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:
Lansing Residential Center for Girls
Lansing, NY

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and

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August 30, 2013

INDIVIDUAL FACILITY MONITORING REPORT:

LANSING RESIDENTIAL CENTER FOR GIRLS

Lansing, NY

I. INTRODUCTION

This is the twelfth 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 Lansing Residential Center for Girls (LRC) on April 15-17, 2013. As noted in the first monitoring report, the Monitoring Team consists of two Monitors, Dr. Marty Beyer, who is responsible for the Mental Health paragraphs of the Settlement Agreement, (hereafter referred to as the MH Monitor) and Dr. David Roush, who is responsible for the Protection from Harm paragraphs (hereafter referred to as the PH Monitor).

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

While completing this report the Monitors learned that Lansing will be closed before the next monitoring visit. Lansing provided trauma treatment for many girls with complex child welfare and mental health histories in a nonsecure setting, and it will be necessary for New York City and counties across the state to create similarly intensive services designed to meet the unique needs of girls. The Monitors will review discharge planning for the current Lansing residents as they are prepared to leave the facility before the end of the summer, 2013. The Monitors decided not to delete the future monitoring sections of this report even though it appears this will be the last monitoring visit to Lansing.

A. Facility Background Information

The Lansing Residential Center for Girls is a non-secure facility for juvenile delinquent females ages 12 through 18 years old. On April 15, 2013, there were 10 girls at Lansing, six on one unit and four on the other unit. One girl had been a revocator at Lansing during the monitoring visit six months previously, had since been released, and readmitted. Another girl had been admitted to Tryon at age 13, discharged to Brentwood, released home for three months and returned to Brentwood, and admitted to Lansing four months later. More than half were recent arrivals: four of the girls at Lansing arrived in less than a month and one 60 days and one 70 days prior to this site visit; the remaining four had been there between 3 1/2 and 4 1/2 months.

The 10 girls ranged in age from 15 to 17 and were committed for: Assault (5), Grand Larceny (1), Petit Larceny (1), Menacing (1), Criminal Mischief (1) and AWOL (1); only one

was designated a CRP although another one had violated the conditions of her release from a program.

The diagnoses of the girls at Lansing include Anxiety Disorder, Depression, PTSD, Mood Disorder, Dissociative Disorder, ADHD, Insomnia, Cannabis Abuse, and Alcohol Abuse. Eight of the 10 girls are prescribed psychiatric medication: three are prescribed Zoloft, three are prescribed Seroquel, and Abilify, Concerta, and Diphenydramine are prescribed for one girl each; two are prescribed Benadryl and one is prescribed Melatonin.

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: Lansing Residential Center for Girls* (Draft), the QAI Report from the Quality Assurance and Improvement (QAI) Bureau in advance of the monitoring visit.

2. Use of Data

The Office of Children and Family Services (OCFS) has a good management information system with access to a wide range of data. A further review of the system and its capabilities allowed for the development of Excel spreadsheets that are provided to the Home Office for the regular collection and dissemination of facility data to the Monitors, including the semi-annual Performance-based Standards (PbS) data. The Monitors were given OCFS' fourth Six-Month Progress Report on the MAP on December 19, 2012.

A data integrity check revealed two discrepancies between the numbers of restraints in the CSU Restraint Log versus of the number of Post-Restraint Examinations conducted by the health clinic. The discrepancies were accounted for in the medical records by identifying youth who had multiple restraints. These comparisons confirmed the accuracy of the data findings of the QAI Report, even though it included a different period of time.

3. Entrance Interview

The entrance interview occurred on April 15, 2013 and included the Monitoring Team and OCFS representatives, including key staff members from the facility. The meeting provided an opportunity for introductions, informal discussion of institutional goals and objectives, an overview of the assessment process, a review and discussion of assessment instruments, and the scheduling of the remaining assessment activities. Those in attendance included: David L. Bach, QAI Director; Sandra Carrk, Project Manager; Diane Deacon, OCFS Legal; Kathy Fitzgerald, Assistant Facility Director for Treatment; Edgardo Lopez, Settlement Agreement Coordinator; Jennifer Mack, Assistant Facility Director - Program; Beverly Sowerby, Facilities Manager; and Eric Warner, Facility Director.

4. Facility Tour

A walkthrough of the facility occurred later in the visit. See the discussion of the physical plant concerns in Paragraph 44.

5. On-Site Review

The site visit included a review of numerous documents available at the facility and not included in the pre-visit document request list. These documents included many reports that occurred in the time between the documents prepared for the Monitors and the on-site assessment. The MH Monitor observed two treatment team meetings, Mental Health Rounds, a DBT group, a Sanctuary group, met with the clinicians, and reviewed five girls' records.

6. Staff Interviews

The Monitors interviewed 18 Lansing staff. In addition to group meetings with staff, the MH Monitor interviewed a YC, a clinician, and a nurse individually. The PH Monitor conducted interviews with two Youth Division Aides (YDA), one Youth Counselor, one AOD, one Facility Director, two nurses, one nurse administrator, and two Assistant Facility Director (AAFD). Perceptions of safety were very high both on the part of staff regarding their own safety and their perceptions of youth safety.

7. Resident Interviews

The MH Monitor interviewed two girls individually, and the PH Monitor interviewed seven (7) girls with an average age of 17.4 years old. Six (6) youth participated in a standard interview and responded to the same questions. Interviews occurred in areas with reasonable privacy from staff. The Monitors selected the youth for interviews.

8. Exit Interview

The exit meeting occurred via conference call at 12:30 PM on April 18, 2013. The Monitors then highlighted areas of importance and concern, but not findings. The exit meeting call was a time for questions, clarifications, and explanations of events and impressions before the draft report went to both Parties. Those in attendance were: Becky Ayers, Nurse II; Sheryl Benedict, Nurse Administrator; Sandra Carrk, Project Manager; Michael Daby, YCI; Diane Deacon, Associate Attorney; Kathy Fitzgerald, Assistant Facility Director For Treatment; Linda Gaydushek, Education Supervisor; Shaun Lang, YC2; Edgardo Lopez, Settlement Agreement Coordinator; Jennifer Mack, Assistant Facility Director - Program; Dr. Maria Morog, Psychologist; Bob Paoletti, YCI; Denise Passarello, QA Specialist; Connie Sargent, Psychologist; Eric Warner, Facility Director. Those participating by phone included: Augustine Amissah, QA Specialist; David Bach, Director, QAI; Jim Barron, Director, Labor Relations; Merle Brandwene, Director Management & Program Support; John Canino, Attorney; Matt Carpenter, Executive Assistant to DJJOY Deputy Commissioner; Erin Cassidy, Executive Assistant to Exec Deputy Commissioner; Myra DeLuke, QA Specialist; Felipe Franco, DJJOY Deputy Commissioner; Larry Gravett, Director, SIU; Regina Jansen, Department of Justice (DOJ) Attorney; Serena Joyce-White, Attorney; Pam Kelly, Director, Bureau of Training; Beth McCarthy, Bureau of Training; Ines Nieves, DJJOY Associate Commissioner; Sheila Poole, Executive Deputy Commissioner; Beverly

Sowersby, Facilities Manager; Monique Thomas, Attorney; Jenne Utting, QA Specialist; Iren Valentine, Director, BBHS.

C. Preface to Protection from Harm and Mental Health Findings

The New York Model has been implemented at Lansing. Staff are actively involved in support teams and Mental Health Rounds and the DAS and phase system are in place. The facility has a calm environment, with strong relationships between staff and residents.

Before this site visit, the DJJOY Quality Assurance and Improvement (QAI) Bureau completed an in-depth review at Lansing, which the Monitors discussed with them. The QAI team commended Lansing for good staff communication and strong leadership. The QAI review also recognized a YDA for excellent de-escalation skills and the YCs for working closely with CMSOs.

Pursuant to Paragraph 73, the Monitors were informed of a male YDA on administrative leave following a Special Investigations Unit (SIU) substantiated finding of sexual misconduct with a Lansing resident.

II. PROTECTION FROM HARM MONITORING

For the second consecutive time, youth and staff evaluate safety as improved.

Lansing has a talented, veteran staff. Interviews with staff and youth confirmed the presence of many capable and caring staff at all levels. Of the 6 youth interviewed, 83% indicated that staff members show residents respect and that staff make more positive comments to youth than negative comments.

Food remains an ongoing challenge. Every youth interviewed complained about the quantity and quality of food. Every youth complained about being hungry at some time during the day. One girl noted what she referred to as too long of a time between dinner at 4:30 PM and a breakfast at 7:30 AM. While there is some latitude in the exact times, the situation seems to violate the 14-hour standard set by the American Correctional Association (ACA). The recommendation here is that food, food preparation, and food delivery or services are issues that can be easily resolved within the ACA guidelines. The implication is that hunger among children and youth is a source of distractibility and irritability, all factors that would increase the likelihood of behaviors that could lead to the necessity for the use of force.

A. Use of Restraints

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

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

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

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

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

PARTIAL COMPLIANCE

COMMENT: Multiple aspects of restraints are included here in addition to two conditions for the use of restraints "where all other appropriate pro-active, non-physical behavioral management techniques have been tried and failed and a youth poses a danger." During staff interviews, all staff had a working knowledge of the new policy, the physical restraint approach, and the exceptional circumstances. Staff again provided accurate answers to the technical questions about these policies and procedures.

An important element of compliance is verifying that practice routinely reflects policy, procedure, and training, particularly that "all other appropriate pro-active, non-physical behavioral management techniques have been tried and failed and a youth poses a danger." However, at Lansing, too many unauthorized and avoidable physical restraints remained despite substantial improvements in restraint-related activities. Factoring into this determination are (a) the Home Office-supplied data, (b) reviews of Restraint Packets, and (c) reviews of restraint videos, along with an understanding of restraint practices and the challenges presented by Lansing youth. Supplementing this perspective are comments from knowledgeable Lansing staff who understand CPM and who (a) discussed the continued existence of avoidable restraints, and (b) described situations where better decision-making by staff could avoid physical restraints. Knowledgeable staff also indicated that Lansing continues to make progress at identifying and correcting avoidable restraints. No one made the argument that Lansing was where it should be with respect to its use of restraints.

Further, the State shall:

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

PARTIAL COMPLIANCE

COMMENT: The policy and procedures are established; the training on the policies and procedures has occurred; and evidence of a corresponding practice includes documentation (written and video), staff reports, and resident reports that are consistent with the policy and procedures. Again, OCFS policies comply with the Settlement Agreement. Lansing administration is familiar with policy and procedure that limit the circumstances when the use of restraints is necessary, and staff interviews affirmed a working knowledge of these circumstances.

As much as Lansing has some of the best staff, the opposite also holds true. Lansing has a large proportion of strong, capable, and positive staff, even in a small facility, however, it also possesses another portion of staff youth identified as the ones who are too quick to move to a physical restraint. These staff members need corrective actions, plans of action, and accountability. Youth indicated that some restraints could be avoided if staff were capable of ignoring some of the situations when residents are angry and simply need to vent. There did not seem to be a middle ground in the youth's descriptions of staff, for when they discussed the effective staff, they talked about patience and staff skills at de-escalation.

