loss, managing feelings and

successfully moving on to other trusting relationships. This is particularly important for the many Finger Lakes residents who have been traumatized by multiple losses. A staff person transitioning into a new role could maintain the same close relationships with several residents (who were progressing toward leaving the facility), and staff in new roles could build relationships with the new arrivals.

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.

QAI reviews every six months of the New York Model implementation at Finger Lakes examine 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 are interviewed, and support teams, Mental Health Rounds, groups and change of shift meetings are observed.

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.

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.

The Finger Lakes Integrated Assessment, IIP, Support Plan, and contact notes by the psychiatrist, clinicians, YCs and CMSO were 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.

The PH Monitor and MH Monitor met with the Finger Lakes TIC to discuss how they utilize their monthly meetings (the most recent of which occurred two weeks prior to the site visit). They reported using the “standard statewide TIC agenda, which includes continuous improvement.” In the most recent TIC the two Assistant Directors for Program led a discussion with staff on how to pay more attention to the details of their relationship with a resident. They described examples of staff being proactive with youth and interventions that could have been done better. In a discussion of how they use restraint data in the TIC, it appeared that the intact teams were not prepared for the influx of new residents in October 2014 (although the fall increase was described as an annual occurrence) and felt less competent because they did not have relationships with the new residents. Unit 4 had the highest increase in restraints for two months, and the intact team had been encouraged to use three or four Red Flag meetings (instead of the TIC tackling the restraint increases). The message to the intact teams provided in the TIC was: “October was a difficult month but not to dwell on ‘things falling apart’ because it takes time to develop relationships with new residents, especially a number of them at a time, but it will happen and stability (and lower restraints) are sure to happen.” With the Director retiring in December, she has continued the process of transitioning her duties to the administrative team.

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

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”) are consistent with the New York Model and comply with 46d.

Staff provide orientation to new residents using the Finger Lakes revised Youth Manual in compliance with 46d.

The 10/14 Finger Lakes QAI report commended the facility’s resident handbook.

On Site Observations Regarding Paragraph 46a-d (11/14)

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 implemented at Finger Lakes. Integrated assessments, support plans, support teams, the Daily Achievement System (DAS), and phase system are in place.

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. With a new DBT contract, the DBT consultant is providing training every other month for Finger Lakes staff, with a focus on integrating DBT skills into units.

Finally, by mid-November, Finger Lakes will have a clinician assigned to each of the six units which makes sustained compliance with Paragraph 46 possible (a new psychologist started on 10/30/14 and a new social worker started on 11/6/14) plus two substance abuse clinicians who will each work with three units. One esteemed long-time Finger Lakes clinician will move from a unit assignment to provide psychological testing for residents and assistance to units with DBT. In previous site visit reports the MH Monitor expressed concern that the clinicians were overloaded. Now being able to focus on the residents of one unit and participating actively in one Intact Team should allow clinicians to increase individual therapy, improve support plans and provide consistent coaching to staff on supporting residents to develop distress tolerance and emotional regulation.

Between 9/15/14-10/15/14, there was variability in how many residents each clinician worked with in individual therapy and how frequently. One clinician provided individual therapy to all 10 of the residents on the unit; one had eight sessions in the month, two had six, three had five. Another clinician also provided individual therapy to all 10 of the residents on the unit; two had three sessions, three had two sessions and five had one session. One clinician provided individual therapy to seven residents; one had five sessions, and the rest had one or two. One clinician provided individual therapy to six residents; two had five sessions, one had three, and three had two. One clinician provided individual therapy to five residents, one or two sessions each. On several Finger Lakes units, neither the requirement that every resident be seen in individual therapy once monthly nor the requirement that every resident prescribed psychiatric medicine be seen in individual therapy weekly was being met. Doing so, now that Finger Lakes has one clinician for each unit, is necessary for sustained compliance.

The placement histories of the 53 Finger Lakes residents revealed that about a third have had no prior placements (other than Reception; 34%), more than a third arrived at Finger Lakes for this placement from aftercare (38%; 6 out of 20 had been released from Finger Lakes to aftercare and returned; 14 out of 20 had been released to aftercare from other facilities), and less than a third were placed at Finger Lakes from another facility other than Reception (28%). This is a high failure rate on aftercare. These findings suggest that the Finger Lakes program and intact unit team management of arriving youth require adjustment to the smaller number with no prior facility experience (with the associated fears and uncertainty) and the large number of youth who may be angry, disappointed in themselves,

hopeless and frustrated after returning from aftercare or being moved from another facility. On any unit the majority of residents being returning and transferred youth who feel that they have already completed the program may adversely affect the minority being introduced to DBT, Sanctuary, therapy, groups, support plans and support teams.

The MH Monitor observed Mental Health Rounds at Finger Lakes with 19 participants: psychiatrist, clinicians, YCs, school representative, and nurse. Eleven residents were discussed, including several with PTSD, one with Disruptive Mood Dysregulation Disorder, another with complicated developmental deficits who was refusing his medication and psychiatric appointments, one who was decompensating and being referred to a MHU, and several residents reacting to the staff changes on their units. Psychiatric medicines were discussed for some of the residents. The collaboration among the psychiatrist, clinicians, and YCs was noteworthy. For a resident with intellectual limitations, the psychiatrist commented that he may be seeking restraints for affection and emotional safety and recommended gentleness to calm him since he “shuts down with an authoritarian approach.” The psychiatrist concluded Mental Health Rounds with a “mini-didactic session” on hyperarousal, which he described as often associated with PTSD, but also characterizing youth who have been traumatized (without a PTSD diagnosis). “The switch that turns on a fight-flight response (normal in dangerous situations) is broken and gets turned on when there is no real danger. With traumatized residents it may be turned on all the time, especially in the cafeteria and classroom. The symptoms include higher heart rate and blood pressure, muscle tension, and being hard to calm down. Restraint can be re-traumatizing, especially if staff come from behind.” The psychiatrist reported that Mental Health Rounds help him learn more about residents and “optimizes the practice of psychiatry.” YCs now frequently come to his office and comment that his observations at Mental Health Rounds and psychiatric consultations are helpful. Unfortunately, YDAs are not included in Mental Health Rounds. It remains a priority for Finger Lakes to manage scheduling at least the mentors or other YDAs working with the residents being discussed to be involved in Mental Health Rounds. The psychiatrist said he has little time to go to intact team meetings and relies on clinicians and YCs to transmit information about diagnosis, response to treatment, and recommendations for working with a youth to the unit teams. The 10/14 Finger Lakes QAI report indicated that of the 14 staff interviewed, 12 responded that they never have participated in Mental Health Rounds. Some staff said they do not get information from Rounds, while others said they receive the information via the log and/or intact team meetings and/or the unit YC. In the Mental Health Rounds observed by QAI, none of the YDAs working with the small number of youth discussed in detail in the meeting were present.

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 MH Monitor met with the large Finger Lakes coaching team of YCs and clinicians who articulated a unified approach to coaching: “Teamwork is so important: everyone supports each other. We appreciate that everyone works so hard. We’re strong on communication. Consistency gives the message to residents that people here care. Some staff need more coaching—and we do not have a sink or swim mentality.” The coaching team discussed the struggle of the intact teams with the large percentage of new admissions and with the importance of reassuring residents that their relationships will continue, even with changing roles on several units. A significant amount of coaching will be required to help the intact teams integrate New York Model

improvements: (a) more trauma responsive work by support teams; (b) with two substance abuse clinicians, there will be more groups on the units, including new treatment groups that will hopefully be smaller than the full unit, and individual therapy will more consistently include substance abuse treatment and relapse prevention, and (c) focus on personal change for successful re-entry for the large number of residents who return from aftercare.

The MH Monitor observed a strong Intact Team with four YDAs, three YCs, and a clinician. The YC was an effective leader, supporting discussion about how they could collaborate to create “an emotionally safe environment,” especially with a combination of four small younger residents and four large older residents. They made good use of each other’s suggestions for how to work effectively with different residents. This Intact Team also meets once weekly for “Rounds” including school and medical staff to review all the residents on the unit.

The MH Monitor observed a DBT group on Emotion Regulation led by a clinician with active involvement of seven residents; one YDA participated and another YDA and YC were present but not involved. Residents were given a deck of cards and asked to build a house; they worked persistently, despite many collapses. After the exercise they described feelings of being frustrated, annoyed and angry. How they had managed their feelings—there was only one outburst of frustration that was well-controlled—was not discussed. The challenging mix of residents on each Finger Lakes unit makes it difficult to ensure learning from groups. The Finger Lakes clinicians continue to struggle with how to make DBT skills useful to residents. With the new DBT contract, a goal at Finger Lakes is to integrate DBT skills into the interactions of all staff with residents. If clinicians were more confident of how to teach mindfulness and emotion regulation skills that residents would use, the incorporation of those skills into daily life on the unit with reinforcement by YDAs would be more likely.

The MH Monitor observed a Sanctuary group with seven residents and three YDAs effectively led by the YC who engaged residents in the discussion.

A new innovation at Finger Lakes was the Phase Advancement Presentation in which each youth requests a higher phase in a meeting and staff each share their positive appraisal of the resident and give guidance for future improvements. At the time of the site visit, a third of the Finger Lakes residents had achieved higher phases: Learning-11 residents on four units, Application-4 residents on three units, and Generalization-2 residents on two units; Unit 1 had five residents on these phases, Unit 2 had three, Unit 3 had none, Unit 4 had four, Unit 5 had three, and Unit 6 had two. The 10/14 Finger Lakes QAI report commended the facility’s unique practice of the phase presentation in which a resident presents what he has achieved justifying phase advancement as an effective process that seems to empower the youth to advocate for themselves and to showcase their accomplishments and skill development.

The MH Monitor reviewed the DAS for several residents. One resident preparing for discharge announced proudly at his support team that his behavior had improved and he had 193 out of 200 achievements that week—this shows the real value of the DAS. None of the other residents whose DAS were reviewed had achieved Level A for phase privileges (24 or more achievements out of 30 in a day). Unit 2 and 4 were using the old program compliance

format of the DAS (Uniform, Language, Fighting, Line Movement, Attendance and Participation). Unit 1 and Unit 6 were using the preferred DAS format, written according to SELF and referencing distress tolerance, emotion management, and interpersonal effectiveness skills (with skills detailed on the bottom of the sheet which supports the integration of DBT and Sanctuary on the unit). Not all the DAS sheets had totals for the day written on them. Although the 10/14 Finger Lakes QAI report found improvement in the use of the DAS at the facility, action was required so all staff complete the DAS in its entirety, including achievement level, in a consistent way across all units.

