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

Facility Monitoring Report:
Columbia Girls Secure Center
Claverack, NY

Marty Beyer, PhD
Mental Health Monitor

And

David W. Roush, PhD
Protection from Harm Monitor

November 10, 2013

INDIVIDUAL FACILITY MONITORING REPORT:

COLUMBIA GIRLS SECURE CENTER

Claverack, NY

I. INTRODUCTION

This is the fourteenth monitoring report for the Settlement Agreement between the United States and the State of New York in the matter of *United States v. the State of New York and the New York State Office of Children and Family Services* (U.S.D.C. Northern District of New York), and it describes the monitoring visit to the Columbia Girls Secure Center (Columbia) on August 21-23, 2013. The Monitoring Team consists of two Monitors, Dr. Marty Beyer, who is responsible for the Mental Health paragraphs of the Settlement Agreement, (hereafter referred to as the MH Monitor) and Dr. David Roush, who is responsible for the Protection from Harm paragraphs (hereafter referred to as the PH Monitor).

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

A. Facility Background Information

Columbia is a 16-bed secure girls facility consisting of two living units, each with a capacity of eight, in a building that also has the school and dining hall and another building with the gym, library, and a classroom. Columbia serves three types of offenders: (1) juvenile offenders/youth offenders who have committed specified serious felonies who are placed by criminal court and who must remain in a secure facility for their confinement. These youth are transferred to the New York State Department of Correctional and Community Services if they must continue to be confined when they reach age 21; (2) juvenile delinquents placed restrictively by the family court who have committed specified serious felonies. These youth must serve a period of the placement in a secure facility and can remain with OCFS involuntarily up to age 21; and (3) juvenile delinquents placed by the family court whose placement in a secure facility has been authorized by the court or who have been transferred from a limited secure facility through an administrative action referred to as being "fennered." These youth may remain involuntarily in OCFS up to age 18. At least one of the residents at Columbia at the time of the site visit who has a 15-life sentence is likely to transfer to an adult prison at age 21.

On August 20, 2013, there were 12 girls at Columbia: nine (9) juvenile offenders/youth offenders and three (3) juvenile delinquents. Seven girls remained from the monitoring visit six months previously. Several residents who had been fennered after serious incidents at Taberg and Lansing remained at Columbia at the time of the site visit.

The 12 girls ranged in age from 14½ to 20; 10 were 16 or older. They had been at Columbia (or Tryon) from 26 days to 973 days (3 had been at Columbia less than three (3) months; three (3) had been there almost a year to almost 2 years). The 12 girls were committed for: Murder (1), Attempted Murder (1), Assault (2), Robbery (4), Burglary (1), Carrying a Weapon (1), Petit Larceny (1), and Criminal Mischief (1).

All the girls at Columbia have psychiatric diagnoses: Generalized Anxiety Disorder (6), Major Depression (3), Dysthymic Disorder (4), Depression (1), ADHD (2), Adjustment Disorder (1), Expressive-Receptive Disorder (1), and Insomnia (1); two have a Cannabis Abuse and one has an Alcohol Abuse diagnoses. All of the girls are also diagnosed with Conduct Disorder. Seven of the girls are prescribed psychiatric medication: Clonidine (3), Remeron (2), Trazodone (1), and Benadryl (2).

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: Columbia Girls Secure 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 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' fifth Six-Month Progress Report on the Master Action Plan (MAP) on June 13, 2013.

A data integrity check revealed one discrepancy between the numbers of restraints in the Central Services Unit (CSU) Restraint Log versus the number of Post-Restraint Examinations conducted by the health clinic. The discrepancy was accounted for in the medical records by identifying the 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 August 21, 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: Sandra Carrk, Project Manager; Diane Deacon, OCFS Legal; Patricia Fernandez, Assistant Director for Treatment; Edgardo L. Lopez, Settlement Agreement

Coordinator; Anne Pascale, Bureau of Behavioral Health Services (BBHS) Chief of Treatment Services; Anita Sapio, Facility Director; and R.J. Strauser, Assistant Facility Director for Programs.

4. Facility Tour

Walkthroughs of the facility occurred throughout the visit.

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 support 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 17 Columbia staff. In addition to group meetings with staff, the MH Monitor interviewed a nurse, a psychiatrist, a Nurse Practitioner (Psychiatric), two clinicians, a Youth Counselor (YC), and a Youth Division Aide (YDA). The PH Monitor interviewed three (3) YDAs, one Facility Director, one Assistant Facility Director, two nurses, one Bureau of Training (BOT) trainer, one Administrator on Duty (AOD), and one Youth Counselor 2.