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 policy and procedures exist; the training on the policies and procedures has occurred; and staff and resident interviews were consistent with the policy and procedures. Interviews with direct care and health care staff revealed a working knowledge of conditions, circumstances, and plans that limit the restraints to youth due to heightened risk of physical or psychological harm. The reviews of Restraint Packets contained no indications of a violation of this paragraph.

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 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. Policy 3247.12 describes a "transitional hold" that moves a youth from a supine restraint to a prone position for the purposes of applying handcuffs. In response to the question about when a face-down (prone) restraint is permissible, new Lansing staff responded that a prone restraint is not allowed and that the "transition hold" is not really a

prone technique because they only move a youth to her side if the application of handcuffs is necessary.

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

COMPLIANCE

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

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

COMPLIANCE

COMMENT: Policy and procedure regarding physical restraint clearly prohibit the use of psychotropic medication solely for restraint purposes. Resident and staff interviews and direct observations provided no evidence of the use of psychotropic medication solely for restraint purposes.

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

COMPLIANCE

COMMENT: Training continues to be a strength. John Wilson and Debra Peet provided thorough review of training records from STARS. The training materials revealed that all but three staff were up-to-date on CPM, the CPM refresher, first aid, and CPR. The ones in who were not up-to-date had been on extended sick leave/workers comp and were scheduled for the next available training session.

In Restraint Packet 411998, the Administrative Review of Physical Restraint Form indicated with a checkmark that only four of the five YDA staff members involved in the restraint were up to date or current in CPM.

B. Use of Force

42. Use of Force. In order to adequately protect youth from excessive use of force at the Facilities, the State shall:

42. a. Continue to prohibit "hooking and tripping" youth and using chokeholds on youth.

COMPLIANCE

COMMENT: The policy and procedures exist; the training on the policies and procedures has occurred; and staff and resident reports are consistent with the policy and procedures. No evidence existed of the use of prohibited physical restraint holds, especially "hooking and tripping" and chokeholds.

42. b. Create or modify and implement a comprehensive policy and accompanying practices governing uses of force, which shall provide, among other things, that the least amount of force necessary for the safety of staff and youth is used.

COMPLIANCE

COMMENT: The policy and procedures are established; the training on the policies and procedures has occurred; and staff and resident reports are consistent with the policy and procedures. Support for compliance came from the views of staff, which consistently described situations where their approach to resident misbehaviors was to use de-escalation (verbal strategies) longer than usual to prevent the need for physical restraint. Residents currently confirmed that staff "talk the girls down" because they are responsive to the residents' issues and want to resolve problems without the use of physical restraint.

When asked if staff use force only when they really need to, one youth responded with a very forceful "yes." She then referenced multiple restraints with a previously released resident who caused the all types of concerns on the part of staff because of her explosive behaviors and her multiple restraints. The youth indicated that she watched as staff tried very hard to calm down this particular youth.

Compliance is tenuous due to the presence of several problem staff. There probably would have been more youth that endorsed the positive roles that staff play, but half of the youth mentioned that staff curse at them. When combined with the uptick in youth injuries from restraints, only partial compliance is warranted.

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

PARTIAL COMPLIANCE

COMMENT: The policy and procedures exist; the training on the policies and procedures has occurred; and evidence of a corresponding practice includes documentation (written and video), staff reports, and resident reports that are consistent with the policy and procedures. Still, documentation is a challenge in every juvenile correctional facility, so the concern is that there are (a) corrective measures for employees to address occasional poorly documented incidents and (b) ongoing training and coaching for those who struggle with adequate documentation. The review of Restraint Packets provided an opportunity to evaluate the level of adequate documentation. See Paragraph 42e. Other than problems surrounding legibility, a sufficient amount of quality control exists through the Facility Administrator's Review to identify errors and omissions in documentation.

An initial reading of the Restraint Packet 424299 indicated that the documentation appear to be appropriate and everything in place until getting to the Incident Report filed by YDA Potter, who was one of the participants in the restraint. YDA Potter wrote, "[the youth] begins to act 'out of it.' I notice she is still breathing but is not responding verbally and begins drooling. I call a Code Blue to be safe." Nowhere else in the documentation is there a reference to this Code Blue. YDA Potter's Incident Report continued, "[the youth] then hears residents from downstairs yelling. She then yells and struggles. She appeared to be 'faking' whatever episode she was having."

If the youth's behavior was so unusual as to cause a fully trained YDA to call a Code Blue and document her concerns in her Incident Report, the Code Blue documentation and communication have to be priorities. However, the Post-Physical Restraint Health Report

completed approximately two (2) hours following the restraint contains no references to a Code Blue, to the behaviors described by YDA Potter, or to the youth's self-report of unusual behavior. As a result, there was no M.D. referral. (See additional discussion of this issue as it applies to Paragraph 42e below.)

The QAI Report continued to express concerns about Restraint Monitoring. The Restraint Monitor did not observe the restraint in two instances, was not present for the restraint in one instance, walked away from the restraint in another instance, and provided less than adequate documentation in Restraint Packets.

42. d. Create or modify and implement a system for review, by senior management, of uses of force and alleged child abuse so that they may use the information gathered to improve training and supervision of staff, guide staff discipline, and/or make policy or programmatic changes as needed.

COMPLIANCE

COMMENT:

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

42. e. Establish procedures and practices whereby each Facility Administrator or his or her designee will conduct weekly reviews of the use of force reports and videotaped incidents involving uses of force to evaluate proper techniques. Upon this review, staff who exhibit deficiencies in technique(s) shall be prohibited from using force until such staff receive documented instruction on the proper technique(s).

PARTIAL COMPLIANCE

COMMENT: The policy and procedures exist, and there is a practice in place. An SG-18 or above facility administrator completes a review and logs the information and recommendation on the OCFS 2091 form, which is reviewed by the Facility Director.

Throughout the monitoring process, this paragraph has become more important because of the “review” and “evaluate” functions contained in this weekly practice. The Facility Administrator review becomes a critical part of the feedback needed to continue the evolution and improvement of CPM and the New York model. With the advent of Quality Assurance, it provides another perspective on the types of staff behaviors that are exemplary or in need of improvement. Much of the narrative for this paragraph identifies issues that affect the nature and extent of physical restraints.

Because of concerns expressed in previous reports about the Facility Administrator’s review of Restraint Packets and videos, Home Office clarified the policy on “Documented Instruction.” Staff informally viewed documented instruction as a disciplinary or formal corrective action, so there seemed to be a hesitancy to use it in a way consistent with the PH Monitor’s interpretation of the Settlement Agreement paragraph.

Paragraph 42e is the Facility Administrator's opportunity to review this new and important procedure (CPM) and to provide a learning tool as a safeguard for youth and staff. That is, it requires Facility Administration to identify the types of behaviors that fit the policy, procedure, and training and also mandates Facility Administration to make learning opportunities for those staff members who have difficulty implementing the new techniques effectively. From the Monitors' perspective, the purpose of documented instruction in this paragraph is to create multiple and ongoing opportunities for staff to learn and practice effective implementation of CPM techniques, including de-escalation.

Lack of Video

Technical difficulties meant that there was no video on four of the CDs provided to the PH Monitor. Unlike previous DVDs where the video was accessible, these videos that used in the domain .ppx versus .pef.

Restraint Packet 219154

The Administrative Review of the Physical Restraint and the Video Review Form were both clear and direct, and both noted a staff behavior that warranted Documented Instruction. The Documented Instruction occurred the same day.

Restraint Packet 424299

The Incident Report filed by YDA Potter, who was one of the participants in the restraint, read, "[the youth] begins to act 'out of it.' I notice she is still breathing but is not responding verbally and begins drooling. I call a Code Blue to be safe." Nowhere else in the documentation is there any additional reference to this Code Blue. YDA Potter's Incident Report continued, "[the youth] then hears residents from downstairs yelling. She then yells and struggles. She appeared to be 'faking' whatever episode she was having."

If the youth's behavior was so unusual as to cause a fully trained YDA to call a Code Blue and document her concerns in her Incident Report, the Code Blue warrants follow-up action. The Post-Physical Restraint Health Report contains no references to a Code Blue. There was nothing in the Restraint Monitor report, the Facility Administrator Review, or the Youth Debriefing Report that addressed how the Code Blue was resolved. YDA Potter was correct in her initial reactions by calling the Code Blue. There was no acknowledgment of this appropriate behavior. Likewise, it was inappropriate for YDA Potter to assume that the youth was "faking" a possible medical emergency, and there was no acknowledgment that a nonmedical staff member had made a medical determination. It should only be within the purview of a Qualified Health Care Professional to assess the Code Blue or other request for medical. Documented Instruction was warranted.

Restraint Packet 411998

Questions continue about how well YDA staff understand and implement New York model strategies related to self-calming and restraint avoidance. This IIP contains two (2) common strategies under the Crisis Prevention and Management Plan, Time Away and Direct Appeal. The psychologist notes that the youth "does not like people touching her. She reported that when she is very stressed, she can calm herself given time and space. She reports that it increases her stress level at these times to have people attempt to assist her

with self-calming. She reports that activities, especially physical activity is very helpful to her in keeping her stress level check." The IIP is dated August 9, 2012.

This appears to be a mixed message to staff, for if it escalates the youth to have staff directly involved in her self calming, how does this square with recommendation number 2 in her Crisis Management Plan of Direct Appeal? Additionally, the video seemed to imply that staff were giving her the time and space as she reported were the variables necessary so that she could calm herself. Nearly 5 months later, the youth has two (2) incidents within the same day where she violates the rules, escalates her behavior when staff appear to be following the IIP, and physically assaults a staff. Moreover, between and March 31, 2012, the same youth was involved in 19 discrete restraint events for rate of 10.4 restraints per 100 bed days.

In the Video Review Form, under the area of the significant issues, the administrative reviewer stated, "staff allowed youth to leave the classroom four and go up the stairs and continued to walk around as she was on ALS (arms length supervision)." The action required is coaching. The question is whether an appropriate response is coaching versus Documented Instruction. Furthermore, it would seem appropriate that an incident of this nature would prompt a red flag meeting to address the relevance of the IIP in light of the youth's behavior. At some point in the implementation of the New York Model, coaching and Documented Instruction related to incidents where youth and/or staff are injured needs to include the involvement of treatment staff. It is important for treatment to guide YDA staff by suggesting alternative de-escalation strategies when those on the IIP are not working.

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. Supervisor staff who are routinely involved in responding to incidents and altercations shall be trained to evaluate their subordinates' uses of force and must provide evaluation of the staff's proper use of these methods in their reports addressing use of force incidents.