The MH Monitor observed IIPs in the reviewed Finger Lakes records; support plans indicated the IIP has been reviewed monthly.

The 10/14 Finger Lakes QAI report noted increased evidence since the March 2014 review of residents meeting with clinicians regularly. The 10/14 Finger Lakes QAI report noted an example of a resident who was court-ordered to receive 60 minutes of individual counseling once a week and there was no indication that this youth received these services.

FUTURE MONITORING

To achieve sustained compliance with paragraph 46 at Finger Lakes, now that there is one clinician on each unit, will require every resident being seen in individual therapy at least once monthly and every resident prescribed psychiatric medicine being seen in individual therapy weekly. Improved integration of DBT skills on units is also important.

The MH Monitor will observe the facility's use of information to regularly assess the effectiveness of interventions for all residents, with attention to teaching self-calming to residents who escalate quickly and modifying support plans, interventions and support team meetings to reduce the rate of returns to Finger Lakes. The MH Monitor will observe how staff are coached in the use of DBT skills on the unit, both in individual discussions and by the inclusion of YDAs in Mental Health Rounds and support teams.

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 in OCFS Facilities" (9/15/14) complies with the requirements of 47a.

Staff at Finger Lakes were observed complying with 47a.

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

COMPLIANCE

A 3/12 memorandum entitled "Contacting Mental Health Professionals Outside of Regular Work Hours" (linked to the Behavioral Health Services policy (PPM 3243.33)) complies with 47b and indicates that "each of the facilities reports having an established procedure in place." Updates regarding the staff person to be contacted for mental health crises after hours at Finger Lakes are decided at the facility level and are maintained at the Central Services Unit (CSU), which complies with 47b.

- 47c. *Require that any youth who experiences a mental health crisis and resorts to maladaptive coping strategies, such as self-injurious behavior, is referred for mental health services following the resolution of the immediate crisis. A qualified mental health professional shall develop a crisis management plan in conjunction with the youth and his or her other mental health service providers. The crisis management plan shall specify methods to reduce the potential for recurrence through psychiatric treatment, treatment planning, behavioral modification and environmental changes, as well as a strategy to help the youth develop and practice positive coping skills. Such services shall continue throughout the duration of the youth's commitment to the Facility.*

COMPLIANCE

The revised PPM 3247.60 "Suicide Risk Reduction and Response in OCFS Facilities" (9/15/14) complies with the requirements of 47c: "From the point of entry into the DJJOY system, throughout all areas of youth programming and extending to the transition back to the community, staff must be continually aware of suicide risk factors and the possibility of adolescent suicide or serious self-harm. Further, when evidence or information arises about the possible suicidal ideation, intent, or behavior of a particular youth, OCFS will respond effectively to maintain the physical safety and emotional well-being of the youth. A youth shall remain on enhanced supervision status until a mental health clinician authorizes modification of the enhanced supervision or removing a youth from special supervision status based on a clinical assessment. Youth on enhanced supervision status will be seen by a mental health clinician to reassess the need for enhanced supervision as frequently as may be indicated by changes in the youth's presentation, whenever possible every 24 hours. When the mental health clinician conducts a mental health evaluation which indicates that the youth is ready for modification or removal from enhanced supervision status, the clinician will consult with administration to develop and enact an appropriate treatment and safety plan."

On Site Observations Regarding Paragraph 47a-c (11/14)

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

Finger Lakes had 20 Suicide and Personal Safety Watches for 16 residents between 6/1/14-10/31/14. This is about the same rate as the seven months before the previous site visit (6.8/month in 5/1/13-10/31/13, 3.9/month in 11/1/13-5/31/14, and 4/month in 6/1/14-10/31/14). Between 6/15-10/28/14, the 11 Suicide Watches at Finger Lakes, by nine residents (one resident had three), were mostly for one or two days (1 day-5, 2 days-3, 4

days-2, 7 days-1). During the same time period, the nine Personal Safety Watches at Finger Lakes, by seven residents (two residents had two), were almost all for one or two days (1 day-5, 2 days-3, 5 days-1). Completing a mental health assessment for suicide every week and then re-evaluating the resident continue to be time-consuming for clinical staff.

For example, clinical contact notes reflect how Suicide Watch was used as a precaution to keep a resident safe at Finger Lakes: staff placed the resident on Suicide Watch because he said he was going to “hang it up.” He was banging the door in his bedroom and attempting to block the window on the door with towels. The next morning, the clinician met with him and he acknowledged that he is so used to getting negative attention, he feels anxiety when he “falls under the radar,” and that he could have handled the situation differently. He had no intention to commit suicide and described things he was looking forward to, and the clinician concluded he was no longer in crisis and discontinued Suicide Watch. [Note: this note was not in the clinical contact notes at the time of the site visit a week after the incident because Finger Lakes staff were having technical difficulty making JJIS entries.]

The 10/14 Finger Lakes QAI report required action to provide consistent and thorough documentation regarding the actions taken and subsequent follow up for any youth requiring a crisis management plan: “With some recent changes in the clinical staffing FLRC should review their training in this area as they have demonstrated in the past an aptitude for scoring high with regard to Crisis Management. One youth’s record reflected lack of documentation of a clinician reviewing his mental health status when he was removed from Suicide Watch. For another youth, documentation of his mood and attitude every 15 minutes while he was on PSW could not be found.”

No Finger Lakes resident was admitted to a psychiatric hospital during 6/1/14-10/31/14.

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.

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.

Finger Lakes records reflect that residents are seen soon after admission by a mental health professional who completes the ISO-30 and begins the Integrated Assessment. Youth who arrive on psychiatric medication or who are referred to the psychiatrist by facility staff are seen, documented in a psychiatric evaluation or psychiatric contact note.

The MH Monitor observed completed and timely Integrated Assessments in the Finger Lakes records that demonstrated compliance with 48a.

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

COMPLIANCE

The procedure for referring a youth for evaluation to a qualified mental health professional was completed. A 2/12 memo described (linked to the Behavioral Health Services policy (PPM 3243.33)) 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 sent to BBHS and facility clinicians in 12/12, 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, updated 10/14) complies with the requirements of 48c.

Efficacy of interventions is discussed in Mental Health Rounds and psychiatric contact notes, and the psychiatrist, Assistant Directors for Treatment and other clinicians bring treatment information to the attention of staff.

Finger Lakes staff continue to work on including in Integrated Assessments: (a) 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; (c) learning disabilities and how they appear to be affecting the resident's behavior; and (d) history of substance use and how it may be related to behavior and trauma. This subparagraph is found in compliance because of the consistent completion of Integrated Assessments at Finger Lakes. The thoroughness of the assessments varies (depending on whether all the sections are completed and the depth of the analysis of past and new information), and continuing progress to achieve universal high quality in the Integrated

Assessments is necessary for sustained compliance with Paragraph 48. Completing thorough Integrated Assessments will continue to be a time-consuming expectation of clinicians.

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, updated 10/14) complies with the requirements of 48d. Finger Lakes staff are working to improve their collaborative agreement on consistent diagnoses for youth through the newly-configured Mental Health Rounds and discussions between the psychiatrist and therapist.

The Finger Lakes psychiatrist writes detailed psychiatric contact notes and psychiatric evaluations, which address diagnosis; psychiatric contact notes usually reference the most recent observations of symptoms and behaviors by the resident's clinician. The psychiatrist can discuss diagnosis with clinicians and YCs in Mental Health Rounds and individual consultations. The psychiatrist is contracted for 16 hours per week, which is not sufficient for him to discuss diagnosis or effective intervention in support team meetings or Red Flag meetings.

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.

The OCFS Psychiatry Manual (3/14, updated 10/14) complies with the requirements of 48e.

On Site Observations Regarding Paragraph 48a-e (11/14)

On November 4, 2014, the 16 Finger Lakes residents prescribed psychiatric medicine had the following diagnoses:

- ADHD, Conduct Disorder
- Conduct Disorder
- Conduct Disorder, Antisocial with Narcissistic traits
- Conduct Disorder, Cannabis Use Disorder, Personality Disorder
- Conduct Disorder, Cannabis/Alcohol Use Disorder

Conduct Disorder, Circadian Rhythm Sleep Disorder
 Conduct Disorder, Rule Out PTSD
 Depression, Conduct Disorder, Cannabis/K2 Use Disorder
 Disruptive Mood Dysregulation Disorder
 Generalized Anxiety Disorder, Conduct Disorder
 Oppositional Defiant Disorder, ADHD, Conduct Disorder
 PTSD, ADHD
 PTSD, Conduct Disorder
 PTSD, Conduct Disorder, ADHD
 PTSD, Conduct Disorder, Cannabis Use Disorder
 PTSD, Conduct Disorder, Personality Disorder

The requirement of Paragraph 48 is to “develop a consistent working diagnosis(es).” OCFS provides clinical guidelines in the BBHS Facility Clinical Procedures and the Psychiatry Manual (3/14, updated 10/14). 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 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.” The OCFS Psychiatry Manual presents 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.

The Finger Lakes psychiatrist’s thorough Psychiatric Contact Notes could be used as a statewide example of outstanding practice. They are easy to understand and concisely describe the resident’s current struggles, the clinician’s and the YC’s reports on progress, efficacy of medication, side effects, diagnosis, and next steps including the symptoms for which psychiatric medication is prescribed.

Since the previous site visit, one psychiatrist left and the remaining Finger Lakes psychiatrist increased his hours to 16 per week. In his usually once monthly sessions with residents he engages them in reflecting on their behaviors, but he is limited to focusing his attention on the fewer than a third of residents who are prescribed psychiatric medicine or who are considering (or their parents are considering) medication--in the previous month he saw three residents with substance abuse diagnoses and two residents with depression diagnoses who were not prescribed psychiatric medicines. Between September 15-October 15, 2014, the psychiatrist was at Finger Lakes on eight days and saw 18 residents, four seen twice and the rest seen once. If he were at the facility more hours, he would be able to see more youth and participate in support team meetings. One psychiatrist 16 hours a week, instead of two psychiatrists each 12 hours week, appears not to be sufficient given the complex needs of Finger Lakes residents.