7. Resident Interviews

The MH Monitor interviewed three (3) girls individually, and the PH Monitor interviewed nine (9) girls with an average age of 16.7 years. Interviews occurred in areas with reasonable privacy from staff. The Monitors selected the youth for interviews.

8. Exit Interview

The exit meeting occurred on August 23, 2013. The Monitors expressed their appreciation for the cooperation and hospitality of the Columbia and OCFS staff. The Monitors then highlighted areas of importance and concern, but not findings. The exit meeting was a time for questions, clarifications, and explanations of events and impressions before the draft report went to both Parties. Those in attendance included: David C. Bach, QAI Director; Carina, Resident; Sandra Carrk, Project Manager; Nancy Copenen, Secretary; Dasha, Resident; Diane Deacon, Legal; Nikita Dickerson, YC1; Erika, Resident; Patricia Fernandez, Assistant Director for Treatment; Renato Guanga, ATT; Cory Jackson, Youth Counselor II; Crystal Jones, Youth Counselor; Chris Latino, Psychologist 2; Edgardo Lopez, Settlement Agreement Coordinator; Robert MacGiffert, QAI Assistant Director; Mahogany, Resident; Deborah Mulligan-Timer, NPP; Anne Pascale, BBHS Chief of Treatment Services; Anita Sapio, Facility Director; R.J. Strauser, Assistant Facility Director for Programs; Kim VonWedel, LMSW; and Ron Williams, YC1. Participating by teleconferencing were Jim Barron, Director, Labor Relations; Lori Clark, Quality Assurance; Myra DeLuke, Quality Assurance; Larry Gravett, Director, SIU; Regina Jansen, DOJ Legal; Alan Kaflowitz, Bureau of Training; Pam Kelly, Director, Bureau of Training; Alyssa Lareau, DOJ Legal; Denise Passarello, Quality Assurance; Sheila Poole, Executive Deputy

Commissioner; Lee Prochera, Deputy Counsel; Mike Rotolo, Quality Assurance; Hilda Saltos, Quality Assurance; Monique Thomas, OCFS Legal; and Iren Valentine, Director, Bureau of Behavioral Health Services.

D. Preface to Protection from Harm and Mental Health Findings

The New York Model has been fully implemented at Columbia. The Daily Achievement System (DAS) and phase system are in place, each resident has a mentor, and each phase requires a certain number of mentoring contacts. Staff members are actively involved in support teams and Mental Health Rounds. Physical restraints decreased to 13 in the past six months. Programs include individuals from the community providing a variety of activities at Columbia including music therapy, pet therapy, arts and crafts, the Sister-to-Sister faith-based program on Sundays, Fun Days with a water slide, bike competitions, Columbia cash earned for buying yarn, hygiene products, and colored socks, and incentive trips to Red Hook Residential swimming pool. It was a pleasure for the MH Monitor to observe a swimming trip that seven girls earned through DAS and the phase system. They were accompanied by six (6) staff and the Columbia Director (while YCs and others remained with two girls on one unit and three girls on the other unit). The recreation specialist sought training to be a lifeguard before the beginning of the summer. Three of the girls were non-swimmers when their lessons started and they were proud to show off their swimming; they also appreciated their fashionable bathing suits and beach towels. The girls had a lot of fun and enjoyed the opportunity for normalized relationships with adults and peers. One staff member grilled lunch and the girls casually walked to the table to enjoy a pleasant picnic. Girls participate in the Columbia Therapeutic Intervention Committee (TIC) where they can make suggestions on programs. Staff consistency continues to be a strength at Columbia—even though many staff commute an hour or more each way, car pools have been supported by flexible scheduling.

Before this site visit, the QAI Bureau completed a thoughtful review at Columbia, which the Monitors discussed with them. The QAI review commended the homelike environment at Columbia that has contributed to residents' perception of being safe.

II. PROTECTION FROM HARM MONITORING

The Monitors find the Protection from Harm Paragraphs (specifically Paragraphs 40-44) in substantial compliance with the Settlement Agreement at Columbia. Pursuant to Paragraph 77, Subsection d regarding "compliance with a portion of the agreement with respect to one or more facilities," the Monitors support an action or petition by Home Office to DOJ for the termination of the Protection from Harm monitoring at Columbia.

This finding does not apply to Paragraphs 45-55.

Restraints are a key element of Protection from Harm Monitoring. Columbia has the most effective use of the New York Model as it relates to use of force and restraints. Several comments are noteworthy:

- The frequency and rate of restraints are very low. Staff members appear to de-escalate emotional crises effectively and to help youth to calm themselves to regain emotional regulation.

- Staff members appear to safely and judiciously delay use of force. In the interviews with youth, 86% indicated that staff use of force only when they really need to.