COMPLIANCE

COMMENT: Training remains a strength of the Protection from Harm Paragraphs. The training on the policies and procedures seemed to have occurred regularly, and the evidence of a corresponding practice from the STARS system was consistent with the requirements of this paragraph. Training records showed that staff members who required retraining for any reason received the training in a timely fashion. Interviews with staff confirmed the staff member's understanding of the training and an awareness of his or her status regarding completeness of the training requirements. Staff members

knew when re-training events would occur and in what activities they were permitted to participate.

A good discussion occurred at Lansing with BOT trainers John Wilson and Debra Peet, along with FD Warner, Edgardo Lopez, Sandra Carrk, and Diane Deacon. Two topics were explored. First, the Restraint Packet reviews have identified several YDA staff that do not possess the physical abilities to implement CPM. PH Monitor's recommendation was that the trainers re-examine their competency criteria and continue to refer those staff with physical limitations to the Facility Administrator for Employee Health Services (EHS) involvement.

The second discussion focused on the training for the Restraint Monitor. The reviews of the Restraint Packets under Paragraph 42 have increasingly called attention to the role the Restraint Monitor plays in a safe and effective restraint event. The current Restraint Monitor curriculum does not provide specialized training in the identification of physical and emotional distress of view while in physical restraint. While these topics were covered at various times during the CPM, first aid and CPR, and New York Model trainings, there is nothing specific to the identification of the physical and emotional distress during restraint. Furthermore, the elements of the Restraint Monitor curriculum described as addressing these two (2) distress issues have not been reviewed by Home Office medical and mental health leadership. The recommendation to BOT training staff and Home Office is to have its medical and mental health directors or their designees review the Restraint Monitor training to ensure that the identification of physical and emotional distress is specifically addressed.

C. Emergency Response

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

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

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

NOT APPLICABLE

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

COMPLIANCE

COMMENT: The policy and procedures exist (PPM 3246.02 and PPM 3247.13); the training on the policies and procedures has occurred; and staff and resident reports are consistent with the policy and procedures. All staff confirmed with acceptable accuracy the call for assistance procedures based on the color code indicators, where Code Yellow = security emergency, Code Blue = medical, Code Green = security, Code Gray = mental health issues, Code Green = Fire/Safety Emergency; and Code White = restraint in progress.

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

A problem arose with Restraint Packet 424299 regarding how a Code Blue was documented and handled. The problem appears to be an isolated incident but, it requires attention under several Settlement Agreement Paragraphs (42 c & e and 44 c & g).

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

COMPLIANCE

COMMENT: The policy and procedures exist (PPM 3246.02); the training on the policies and procedures has occurred; and staff reports were consistent with the policy and procedures. The PH Monitor verified the existence of the response team chart in the CSU booth and the log entry of response descriptions in the CSU logbook.

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

COMPLIANCE

COMMENT: The monitoring visit included a review of the Redbook, the red notebook in each DOJ facility that is a collection of emergency policies and plans. Confusion exists here. In response to the question about the facility emergency response plan, administrators have made reference to the Redbook. Home Office has supplied clarity on the specific policy related to this paragraph and continued monitoring will redirect its focus on the Home Office identified emergency response plan. Around the two documents, a practice existed consistent with the expectations of the paragraph.

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

COMPLIANCE

COMMENT: The policies and procedures referenced in paragraphs 41-43 are addressed primarily in policies 3247.12 and 3246.02. These policies are part of the CPM training, and the STARS system confirms the Lansing staff's successful completion of the training.

D. Reporting and Investigation of Incidents

44. Reporting and Investigation of Incidents. The State shall adequately report, investigate, and address the following allegations of staff misconduct:

i. Inappropriate use of restraints;

ii. Use of excessive force on youth; or

iii. Failure of supervision or neglect resulting in:

(1) youth injury; or

(2) suicide attempts or self-injurious behaviors.

To this end, the State shall:

44. a. Create or modify and implement policies, procedures, and practices to require that such incidents or allegations are reported to appropriate individuals, that such reporting may be done without fear of retaliation, and that such reporting be done in a manner that preserves confidentiality to the extent possible, consistent with the need to investigate and address allegations.

COMPLIANCE

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

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

COMPLIANCE

COMMENT: There was one review of an SIU report of investigation on this monitoring visit. This was the report mentioned in Paragraph 44e. The report was thorough and fair.

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

COMPLIANCE

COMMENT: The policy and procedures exist, and staff and resident interviews were consistent with the policy and procedures. The key issue here was the safeguarding of a youth's opportunity for a candid conversation during a post-restraint examination with a trusted health care provider, so that she can then more easily provide confidential information regarding the use of force incident, any allegations of excessive use of force, and any injury complaints.

The clinic continues to be a Protection from Harm asset. Interviews with the health clinic staff confirmed that a continued understanding of the policies and procedures, their professional obligations, and what appeared to be a trusting and helpful demeanor. Nurses appeared to understand their mandatory reporting requirements, and they described the Post-Restraint Examination (PRE) procedure that allows the examination to occur with a reasonable amount of privacy. There were no changes in the procedure for doing PREs since the last monitoring visit. Parenthetically, in a discussion about the Post Restraint Examination and confidentiality, one youth specifically indicated that the nursing staff did not turn on the radio, so she believed that the staff member could hear her conversation.

QAI noted several situations where the transporting staff member was involved in the restraint. On three (3) other Post-Physical Restraint Examination Forms, no transporting staff member was identified. Care is needed to maintain good documentation in support of compliance.

In Restraint Packet 424299, an Incident Report stated, "[the youth] begins to act 'out of it.' I notice she is still breathing but is not responding verbally and begins drooling. I call a Code Blue to be safe." Nowhere else in the documentation is there a reference to this Code Blue, perhaps because the Incident Report continued, "[the youth] then hears residents from downstairs yelling. She then yells and struggles. She appeared to be 'faking' whatever episode she was having." If a youth's behavior is so unusual as to cause a fully trained YDA to call a Code Blue and document this concern in an Incident Report, the Code Blue warrants follow-up by medical. The problem is that medical was not aware of the Code Blue. The Post-Physical Restraint Health Report completed approximately two (2) hours following the restraint contained no references to a Code Blue, to the behaviors described by the YDA, or to the youth's self-report of unusual behavior. As a result, there was no M.D. referral. It should only be within the purview of a Qualified Health Care Professional to assess the appropriateness of a Code Blue or other request for 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.*

COMPLIANCE

COMMENT: The Special Investigations Unit conducts investigations under new and updated policy and procedure. Reviews of SIU investigations have revealed careful and thorough investigations, completed in a generally timely fashion.

44. e. Create or modify and implement policies, procedures, and practices to require prompt and appropriate corrective measures in response to a finding of staff misconduct described above.

PARTIAL COMPLIANCE

COMMENT: The expectation of prompt and appropriate corrective measures is an important part of compliance, even though most of the variables affecting this paragraph are controlled by Home Office and are, therefore, systemic. Recent monitoring reports have noted improvements by Home Office regarding the timeliness (prompt) of investigations and disciplinary notices. However, the DeMarco arbitration finding described below represents the type of problem that undermines compliance with this paragraph.

In the previous Lansing report (January 13, 2013), Restraint Packet 366692 described an incident that resulted in an investigation and a Notice of Discipline based on SIU guilty findings for (a) Failure to call for assistance, (b) Use of unauthorized physical force, (c) Use of excessive physical force, (d) Striking a resident, and (e) Providing false testimony during interrogation. Here was a situation where SIU, a competent investigative unit, conducted a thorough investigation of the incident and issues the aforementioned findings. The investigation was referred to Labor Relations, and a recommendation for termination moved forward. In November 2012, PH Monitor reviewed Restraint Packet 366692 as part of the monitoring process for Lansing. The review included a reading of all the documentation in the Restraint Packet in addition to the viewing of the video. The January 2013 final Lansing Report included the statement, "The intended action was termination of employment, an appropriate response when implemented." Nothing has changed to alter this opinion.

However, a review of the Site Visit Reports for Lansing noted on February 13, 2013 that the employee under recommendation for termination had been reinstated and was currently serving as the Acting Recreation Specialist. A review of the ARTS Master Ad Hoc with Staff Names list indicated that between December 6, 2012 and March 31, 2013, the individual in question had been involved in 15 restraints.

At nearly the same time, an expedited disciplinary arbitration was held before Alan DeMarco, Arbitrator (Case No.: 12-DIS-1007). Mr. DeMarco's findings disagreed with those of Home Office, SIU, and the PH Monitor. The pathway Mr. DeMarco used to return the employee to work seemed convoluted and irrational. If this decision stands as precedence, it will be increasingly more difficult or nearly impossible for OCFS to terminate employment. Consider the following:

1. Mr. DeMarco created a new category of inappropriate staff behavior when he wrote, "The force was likely more than necessary, but not to the level to be labeled 'excessive.'" This creates a problem for monitoring since the Monitors believe that anything that is in excess of what was necessary is, by definition, excessive.

2. Mr. DeMarco labeled the staff member's behavior as "the wrong course of action" along with an acknowledgment that the staff member engaged in "free lancing" (behaviors commonly associated with staff members who do not follow work rules and act outside of

policies and procedures) so admonished the staff member to not get into another situation "Where he takes it upon himself to address the situation anyway that suits him."

3. This reasoning is nonsensical. If an arbitrator must find the employee not guilty of excessive force in order to dismiss an allegation of excessive force, Mr. DeMarco by all appearances has engaged in his own version of "free lancing" and has conjured a new category of force, which is "in excess of what is necessary" but is less than "excessive." The decision appears to dodge a finding in support of termination. If arbitration presumes a compromise in severe disciplinary recommendations, then termination as the ultimate disciplinary sanction will be difficult. On the contrary, if a preponderance of the evidence had indicated that the facts in the case favored the employee, then it would have been appropriate to land on a lesser sanction. However, it seems unreasonable and inappropriate to create a new category of inappropriate behavior in order to avoid a finding for termination of employment. To reiterate, termination of employment was an appropriate action and was consistent with Paragraph 44e.

The discussions with Home Office legal of the challenges presented by certain arbitrators indicated that it is not uncommon for recommendations of termination to be overturned. Mr. DeMarco's finding presents an example of a substantial challenge to Paragraph 44 e. Even though this issue is systemic, situations such as these require special discussion and review. An identifiable obstacle of this nature should compel some type of special remedial efforts by Home Office.

44. f. Provide adequate training to staff in all areas necessary for the safe and effective performance of job duties, including training in: child abuse reporting; the safe and appropriate use of force and physical restraint; the use of force continuum; and crisis intervention and de-escalation techniques. Routinely provide refresher training consistent with generally accepted professional standards.

COMPLIANCE

COMMENT: The policy and procedures exist (PPM 2801.00, PPM 3247.00, PPM 3247.01, PPM 3247.12, and PPM 3456.00); the training on these topics has occurred as documented in STARS; and staff descriptions of the training are consistent with the policy and procedures.