■ exemplifies the challenges of staff understanding the evolving formulation of a resident’s diagnosis and implications for their role in assisting him. ■ is a 16-year old at Finger Lakes for two months for trespassing; it is his first placement. His Integrated Assessment is excellent. He was exposed to drugs in utero, his mother had a history of mental

illness and substance use, and he was placed with his maternal grandmother who adopted him and his siblings. Other than a history of substance use, no information was provided regarding his father. He was the victim of and witness to community violence and used cannabis since age 14. His Reception assessment indicated that he was previously diagnosed with ADHD, and poor attention and restlessness were observed at Reception. He also had moodiness, hostility, negative self-evaluation, anger problems, and a diagnosis of Bipolar Disorder. There was not enough information to support a history of mania/hypomania, and his Reception diagnosis was Depressive Disorder, ADHD, Cannabis Abuse, and Conduct Disorder. ■ Finger Lakes support plan was not trauma-responsive despite the thoroughness of the Integrated Assessment. The goals in his support plan were: acquiring a facility job, minimizing his length of stay and returning home, and advancing to Learning Phase. Only standard interventions for the YC, clinician, and teacher were listed. His clinician was to help him with "skill-building to assist him in modifying his behaviors, working on DBT skills in individual and group therapy, including Distress Tolerance, Interpersonal Effectiveness, and Emotion Regulation skills." His diagnosis was PTSD. There was no mention of substance abuse treatment in either his support plan or recent clinical contact notes, despite a Cannabis Abuse diagnosis. Between 9/30-11/7/14 ■ had individual mental health treatment four times (including a follow-up suicide assessment and removal from SW), individual counseling was provided by his YC five times, and he participated in 26 groups during those five weeks. In his most recent psychiatric contact, ■ was unable to give himself credit for his improvement described by his YC and clinician, or acknowledge that he has positive qualities. He said he had not received much positive support in his childhood and the few relatives who were reliable often dwelled on his mistakes. He reported that his nightmares have reduced since taking Prazosin, but he still experienced a lot of hypervigilance during the day. He lost control of his anger due to intense hypervigilance in a chaotic scene in the cafeteria. The psychiatrist increased one medication for PTSD and added another to address anger outbursts and hyperarousal.

A 15-year old who arrived a week before the site visit was first recognized at Finger Lakes as having PTSD behind his reactivity. He was referred to the psychiatrist by his clinician who had observed substantial signs of PTSD, with hypervigilance, nightmares and losing his temper quickly and being difficult to calm down. A lengthy, detailed Psychiatric Diagnostic Evaluation was completed in less than a month after he arrived. Apparently it was the first time he had talked in depth about the trauma of witnessing his mother's death. The psychiatrist proposed Prazosin for nightmares and Fluoxetine for other PTSD symptoms in a lengthy conversation with his aunt, his guardian, who is against psychiatric medication and wanted some time to research the proposed medications. The psychiatrist concluded that TS is motivated for treatment and recommended trauma-focused therapy.

FUTURE MONITORING

To achieve sustained compliance with paragraph 48 at Finger Lakes will require consistently thorough Integrated Assessments.

The MH Monitor will review diagnostic practices and efforts to routinely arrive at agreement about what is behind a resident's behavior and how staff can effectively respond at Finger Lakes.

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 rationale for the prescription of each medication, and the target symptoms intended to be treated by each medication.*

COMPLIANCE

The revised PPM 3243.32 entitled "Psychiatric Medicine" (9/15/14) complies with 49a: "When medicine is indicated, the diagnosis/diagnoses, the symptoms targeted by the medicine and the rationale for use of each medicine shall be clearly stated in the psychiatrist's evaluation and contact notes located in the Juvenile Justice Information System (JJIS). Copies of the psychiatrist contact notes shall be included in the Mental Health section of the youth's medical record."

The OCFS Psychiatry Manual (3/14, updated 10/14) complies with the requirements of 49a.

The Psychiatric Contact Note links diagnosis with the medication prescribed. The MH Monitor observed a Finger Lakes psychiatrist explaining the rationale for prescribing particular medication to treat a resident's symptoms.

- 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

The revised PPM 3243.32 "Psychiatric Medicine" (9/15/14) complies with 49b.

The OCFS Psychiatry Manual (3/14, updated 10/14) complies with the requirements of 49b.

The MH Monitor reviewed thorough Psychiatric Contact Notes by the Finger Lakes psychiatrist in JJIS indicating diagnosis, efficacy, symptoms, side effects, and the rationale for continuing, changing or discontinuing each medication in compliance with 49b.

The revised PPM 3243.32 " Psychiatric Medicine" (9/15/14) required: "The use of three or more medicines simultaneously to treat one youth is discouraged and may only occur following consultation from the supervising psychiatrist. Use of two medicines from the same class is also discouraged." A JJIS note in the youth's record documents the consult.

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

The revised PPM 3243.32 " Psychiatric Medicine" (9/15/14) complies with 49c: "The psychiatrist, psychiatric nurse practitioner and mental health clinician will assess youth for beneficial effects of medicine on the target symptoms. Clinicians met with youth weekly for scheduled visits. Prescribers meet with youth monthly, and more often when clinically indicated. Each youth prescribed psychiatric medicines shall be assessed by the psychiatrist or psychiatric nurse practitioner every 30 days or more frequently when clinically indicated. The psychiatrist or psychiatric nurse practitioner will conduct a clinical interview including a mental status exam of the youth, review lab results, review clinical assessments for side effects, review and sign medicine refusals, and consider any additional information provided by the clinician and direct care staff who work with the youth. This evaluation shall be documented in the psychiatrist's contact notes in JJIS. The medication treatment will be continued or adjusted as indicated by the findings."

The OCFS Psychiatry Manual (3/14, updated 10/14) complies with the requirements of 49c.

Forms to track laboratory findings and side effects comply with 49c and were completed in Finger Lakes records. A Health Services site visit report indicated that the Nursing Supervisor completed an audit on five charts in August 2014, and found that they met standards for monitoring side effects on all psychiatric medications.

On Site Observations Regarding Paragraph 49a-c (11/14)

On November 4, 2014, 16 of the 53 residents at Finger Lakes were prescribed psychiatric medicines (Clonidine (5), Risperidone/Risperdal (4), Prazosin (2), Abilify (1), Intuniv (1), Olanzapine (1), Prozac (1), Quetiapine (1), Remeron (1), Seroquel (1), Trazodone (1), Vistaril (1), and Zoloft (1)) to address symptoms of the following diagnoses:

ADHD, Conduct Disorder	Risperdal, Zoloft, Intuniv
Conduct Disorder	Risperidone
Conduct Disorder, Antisocial with Narcissistic traits	Risperidone
Conduct Disorder, Cannabis Use DO, Personality DO	Sertraline, Olanzapine, Clonidine
Conduct Disorder, Cannabis/Alcohol Use Disorder	Risperidone
Conduct Disorder, Circadian Rhythm Sleep Disorder	Trazodone
Conduct Disorder, Rule Out PTSD	Clonidine
Depression, Conduct Disorder, Cannabis/K2 Use Disorder	Prozac

Disruptive Mood Dysregulation Disorder Abilify
 Generalized Anxiety Disorder, Conduct Disorder Clonidine
 Oppositional Defiant Disorder, ADHD, Conduct Disorder Clonidine
 PTSD, ADHD Clonidine, Vistaril
 PTSD, Conduct Disorder Prazosin, Remeron
 PTSD, Conduct Disorder, ADHD Seroquel, Prazosin
 PTSD, Conduct Disorder, Cannabis Use Disorder Quetiapine
 PTSD, Conduct Disorder, Personality Disorder Clonidine

On November 4, 2014, two of the 16 Finger Lakes residents prescribed psychiatric medication were prescribed three psychiatric medications: a 15-year old diagnosed with Conduct Disorder, Cannabis Use Disorder and Personality Disorder was prescribed Sertraline, Olanzapine and Clonidine. The other, a 15-year old diagnosed with Conduct Disorder and ADHD, was prescribed Risperdal, Zoloft and Intuniv. Psychiatric contact notes reflect the careful assessment of medication efficacy and informing others on the team about symptoms. He had a history of MHU placement and was adjusting poorly at Finger Lakes since his admission six weeks previously. He asked the psychiatrist to discontinue his psychiatric medicines because he thought they were not effective: "he has been most recently diagnosed with ADHD, Conduct Disorder, and Anxiety NOS in addition to borderline intellectual functioning and expressive language disorder. He presented with concrete reasoning, limited fund of knowledge, and speech issues. His anxiety may be performance type related to his self-consciousness about his intellectual impairment. It is not clear from the records if Zoloft has helped. It may be that Risperidone has helped him become less violent and aggressive, since he has not behaved that way here. It is possible that Intuniv is treating his hyperactivity, since he has not exhibited any here. He has tried to act out to get himself transferred to Industry, where he is more comfortable. Continue Risperidone for impulsive aggression. Continue Intuniv for hyperactivity. Continue Zoloft for anxiety for now. Psychiatrist discussed various therapeutic interventions with clinician. Psychiatrist recommended obtaining further collateral history from his family and investigating if they can assist him in adjusting to FLRC." This resident's Integrated Assessment indicated a trauma history that was not mentioned by the psychiatrist as possibly connected to his anxiety and aggression. His grandmother and aunt raised him because his mentally ill mother was in and out of prison for drug crimes, and he only began living with her five years ago. He reported guilt about his grandmother's death, as he feels responsible because "she died of stress," and he and his older brother were "stressing her out." A previous OCFS clinician indicated he was probably abused, and he reported witnessing community violence including the shooting of his aunt. His development was likely affected by prenatal substance exposure and brain injuries from lead poisoning and a concussion with loss of consciousness from a car accident. He reported smoking cannabis daily since the age of 10. He had a psychiatric hospitalization in 2012. His previous diagnoses were Conduct Disorder, Cannabis Abuse, Mixed Expressive Receptive Language Disorder, Posttraumatic Stress Disorder (provisional), ADHD, Reading Disorder, Disorder of Written Expression, Generalized Anxiety Disorder, Disruptive Behavior Disorder, Rule Out Cognitive Disorder, and Rule Out Cannabis Dependence.

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 Psychiatry Manual (3/14, updated 10/14). 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.

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 Finger Lakes.