Columbia staff members have provided the Monitors with two of the best examples of effective ways to use New York Model principles to resolve crises. In addition to the June 2012 incident described in the October 31, 2012 *Facility Monitoring Report: Columbia Girls Secure Center* (pp 11-12), the Monitors were present when staff members again demonstrated creative problem-solving and the use of a peer to prevent a physical restraint. These types of applications of New York Model concepts reflect the progress that Columbia has made in its program development and integration.

Youth and staff spoke positively of the communications and relationships within and between both groups. Given the particularly challenging nature of this population of youth, Columbia staff members appears to have created a peer culture that influences behaviors positively. This can also be attributed to the increased effectiveness of the New York Model implementation.

Food Services always provide good meals during a monitoring visit, but the Columbia meals were very good with regard to both quantity and quality. Consistent with the "big picture" approach, Columbia uses food and meal times as an opportunity to strengthen communications and relationships within and between residents and staff. Columbia staff members believe that stronger relationships are important in the de-escalation process and, as such, strengthen the Protection from Harm elements in the New York Model. One logical, powerful, and important innovation is "Breaking Bread" where youth and staff eat together. The important characteristic is that staff eats the same food as the youth at the same time. The circumstances surrounding these events foster informal conversations, provide a shared experience, and generate laughter. It also helps to create a normalized or more homelike event, approximating a situation where a family would gather together to share a meal and conversation about the day's activities. Home Office has limited the number of times that Columbia can provide the "Breaking Bread" experience. During those other occasions, staff members bring their own food for their meals and sometimes do not eat with youth.

Youth and staff reported high levels of safety. There were no expressions of concern or fear of harm in either group of interviewees. When youth were asked to rate their personal safety on a scale of 1 to 10 with 10 being the highest, their average response was 7.86. This is a 16% increase from the February 2013, monitoring visit. When asked what more could be done to improve resident safety, four (4) of the youth indicated that YDA staff needed to improve in the areas of fairness and consistency. These types of responses can be interpreted in different ways. First, the fairness and consistency response is a reflection of progress since this is a relatively low level concern about safety. The absence of a pattern of specific examples of danger represents progress in the implementation of the New York Model. Conversely, fairness and consistency are persistent concerns in every program, and they that have the potential of leading to confrontations and uses of force if they are not addressed in an ongoing fashion by all staff, especially the Therapeutic Intervention Committee (TIC).

A. Use of Restraints

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

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

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

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

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

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

COMPLIANCE

COMMENT: Columbia has sustained its compliance with this paragraph. The PH Monitor's review of data, including multiple Restraint Packets, combines with direct observations, youth and staff interviews, and the conclusions from the Columbia QAI Report to support this finding.

The Crisis Prevention and Management (CPM) policy and procedure 3247.12 along with PPM 2081.00 and PPM 3247.14 fulfill the requirement that OCFS create a new set of requirements on the use of restraints. During staff interviews, all staff members had a working knowledge of the policy and the physical restraint approach. Columbia administration is familiar with policy and procedure that limit the circumstances when the use of restraints is necessary, and staff interviews confirmed a working knowledge of these circumstances.

Columbia staff members are sensitive to avoidable restraints, i.e., those situations where staff decisions may have inadvertently escalated a youth's behavior versus a situation where a different set of decisions would likely have continued de-escalation and, thereby, avoided a restraint. Administration demonstrates a high level of sensitivity to the needs of youth and staff in conflict situations, and the quality of coaching and Documented Instruction is also good. Administration also seems to err on the side of avoiding a

restraint event by providing coaching and Documented Instruction in situations where staff may have believed that the situation was handled appropriately. Setting high expectations for staff behavior is a positive indicator of the commitment to youth safety.

Another indicator of Columbia's youth safety focus is a more macro-oriented view of a restraint event. Columbia staff members appear to be more sensitive to a larger continuum of behavioral regulation/deregulation and calming, so staff interventions incorporate more information and options than at other facilities. This approach seems to provide Columbia staff with more information and how it can be used to strengthen de-escalation. This "big picture" perspective seems to encourage, if not justify, thinking "outside the box." For example, when a girl who was a potential suicide risk was in her room with her window covered, one staff member was sent outside to look through the youth's exterior window to maintain visual contact and to ensure she was not trying to hurt herself. In the interim, the staff members inside the building were able to maintain verbal contact while implementing another alternative strategy to resolve the situation without any use of force.

Further, the State shall:

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

COMPLIANCE

COMMENT: Columbia has sustained its compliance with this paragraph. The PH Monitor's review of data, including multiple Restraint Packets, combines with direct observations, youth and staff interviews, and the conclusions from the Columbia QAI Report to support this finding.

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.