The Restraint Packet reviews contained documentation by staff that multiple different interventions proved to be ineffective. Because there was no additional explanation or investigation, the source of the ineffectiveness remains a question. It might have been that de-escalation techniques were not applied or implemented correctly or it might be that the techniques were implemented properly and proved to be ineffective. Either way, resolution of these concerns is important for the continued growth of the New York Model and CPM as a safeguard for Protection from Harm issues.

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

PARTIAL COMPLIANCE

COMMENT: The Monitors have expressed concerns about staff supervision and accountability in several previous monitoring reports, so the Home Office change in

administration is a welcomed action. A lack of accountability may have been a contributor to the challenges facing new Lansing leadership, which includes the presence of several problem staff members. Staff and residents acknowledged the presence of ineffective and inappropriate staff behaviors. Of the 6 youth interviewed, only 50% indicated that staff are good role models, whereas only 33% indicated that staff are fair about discipline issues. Follow-up questions to these responses revealed a small group of staff whose behaviors were sufficiently problematic for these youth that these staff negatively influenced the youth's perceptions.

It clearly is a strength that the current leadership acknowledges the presence of some very challenging staff, and there appears to be a commitment to implementing staff development plans with a sufficient specificity and accountability so as to provide a clear opportunity for those who have the ability to be a successful or effective staff member to choose to do so.

44. h. The State shall utilize reasonable measures to determine applicants' fitness to work in a juvenile justice facility prior to hiring employees for positions at the Facilities including but not limited to state criminal background checks. The State shall update state criminal background checks and SCR clearances for all staff who come into contact with youth every two years.

NOT APPLICABLE

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

III. MENTAL HEALTH MONITORING

This site visit at Lansing revealed continued progress in implementing the New York Model. For the ten mental health paragraphs of the Settlement Agreement, two policies have not been finalized (new policy on Facility Admission Process and an update on the integration of PPM 3443.00 "Youth Rules" in the New York Model) and Juvenile Justice Information System (JJIS) instructions for the new mental health sections, psychiatry coverage, additional psychiatry guidelines, and the OCFS substance abuse manual are being completed. The MH Monitor cannot fully assess compliance until the policies and procedures are finalized and staff demonstration of consistent application of training and adherence to practices can be observed.

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

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

46a. Create or modify and implement policies, procedures, and practices for an effective behavioral treatment program consistent with generally accepted professional standards and evidence-based principles. The behavioral treatment program shall be implemented throughout waking hours, including during school time.

COMPLIANCE

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

Policy PPM 3243.33 entitled "Behavioral Health Services" responds to the Settlement Agreement by describing treatment that is "child and family-focused, culturally competent, developmentally appropriate, trauma informed, empirically validated and well integrated with other facility and community services" which complies with 46a.

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

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

COMPLIANCE

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

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

PARTIAL COMPLIANCE

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

The new mental health sections of the JJIS comply with 46c (these were not yet in place to be observed at Lansing). The MH Monitor was provided with an impressive JJIS demonstration at Home Office on February 5, 2013. JJIS is the OCFS Juvenile Justice Information System, a comprehensive automated system used to track youth in OCFS custody, including but not limited to case management, movement histories, legal histories, and administrative/billing. Reception diagnostic information, Integrated Assessment, IIP (Individual Intervention Plan), Facility Initial Mental Health Assessment (which includes mental status exam and results of suicide risk assessment), contact notes (by psychiatrists and other clinicians, as well as facility and CMSO case managers), Integrated Support Plan (with updated diagnosis), and Transition Plan are all included on JJIS. JJIS is designed to

capture how a strengths-based, trauma-responsive approach is being implemented with each resident and tracks the diverse interventions of the New York Model. JJIS makes it possible to document practice according to the procedures that comply with several mental health paragraphs in the Settlement Agreement and allows for the regular assessment of the effectiveness of interventions required by 46c.

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

The Assistant Directors for Treatment of the four DOJ facilities and social work supervisors saw the JJIS demonstration. The BBHS Director of Treatment Services and the JJIS clinical coach are in the process of meeting with each facility to instruct in the use of the JJIS and also provide examples of writing goals that reflect the resident's aspirations and the staff's assistance in clarifying the steps to achieve them. A JJIS technical manual is being developed (expected summer, 2013), to be complemented by a BBHS clinical procedural guide. A crucial next step will be to ensure that this documentation system includes all the non-clinical staff involved in the resident's progress and fully reflects the teamwork necessary for his/her success. Positive illustrations of educational services outside this Settlement Agreement but nonetheless important include educational testing results that are reflected in the Integrated Assessment and in JJIS as monthly updates in the academic progress of the residents, including new assessment results, recent achievement scores, passing Regents, new IEPs, and what educational and other staff are doing to support that progress.

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

46d. Explain the behavioral treatment program to all youth during an orientation session, setting forth Facility rules and the positive incentives for compliance as well as the sanctions for violating those rules. The rules for the behavioral treatment program shall be posted conspicuously in Facility living units.

PARTIAL COMPLIANCE

OCFS requested an extension to 3/13 for the Facility Admission and Orientation policies and PPM 3443.00 "Resident Rules" (renamed "Youth Rules") which have been revised for consistency with NY Model and are in the final stages of review. The Daily Achievement System description in the New York Model training materials complies with the requirements of 46d and is being implemented at Lansing.

On Site Observations Regarding Paragraph 46a-d (4/13)

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

Lansing staff recently participated in additional New York Model training. Staff reported that the New York Model is fully implemented at Lansing, with mentoring being the most recently implemented element. In May 2013 they plan to incorporate mentoring sheets into the phase system. They reported that because of groups, support teams, DAS incentives, off-campus activities, and motivation to achieve phase advancement "there is a lot of buy-in to our program among the girls. There is an active resident committee."

Phase advancement is considered at every support team meeting. Lansing staff go through the phase advancement checklist with the resident asking her whether she thinks she has met each expectation; when staff disagree with her, they say so and unless the resident persuades them otherwise, the staff view prevails. Typically this process empowers the resident to award herself a phase advancement or acknowledge she was not ready yet. If the resident is ready between support team meetings, her YC, therapist, and YDA meet with her in a special phase advancement meeting using the same process.

The MH Monitor observed Mental Health Rounds at Lansing. They were led by the clinician, with the psychiatrist contributing and the Assistant Director for Treatment, nurse, YCs and YDAs participating. All 10 girls at Lansing were discussed in Mental Health Rounds, and there was a good exchange among staff about each one. Their focus was what they could do to address each girl's current needs. Two girls were described as "blindsided" by their CMSO and were struggling with surprise information about delayed release and place of release. Two girls have significant family obstacles for placement and responses to their hopelessness were addressed. Staff showed caring and an appreciation of each resident's strengths. For several residents, participants strategized together how to increase the reassurance they were providing. In the debrief with participants in Mental Health Rounds, the thoroughness of the discussion was commended. Participants in Mental Health Rounds compared their response to the two complex, challenging residents at the previous two site visits to their recent admission and recognized that the current calm environment at Lansing made it possible for them to help her be less agitated soon after she arrived. The QAI review described the participants in Lansing Mental Health Rounds as "comfortable in sharing their perspectives of the youth and in particular, a candid conversation was observed between the psychiatrist and a clinician in processing their differing opinions of where they felt a particular youth was at diagnostically."

The MH Monitor observed an engaging DBT group at Lansing, facilitated by a clinician supported by an active YDA. A game of DBT Jeopardy was used effectively to elicit practical applications of DEARMAN, GIVE, and FAST. The teamwork was outstanding with residents and staff on teams together helping each other. Had this group been videotaped for staff training it would have been an instructive demonstration of optimal YDA participation and involvement of residents. This fun learning experience engaged

both longer-stay residents (who are frequently bored in groups they think they are repeating) and new admissions who are just learning DBT. The QAI Review described "Mind the Music" (a different, and popular, DBT group at Lansing) as a creative method for engaging residents. However, QAI was concerned at the minimal participation in the group by YDAs: "their presence seemed to be a function of supervision rather than an integration of treatment into the daily program. There were multiple missed opportunities for teachable moments and positive feedback for the residents."

The MH Monitor observed an outstanding Sanctuary group at Lansing, led by a well-prepared resident who guided participants through the types of safety. YDAs and the YC were involved in the discussion. Another resident led the group in a game of Hangman. In the debrief of the group that included the residents, the resident who led agreed to do the group again applying the different types of safety to their lives in the community.

A key to implementation of the New York Model is a functioning team of coaches. A strong facility coaching team ensures that the New York Model becomes a way of thinking by staff and youth, rather than simply a clinical service. The Lansing coaching group has expanded to 12 individuals: the Assistant Director for Treatment, clinicians, and YCs participated in a thoughtful exchange of ideas with the MH Monitor about how they guide staff. They described helping staff move to higher levels since the last site visit: "Coaching never ends. We empower staff and provide information. Staff have really improved in helping residents manage emotions. They do much more than in-the-moment crisis management. We help them with a broader application of their learning in the daily milieu. Every interaction supports a resident's positive change." A clinician described guiding staff in "the idea of intentional relationships. We validate residents and that leads to them having hope. We support all staff in dealing with hopeless residents. Radical Acceptance means being able to take a different path. We are glad that staff aren't rescuing residents from their lives. A resident's goal is carried in her—staff help her." Lansing coaches are guiding staff in trauma-responsive, relationship-driven, culturally competent, and strengths-based teamwork to meet their residents' complex needs. The coaches described four current areas they are focusing on: (a) encouraging YDAs to participate actively in groups; (b) helping staff keep positive about a resident's progress when family problems are so significant, especially if a girl returns to Lansing; (c) providing a teacher consultation meeting; and (d) trauma recovery for staff.

The MH Monitor observed Lansing's DBT support team. In this session they discussed several challenging residents who staff were working collaboratively to manage: "Good news—both are doing much better and turned things around because they had hope. Not future hope yet, but something immediate, something achievable to hope for (like the quilt one girl asked for)." The coaches felt proud that unlike the extremely challenging residents in the past, these girls' out-of-control behaviors had quickly been reduced by skillful staff intervention.

The MH Monitor observed IIPs (Individual Intervention Plans) in the reviewed Lansing records; support plans indicate the IIP has been reviewed monthly.

The Lansing DAS has evolved since the site visit six months ago; it is more deficit driven and rule compliance focused than the skill-based Columbia DAS that seems more consistent with the New York Model:

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

- Avoids physical/verbal aggression or horseplay
- Avoids kicking, punching, breaking objects, throwing objects/food, spitting
- Avoids inappropriate sexual language/acts
- Avoids being disruptive in school and group/program activities

Manages Emotions: Uses skills to avoid conflicts or problems

- Avoids engaging in blaming others
- Seeks help from staff to remain safe
- Responds to coaching from staff
- Uses skills to manage emotion to avoid unsafe situations (ART, problem solving, DBT skills)

Deals with Loss: Accepts circumstances

- Accepts responsibility for behavior
- Accepts being told "no"
- Accepts having to wait

Works toward the Future: Plans for the future/Shows effort and works toward goals

- Attends school and group/program activities
- Participates in community meetings—engages in goal setting
- Raises hand and answers questions
- Attempts assignments
- Volunteers for tasks

Participation: Engages with compliance with basic program expectations

- Wears safety plan/uniform
- Attend meals
- Line movements
- Moves with unit

The Lansing DAS is scored on the above five areas five times daily (3-7 PM, 7 PM-6 AM, 6 AM-9 AM, 9 AM – 12 PM, 12 PM-3 PM).