FUTURE MONITORING

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

The MH Monitor will observe discussions of efficacy of psychiatric medicines 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 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

The revised PPM 3243.32 " Psychiatric Medicine" (9/15/14) and Policy PPM 3243.15 entitled "Refusal of Medical or Dental Care by Youth" comply with 51a. PPM 3243.32 contains procedures when youth refuses psychiatric medicine.

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

The revised PPM 3243.32 " Psychiatric Medicine" (9/15/14) and Policy PPM 3243.15 entitled "Refusal of Medical or Dental Care by Youth" comply with 51b. PPM 3243.32 contains procedures when youth refuses psychiatric medicine.

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 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 Finger Lakes residents' support teams that complies with 51e.

In addition, the revised PPM 3243.32 " Psychiatric Medicine" (9/15/14) requires that: "The psychiatrist or psychiatric nurse practitioner shall exchange information about the youth with the assigned clinician, counselor and other team members on an informal basis. This exchange of information will also occur at mental health rounds attended by the psychiatrist or the psychiatric nurse practitioner. The psychiatrist and psychiatric nurse practitioner attend weekly mental health rounds with other members of the support/treatment team including teachers, clinicians, YCs, YDAs, nurses, and recreation therapists."

██████ is a 16 year old who had been at Finger Lakes for a ██████ for robbery with a diagnosis of Conduct Disorder and Cannabis/Alcohol Abuse. A Psychiatric Contact Note two weeks after the site visit indicated that he refused medication for the last 6 out of 7 days. His clinician reported that he continued to display difficult behavior. He demanded a change to stimulant medication to treat ADHD but he was unwilling to describe his symptoms. The psychiatrist discontinued Risperidone at the resident's request, but indicated in his note that he would consider a higher dose or alternative in the future to address impulsive aggression. The psychiatrist discussed possible strategies to engage him with his clinician.

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

The revised PPM 3243.32 " Psychiatric Medicine" (9/15/14) complies with the requirements of 52 and contains guidelines for informed consent for psychiatric medicines: "The assent and understanding of the youth shall be sought for psychiatric medicines. The youth needs to understand, in accordance with his or her developmental ability, how the medicine may impact the way he or she feels, acts, and thinks, as well as the benefits and risks of treatment. To obtain assent, the psychiatrist shall discuss with the youth in person, the

name of the medicine, the dose, and the reasons for prescribing, common side effects, and potentially serious side effects, and obtain the youth's verbal assent to comply with the treatment. The youth's verbal assent will be documented in the psychiatrist's evaluation or contact notes."

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.

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

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 and how to utilize both in support teams "The NY Model: Treatment Team Implementation Guidelines" complies with 53a.

Support teams at Finger Lakes 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 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.

Sustained compliance with 53c requires that the Finger Lakes psychiatrist participate in support teams of residents with complex diagnoses and/or psychiatric medicine issues.

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

Some Finger Lakes Integrated Assessments, clinical evaluations, and Mental Health Rounds describe the effects of trauma on residents' behavior and are part of planning interventions. Many residents' support plans, a key aspect of the New York Model, do not include trauma. 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, and trauma must become a safer topic in each resident's change process. Now that Finger Lakes has a clinician for every unit, sustained compliance with 53d means demonstrated improvement in support plans that incorporate the resident's trauma history from the Integrated Assessment and tailor skill-building in response to it. Expert trauma treatment consultation for clinicians and YCs may be warranted, followed by Intact Teams improved understanding of how DBT skill-building and residents feeling safe are parts of trauma recovery. A unit-by-unit review of the connection between the trauma history in Integrated Assessments and incorporation of trauma recovery in individual work with residents, as well as training for intact teams (using resident examples) are recommended, with discussion of the findings at the next site visit.

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 at Finger Lakes were observed complying with 53e and the support team meetings observed by the MH Monitor complied with 53e.

This subparagraph is found in compliance because of Finger Lakes outstanding support team meetings. Now that Finger Lakes has a clinician for every unit, sustained compliance with this subparagraph means demonstrated improvement in helping residents articulate their goals that (a) are personal change goals, (b) are not generic program-compliance or return home goals, (c) include addressing the trauma behind behavior and (d) each staff person on their teams identifying what he/she will do to support each resident's daily steps to achieve his goals.

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 Finger Lakes were observed complying with 53f.

Now that Finger Lakes has a clinician for every unit, sustained compliance with 53f means demonstrated improvement in assisting each resident who returns to or is placed at Finger Lakes after failure in the community to craft a new support plan that addresses 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 (11/14)

The MH Monitor observed three outstanding Finger Lakes support team meetings which demonstrated supportive relationships with residents and effective communication with family and CMSO.

■ is a 14-year old at Finger Lakes for three months; he was placed at ■ 6/13, moved to ■ 4/14 after an assault and moved to Finger Lakes 8/14 after continued serious behaviors. He had inpatient hospitalizations in 2009 and 2011 and residential placement 2011-12. The death of his ■ in 2012 was traumatic. In 2012 he requested a foster home placement after running away from home repeatedly due to friction in his relationship with his mother—who has been hospitalized ■ --and her boyfriend with whom he lived with ■ siblings. In 2012, his tested IQ was 76, with very low processing speed and his diagnosis was Mood Disorder and Anxiety Disorder. In a thorough 2013 county mental health assessment he was described as emotionally immature, naïve and childlike and his emotional dysregulation was attributed to early attachment problems with his mother (the family was homeless and a sibling was born when ■ was ■). A diagnosis of Autism Spectrum Disorder was considered due to his misperceptions, sensory overload, rigid thinking style, problems with transitions, and processing difficulties. He functioned better with consistent structure, low stress and effective psychiatric medication. Past diagnoses of pervasive developmental disorder and depression were noted. A complete developmental work-up, including assessment of pragmatic language and sensory processing, was recommended. At Reception in 12/13 his exposure to lead and the family's homelessness was described, his IQ was 69, he was working at the 2nd grade level with poor verbal comprehension and his diagnosis was Adjustment Disorder with mixed emotions Rule Out PTSD and Rule Out ADHD. At Finger Lakes, ■ diagnosis was given as Conduct Disorder and Cannabis Use Disorder, with no psychiatric medicine and no justification for the rejection of other recent diagnoses. His Finger Lakes IIP in 10/14 was identical to his 12/13 IIP at Industry. His Finger Lakes support plan did not reflect the 2013 assessments. His simplistic goals were to follow staff directives and process emotions (anger) and only the clinician and YC indicated how they would assist him. His support plan listed the same diagnosis as Reception (12/13) and the rule outs had not been resolved in over 10 months. It was assumed that he would be returning to his mother, despite his mother's unresponsiveness to staff efforts to involve her, a long history of rejection by his mother, ■ and her coping with ■ recent release from Finger Lakes. Between 8/29-10/30/14 ■ had individual therapy six times, individual counseling was provided by his YC nine times, and he participated in 41 groups. He reacted to name-calling by other residents and was worried about not being able to live with his mother. In October, 2014, ■ initiated a meeting with

the psychiatrist to request a resumption of psychiatric medication. He thought the medication would help him with his anger, but the psychiatrist disagreed, presenting him with his good behavior at Finger Lakes while off medication. The psychiatrist screened him for PTSD and depression and concluded that he had experienced substantial trauma but reported no PTSD, depression or anxiety symptoms. The psychiatrist diagnosed Conduct Disorder and Cannabis Abuse and indicated that there was no current indication for psychiatric medication. On 11/1/14 while in ALS due to repeated fights, he talked with his clinician about his frustration that once his YC left the unit his replacement would not be working on his release about which the clinician reassured him. The MH Monitor observed [REDACTED] 90 day support team meeting, convened by his YC with the CMSO present in addition to his clinician, nurse, teacher, unit manager and Assistant Director for Treatment. Neither his YC nor his CMSO had been able to reach his mother by telephone—she has had no contact with OCFS since his placement at Finger Lakes in 8/14. After weeks of improved behavior, [REDACTED] had three assaults this week, a Red Flag meeting and was placed on ALS. He attributed this to his YC being moved and his fears, given his mother's lack of involvement, that he would never get released. His clinician added that he was also losing his clinician who was being replaced with a new clinician for the unit. The Assistant Director for Treatment said it was necessary to plan with [REDACTED] how his relationships with staff will be stable during the transition and reassure him that Finger Lakes and his CMSO are working consistently on his release. However, the CMSO expressed frustration: "How can his plan be to place him with his mother if she cannot be reached and a home study cannot be done?" [REDACTED] joined the support team, and his YC was caring and direct. His IIP and goals were reviewed quickly and it was evident that [REDACTED] struggled to communicate. He told the team his problem was that his YC was leaving, and his YC reassured him that he would still be in the building. His YC asked what it would take for him to get off ALS and [REDACTED] responded, "I have to stay away from negative peers. I have to focus on myself." The CMSO questioned him about his uncle, who he had mentioned to his YC. He provided an address and phone number but said his mother would not approve placement with his uncle. His teacher reported [REDACTED] is passing everything. His clinician said he was doing well in individual counseling. His CMSO said, "I know you can keep up your good behavior and make your phase. I'm not going anywhere. No one is falling asleep on your paperwork." The CMSO said they would get him services three hours a week from YAP. [REDACTED] asked if he could return to a boxing program near his home. This resident—who has a long history of rejection, complex mental health problems and cognitive limitations—has been asking for a foster home since 2012—at 15, he could thrive in treatment foster care. Placing him with relative who probably cannot provide trauma-responsive care even with community mental health services, will likely lead to a return to a facility. Despite the strong relationships evident in [REDACTED] support team, his deterioration and significant placement problems were in part the result of a poor understanding of the combination of his emotional immaturity, attachment problems, and processing difficulties clearly documented before he arrived.