The Columbia uses of force appear to be appropriate both in the limitation of force to the minimum amount necessary and in the application of force consistent with the exceptional circumstances in Paragraph 41. Seventy-five (75) percent of the youth interviewed, who had been restrained, indicated that they did not believe staff members were trying to hurt them during the restraint. Isolated examples exist where this is not the case, but these staff errors in judgment are not typical of the overall approach to youth crises. Additionally, the corrective actions applied by administration in these circumstances have been appropriate.

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: Columbia has sustained its compliance with this paragraph. The PH Monitor's review of data, including multiple Restraint Packets, combines with direct observations, youth and staff interviews, and the conclusions from the Columbia QAI Report to support this finding.

The policy and procedures exist; the training on the policies and procedures has occurred; and staff and resident interviews were consistent with the policy and procedures. 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: Columbia has sustained its compliance with this paragraph. The PH Monitor's review of data, including multiple Restraint Packets, combines with direct observations, youth and staff interviews, and the conclusions from the Columbia QAI Report to support this finding. The policy and procedures exist; the training on the policies and procedures has occurred; and staff and resident reports are consistent with the policy and procedures.

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

COMPLIANCE

COMMENT: Columbia has sustained its compliance with this paragraph. The PH Monitor's direct observations, youth and staff interviews, and the findings from the Columbia QAI Report support this finding. Policy and procedure clearly prohibit the use of

chemical agents such as pepper spray. Resident and staff interviews and direct observations provided no evidence of the use of pepper spray.

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

COMPLIANCE

COMMENT: Columbia has sustained its compliance with this paragraph. The PH Monitor's review, including multiple Restraint Packets, combines with direct observations, youth and staff interviews, and the conclusions from the Columbia QAI Report to support this finding. Policy and procedure regarding physical restraint clearly prohibit the use of psychotropic medication solely for restraint purposes. Resident and staff interviews and direct observations provided no evidence of the use of psychotropic medication solely for restraint purposes.

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

COMPLIANCE

COMMENT: Training remains in compliance. Mr. Guanga assembled a streamlined staff training history notebook. The training materials revealed that all but two newly hired staff members were up-to-date on CPM, First Aid and CPR. Those requiring Restraint Monitoring training had completed it. Regarding completion of the CPM training course as a core prerequisite for conducting physical restraints, only two staff members did not qualify. Both were new employees who had not completed the Academy training. There were copies of individual memos sent to each employee from administration advising them that until they have completed the required CPM and first aid/CPR courses, they are not allowed to participate in physical restraints.

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: Columbia has sustained its compliance with this paragraph. The PH Monitor's review of data, including multiple Restraint Packets, combines with youth and staff interviews and the conclusions from the Columbia QAI Report to support this finding. The policy and procedures exist; the training on the policies and procedures has occurred; and staff and resident reports are consistent with the policy and procedures. No evidence existed of the use of "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: Columbia has sustained its compliance with this paragraph. The PH Monitor's review of data, including multiple Restraint Packets, combines with direct observations, youth and staff interviews, and the conclusions from the Columbia QAI Report to support this finding. 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.

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

COMPLIANCE

COMMENT: Columbia has sustained its compliance with this paragraph. The PH Monitor's review of data, including multiple Restraint Packets, combines with the conclusions from the Columbia QAI Report to support this finding. 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.

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: Columbia has sustained its compliance with this paragraph. The PH Monitor's review of multiple Restraint Packets combines with staff interviews and the conclusions from the Columbia QAI Report to support this finding. The Therapeutic Intervention Committee (TIC) is the "review by senior management." The TIC has mandatory attendees that include the Facility Director or designee, Clinical, Assistant Director, AOD, YDA, YC, Medical, Kitchen, Maintenance, Recreation, Spiritual (if on staff), Education, and youth (for last agenda items only). Additionally, the documentation provided by Home Office included minutes from several TIC meetings. The TIC will be an important part of the new Graduated Response protocols tied to the new restraint metrics. Home Office should carefully monitor the TIC to help it reach its full potential within this new system.

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

COMPLIANCE

COMMENT: Columbia has sustained its compliance with this paragraph. The PH Monitor's review of multiple Restraint Packets, including the Video Review Forms (VRF), combines with administrative interviews and the conclusions from the Columbia QAI

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

Throughout the monitoring process, this paragraph has become more important because of the "review" and "evaluate" functions contained in this weekly practice. The Facility Administrator review becomes a critical part of the feedback needed to enhance the effectiveness of CPM within the New York Model. With the advent of Quality Assurance, it provides another perspective on the types of staff behaviors that are exemplary or in need of improvement.