The Lansing DAS is limited by not including an individual goal of the resident. OCFS noted that facilities have successfully implemented DAS when they use Effort as the fifth criteria of achievements, and that incorporating an individual's goal is the highest standard. A separate, and the primary, concern raised by the MH Monitor about the Lansing DAS is that it is rule-oriented as compared to the Columbia skill-based DAS.

The DAS for three residents from the two units—who were described in Mental Health Rounds as having significant challenges in the program—were reviewed for two days the week prior to the site visit:

E	23	25
J	24	25
D	21	16

These high DAS scores may show progress by these residents, but could reflect a DAS that is not sufficiently challenging for residents. On one resident's DAS it was noted that she "owes 25 points from LI" and "owes [another] 15 points from LI," that seemed inconsistent with an achievement approach that emphasizes successes (the DAS is not a point system).

The QAI review of three Lansing records found that two had numerous contact notes supporting the frequency and regularity the clinician meets with youth (including one with multiple times the clinician changed her schedule to meet the youth's requests and one with diligent effort in connecting the youth with her parent, grandmother, and CMSO worker). The third record had only one clinical contact note, indicating the resident had not had the required sessions with a clinician at least every 30 days or any documentation that the clinician had contact with youth's family (or made attempts thereof) every 30 days. The QAI Report included a youth survey reflecting Lansing residents' understanding of their support plan, safety plan, support team, and DAS.

Lansing residents all have long histories of complex family problems and multiple placements that have not been successful in meeting their needs. Four months—the typical Lansing stay—is simply not enough time to initiate sufficient treatment that could be expected to continue in the community. Furthermore, the four months is spent supporting residents to gain skills in emotional regulation and distress tolerance and not on the intensive application of these skills and the insights gained from program to changing family dynamics. A few residents make peace with not living with family, but most return to the family conflict that contributed to their placement. There does not appear to be a direct connection between the work done at Lansing and sufficiently intense individual and family treatment in the community, which sets a resident who has made progress up for predictable failure.

FUTURE MONITORING

When they are available, the MH Monitor will review:

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

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

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

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

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

47a. Train all appropriate staff, including direct care staff, on appropriate positive strategies to address a youth's immediate mental health crisis, including a crisis manifesting in

self-injurious behavior or other destructive behavior. Such strategies should be utilized in an effort to stabilize and calm the youth, to the extent possible, while awaiting the arrival of a qualified mental health professional. Staff shall not resort to uses of force, including restraints, except as provided in paragraphs 41 and 42 [of the Settlement Agreement].

COMPLIANCE

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

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

Mental health staff at Lansing were observed complying with 47a.

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

COMPLIANCE

A 3/12 memorandum entitled "Contacting Mental Health Professionals Outside of Regular Work Hours" (linked to the Behavioral Health Services policy (PPM 3243.33) finalized in 5/12) complies with 47b and indicates that "each of the facilities reports having an established procedure in place." Updates regarding the staff person to be contacted for mental health crises after hours at Lansing are decided at the facility level and are maintained at the Central Services Unit (CSU), which complies with 47b.

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

COMPLIANCE

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

On Site Observations Regarding Paragraph 47a-c (4/13)

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

Six girls had been on Personal Safety Watch or Suicide Watch at Lansing in the previous six months, one of them four times, one of them three times, and one of them twice.

The MH Monitor reviewed a record of a girl who arrived from Reception on Suicide Watch. The therapist interviewed her immediately and concluded she was not suicidal.

She called Reception and they indicated she had not been suicidal at release and decided it was an error on the transport document. The clinician documented this and removed her from Suicide Watch.

In the six months before this site visit, one Lansing resident was taken to the local emergency room for psychiatric evaluation 11 times, one of which led to a 16-day hospitalization at Elmira Psychiatric Center (10/12); another resident went to the local emergency room for psychiatric evaluation twice.

FUTURE MONITORING

The MH Monitor will document that the elements of revised PPM 3247.60 "Suicide Risk Reduction and Response" are followed with residents.

The MH Monitor will observe coaching of staff on teaching youth to self-calm, de-escalation, and chain analysis.

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

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

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

The QAI review of Lansing reported that three reviewed records contained documentation, on form OCFS-1448, that the youth were screened within one hour of admission and prior to entry into the general population. Two of three records indicate that the youth met with a clinician within 72 hours of admission.

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

determination is made that the youth should be transferred to a more appropriate setting, the State shall immediately initiate procedures to transfer the youth to such a setting.

COMPLIANCE

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

48c. Require that assessments take into account new diagnostic and treatment information that becomes available, including information about the efficacy or lack of efficacy of treatments and behavioral interventions.

PARTIAL COMPLIANCE

The Integrated Assessment form complies with 48c.

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

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

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

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

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

48d. Create or modify and implement policies, procedures and practices to require that for each youth receiving mental health service, the youth's treating qualified mental health professional(s), including the treating psychiatrist, if applicable, develop a consistent working diagnosis or diagnoses. The diagnosis or diagnoses shall be updated uniformly among all qualified mental health professionals providing services to the youth.

PARTIAL COMPLIANCE

Mental health staff at Lansing were observed discussing residents' symptoms and diagnoses in Mental Health Rounds, support teams, and clinical contact notes, in compliance with 48d.

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

48e. Create or modify and implement policies, procedures, and practices to require that both initial and subsequent psychiatric evaluations are consistent with generally accepted professional standards. Initial evaluations should be legibly written and detailed, and should include, at a minimum, the following information for each youth evaluated: current mental status; history of present illness; current medications and response to them; history of treatment with medications and response, including adverse side effects or medication allergies; social history; substance abuse history; interviews of parents or guardians; review of prior records; and explanation of how the youth's symptoms meet diagnostic criteria for the proffered diagnosis or diagnoses.

COMPLIANCE

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

On Site Observations Regarding Paragraph 48a-e (4/13)

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

If the Integrated Assessment and/or support plan has a different diagnosis than the psychiatrist's diagnosis, agreement must be arrived at about a diagnostic formulation through a collaborative process of considering the resident's history, the basis for the psychiatrist's conclusions, and the basis for other clinicians' conclusions. Youth must have diagnoses based on the presence or absence of specific symptoms and symptoms must meet criteria for the diagnosis. These collaborative case formulations should be documented in the Integrated Assessment initially and in subsequent treatment plans. The target symptoms necessitating treatment with psychiatric medication must be documented in order to determine to efficacy of medication.

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

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

> rounds will assist in integrating the psychiatric and behavioral health services of each youth into a broader holistic understanding of the youth and the family. (Page 3)
>
> The psychiatrist and nurse practitioner participate in the weekly mental health rounds and contribute information about diagnosis(es), medication, benefits and side effects. Consensus of team members is achieved during these meetings, with resultant modification of treatment parameters by all participants according to the team discussions. The Axis I primary diagnosis may change as treatment progresses and more information about the youth becomes available. (Page 7)
>
> If the clinician does not participate (in the psychiatric visit with the youth], they will meet with the psychiatrist prior to the youth's session to communicate regarding treatment issues and progress. The treating clinician and the psychiatrist (with input from the mental health rounds team) will develop a single working diagnosis, which is reflected in JJIS and in the Treatment Plan. The treating clinician is also responsible for communicating any and all changes to the youth's treatment (including medication changes, expected outcomes of medication changes, potential side effects, etc.) to the treatment team following the youth's psychiatric visit. (Page 8)

Compliance regarding consensus diagnosis cannot be determined until the MH Monitor is provided the procedural manual being developed for clinical documentation in JJIS. The BBHS policy only addresses discussions of the diagnosis among the psychiatrist and other clinicians at Mental Health Rounds. How the psychiatrist's initial diagnosis, the diagnosis from Reception, and other clinicians' initial diagnostic impressions are combined in the Integrated Assessment and then how refinements in the diagnosis in the psychiatric and other clinical contact notes result in an updated consensus diagnosis in each support plan is crucial. While it is true that adolescents' diagnoses can be expected to change, the Settlement Agreement requires that the psychiatrist treat symptoms of an identified diagnosis with medication appropriate for that diagnosis and that the other staff working with the youth agree about that diagnosis, which is reflected in the support plan.

[redacted], a 16-year old who arrived at Lansing ten days before the site visit, is an example of the importance of documenting an evolving diagnostic formulation. The MH Monitor observed a moving poetry reading with four girls presenting their poems and [redacted]s images were memorable of her family sitting around the dinner table with one empty chair missing her but also glad she was not there. Her parents were born [redacted] and came to the U.S. before she was born; [redacted], and she lives with her mother and her boyfriend. Her behavior problems began when she was 10 and she was prescribed Concerta in 3rd grade and Zyprexa a year later, but her mother discontinued both. Her mother sent her to live with her father [redacted] for nine months, which she did not like. When she returned, she was sent to placement as a PINS. Her mother said she has "deep anger," and she had no idea why. A weak 2/11 mental health evaluation diagnosed Parent-Child Relational problem; ADHD (by history) Cannabis and Alcohol abuse (provisional). When she was detained, she had been AWOL from a residential placement for two years. Yet the superficial Reception assessment did not discuss her two-year AWOL. It was entirely checklists, most of them not checked. No symptoms were listed or an explanation for the diagnosis of Conduct Disorder, Intermittent Explosive Disorder, Depressive Disorder, Insomnia, Cannabis and Alcohol abuse (provisional). A Psychiatric Contact Note shortly after she arrived at Lansing documented "insomnia and anger control. She blacks

out during severe angry outbursts. Nightmares, sweating, difficulty breathing, flashbacks. Symptoms of OCD. Feels depressed." The psychiatrist wrote, "I do not think she has ADHD. There is much more to be discovered about her." He diagnosed Depression, Anxiety Disorder, Insomnia, Rule Out PTSD, Rule Out Dissociation.

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

DEPRESSION 27% of youth prescribed medication (12)

(including Depression NOS, Major Depressive Disorder, and Dysthymic Disorder)

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

MOOD 27% of youth prescribed medication (12)

(including Mood Disorder, Mood Disorder NOS, and Mood Dysregulation)

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

ANXIETY 23% of youth prescribed medication (10)

(including Anxiety Disorder, Anxiety NOS, and Generalized Anxiety Disorder)

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

INSOMNIA 32% of youth prescribed medication (14)

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

ADHD 23% of youth prescribed medication (10)

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

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

interpreting symptoms that is likely to play a significant role in achieving diagnostic agreement.