[REDACTED] is a 15-year old who has been at Finger Lakes for almost seven months for carrying a weapon. He was placed at [REDACTED] 2/13, released, returned as a revocator and released home 8/13. He lived with his mother and [REDACTED] younger siblings; his father is incarcerated. At [REDACTED] in 2013, his FS IQ was 94 (verbal-102), he was reading and doing math at the college level, and his diagnosis was Disruptive Behavior Disorder. His Reception diagnosis was Conduct Disorder, Cannabis Abuse, Rule Out Mood Disorder. His Finger Lakes Integrated

Assessment did not indicate what was behind his behavior although he had experienced many losses with the deaths of his [REDACTED] and the incarceration of his father when [REDACTED] was 10; he had also witnessed domestic violence. He had anger problems and difficulty following rules since he was a young child. He reported using marijuana daily since age 11 and skipping school since 7th grade. His diagnosis in the Integrated Assessment was Oppositional Defiant Disorder, Rule Out Cannabis Dependence, Rule Out Conduct Disorder. [REDACTED] IIP remained the same as six months earlier: Time Away, Hurdle Help, and Direct Appeal. In his 9/28/14 support plan, his goals were Look into getting into AP classes when he returns to the community and Transition to group home. The only staff interventions were the clinician helping with DBT and self-control. He was “doing well controlling anger but needs to show improvement in school—he does not finish work and is disruptive to class. He struggles with peer pressure.” Between 8/29-10/30/14 [REDACTED] had individual therapy three times, individual counseling with his YC six times, and he participated in 28 groups during those two months. There was no indication that he was receiving individual substance abuse treatment although he had previously had a substance abuse diagnosis and notes did not indicate that Cannabis Dependence had been ruled out since 4/14. His record reflects an intelligent youth who gets easily bored and influenced by peers with a history of trauma that might be behind his anger problems. Group counseling was the primary intervention provided at Finger Lakes, which is unlikely to address his trauma. The MH Monitor observed [REDACTED] last support team meeting before going to a group home; it was convened by one YC and his other YC, clinician, nurse, vocational teacher, substance abuse counselor, unit manager, and Assistant Director for Treatment participated. On videoconference, the Watertown CMSO was in the office with his Utica CMSO and his mother to plan the details of the aftercare services he would receive in the group home in Watertown. His mother signed the paperwork for his group home placement and the Watertown CMSO planned to deliver it to the group home that afternoon. His YC made it clear that the purpose of the support team meeting was to plan his transition: “Your goal is to continue to do well here so you can go to the group home and play on the basketball team.” His YC said the group home interviewer said [REDACTED] was the best he had interviewed—smart, serious about basketball and personable. The CMSO asked if [REDACTED] had gotten an alarm clock since the last team meeting and was doing better at getting up for school. The teacher reported that he is on High Honor Roll. [REDACTED] explained that he did credit recovery and will be in 10th grade in January; he said he did extra work to keep busy at school. His YC was complimentary about his school performance. His clinician said he was improving in distress tolerance with time away and ventilation. They asked if he was anxious about returning to regular school and he said he wants to stay on task when he meets new people. The CMSO said, “We will help you maintain yourself.” The CMSO was responsive to the resident’s priorities—he said he would talk to the basketball coach at the high school about trying out as soon as he arrived and to the group home staff about his participation in a substance abuse treatment program. The CMSO who had seen [REDACTED] fail three times in 18 months in the community said, “You turned it around in there in 30 days. In the community you have to stay focused.” After the support team, we discussed how it might be helpful for [REDACTED] to understand his fear of failure and its connection to his father having been a good student and athlete and now being incarcerated. Supporting him to write a letter to his father asking for permission to succeed, to do better than his father did, was discussed. Furthermore, [REDACTED] has no experience

making friends with good students or athletes—perhaps a helpful homework assignment might be to write how he would do so and discuss it with his YC and CMSO.

■ is a 16-year old at Finger Lakes almost 10 months after an assault. He lives with his ■ siblings (■) and ■ cousins since his mother left ■ six years ago; he witnessed his ■ being killed. He had a weapon charge in 2011, two other charges in 2012 and 2013 for which he was sent to a ■ residential placement, and another weapon charge in 2013. A 1/13 mental health report gave him a diagnosis of Conduct Disorder, Rule Out PTSD, Rule Out Cannabis Abuse, Rule Out Communication Disorder. A 6/13 report from the residential program indicated that he had trouble with self-control and disrespect, made poor decisions with peer pressure and had trouble focusing in school. His Finger Lakes Integrated Assessment (2/14) reported he was reading at the 6th grade level and doing math at the 7th grade level. He appeared depressed, but did not want therapy. He denied marijuana use despite being caught with marijuana at school. His Reception diagnosis had been Conduct Disorder, Rule Out Depressive Disorder, and Rule Out Cannabis Abuse. Between 8/30-11/3/14 ■ had individual therapy twice, individual counseling by his YC eight times, and he participated in 29 groups. He has a significant trauma history, and a PTSD Rule Out (1/13) and Depressive Disorder Rule Out (1/14), but group counseling was the primary intervention provided at Finger Lakes. There was no indication that he was receiving individual substance abuse treatment although he had previously had a substance abuse diagnosis and there were no notes reporting that Cannabis Dependence had been ruled out since 2/14. He was worried about not having a place to live in the community because his aunt was homeless. His older brother, who is employed, has agreed to let ■ live with him. The MH Monitor observed ■ last support team meeting before being placed with his brother, convened by one YC, and his other YC, clinician, nurse, and Assistant Director for Treatment participated with his brother, CMSO and two community programs on videoconference from the Bronx. The meeting was disjointed because it was a surprise to Finger Lakes staff that the CMSO announced a possible release date two weeks away now that his brother has decided to take him. His brother had many basic questions about his care; the B2H provider felt pressure to move quickly so services could be in place. The Finger Lakes staff responded to the stress of the situation by calmly coordinating a lot of planning that usually would have been done outside the support team meeting. Finger Lakes reported that for 90 days ■ has been doing well, works in the kitchen, is on application phase and is eligible to do community service; he is in regular education and made honor roll. He was described as a hard worker who has learned to walk away from fights; he has a good relationship with his YC and clinician. He is not taking medication and community substance abuse services were not recommended. But ■ was described as needing individual therapy to continue to learn how to express his emotions rather than suppressing them and then having anger problems. One YC reached out to ■ ■ talking directly to him about what to expect and responding to his worries about how to enroll him in school and how to provide supervision given his job. With ■ in the team meeting, they went through the checklist of his next phase by becoming a role model, the challenge of discussing the connection between his history and current behavior, and using Radical Acceptance and Mindfulness effectively. Unfortunately, these steps were not made applicable to the community.

As these three residents demonstrate, Finger Lakes support team meetings remain a strength, but staff are working to improve treatment: (a) support plans are not sufficiently individualized, (b) the large number of residents returning from aftercare require special assistance in defining the changes they will make in order to be successful in the community, including relapse prevention; and (c) the trauma behind behavior problems is identified in Integrated Assessments that often is not incorporated into the support plan goals and remains untreated at Finger Lakes.

Finger Lakes staff continue to struggle to provide effective individual trauma treatment. For example, [REDACTED] a 14-year old who arrived at Finger Lakes in October, 2014, was diagnosed with PTSD. His Integrated Assessment detailed a significant trauma history, including sexual abuse [REDACTED] abandonment, and familial rejection. He has an extensive history of mental health treatment and taking psychiatric medications. He has a history of elevated blood lead levels during the first year of his life. He and his siblings were placed with their [REDACTED] but while they remained with them, since age 6 [REDACTED] has been under the guardianship of DSS; he was placed in a foster home for a year and then went to [REDACTED], remaining there for three years. His parents relinquished their rights and he moved to a pre-adoptive foster home. The adoption was unsuccessful, and although he officially remains free for adoption, he has voiced his desire not to be adopted. He has significant social and interpersonal skill deficits and a history of aggression toward staff and peers in placement. He was sent to Finger Lakes with a Criminal Mischief charge for breaking a window at [REDACTED]. He had a 3.0 SNAP score, but there is no indication in his EMRC psychological evaluation that he has a substance use diagnosis. His tested FSIQ in 2005 was 103, and on another test he obtained a Composite IQ of 108. In 2014 testing he had an overall index of 95, in the average range. "Interacting with him can be confusing because he clearly is an intelligent youth, but does not have behavioral control. RS's early neurological development however, was clearly affected. It is reported he suffered speech, language, and gross motor delays with lower extremity malformations. He shows many behaviors associated with the PDD spectrum. He has a history of delayed development in language and motor; his lack of social understanding of others, social circumstances, and even affect recognition have been tested formally and found deficient. Of most concern is his aggression and impulsivity. He easily becomes overwhelmed with affect that he is does not seem to know how to contain, also in line with PDD spectrum adolescents." The Finger Lakes psychiatrist saw [REDACTED] eight days after his admission, reviewed past evaluations and talked with his DSS worker: "He initially explained his failure to bathe on the bathrooms not being clean. After further discussion, he divulged that both his issues with bathing and with toileting are related to past sexual trauma. He experiences intrusive traumatic memories in these situations. He also feels afraid that he will be attacked. His fear thus far has caused him to avoid staff, but he acknowledges feeling relief when he is able to talk. He has assaulted two staff members and has been restrained three times thus far. Staff has observed a short fuse and it takes him quite a while to calm down. In addition, during such an episode, his speech becomes unintelligible and he is irrational. It may be that his exposure to trauma is underestimated in the records. He reported substantial PTSD symptoms. Autism has been suspected as well. There is no clear evidence that treatment efforts have helped him make progress to date. Perhaps an explanation is that when he is afraid and ashamed leading him to withdraw socially, he could appear as if autistic. Overall, [REDACTED] has lived a very traumatic and

difficult life. He suffered abuse and neglect and never really had a family or stable relationships over time. He had lead poisoning which affected his neurocognitive development but at present he does not display any cognitive impairment. He clearly meets PTSD criteria and is likely developing a personality disorder. This is manifested by his interpersonal difficulties with abandonment and conflict as well as his tendency to show regressive behaviors when in distress. Discontinue Concerta as no clear benefit and has refused for four days. Discontinue Lamotrigine as no clear benefit and no clear indication. Taper off Abilify as no clear benefit. He may benefit from other medication in this class to address aggressive behavior in the future. Begin trial of Clonidine to address PTSD hyperarousal. If he does not show improvement, especially in regressive behaviors, or they become worse, psychiatrist recommends referral to a dedicated mental health unit." RS's first support plan at Finger Lakes did not reflect the depth of the Integrated Assessment or Psychiatric Contact Note. His only goal was "he would like to stabilize in limited secure setting so that he may be stepped down or released to an approved release option." His YC was practicing skills to interact appropriately with peers. His clinician was working on DBT skills. Education planned a CSE meeting several weeks later to develop an IEP: "He is a very strong reader with great comprehension. He participates in class discussion with some good insights. His behavior can be immature and disruptive when agitated, fearful, or angry." The family section of the support plan noted: "████ primary goal is to return to live with his family, which is not an option due to him being freed for adoption. He struggles tremendously with the reality of not being able to live with his family, and enhancing his skills to help him manage the anger, sadness, and frustration is essential, which will be addressed through individual therapy with the enhancement of skills."