The PH Monitor's review of the Restraint Packets produced results consistent with the QAI Report. The review provided an opportunity to use the new inductive review instrument and produced several details that prompted additional discussion with Assistant Facility Director Strauser regarding documented instruction and coaching decisions.

One Restraint Packet analysis captures the strengths and areas for improvement involved in the Columbia Facility Administrative Review. Regarding Restraint Packet #478899, AFD Strauser and the PH Monitor reviewed following issues:

- The documentation was generally very good, particularly the Incident Report by AFD Strauser. Additionally, when errors occurred in documentation, they were noted as such. The Administrative Review is very thorough.
- Three (3) instances of documented instruction were associated with this Restraint Packet, and all three appeared to be a very appropriate response to staff behavior. All were implemented in a timely fashion.
- In an instance where AFD Strauser determined that formal counseling was necessary, it occurred quickly.
- Arising from the documentation was a claim by the youth (one of the combatants in a fight) that she had been attacked and actually cooperated after the breakup of the fight but was restrained anyway. The documentation provided some support for her claims. This prompted a discussion about whether being in a fight and defending yourself qualified as an exceptional circumstance (see Paragraph 41) and, therefore, justification for physical restraint "to protect the safety of any person." AFD Strauser had a good understanding of the issues and noted that the disciplinary action for the youth was held in abeyance for 30 days, a period where further investigation of the incident might generate new information warranting disciplinary action. This, too, prompted additional discussion about the rationale 30 days versus five (5) or 10 days to gather information sufficient to expunge the disciplinary action. These were good and constructive discussions and also indicators of the concern on the part of the Columbia administration to consider a range of factors related to fairness and consistency in discipline.

The review of this Restraint Packet proved to be encouraging with respect to confidence in the Administrative Review process to protect youth safety.

Coaching and Documented Instruction are common, even though restraints are infrequent. Administration and QAI suggest that the lack of frequency of restraints explains why there are minor mistakes in the application of the techniques due to lack of practice. In interviews with staff, several grumbled initially about having to attend a Documented Instruction and receive coaching as they seemed to say to the staff that they were not doing their jobs appropriately. This seemed to be a short-lived reaction as the same staff members also talked about the benefits of Documented Instruction and coaching, even stating that a regular part of every restraint follow-up should be a coaching session for the staff involved to stay sharp on skills and strategies.

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

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

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

COMPLIANCE

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

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

COMPLIANCE

COMMENT: Home Office has addressed the requirement for an emergency plan through the development of the Crisis Response and Radio Communications Policy (PPM 3246.02). The policy complies with the intent of this paragraph. Further, Local Practice, which interprets the policy for implementation at Columbia, is expressed in the Columbia Girls Secure Center Local Operating Practice (3246.02). The Local Policy complies with the intent of the paragraph. It is recommended that the approval and the effective date sections of the Local Operating Practice be signed and dated.

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

COMPLIANCE

COMMENT: Columbia has sustained its compliance with this paragraph. The PH Monitor's review of training records combines with staff interviews and the conclusions from the Columbia QAI Report to support this finding. The policies and procedures

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

D. Reporting and Investigation of Incidents

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

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

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

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

i. Inappropriate use of restraints;

ii. Use of excessive force on youth; or

iii. Failure of supervision or neglect resulting in:

(1) youth injury; or

(2) suicide attempts or self-injurious behaviors.

To this end, the State shall:

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

COMPLIANCE

COMMENT: Columbia has sustained its compliance with this paragraph. The PH Monitor's review of restraint documents including reporting actions, along with interviews with staff and youth, yielded similar results. No one commented about a reluctance or fear of retaliation when faced with the need to report another worker regarding an alleged incident of an inappropriate use of force or suspected abuse.

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

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

Second through Fourth Sentences: COMPLIANCE

COMMENT: There were no allegations for investigation. If there had been allegations, the Facility Director would make the initial determination in conjunction with his/her supervisor (the Facilities Manager) and with OCFS regional staff supervised by another arm of OCFS that oversees the creation of a safety plan in the event of an abuse/neglect allegation.

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: Columbia has sustained its compliance with this paragraph. The PH Monitor's review of data, including the Post Restraint Examination (PRE) procedures and documentation, combines with direct observations, youth and staff interviews, and the conclusions from the Columbia QAI Report to support this finding. 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 health clinic remains a key part of Protection from Harm safeguards. Clinic staff members continue to be knowledgeable about reporting functions related to abuse allegations, and there was no evidence of any hesitancy to report on the part of a Qualified Health Care Professionals for fear of retaliation or reprisal.