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

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

FUTURE MONITORING

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

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

The MH Monitor will review additional psychiatry guidelines.

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

49. Use of psychotropic medications. The State shall require that the prescription and monitoring of the safety, efficacy, and appropriateness of all psychotropic medication

use is consistent with generally accepted professional standards. To this end, the State shall:

49a. Create or modify and implement policies, procedures and practices to require that any psychotropic medication is: prescribed only when it is tied to current, clinically justified diagnoses or clinical symptoms; tailored to each youth's symptoms; prescribed in therapeutic amounts, as dictated by the needs of the youth served; modified based on clinical rationales; documented in the youth's record with the name of each medication; the rational for the prescription of each medication, and the target symptoms intended to be treated by each medication.

COMPLIANCE

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

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

49b. Create or modify and implement policies, procedures and practices for the routine monitoring of psychotropic medications, including: establishing medication-specific standards and schedules for laboratory examinations; monitoring appropriately for common and/or serious side effects, including requiring that staff responsible for medication administration regularly ask youth about side effects they may be experiencing and document responses; establishing protocols for timely identification, reporting, data analyses and follow up remedial action regarding adverse drug reactions; monitoring for effectiveness against clearly identified target symptoms and time frames; requiring that such medications are used on a time-limited, short-term basis where such use is appropriate, and not as a substitute for adequate treatment of the underlying cause of the youth's distress; requiring that youth are not inhibited from meaningfully participating in treatment, rehabilitation or enrichment and educational services as a result of excessive sedation; and establishing protocols for reviewing such policies and procedures to require that they remain consistent with generally accepted professional standards.

COMPLIANCE

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

The Lansing psychiatrist completes a Psychiatric Evaluation form or enters a Psychiatric Contact Note in JJIS indicating diagnosis, efficacy, symptoms, side effects, and the rationale for continuing, changing or discontinuing each medication in compliance with 49b.

49c. Require that the results of laboratory examinations and side effects monitoring are reviewed by the youth's psychiatrist, if applicable, and that such review is documented in the youth's record.

COMPLIANCE

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

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

On Site Observations Regarding Paragraph 49a-c (4/13)

On March 19, 2013 all of the 10 girls at Lansing had one or more psychiatric diagnoses and 8 were prescribed psychiatric medication:

Anxiety Disorder	Seroquel
Anxiety Disorder, Insomnia	Zoloft
Anxiety Disorder, Insomnia	Seroquel
Anxiety Disorder, Depression, ADHD, Insomnia	Seroquel, Concerta
Conduct Disorder, Cannabis Abuse, Mood Disorder	
Depression, Insomnia, Dissociative Disorder	Zoloft, Benadryl
Depression, Anxiety, Dissociative Disorder, Insomnia	Benadryl
Dissociative Disorder, Insomnia	Abilify, Diphenhydramine
Dysthymic Disorder, Depressive Disorder	Zoloft
PTSD, Alcohol Abuse	

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

An OCFS draft document requires that "the psychiatrist will use no more than three psychotropic medicines in his/her treatment of a youth. At presentation, the number of medications may be greater, but needs to be tapered to no more than three. If the psychiatrist can justify the usage of more than three medicines, then it is important to discuss this usage with the Chief Psychiatrist. The psychiatrist will use no more than one medicine per class, i.e., one antipsychotic, antidepressant, mood stabilizer. If the psychiatrist can justify the usage of more than one medicine per class, then it is important to discuss this usage with the Chief Psychiatrist." No Lansing residents were prescribed more than two psychiatric medications at the time of site visit.

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

Six Lansing residents are being prescribed medication for insomnia and an unknown number of other residents have sleep problems. The MH Monitor recommends that sleep-enhancing skill building be incorporated into groups and individually by evening shift staff, supported by the youth's team. Traumatized youth have to learn how to put themselves to sleep without substances, which requires feeling safe and trusting that staff

will take care of them. Not only may bedtime remind them of night fears, but they miss home and the familiarity of sleeping with family members so going to bed may accentuate their loneliness. Given the importance of sleep to emotional regulation, more attention to self-soothing strategies for sleep is a priority. OCFS responded to this concern with a 1/13 BBHS memo to clinicians encouraging them to assist their teams in increasing staff awareness and competency around the issue of sleep hygiene, with follow-up discussion planned during regular clinical meetings.

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

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

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

The QAI survey of nine Lansing residents found that six indicated they were taking medication and knew what they were and why they were taking them, three of whom said they were helping them.

FUTURE MONITORING

The MH Monitor will review additional psychiatry guidelines.

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

The MH Monitor will review consistency of recording laboratory results.

The MH Monitor will observe discussions of efficacy of medication at Mental Health Rounds and support teams.

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

50. Staff training on psychiatric medications and psychiatric disabilities. The State shall create or modify and implement policies and procedures requiring staff in Facilities to complete competency-based training on psychotropic medications and psychiatric disabilities.

50a. The training shall provide, at minimum, an overview of the behavioral and functional impact of psychiatric disabilities on youth, common treatments for such psychiatric disabilities, including both behavioral and pharmaceutical interventions; commonly used medications and their effects, including potential adverse side effects and intended benefits; and warning signs that a youth may be suffering a serious adverse effect of a psychotropic medication and the immediate and follow-up actions to be taken by the staff in such an incident.

COMPLIANCE

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

50b. The State shall create or modify and implement policies, procedures and training materials for staff at all Facilities as follows: Staff employed at the Facilities who routinely work directly with youth (but not including qualified mental health professionals or medical professionals) shall complete a minimum of six (6) hours of competency-based training regarding psychotropic medications and psychiatric disabilities annually for the term of this Agreement. Such staff includes, but is not limited to, Youth Division Aides, Youth Counselors, teachers, recreation staff, licensed practical nurses, Facility Administrators, and Deputy Administrators. All other staff at the Facilities shall be required to complete a minimum of one (1) hour of competency-based training on psychotropic medications and psychiatric disabilities annually for the term of this Agreement.

COMPLIANCE

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

On Site Observations Regarding Paragraph 50a-b (4/13)

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

Of 23 staff respondents in the QAI review of Lansing, 14 said they did not know what psychiatric medications youth were taking and 12 did not know why they were taking the medication; 15 did not know the potential side effects of youth medications. Fifteen out of 23 staff said they had not had enough training on dealing with youth with mental health issues.

FUTURE MONITORING

The MH Monitor will continue to observe Mental Health Rounds, review records and interview staff regarding psychiatric medication.

51. Psychotropic medication refusals. The State shall create or modify and implement policies, procedures, and practices regarding psychotropic medication refusals by youth, which provide, at minimum, as follows:

51a. All youth who are scheduled to receive medication shall be taken without the use of force to the medication administration location at the prescribed time. Any youth who expresses his or her intent to refuse medication shall communicate his or her refusal directly to medical staff.

COMPLIANCE

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

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

Nursing staff at Lansing described practices that comply with 51a.

51b. In circumstances where staff's verbal efforts to convince a youth to report to the medication administration location results in an escalation of a youth's aggressive behavior, staff shall not forcibly take the youth to receive medication. The supervisor shall document the youth's refusal on a medical refusal form, and shall complete an incident report documenting the circumstances of the refusal, including the justification for not escorting the youth to medication.

COMPLIANCE

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

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

Nursing staff at Lansing 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 Lansing 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 Lansing residents' records that comply with 51d.

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

COMPLIANCE

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

On Site Observations Regarding Paragraph 51a-e (4/13)

The MH Monitor observed documentation in a Lansing record when a resident refused psychiatric medication. If a resident refuses psychiatric medication, the psychiatrist meets with the youth to clarify why (and why the youth is refusing and what the psychiatrist has done to address the side effects and/or other reasons for refusal should be included in the Psychiatric Contact Note) and these issues are discussed in support team.

FUTURE MONITORING

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

52. Informed consent. The State shall revise its policies and procedures for obtaining informed consent for the prescription of psychotropic medications consistent with generally accepted professional standards. In addition, the State shall require that the information regarding prescribed psychotropic medications is provided to a youth and to his or her parents or guardians or parson(s) responsible for the youth's care by an individual with prescriptive authority, such as a psychiatric nurse practitioner. This information shall include: the purpose and/or benefit of the treatment; a description of the treatment process; an explanation of the risks of treatment; a statement of alternative treatments, including treatment without medication; and a statement regarding whether the medication has been approved for use in children.

COMPLIANCE

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

On Site Observations Regarding Paragraph 52 (4/13)

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

FUTURE MONITORING

The MH Monitor will continue to review informed consent forms in records

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

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

COMPLIANCE

The New York Model implementation training included the integrated assessment and support plan (formerly treatment plan), and how to utilize both in support teams (formerly treatment teams). "The NY Model: Treatment Team Implementation Guidelines" complies with 53a. BBHS has revised the support plan and the integrated assessment and these will be presented to staff in facility JJIS demonstrations, along with guidance to strengthen staff skills in identifying needs and writing goals with residents.

The support team practices at Lansing comply with 53a.

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

COMPLIANCE

Mental health staff at Lansing 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.

PARTIAL COMPLIANCE

Support team meetings at Lansing comply with 53c.

The Parties interpret 53c to mean (a) the psychiatrist has input at support team meetings through their contact notes and communication between the psychiatrist and clinicians during Mental Health Rounds and informally and (b) the psychiatrist will attend support team meetings when their participation is clinically indicated for a specific resident. Although the Lansing psychiatrist's contact notes, discussions at Mental Health Rounds, and informal communication with staff are utilized at support teams, there are times the psychiatrist's participation in a support team would be important. It seems unlikely that there could be a six-month interval between monitoring visits when the psychiatrist's participation in some support teams was not clinically indicated. If the psychiatrist participates in no support team meetings, the facility must demonstrate that there was no support team in six months in which the psychiatrist's participation was not clinically indicated.

53d. If a youth has a history of trauma, require that treatment planning recognizes and addresses the youth's history of trauma and its impact and includes a strategy for developing appropriate coping skills by the youth.

PARTIAL COMPLIANCE

Lansing Integrated Assessments, clinical evaluations, and Mental Health Rounds describe the effects of trauma on residents' thinking and behavior and are part of planning interventions. But sometimes the resident's support plan, a key aspect of the New York Model, does not include trauma. For some residents, the clinical contact notes indicate trauma work by the resident. This may be considered private between the resident and one or two clinicians and not something they want discussed with their team and/or family. To meet the Settlement Agreement's requirement for "a strategy for developing coping skills [for trauma] by the youth," the effects of trauma on the resident's behavior must be part of staff assistance in the youth's development of goals. Hopefully, the more support plans reflect both the resident's views and the staff's understanding, trauma will become a safer topic in the process of residents changing their thinking and behavior.