Another resident's record reflects significant trauma but difficulty treating it. █████ arrived at Finger Lakes in 9/14 and his Integrated Assessment documents his trauma history: "His father is a veteran of Desert Storm who suffered mental illness following his services. He has spent significant time in and out of VA hospitals and is currently hospitalized. █████ has contact with him about every █████ years. Currently, there is talk of more regular contact, a request made by his father and endorsed by his mother. The family has experienced significant financial and housing instability." In 2012 █████ was involved with an older adult who apparently sexually abused him: "his mother became concerned about changes in his behavior and called the police who arrested the adult █████ indicated was a woman who turned out to be a 48-year old man." █████ was admitted to █████ in 2012 on a █████ diagnostic placement; he stared off into space, laughed, and had a strained relationship with other residents. █████ endorsed near daily cannabis use and weekly alcohol use, starting about the age of 12. He described himself as a "street kid." On a PTSD Index he endorsed the item "Having an adult or someone much older touch your private sexual body parts when you did not want them to." At Reception his IQ could not be accurately assessed, and neurocognitive testing was recommended. Individual therapy was also recommended because he was ruminating a lot but not revealing what was bothering him. Family therapy was seen as beneficial to capitalize on his mother's support and assist with increased contact with his father; his mother lives out-of-state, but she planned to move to New York. Nevertheless, his support plan was superficial, not capturing his need for trauma treatment or the connections among his family and sexual trauma, substance use and peer problems. A month after arriving at Finger Lakes, he had three goals: Goal #1 Release to parents; Goal #2 Improve

behaviors toward peers and staff; and Goal #3 Reduce acting out, oppositional and disruptive behavior. Only Goal #3 had been started. [REDACTED] clinician was meeting with him weekly; IQ testing was planned with the goal of "assisting him in becoming aware of his cognitive limitations and teaching him positive coping skills." He had two Red Flag meetings, had been restrained many times, did not feel safe on the unit, antagonized other residents and refused to go to school. His diagnosis, Conduct Disorder and Moderate Mental Retardation, did not reflect trauma.

Another resident's need for trauma treatment appeared to have been lost in the struggle to manage his behaviors, and apparently therapy was not being provided to connect his anger with unresolved trauma. [REDACTED] Integrated Assessment (4/14) indicated that he experienced years of severe trauma: [REDACTED] domestic violence, divorce, sexual abuse by his [REDACTED] and physical abuse by his [REDACTED]. He had a history of special education, psychiatric hospitalization, and psychiatric medication and had been in several OCFS facilities. He had an antagonistic relationship with both his parents and stepfather. When he was admitted to Finger Lakes, he was depressed, hopeless and a risk of suicide. The reliability of his reports of being a polydrug user and dealer was unknown. His Reception diagnosis was Depressive Disorder. His Integrated Assessment recommended individual therapy to address sexual trauma and anger associated with sexual abuse, substance abuse treatment, and obtaining his GED. Two months later, a psychiatric contact note indicated "no depressive or anxiety symptoms or suicidal thoughts. Sleeping adequately without Trazodone—discontinued last month because he had been refusing for a month. Clinician reports improved behavior. No current indication for psychiatric medication. Diagnosis: Conduct Disorder and a vague history of depressive illness." Five months after arriving at Finger Lakes, [REDACTED] support plan documented his desire to make Learning Phase. Goal #1: Learn adequate coping skills and conflict resolution skills to help manage anger. During individual therapy, he will work on resolving the core conflicts which contribute to anger outbursts. Goal #2: Obtain adequate coping skills to help manage anger. Goal #3: I don't want to be with OCFS anymore. Follow the program rules and norms every day. [No interventions]. Goal #4: Improve on negative/ bad language [No interventions]. Goal #5: Work on his social skills. His diagnosis in his support plan remained Depressive Disorder. Based on clinical contact notes, between 9/29-11/5/14, [REDACTED] had no individual therapy, six individual counseling sessions with his YC, and 15 groups. In 11/14 [REDACTED] had been at Finger Lakes more than six months and CMSO visited his mother who [REDACTED] had assaulted. His mother said he is disrespectful on the phone. She requested vocational testing because he is 17 years old, in 9th grade and may have a difficult time adjusting to attending school once he is home. [REDACTED] spoke with his aftercare worker and is concerned that he will have to enter drug rehab upon his return to the community which he does not think he needs because he has been clean since being placed at Finger Lakes.

The MH Monitor met with the two Finger Lakes Assistant Directors of Treatment and the BBHS Regional Coordinator to inquire about their efforts since the previous site visit to improve the quality of Integrated Assessments and support plans. Coaching on how to improve the quality of support plans has not progressed as quickly as they would like but with two new clinicians, there will be an opportunity to do more. In a recent meeting with the clinicians, the Assistant Directors of Treatment led a discussion about improving services for revocators focusing on the skills they need to be successful on their return to the community.

When a resident returns from aftercare, Finger Lakes staff do not get information about what happened in the community causing the revocation. The resident returns anxious, hopeless, and feeling they have failed, and they struggle to get back on the wave of success they experienced as they left Finger Lakes. It is difficult for staff to help the resident get back on track. The Assistant Directors of Treatment have made an improvement in the Finger Lakes response to revocators: having a Red Flag meeting immediately when a resident returns, after having obtaining an update from the CMSO. One revocator Red Flag meeting occurred for each unit in the month before the site visit, and they hope to make it a practice for all revocators. The Assistant Directors of Treatment are making the annual mental health training for staff more Finger Lakes specific, and they are in the process of surveying the YDAs to learn more about what they would find helpful. The BBHS Regional Coordinator had not been to Finger Lakes since the last site visit. The new Social Work supervisor visited Finger Lakes three times in August and September 2014 to provide 2-hour JJIS Community Reentry Plan form training and review the DBT binder. BBHS staff visited Finger Lakes in September 2014, to work with two units, including reviewing the support plans of residents with the new YC. BBHS summarized their efforts as “encouraging improved goal formulation by using NY Model ISP guidelines and goal work sheets during support teams: goals must be youth-driven and motivating to the youth. Objectives are the specific areas identified as the impediments to goal achievement. Objectives/Interventions must be very detailed, as there should be consistent follow up of a youth’s progress on such interventions during weekly counseling sessions and YDA mentoring. Thus, everyone has a role in reinforcing the items on a youth’s support plan. DBT has been one of the primary interventions suggested, however, the teams were also encouraged to utilize other resources to obtain tangible skill building activities.” DBT training occurred in July and August 2014 at Finger Lakes (with a group of 8 YDAs, at least one from each unit) and in October 2014 (with the educational team). The Sanctuary consultant provided two 4-hour sessions to Finger Lakes staff in July 2014 and consultation in September 2014.

Finger Lakes staff is completing support plans so that the boxes on the form are filled. However, rather than improving in quality, some Finger Lakes support plans appear to be less individualized than in the past. The implementation steps are standardized (clinicians and YCs provide identical support to residents, despite the differences among what youth need and the relationship focus of the program) and all the staff in the team rarely have supports they will provide listed. Some support plans read as if they were done to satisfy documentation requirements, but not to be used by the youth, family, CMSO or relied on by the team to tailor trauma treatment or substance abuse treatment or for phase advancement or release planning. The goals are not individualized and narrowly focus on adherence to the Finger Lakes program. All youth want phase advancement, all youth want to keep their release date—it seems pointless to mislabel as personal goals these universal program requirements. Goal-writing with youth is not easy, but what has been overlooked in the push to complete support plan paperwork is guiding residents to recognize what has to change for each one to be successful in the community. It would be a universal resident hope to “go home and successfully stay home,” and the question asked of youth in order to write a goal unique to him would be, “What has to change for you to be successful at home?” The youth’s answer to that question—for example, “not be influenced by peers” or “figure out why I get so angry and learn not to” or “have better communication with my mother” or “feel like I can do

better in school”—will also be the guide for how he will be successful at Finger Lakes (not because his goal is program compliance but because what has to change for community success also has to change for success on the unit with peers and staff).

To achieve sustained compliance with the requirement that support “plans are modified based on the efficacy of interventions,” Finger Lakes clinicians and YCs, with coaching provided by the Assistant Directors for Treatment and BBHS consultation, must focus on the 38% of residents who return from aftercare (a third of them are Finger Lakes returnees, and the majority had been released to aftercare from other facilities). When a resident returns from aftercare, his new support plan should reflect specifically what it will take for him to be successful in his subsequent re-entry. The reasons their gains prior to release on aftercare had not continued in the community must be specified in each returnees’ support plan.

The 10/14 Finger Lakes QAI report commended the support teams observed at the facility. The 10/14 Finger Lakes QAI report required action to improve the development and documentation of goals and objectives that are measurable and transferable to the community. The 10/14 Finger Lakes QAI report required action for utilizing information from the Integrated Assessment to develop coping skills in the ISP.

FUTURE MONITORING

To achieve sustained compliance with paragraph 53 at Finger Lakes will require consistent individualized, trauma-responsive support plans directed toward success in the community.

The MH Monitor will continue to review support plans to verify improvement in helping residents articulate personal change goals that are not generic program compliance or return home goals for which each staff person on their teams identify what he/she will do to support each resident’s daily steps to achieve his goals.

The MH Monitor will continue to review support plans to verify improvement in addressing the trauma behind behavior problems identified in Integrated Assessments that must be incorporated into the support plan goals and treated at Finger Lakes.

The MH Monitor will continue to review support plans to verify improvement defining the changes they will make in order to be successful in the community for the large number of residents returning from aftercare.

The MH Monitor will continue to verify that the Finger Lakes psychiatrist participates in support teams of residents with complex diagnoses and/or significant psychiatric medicine issues.

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 provides 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.

PENDING COMPLIANCE

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

Finger Lakes finally has two clinicians working as substance abuse clinicians. One had been covering a unit as a clinician and now that an additional clinician has been hired for that unit, both substance abuse clinicians will provide only substance abuse services, each on three units. In early November, the new substance abuse clinician had just arrived. At the time of the site visit, individual and group substance abuse services had decreased since the previous site visit.