44. d. Create or modify and implement policies, procedures, and practices to require that all allegations of staff misconduct described above are adequately and timely investigated by neutral, trained investigators and reviewed by staff with no involvement or personal interest in the underlying event.

i. Such policies, procedures, and practices shall address circumstances in which evidence of injuries to youth, including complaints of pain or injury due to inappropriate use of force by staff, conflicts with the statements of staff or other witnesses.

ii. If a full investigation is not warranted, then the reasons why a full investigation is not conducted shall be documented in writing. In cases where a youth withdraw an allegation, a preliminary investigation shall be *conducted to determine the reasons for the withdrawal and, in cases where it is warranted, a full investigation will be conducted.*

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

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

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

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

COMPLIANCE

COMMENT: The policy and procedures exist (PPM 2801.00, PPM 3247.00, 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.

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

COMPLIANCE

COMMENT: The level of supervision at Columbia is consistent with generally accepted professional practices. Additionally, Home Office has improved the Restraint Monitor training curriculum to further strengthen staff supervision and youth safety during restraint events.

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

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

III. MENTAL HEALTH MONITORING

The MH Monitor concluded that Columbia was in compliance with the ten mental health paragraphs of the Settlement Agreement at this site visit. Columbia is an exemplary facility. The collaborative work among staff is impressive. Relationships between staff and girls continue to be the key to the residents' observable progress. Increasingly sophisticated implementation of the New York Model was evident which is particularly noteworthy in a facility with unusually immature girls in combination with half the residents being 18 or older and some girls who have been in custody for years with girls who are released in four months. Home Office has completed policies, guidelines and a manual to comply with the mental health paragraphs of the Settlement Agreement, and Columbia staff were observed demonstrating application of training and adherence to required practices.

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

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

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

COMPLIANCE

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

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

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

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

COMPLIANCE

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

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

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

COMPLIANCE

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

Through support teams and Mental Health Rounds, Columbia staff are complying with 46c on an individual basis. Columbia staff discuss the effectiveness of interventions facility-wide and make adjustments to their practices during Mental Health Rounds, TIC meetings, and change of shift meetings in compliance with 46c. How to disseminate findings from the QAI review was under discussion as an important way to enhance the effectiveness of their interventions.

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

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

COMPLIANCE

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

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

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

On Site Observations Regarding Paragraph 46a-d (8/13)

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.

In progressing with the New York Model, Columbia faced challenges with implementing mentoring and phase advancement. They reported that having the residents be responsible for scheduling and keeping track of mentoring contacts has been successful. Staff members have been trained to be precise in completing mentoring notes, and mentoring has become an important part of phase advancement. Staff members are pleased that [redacted], an 18-year old who was placed in 5/12, is the first Columbia resident to achieve Future Phase, and she has inspired several other long-stay residents to strive for Future Phase.

The MH Monitor observed outstanding Mental Health Rounds at Columbia. Participants included the psychiatrist, the Assistant Director of Treatment, a therapist, the substance abuse clinician, both YCs, the nurse, the PNP, a teacher, a YDA and the BBHS Director of Treatment; everyone participated and made contributions that were valued. They discussed two residents. [redacted] is a 16-year old previously at [redacted] and [redacted] who was discharged in [redacted], was revoked to [redacted] in [redacted] and fennered to Columbia in 11/12. Her diagnosis is Generalized Anxiety Disorder, Major Depression, ADHD and Severe Mood Dysregulation, but contact notes described her as having Reactive Attachment Disorder. Since her placement in foster care in early childhood, she had a difficult relationship with [redacted]; during her first stay at Columbia she made significant progress, including an improved relationship with [redacted] to whom she returned unsuccessfully. She was discussed at Mental Health Rounds during the site visit six months previously because she was struggling. Since then, she has been learning to make decisions not driven by emotions and understanding the connection of trauma to behavior. She visited the [redacted] and now accepts it as a step to independent living. She passed a Regents, uses DBT skills, is no longer prescribed psychiatric medication, and helps other residents. Staff commented, "She is a completely different girl."

[redacted] is a 16-year old who has been at Columbia for 10 weeks and from the beginning was dependent on her co-defendant who is also at Columbia. Her diagnosis is Conduct Disorder, Rule Out ADHD and she is prescribed Clonidine. She abused alcohol and marijuana and is an active participant in substance abuse group. Her tested IQ was 73, she reads at the 4th grade level, and she acts much younger than her age. Staff discussed her sensitivity to criticism and that being confrontational is an attempt to cover up her lack of comprehension. Participants believe she has been traumatized, but has not disclosed it. Because her diagnosis is uncertain, a neurodevelopmental evaluation was considered, although she is leaving in two months.

The MH Monitor suggested administrative improvements in the excellent Mental Health Rounds at Columbia: (1) providing coverage so the AOD could routinely participate; ideally both the Assistant Director for Program and the AOD would participate, although perhaps they could alternate weeks; (2) once a month having Mental Health Rounds after 3 PM so the evening shift could participate; and (3) having one YDA from each unit at every Mental Health Rounds.