53e. Require that treatment plans are individualized for each youth, and that treatment plans include: identification of the mental and/or behavioral health issues to be addressed in treatment planning; a description of any medication or medical course of action to be pursued, including the initiation of psychotropic medication; a description of any individual behavioral treatment plan or individual strategies to be undertaken with the youth; a description of the qualitative and quantitative measures to monitor the efficacy of any psychotropic medication, individual behavioral treatment plan or individual strategies utilized with the youth; a description of any counseling or psychotherapy to be provided; a determination of whether the type or level of treatment needed can be provided in the youth's current placement; and a plan for modifying or revising the treatment plan if necessary.

PARTIAL COMPLIANCE

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

"Goal Writing and Support Plans in the New York Model" (4/12/13) provides helpful and specific guidance for goal writing to maximize the motivation and engagement of youth by "starting where they are" and beginning services with their goals. Strengths to build on to achieve their goals is stressed as an important part of writing support plans. This document guides staff in how to help youth develop goals by validating and breaking goals into components they can achieve. Staff are encouraged to work with youth to identify the reward for them for working toward the goal. Utilizing the examples of goals, objectives, supports/services/interventions in these guidelines will improve support plans. The one-page document Support Team Staff Notes walks staff through an analysis of their role in assisting a youth to his/her goal. The one-page Goals Worksheet is for staff to help youth identify their goals and break them down into achievable components to assist in the development of the support plan with the resident and prepare the resident to speak up at the support team meeting.

At the time of the site visit, these guidelines for writing effective goals did not appear to be implemented yet at Lansing, but they were making efforts to improve support plans. Consistently strong support plans—including building from the Integrated Assessment, clear goals based on the resident's aspirations with the addition of staff

expertise, and all team members' interventions (not just clinicians) stated specifically--is being monitored to determine full compliance.

53f. Require that treatment plans are modified or revised as necessary, based on the efficacy of interventions, new diagnostic information, or other factors. The treatment plan shall be updated to reflect any changes in the youth's mental health diagnosis.

COMPLIANCE

Mental health staff at Lansing were observed complying with 53f and the support team meetings observed by the MH Monitor complied with 53f.

On Site Observations Regarding Paragraph 53a-f (4/13)

The MH Monitor observed two Lansing support team meetings. [redacted] is a 15-year old from [redacted] who had been at the facility almost four months on a modification after stealing from her grandmother a year before. She has not seen her [redacted]-year old father, who lives out-of-state, since she was 5. She lived with her [redacted]-year old mother, maternal grandmother, [redacted]-year old brother, and [redacted] younger half-siblings. She experienced years of neglect and witnessing domestic violence, with Child Protective Service investigations. She was chronically truant from her 8th grade special education self-contained school for learning disabilities, ADHD and behavior problems. She had multiple psychiatric hospitalizations due to aggression. A 5/12 psychological evaluation found significant impulse control and attention-seeking problems, a strong need for acceptance, and marijuana and alcohol use; her FS IQ score was 80 (low average), with borderline verbal and average perceptual abilities. Seroquel, Concerta, and Lamictal were prescribed. The Reception Psychological Report (12/12) indicated [redacted] was sent to [redacted], then [redacted], and then [redacted], with multiple AWOLs from these program. She was diagnosed with Conduct Disorder, Mood Disorder (provisional), Learning Disorder, ADHD (by history), relational problems, Rule Out Cannabis and Alcohol Abuse. Her WISC FS IQ was 76 (borderline) and she was reading at the 6th grade level and doing math at the 4th grade level. [redacted]'s Integrated Treatment Plans at Lansing in 2/13 and 3/13 were identical and were inadequate. She was described as self-injurious, cursing at staff, not following instructions, and not safe when horseplaying with peers. Goal #1-Follow basic rules of facility, with objectives the same as the goal. Interventions were to continue to meet with her therapist, YC, and psychiatrist. Goal #2-Stop cursing, with objectives the same as the goal and the same interventions as Goal #1. The Psychiatric Contact Note (3/20/13) listed a diagnosis of Anxiety Disorder and Insomnia, and she requested more medication because she was angry and not sleeping. The psychiatrist noted that he and her therapist "explained her anxiety" and he increased Quetiapine to address anxiety and insomnia. Contact notes documented that between her admission in 12/12 and 3/12, the psychiatrist saw her six times; between 3/6/13 and 4/8/13, her therapist saw her 15 times; in the last month she had individual counseling with her YC four times and she participated in nine DBT groups. [redacted] wrote a letter to the OCFS Commissioner and got approval for early release. Staff commented that the reasons she sent to the Commissioner for release were impressive—she drafted it, got feedback from staff, and revised it. She had a videoconference with her mother the week before the site visit to discuss her release. Her support team meeting was convened by her YC with the Assistant Director for

Treatment, therapist, teacher, other YC, nurse, and YDA; her mother was on the phone; her aftercare worker was away, her supervisor had agreed to participate in support team, but was not there when called. Participants discussed her strengths, commending her for taking the initiative rather than acting out. She had decreased her cursing to almost zero, was using coping skills to deal with severe anxiety, and was tolerating her mother being dismissive. In school her behavior was better but "she needs to get motivated to do work; she can't understand science and history and her anxiety is so high she can't concentrate." Then [redacted] joined the team with her YDA. When she arrived, her YC checked in with her: "Where is your anxiety on a scale of 1 to 10?" She said, "10." Positive comments by her YDA were followed by participants telling her how much improvement she was making. Her IIP and her goal, which is still to leave Lansing and get a job, were reviewed. Her mother said her former therapist is willing to take her back. The phase checklist was used effectively—all the team members participated in going through each item on the checklist, and she got a positive review and made Phase 3. Her YC checked in with her: "Where is your anxiety on a scale of 1 to 10?" She responded, "Down to 1" and she was smiling for the first time. In the debrief of the support team, the staff commented that was the best support team she has had. "Managing her emotions, especially anxiety, is such a challenge for her. She is very shy, and it is hard to pull things out of her. We wish she could talk more about her progress." They went on to discuss how to change support teams to fit shy residents, perhaps by helping her write out in advance what she wants to say. The next team is her last and they plan make it one where she actively takes charge. Contact notes indicate that most of[redacted] focus is on going home immediately. Her CMSO's most recent note indicated that her mother did not want her released before the end of school year; her team was concerned that her CMSO showed irritation that she was given an early release.

[redacted] is a bilingual 15-year old from[redacted] who had been at Lansing three weeks for criminal contempt (after going AWOL). Her Lansing Integrated Assessment (completed within 15 days of her arrival) was thorough. [redacted] Their mother moved back in and the three children were described as filthy with no food or clothes. Soon after, her mother reported [redacted]'s aggression against her. She described her father as "a physically abusive, criminal addict" and her mother as "stupid and crazy." [redacted] was AWOL twice from [redacted] RTC where she was sent in 6/12; she had a history of polysubstance abuse and age 12 had been suicidal, with a drug overdose in 12/12. Her [redacted] got guardianship in 3/13. In Reception, her tested FS IQ was 93. The Integrated Assessment noted under Special Treatment Needs that she acknowledges her trauma history but does not talk about it and needs but does not want substance abuse treatment. The loss of her father was noted as traumatic: "she lost her life with him, which was maladaptive, but the only life she knew" and as a result needs help developing trusting relationships and learning skills to manage feelings. She wants to put substance abuse behind her and hopes to be a dentist or doctor. Her diagnosis was Anxiety, Depression, Polysubstance abuse, Rule Out PTSD, Rule Out Reading Disorder. Her 4/3/13 Psychiatric Contact Note diagnosed

Anxiety Disorder and Zoloft was prescribed. Between 3/27/13 and 4/11/13, [redacted] saw her therapist five times, the psychiatrist twice, and was in five groups. In her initial session with her therapist she had a long list of worries but was unable to identify any strategies to feel better or deal with anger. [redacted]'s Support Team was convened by her YC with the Assistant Director for Treatment, therapist, nurse, and vocational specialist, and her aunt on the phone. Aftercare was not available. It was noted she had been at Lansing for three weeks following AWOL from [redacted] where she had been for three months. She was having no problems at Lansing where she spends most of her time in her room reading; she is very quiet in school. Her therapist said she works well in therapy and is strongly motivated although it is hard for her to talk: "It is taking time for her to recover from years of not having structure, predictability or trustworthy adults in her neglectful home. She's been damaged by those painful years. She needs help figuring out her loyalty to her father who was her primary relationship but also was harmful to her, and she is likely to take it out on her [redacted]." Her therapist carefully explained [redacted]'s progress to her [redacted] who commented, "It sounds wonderful, what I've been wanting to hear." She will have been in placement a year if she is released in June and has not lived with her[redacted]). Her aunt said how difficult it was for her to be so far away, but they will make the six-hour trip soon. Her therapist recommended family therapy in the interim so family issues could be discussed. She is at grade level in math, is working on science and social studies, but does not like reading; art is her favorite class. Lansing is still waiting for test results from [redacted] that may indicate a need for special education services. The nurse commented that [redacted] did not like taking her medication in the morning so the single dose was changed to noon and she takes it consistently. [Meanwhile, Child Protective Services arrived at Lansing to interview[redacted] about complaints she made at [redacted] and her YC asked them to wait until her support team was over—it is unacceptable that they would not have scheduled an interview in advance, not on the day of her first support team.] [redacted] arrived with her YDA who added how well she is doing. Her IIP was reviewed. They discussed her goals: Goal #1 Strategies for handling strong feelings. Goal #2 Success in school. Staff told her they would help her achieve her goals. Her family goal is to build a stronger relationship with her aunt so it is easier to go home. Her aunt told her, "I love you. I am proud of you. I'm really happy about what I'm hearing about how well you are doing." During the debrief of her support team meeting, staff commented that it was disappointing that because her aunt lives so far from the CMSO, she could not be on videoconference and that it was unfortunate her aftercare worker had not participated. Once again, the challenge of a very shy resident was noted and team members will encourage her to prepare a presentation for her next team meeting. Staff frustration with[redacted] likely short stay and challenge of moving to her aunt's ("a huge change between her father's home and aunt's home, with a lot of old history"), with no support for her aunt was discussed. The MH Monitor inquired whether there was a Multidimensional Treatment Foster Care home--which provides strong support for a foster parent and the relative the teenager will move to—available, but the team had not heard of the program.

Lansing staff have improved in writing specific treatment goals and steps to support the resident's goals explicitly connected to the skill building of the New York Model. The observed Lansing support teams showed caring communication with residents and including their families. Aspects of support teams requiring improvement are (a) designing

ways each staff can help the resident achieve their goals; (b) incorporating the Integrated Assessment findings into the team discussion and support plan; and (c) making connections between the resident's goals at Lansing and success in the community.

Instead of a formal curriculum for teaching staff how to complete the new JJIS support plans, OCFS is providing in-person system walk-through and continued coaching by BBHS. JJIS Support Plan Coaching facility staff has begun. Coaching will be to sit with Clinicians, YC's, Teachers, and Medical staff at their computers to guide them through the new form. On 2/1/13, the new Integrated Support Plan was released in JJIS. The BBHS Director of Treatment Services and the JJIS clinical coach will coach at each facility, sitting in on a support team and providing the clinicians feedback about the meeting and how to create a support plan on JJIS.