Since substance abuse staffing had just been reconfigured and there were as-yet-not-implemented plans for a new curriculum and pull-out groups at the time of the November, 2014 site visit, the next review by the Monitor will be crucial in determining sustained compliance with this subparagraph.

On Site Observations Regarding Paragraph 54a-b (11/14)

Like the process of becoming trauma-responsive, learning to meet the needs behind substance use is important for all staff, not just clinicians. Many Finger Lakes residents have a history of substance use noted in Integrated Assessments, but not reflected in goals in most support plans. Applying skills being learned in the facility 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 a resident's presentation of his portfolio before release. 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 intact teams among the clinicians, YCs, and YDAs 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. The MH Monitor reviewed few Finger Lakes records in which clinicians documented the required incorporation of substance abuse treatment in individual therapy for residents with a substance use diagnosis. The MH Monitor again recommends a consultation group for all the clinicians on how to integrate substance use treatment (and connecting it with trauma) into individual therapy and including these approaches in the intact teams.

The MH Monitor observed an unsuccessful substance abuse group on a unit described as "all riled up" because of several incidents. The YC unit manager calmed the residents and soon seven residents were seated. In the community meeting several of them said they were angry, upset and frustrated, but these feelings were not talked about. The substance abuse clinician read from a curriculum about using substances to numb feelings. The approach did not fit the residents and no effort was made to draw the residents into the topic. Both substance abuse clinicians talked about how avoiding feelings with substances only makes matters worse. Several residents disagreed and said marijuana helps them calm down, but

they were not engaged in discussion. The group was suddenly ended 20 minutes after it began, the residents' body language still conveying unacknowledged frustration.

The two substance abuse clinicians indicated they have been instructed by their Home Office supervisor to begin the Phoenix curriculum in "pull-out" groups for the youth on their units who have substance abuse diagnoses. They said they are supposed to make sure that all youth have the appropriate substance abuse assessments with results noted in the Integrated Assessment. They did not articulate the requirement that youth with substance abuse diagnoses must receive individual (minimally twice per month) and group (minimally once per week) substance abuse treatment, as dictated by policy.

These activities had not been initiated at the time of the November 2014 site visit. Between 9/15/14-10/15/14, one of the substance abuse clinicians provided substance abuse groups on three units; two met three times (Unit 3 -9/17, 10/1, 10/15 and Unit 6-9/16, 9/30, 10/14) and one met twice (Unit 4 -9/18, 10/2). This substance abuse clinician had one individual session with three residents. Between 9/15/14-10/15/14, the former substance abuse clinician who was re-assigned to a unit as a clinician provided substance abuse groups on three units; one met three times (Unit 2-9/18, 9/25, 10/2) and two met twice (Unit 1-9/23, 10/10 and Unit 5-9/16, 10/14). This clinician also had individual sessions with the six residents on the unit (from 2-5 sessions during the month.). During this time Finger Lakes was waiting for two new clinicians and one new substance abuse clinician. In the site visit, neither the administration nor the substance abuse clinicians acknowledged that the facility had been out of compliance with Paragraph 54 or had taken steps since QAI found a reduction of substance abuse services. There was no formal presentation regarding how and how soon the facility would comply with the implementation of a new curriculum, new scheduling of groups or verifying individual substance abuse treatment. Once again, a full substance abuse individual and group treatment program was promised. Home Office did not offer a specific, realistic plan for how the two substance abuse clinicians or their supervisors will confirm that substance abuse assessment results are in the Integrated Assessment or how, or how often, they will ascertain youth are receiving substance abuse treatment in individual therapy. Furthermore, the responsibility for insuring that for youth with substance abuse diagnoses, treatment is incorporated in the goals and interventions on their support plans, including a relapse prevention plan, and in their Community Re-Entry plans was not described by the two substance abuse clinicians--or anyone else--as their role.

For a few Finger Lakes residents, the required substance abuse treatment has been provided. ■ is an example of a resident with a "significant substance abuse history" and a desire to avoid substances whose clinician was the former substance abuse clinician and provided substance abuse treatment that complies with Paragraph 54. Substance abuse triggers were included in the objectives in his support plan, and he participated in three substance abuse groups led by his clinician and five individual therapy sessions in the month prior to the site visit. ■ Integrated Assessment indicated that he had a history of involvement in community violence beginning when he was 11, with six violent offenses in seven months in 2012. He was placed at ■ for almost two years (2012-1014) and had continued physical fighting and AWOLs. Shortly after being released from his prior placement, he was sent to Finger Lakes for frequenting a gang neighborhood and not following curfew. He lives in a violent area, participated in gang violence and was likely the

victim of violence. His mother, a former crack addict, was jailed for months in 2013 after she fell asleep on the couch, her children were playing with matches, and the house burned down. ■ had been diagnosed with ADHD and prescribed psychiatric medicine in placement. His Reception diagnosis was Conduct Disorder, Cannabis Abuse, Rule Out Alcohol Abuse and "anger management training" was recommended. But at the time of his Finger Lakes assessment, he was "handling his emotions without resorting to aggression" and was articulating his desire to stay away from gangs and not return to marijuana use. His support plan included: Goal #1: Develop skills to help him be successful in the community. Clinician will complete substance abuse assessment and assist him with identifying the triggers for substance abuse. YC-Innervisions groups; list of activities he can do when he is bored. Goal #2: Move up to Learning Phase. Clinician will assist with practicing DBT skills to assist with aggressive urges. Education team and YC-encourage to use DBT skills in school. Clinician will schedule a psychiatric assessment for medication for ADHD symptoms. His diagnosis remained Conduct Disorder, Cannabis Abuse. In the 10/28/14 Psychiatric Contact note the psychiatrist gave a different diagnosis than his support plan seven weeks earlier. The psychiatrist concluded that the underlying cause of his hyperactivity and poor concentration is anxiety rather than ADHD. He is several grade levels below his age (R-4 M-3) and feels anxious with school performance around his peers leading to the anxiety symptoms and avoidance he shows in school. "■ is a 14 year old boy with GAD and performance anxiety who has shown a good response to Clonidine. He has gained confidence and improved his performance in school. Continue Clonidine for anxiety." The psychiatrist did not mention trauma as a contributor to anxiety or the connection among his substance abuse, anxiety, and trauma. Hopefully, ■ support plan will soon reflect his understanding of what he is learning about his substance abuse, anxiety and trauma that will assist him in achieving his goal of staying away from violence and substances when he returns to the community. This example of documented substance abuse treatment (combined with DBT skills and psychiatric treatment for anxiety) is rare at Finger Lakes. On other units, numerous residents with substance abuse diagnoses had support plans that did not reflect substance abuse-related goals or interventions, effective substance abuse treatment groups were not provided, and relapse prevention was not documented in re-entry planning.

The 10/14 Finger Lakes QAI review concluded that substance abuse programming scored within the Not Meeting Standards range and reported a decline in progress in substance abuse treatment since the March, 2014 review. During the previous review, documentation and/or provision of individual substance abuse treatment were weaknesses, as well as the consistent provision of Innervisions and these two areas continued to need improvement in October 2014. The 10/14 Finger Lakes QAI report required action to (a) promote the practice of youth being referred to the appropriate services; (b) consistently provide and document individual and group substance abuse therapy to all youth requiring such; and (c) consistently provide a substance abuse prevention and education curriculum. The 10/14 QAI report indicated that to promote the consistent provision of Innervisions, Finger Lakes planned to have substance abuse clinicians monitor and document the groups being held for their respective units. As of 10/9/14 it was reported that a protocol regarding youth who need substance abuse services was established. Two clinicians were identified in the facility plan that included procedures for assessment, referral, and treatment for substance abuse. The 10/14 Finger Lakes QAI report required that when youth have a

substance abuse diagnosis, objectives related to their substance abuse treatment should be included in their support plan. The 10/14 Finger Lakes QAI report documented the lack of follow-through for a resident of Reception's recommendation that the youth be further evaluated and treated for substance abuse issues. There was no indication of further evaluation at Finger Lakes, and the youth had only attended two substance abuse groups in the three months since his admission. The 10/14 Finger Lakes QAI report noted another example of a resident who arrived at the facility with a substance abuse diagnosis, and no explanation was documented when this diagnosis was removed. The 10/14 Finger Lakes QAI reported on an observation of an inadequate substance abuse treatment group. The group only lasted 15 minutes, the clinician read from a written document and did not focus on youth, and although they sat politely, the residents were not engaged in the group.

FUTURE MONITORING

The MH Monitor will review evidence that all youth with substance abuse diagnoses on six units are receiving individual (minimally twice per month) and group (minimally once per week) substance abuse treatment (not only InnerVisions) which is documented in support plans, clinical contact notes for individual therapy and Community Re-Entry Plans. With assistance from Home Office and the Assistant Directors for Treatment, by the next site visit it is expected that Finger Lakes will be able to demonstrate that (a) the two substance abuse clinicians are each working with their three intact teams to insure that all youth with substance abuse diagnoses are involved in effective treatment groups; (b) clinicians receive consultation and are incorporating substance abuse treatment in trauma-responsive individual therapy; and (c) a system for insuring consistent documentation of substance abuse goals and relapse prevention is being utilized.

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.

The new Community Re-Entry Plan complies with 55b.

The Community Re-Entry Plan is designed to consolidate information from the Integrated Assessment, support plan, and other sources (including the current IEP, transcript, and other school and vocational information to be provided to the youth's next school). Community Re-Entry Plans include referrals to mental health and other services. Like support plans, each discipline submits 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 are entered, with the services to be provided in the community. A primary purpose of the last support team meeting before transition and of the Community Re-Entry Plan is to tailor the youth's goals to success in the community, so his supporters understand their role in helping him regulate emotions, tolerate distress, and avoid relapsing.

Finger Lakes staff have been trained in completing Community Re-Entry Plans but CMSO training delayed their inauguration at Finger Lakes. The first Finger Lakes Community Re-Entry Plan was reviewed after the November 2104 site visit.

This subparagraph is found in compliance because of the impressive work of Finger Lakes staff in arranging individualized re-entry services for residents. To achieve sustained compliance with paragraph 55 at Finger Lakes, now that there is one clinician on every unit, will require preparing thorough and usable Community Re-Entry Plans as an important way to support each resident's continued use of what he has learned at Finger Lakes in the community.