A key to implementation of the New York Model is a functioning team of coaches. A strong facility coaching team ensures that the New York Model becomes a way of thinking, rather than simply a clinical service. The Columbia coaching team convened for a

discussion with the MH Monitor and described their ongoing efforts to provide "in-the-moment, on-the-floor coaching" with all staff. They also discussed the importance of being purposeful about culture change. For example, when decisions were made to have Fun Day and swimming, they did not have staff discussions first to "delineate how residents would earn these activities" and they learned from the problems that created. The MH Monitor encouraged the coaching team to find opportunities for staff to be recognized for their successes. For example, during the site visit the MH Monitor observed effective crisis prevention with a recently fennered resident who had previous restraints. Staff collaborated to help her calm herself, and their skillfulness deserved recognition (had she been restrained, attention would have been given to whether sufficient de-escalation efforts had been made, but there is no routine formal recognition for avoiding a restraint). Furthermore, in a support team meeting observed by the MH Monitor, the resident's appreciation that she had learned patience should have led to all staff being recognized for their months of being patient with her. The Columbia coaching team agreed to create more opportunities for small successes to be appreciated and for purposeful culture change. The Columbia coaching team will also pursue methods for disseminating the findings from the QAI review which recognize their accomplishments.

DBT groups are strong at Columbia, and staff members are interested in DBT skill training which the Assistant Director for Treatment is developing. For the long-stay residents, new approaches to advanced DBT may be necessary.

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

FUTURE MONITORING

The MH Monitor will continue to review documentation of the consistency of DBT and Sanctuary groups and other therapeutic interventions and the progress being made by residents, New York Model coaching, and ongoing implementation of successful Mental Health Rounds, the Daily Achievement System and phases, and Columbia's use of information to regularly assess the effectiveness of interventions.

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

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

COMPLIANCE

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

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

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

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

COMPLIANCE

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

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 (8/13)

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

In the previous six months two girls were placed on Personal Safety Watch at Columbia, one in 2/13 and one in 7/13. Both were returned to regular program within a day. [redacted] is a 17-year old at Columbia for 10 weeks after running away from a residential drug treatment program; she had been placed in a psychiatric hospital for attempting suicide and was abusing marijuana, heroin and cocaine. Her tested IQ was 72, but she was reading and doing math at the 7th grade level. Her diagnosis is Generalized Anxiety Disorder, Dysthymic Disorder, Bereavement, Cannabis Dependence and Conduct Disorder. The thorough Integrated Assessment described her anger and sadness when her father died in 2012. [redacted] has a model support plan that could be used for statewide staff training. Her Goal #1 was managing her anger (by learning mindfulness and identifying anger reducers). Her Goal #2 was to stop using drugs (by discussing reasons for drug use, urges she has to use drugs, and her choices in the community that sustained drug use).

Interventions by all staff should have been specifically defined in her support plan, since stopping drug use is not just the work of her therapist or substance abuse group. At the time of her Personal Safety Watch, the Assistant Director for Treatment helped [redacted] do a chain analysis to understand how she acted when she got upset believing her mother might not visit for her birthday.

In the previous six months, no Columbia residents were admitted to a psychiatric facility.

FUTURE MONITORING

The MH Monitor will continue to review documentation of Columbia's response to mental health crises of girls.

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

48a. Create or modify and implement policies, procedures and practices to require that each youth admitted to a Facility is comprehensively screened by a qualified mental health professional in a timely manner utilizing reliable and valid measures. The State shall require that any youth whose mental health screening indicates the possible need for mental health services receives timely, comprehensive, and appropriate assessment by a qualified mental health professional and referral when appropriate to a psychiatrist for a timely mental health evaluation.

COMPLIANCE

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

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

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

setting, the State shall immediately initiate procedures to transfer the youth to such a setting.

COMPLIANCE

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

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

COMPLIANCE

The Integrated Assessment form complies with 48c.