The QAI review of Lansing surveyed 10 youth and found that 8 said they had a support plan, 7 said they helped developed their goals, 6 said they attend support team meetings, and 5 said their parent/caregiver participated in their support teams

FUTURE MONITORING

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

The MH Monitor will continue to observe support team meetings.

The MH Monitor will continue to review psychiatry participation in support teams.

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

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

PARTIAL COMPLIANCE

OCFS is using Innervisions, generally led by YDAs, for substance abuse prevention education at other facilities, but is looking for a new program on total well-being including substance abuse education.

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

54b. All youth who are known to have current problems with substance abuse or dependence are provided adequate treatment for those problems while residing at a Facility.

PARTIAL COMPLIANCE

OCFS is using Triad for substance abuse treatment at other facilities.

Like the process of becoming trauma- responsive, learning to meet the needs behind substance abuse is important for all staff, not just clinicians. A necessary element of coaching on New York Model implementation is ensuring that each resident integrates DBT skills learned in substance abuse treatment with those learned in DBT group and the

coping skills learned through SELF. This will require strong communication in support teams and Mental Health Rounds among the therapist, substance abuse clinician, YCs, YDAs and the rest of the team on how to support each resident's individual progress in self-calming and how she can use these skills to avoid substance use in the community.

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

On Site Observations Regarding Paragraph 54a-b (4/13)

Lansing still does not have a substance abuse clinician; they hope to hire a staff person shared with Finger Lakes. The Innervisions substance abuse education group is not meeting at Lansing. The QAI review noted that Lansing received a temporary waiver from BBHS to allow YCs to conduct the Triad group until the position is refilled. QAI described Triad as "an intervention for adolescent girls with histories of substance abuse, emotional problems, and violence/trauma/abuse. This is an intensive treatment that emphasizes taking the time to ask questions and to listen without judgment to empower the search for self-identity in order to improve their mental health, to identify their strengths, and to support their survival and healing from violence and trauma. The ideal group size is 5-10 members and the group format is designed to meet once a week for two hours or twice a week for 1.5 hours. It has been suggested that this amount of time creates a safe and secure environment and allows the group members to explore and process emotionally difficult material. The Triad model recommends experienced clinicians with either mental health or substance abuse training, who are knowledgeable about group processes with adolescents. The group's facilitator should receive special training in treating co-occurring disorders and in working with people that have trauma-related disorders. The facilitators need to be prepared to respond to flashbacks and other dissociative experiences a group member may undergo if triggered. Ongoing supervision by a trauma specialist is recommended." QAI recommended that a clinician, not a YC or YDA, facilitate Triad at Lansing to ensure that youth who have significant substance abuse history and have SNAP scores of 3 or above receive the appropriate screening and treatment.

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

FUTURE MONITORING

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

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

The MH Monitor will review the effectiveness of this treatment approach in preparing residents to resist internal and external pressures to abuse substances when they return to the community.

55. Transition planning. The State shall require that each youth who has mental health issues, or who has been or is receiving substance abuse treatment, which is leaving a Facility has a transition plan. The State shall create or modify and implement policies, procedures, and practices for the development of a transition plan for each such youth. The transition plan shall include information regarding:

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

COMPLIANCE

The Continuity of Care Plan complies with 55a.

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

PARTIAL COMPLIANCE

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

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

The Transition Plan includes: (1) identifying information, including family, CMSO (aftercare), community service provider, attorney, other important adults, supportive peer resource; (2) housing (where the youth will live and plan if housing must be found before re-entry); (3) health insurance information; (4) educational/vocational program planned and additional steps to arrange for it; (5) adult permanency/alternative release resource; (6) continuing support services and additional steps to arrange for them; (7) important documents still required; (8) workforce support and employment services; (9) pregnant/parenting youth (if applicable); and (10) youth's safety plan.

OCFS indicated that "Continuity of Care Plans and Transition Plans are meant to be looked at together. Both are used; neither is meant to be a single reference point. They are completed by different staff and meant to be used together when a youth is discharged. The Continuity of Care Plan contains protected health information and as a result of HIPAA laws, it cannot be shared with everyone. The Transition Plan does not have the same restrictions."

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

COMPLIANCE

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

On Site Observations Regarding Paragraph 55a-c (4/13)

The MH Monitor reviewed the one-page Continuity of Care Plan for [redacted]. [redacted] was at Lansing for six months in 2011. [redacted] returned to Lansing a year later at age 16 in 7/12 for assault as a CRP. She was pregnant and when her mother said she could not return home if she continued the pregnancy, [redacted] decided to be taken to [redacted] for an abortion and returned to Lansing. Her diagnosis was Anxiety Disorder and she was prescribed Seroquel. Her 9/12 Integrated Treatment Plan shortly before leaving indicated she "continues to utilize skills to solve problems with her peers and has displayed good emotional regulation;" she had leadership skills and was motivated to do well in school. Her goal was "increase her ability to manage her anger and frustration to maximize her ability to achieve her goals of going home and graduating from school." There was no family goal. Her Lansing plan had the Reception diagnosis of Depression. [redacted] was discharged to her home in [redacted] on 10/12 after three months at Lansing. Her Continuity of Care Plan listed mental health counseling and substance abuse treatment in a mental health center in [redacted], NY; she was discharged with a 30 day supply of Seroquel and, although she did not have a scheduled psychiatry appointment, it was indicated one would be arranged in that mental health center. [redacted] returned to Lansing four months later (2/13) for her third stay in two years. This history indicates that a Continuity of Care Plan that simply refers a resident to a mental health agency, without being accompanied by a support plan she has helped to create with her goals and skills in the facility applied to her community placement, is not likely to be effective.

There were several examples in this site visit of CMSO offices not operating with New York Model principles. When CMSO staff are out-of-step with the New York Model (especially engaging youth to play an active role in goal setting and using their skills for emotional regulation and distress tolerance), it undermines both (a) support teams, especially at a short-stay facility and (b) re-entry services designed to fit the resident. In other facilities there have been many examples of upstate CMSOs actively participating in support teams by videoconference and in person, but at Lansing particularly Long Island and Hudson Valley CMSOs are not regular participants and videoconferencing is underutilized.

The Transition Plan screens comply in part with the Settlement Agreement by including information about all aspects of the youth's services in the community. However, two important functions of a Transition Plan are: (1) Providing specific guidance for a resident's family, school and other providers about her needs and how each of them can support her distress tolerance, self-calming and interpersonal effectiveness skills (including how, specifically, she can make use of her Safety Plan and other New York Model skills in the community); and (2) Identifying her team in the community to help the young person reach her goals and giving each team member (youth, family, OCFS staff, service providers) the telephone number and address of each person/service on the youth's community support team. A transition plan should define how a resident's treatment plan and gains in the facility will continue in the community: if, for example, one of a youth's goals in the facility was "Learn how to manage frustration," then in the last support team meeting before re-entry, important supporters in the community would have been present or on tele/video conference so they understood their role in helping the youth tolerate frustration in the community. Just as the youth and everyone on her team at the facility use her support plan to assess progress and refine supports, OCFS should help the youth, her

family and service providers be able to rely on her transition plan as her support plan in the community. All the residents in the four DOJ facilities are receiving individual therapy and individual counseling and are participating in DBT and Sanctuary groups and most are participating in substance abuse treatment groups. The Settlement Agreement wording does not limit the need for a continuity of care plan to youth prescribed psychiatric medication; it includes all residents with the terms "mental health issues" and "receiving substance abuse treatment" in the facility. The Settlement Agreement wording "referrals to mental health *or other* (emphasis added) services when appropriate" requires continuity of care planning for almost all OCFS residents because most residents receive treatment in the facility to meet their mental health and substance abuse needs. This could include, in addition to referrals to therapy, medication management and substance abuse treatment on the Continuity of Care plan, referrals to B2H services, YAP services, mentoring services, and educational services. Referrals for these services are important for transition plans for all youth, not just those requiring medication management in the community. Some residents have a goal of discontinuing psychiatric medication before they are discharged, and they might be at greater risk of return to the facility than those residents who have a Continuity of Care plan for follow-up by a mental health provider in the community. Through the New York Model OCFS has implemented the integrated assessment and integrated support plan, and hopefully, a revised Discharge Plan format could become an integrated transition plan that includes all elements of a youth's successful re-entry to the community without violating HIPAA.

FUTURE MONITORING

The MH Monitor will review the Discharge Plan in JJIS.

The MH Monitor will review Discharge Plans and Continuity of Care plans of recently released residents.

IV. DOCUMENT DEVELOPMENT AND QUALITY ASSURANCE

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

PENDING REVIEW

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

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

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

PARTIAL COMPLIANCE

COMMENT: A positive element of the monitoring process has been the creation and implementation of the Quality Assurance and Improvement (QAI) Bureau. The Monitors received the *Pilot Program Review: Lansing Residential Center* (Draft) also referred to as the QAI Review of Lansing before the monitoring visit and then had an opportunity to discuss its contents and findings before the Lansing monitoring visit. Again, the Quality Assurance and Improvement (QAI) Bureau has produced an excellent report, identifying many of the same issues observed by the Monitors. The Monitors also appreciated the change in the format of the report, especially the tracking of an individual youth's indicators over time and across placements.

The Monitors met with QAI staff members to discuss the LRC report. Attendees included Augustine Amissah, QA Specialist; David L. Bach, QAI Director; Sandra Carrk, Project Manager; Lori Clark, QA Specialist; Diane Deacon, Assistant Deputy Counsel; Myra DeLuke, QA Specialist; Edgardo Lopez, Settlement Agreement Coordinator; and Denis Passarello, QA Specialist. The high-quality QAI reports are becoming an important resource for ongoing OCFS assessment of compliance with the Settlement Agreement.

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

57. a. create or modify and implement policies and procedures to address problems that are uncovered during the course of quality assurance activities; and

COMMENT: No corrective action recommendations exist as a result of the Lansing 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 Lansing monitoring visit.

V. SUMMARY

As mentioned earlier, the Monitors learned that Lansing will be closed before the next monitoring visit. Lansing provided trauma treatment for many girls with complex

child welfare and mental health histories in a nonsecure setting, and it will be necessary for New York City and counties across the state to create similarly intensive services designed to meet the unique needs of girls. The Monitors will review discharge planning for the current Lansing residents as they are prepared to leave the facility before the end of the summer, 2013. The Monitors decided not to delete the future monitoring sections of this report even though it appears this will be the last monitoring visit to Lansing.

We observed good practice, caring relationships with girls, and outstanding, committed staff at Lansing. From both the Protection from Harm and Mental Health perspectives, we enjoyed our interactions with many staff who represented the best of OCFS; and, more importantly, we appreciated the hospitality, collegiality, and mutual respect that was a part of the Lansing monitoring experiences.