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 (11/14)

Finger Lakes has an exemplary process to support residents in articulating 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. The MH Monitor enjoyed observing [REDACTED] release presentation to the Director, Assistant Directors, and his YC. He is a 16-year old on Learning Phase who had been at Finger Lakes for less than five months. He did an excellent job reviewing his portfolio including his resume and teacher report and describing his plans to succeed in the community. The release plan presentation is an outstanding re-entry preparation process that fits well with support teams and could inform the Community Re-Entry Plan.

The MH Monitor was informed about the delay in training on Community Re-entry Plans due to extended medical leave by the trainer. Finger Lakes staff received a 2-hour training on Community Re-entry Plans from the new Social Work Supervisor (clinicians, YCs, and medical and education staff). The three new YCs and two new clinicians will be trained in December. At the time of the site visit, CMSO staff were being trained in the Community Re-entry Plans and were directed to start doing CRPs in JJIS in December 2014.

The MH Monitor reviewed the first Community Re-entry Plan completed at Finger Lakes, and both the content and format, while technically complying with 55b, were problematic.

■ is a 16-year old admitted to Finger Lakes in July, 2014 and released in November, 2014. His Integrated Assessment described a significant trauma history, including parental and sibling incarceration, CPS involvement in the family, his ■ being killed, and exposure to community violence. ■ lived with his mother and ■ siblings; he had no relationship with his father who was incarcerated, released in 2012, and returned to prison for a parole violation. ■ had an IEP, was in 10th grade, and his classroom behavior interfered with his learning. ■ last support plan before discharge (10/30/14) concluded that “Youth has demonstrated the ability to reach his goals and apply his learned skills in a practical setting. However, he continued to present as very guarded, and refuses individual therapy as well as participating very minimally in groups. He denies any mental health symptoms and continues to state that he ‘doesn’t need’ any sort of counseling or individual or group therapy.” His goals were simplistic, and after four months in the facility, his clinician’s intervention was still to “continue to work to build engagement with ■ and offer appropriate encouragement and feedback around school participation and success and to assist him in modifying his behaviors to meet his goals.” At Finger Lakes, ■ had the same diagnosis as in Reception: Conduct Disorder, Rule Out Depressive Disorder (although it had not been ruled out in four months). He refused to meet with the psychiatrist (last recorded in a psychiatrist note in August, 2014) and was not prescribed psychiatric medicine. ■ Community Re-entry Plan (completed 10/20/14) raised several concerns about this approach to discharge planning, particularly because it did not capture the many efforts—commended in previous monitoring reports—by Finger Lakes staff to facilitate each youth’s success in the community. The plan is 20 pages long and is not a document that can be easily referred to for guidance about how to support him in the community. It has outdated, incorrect information. ■ Continuity of Care plan and his ISP said he was not prescribed psychiatric medicine at the time of discharge, but his previous medication and Reception psychiatrist are listed in the Community Re-entry Plan. His goals from the facility are listed as his goals in Community Re-entry Plan, and they are facility-specific and have no application to goals he might have in the community. (Goal #1 Earn opportunity to work in facility. He will need to demonstrate time management, pro social skills, trustworthiness, and pass all of his classes. Goal #2 Minimize length of stay in facility. He will participate in class, respectfully and patiently requesting assistance when needed. He will participate in individual and group counseling, attend school and pass all subjects, not have any codes called for his behavior, and participate in all other program areas). Furthermore, it is confusing to attempt to connect these two goals and progress with a section called Needs/Goals which is organized by staff person. For example, under CMSO Case Manager: “Youth will need to attend school and participate in community programming. Youth will need to comply with community aftercare requirements. Youth goals are to continue with education and prepare for vocational training school like job corp. Youth mother wants youth to obtain part time employment, attend educational services and prepare for vocational training school.” This does not fit the guidance for writing goals, which might instead have led to something like, “In order to achieve his goal of going to Job Corps, ■ will get up in the morning and go to all his classes everyday at ■ High School so he can finish this school year, which is required by Job Corps.” The course of treatment section of his Community Re-entry Plan is not written in a way that would help ■ his mother or his CMSO use the skills he learned at Finger Lakes to cope successfully with frustration at home and community school (“He has worked with members of his support team to learn skills, particularly DBT distress tolerance, emotion regulation, and interpersonal effectiveness skills

that can assist him in modifying his behaviors in order to be successful in the community”). The background information section in [REDACTED] Community Re-entry Plan is a cut-and-paste conglomeration, with trauma exposure not linked to behaviors, emotional regulation or services to address these. His diagnosis is not explained, and there is reference to two psychiatric hospitalizations in 2011 and 2012 without any mental health information from these. The Mental Status Exam in [REDACTED] Community Re-entry Plan is undated and has no indication of the mental health professional who prepared it; mental status is a current assessment, and if it is from the past, it has little relevance. Finally the first page of the Community Re-entry Plan has information that should appear later—it should start with the person with whom he will be living (not law guardian/defense counsel). Next on the CRP form should be specific, individualized goals for success in the community linked to the skills learned at Finger Lakes applied to the community, but they are not listed.

The only improvement in compliance with subparagraph 55b at Finger Lakes since the June, 2014 site visit was the two hour Community Re-entry Plan training and the completion of one Community Re-entry Plan.

FUTURE MONITORING

The MH Monitor will continue to review Finger Lakes Community Re-Entry Plans to verify improvement in their usefulness for youth, families, and providers to support the continuation of the resident’s progress in the community.

IV. DOCUMENT DEVELOPMENT AND QUALITY ASSURANCE

56. *Document Development and Revision.* Consistent with paragraph 68³ 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:

COMPLIANCE PENDING

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

COMMENT: A 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 Finger Lakes) before the monitoring visit and then had an opportunity to discuss its contents and findings before the Finger Lakes 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.

Over a year ago, QAI implemented GRS as a quality assurance strategy, incorporating performance metrics developed with the assistance 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 GRS protocols and action plans. More importantly, this QAI initiative recognized that reliable critical performance metric/restraints safeguards influence the monitoring in ways that expedite agreement among the Parties about compliance. This sentiment was formally expressed with two separate caveats in the September 2014 FLRC monitoring report:

The Monitors' endorsement of the new protocols indicated approval of a reasonable, logical, and coherent policy, while *remaining observant of the actual effect on uses of force* by these new protocols. Evidence *currently* exists that the protocols work at Finger Lakes. (emphasis added)

While Home Office maintained that the GRS has proven successful on one occasion and that it is unreasonable to expect any system involving incarcerated youth to be perfect, it would be equally unreasonable for the parties to assume that one trial learning is sufficient for compliance. Just as Home Office has maintained that compliance determinations should not turn on one incident, so, too, does GRS validation reflect a similar approach: Demonstrate that GRS works more than once. For this reason, the October FLRC GRS "red zone" status prompted a discussion of extended time for Home Office to validate GRS effectiveness (demonstrate a second example of effectiveness) and to sustain compliance with this and other Settlement Agreement paragraphs. The central concern was the stability of youth, staff, and the Intact Teams.

At its optimum, GRS anticipates and alerts staff at the Home Office and facility levels of impending changes so that appropriate corrective or preventive actions can be taken. Parenthetically, the December 2014 data show FLRC GRS restraints in the "yellow" zone, which was a second, therefore, validating use of the GRS to move use of force out of the "red zone" in 60 days or less.

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 Finger Lakes 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 Finger Lakes visit.

V. SUMMARY

Compliance remains fragile at Finger Lakes. The Intact Teams and collaboration of clinicians, YCs, and other staff are commendable. Maintaining the stability observed in the June 2014 site visit proved difficult with the stress of new arrivals, higher restraints, and personnel changes in October 2014.

Soon after the November, 2014 site visit, Finger Lakes was finally going to have a full-time clinician providing individual and group therapy on each unit which is essential, not only for effective treatment of residents but also the functioning of the intact teams and coaching the effective integration of DBT and Sanctuary skills on the units. The unit clinicians and substance abuse clinicians continue to require more intensive guidance in improving support plans (and Community Re-Entry Plans), particularly ensuring that residents' goals reflect trauma coping skills, address substance use, and are individualized (not generic program adherence goals).

The Monitors offered to extend the monitoring period for two months to give the Finger Lakes Intact Teams the opportunity to recover stability after the combination of factors leading to increased restraints and the impact of personnel changes. The Monitors emphasized the importance of ensuring that residents felt safe (which would enhance emotion regulation and reduce acting out) by focusing on preserving each resident's closest relationships. The Monitors stressed that the Intact Teams needed substantially enhanced support to return the units to where they had been in the June, 2014 site visit. Staff were obviously exhausted in November, 2014 in part due to working double shifts as a result of staff being out from restraints, the additional work of restraint paperwork and time-consuming responses to codes. Intact Teams needed special shoring up so they could concentrate on their relationships with residents as changes in YCs, clinicians, and substance use treatment occurred. The clinicians and YCs also required additional support so they could play a primary coaching role in the Intact Teams focus on residents feeling safe, but while also continuing their work in improving support plans, learning to prepare quality Community Re-Entry Plans, and implementing substance abuse treatment across units—all necessary for sustained compliance. Following the November 2014 visit, the Monitors clarified expectations for substance abuse treatment compliance with the Settlement Coordinator.

Home Office has worked hard to change the institutional culture at the two facilities remaining under the Settlement Agreement. It has enhanced staff training, built an innovative treatment program, and implemented a much better strategy for use of force. The approach to the use of force is substantially improved. However, these programmatic improvements do not automatically mean that they will be implemented as intended by direct care staff. Serious injuries to youth can and do occur even in situations where exemplary policy and procedure exist. From a risk management perspective, the risk of injury has been managed better but not eliminated.

The Monitors' November 2014 visit and preliminary findings prompted renewed discussions with the Settlement Coordinator regarding a clear understanding and

guidelines on the role of quality assurance in safeguarding Protection from Harm concerns as reflected in the settlement agreement paragraphs. Mutual agreement now exists about the role of GRS, and the elements of this agreement are incorporated in the protection from harm section of the report. The best interest of youth and staff benefits from this agreement, which promises to expedite the resolution of the settlement agreement with the mechanism in place to safeguard protection from harm following a facilities release from the settlement agreement. The existence of the GRS agreement does not, however, diminish the Monitors' concern that Home Office maintains adequate levels of assistance to institutional staff to sustain compliance.