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

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

COMPLIANCE

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

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

COMPLIANCE

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

On Site Observations Regarding Paragraph 48a-e (8/13)

BBHS policy requires that "mental health rounds will assist in integrating the psychiatric and behavioral health services of each youth into a broader holistic understanding of the youth and the family" (Page 3). The psychiatrist and nurse practitioner participate in the weekly mental health rounds and contribute information about diagnosis(es), medication, benefits, and side effects. Consensus of team members is achieved during these meetings, with resultant modification of treatment parameters by all participants according to the team discussions. The Axis I primary diagnosis may change as treatment progresses and more information about the youth becomes available (Page 7). If the clinician does not participate (in the psychiatric visit with the youth], they will meet with the psychiatrist prior to the youth's session to communicate regarding treatment issues and progress. The treating clinician and the psychiatrist (with input from the mental health rounds team) will develop a single working diagnosis, which is reflected in JJIS and in the support plan (Page 8). The BBHS Facility Clinical Procedures expand on the policy: the clinician updates the youth's current diagnosis in the support plan, but "only if changes are agreed upon between the clinician and psychiatrist. The assistant facility director for treatment should be consulted when the facility clinician and psychiatrist are unable to reach an agreement about the youth's diagnosis. The regional social work supervisor and chief of treatment services should also be consulted in instances where the primary treatment team is unable to reach consensus surrounding the youth's diagnosis." The BBHS Facility Clinical Procedures define a process that ensures that all support team members "are providing interventions to assist the youth and family in effectively managing or reducing symptoms associated with the current diagnosis." When a diagnosis is given at reception or secure facilities, in the facility diagnostic evaluation, the integrated assessment, and the support plan, the uniform working diagnosis screen in JJIS is automatically updated to keep track of the diagnostic history of the youth. This system for updating diagnoses may be undermined by two discrepancies the MH Monitor has observed in the DOJ facilities: (1) it appears that in each psychiatric contact note, the psychiatrist renders the diagnosis of the youth at that session—these notes can be written 1-4 times monthly, and a range of diagnoses may be given; if the psychiatrist and clinician do not discuss current diagnosis immediately before the support team, the support plan may carry over the diagnosis from the previous support team without regard to changing interpretation of symptoms by the psychiatrist; and (2) the diagnosis and medication list prepared by facilities for monitoring visits are different from the diagnosis in the most recent support plan and/or most recent psychiatric contact note (medications are also often not up-to-date on those lists).

The August, 2013 version of the Scope of Work of OCFS Psychiatrists was reviewed by the MH Monitor; it is being finalized by the newly-appointed consulting Chief Psychiatrists. It briefly lists the ten duties of OCFS psychiatrists, including medication management, attending weekly Mental Health Rounds, attending support teams as directed by the facility administrator, restrictions on number of medications, required laboratory studies, informed consent, and psychiatric emergency evaluations. It does not provide guidance for psychiatrists about their role consistent with the New York Model requirement of integrated care among all staff in the facility and community. It does not describe the role of the psychiatrist in reaching a uniform consensus diagnosis with others on the youth's support team, nor how the psychiatrist's changing diagnostic interpretation

of symptoms will benefit the work of other team members with the youth. While it is true that adolescents' diagnoses can be expected to change, the Settlement Agreement requires that the psychiatrist treat symptoms of an identified diagnosis with medication appropriate for that diagnosis and that the other staff working with the youth agree about that diagnosis, which is reflected in the support plan. A Home Office next step is for the practice guidelines in the BBHS Facility Clinical Procedures to be re-framed by a New York Model-experienced psychiatrist for psychiatrists, with particular attention to diagnosis, helping staff make use of information about symptoms and medication, and the role of the psychiatrist in Mental Health Rounds and support teams.

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

ADHD 23% of youth prescribed medication (10)

Columbia	25% (2)
Finger Lakes	35% (7)
Taberg	7% (1)

MOOD 21% of youth prescribed medication (9)
(including Mood Disorder and Mood Dysregulation)

Columbia	
Finger Lakes	10% (2)
Taberg	47% (7)

INSOMNIA 16% of youth prescribed medication (7)

Columbia	25% (2)
Finger Lakes	
Taberg	33% (5)

DEPRESSION 9% of youth prescribed medication (4)
(including Depression, Major Depressive Disorder, and Dysthymic Disorder)

Columbia	39% (3)
Finger Lakes	5% (1)
Taberg	

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

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

In July, 2013, more youth were diagnosed with depression at Columbia (39%) and Mood Disorder at Taberg (47%) while 35% of youth at Finger Lakes and 25% of youth at Columbia were diagnosed with ADHD. There was a large reduction of diagnosing

depression (27% in January 2013 to 9% in July 2013), anxiety (23% in January 2013 to 9% in July 2013) and insomnia (32% in January 2013 to 16% in July 2013) across the three facilities. Diagnosis of ADHD was the same between January and July 2013 (23% of youth) and similar for Mood Disorders (27% in January 2013 and 21% in July 2013).

Although divergent diagnoses among the individual youth in the three facilities are expected, these discrepancies appear to be larger than likely would be accounted for by population variation. The former Chief Psychiatrist indicated that depression, mood problems and anxiety are within the same cluster of diagnoses and that what is necessary is diagnostic consensus among the facility clinicians where the resident is being treated. Nevertheless, the differences above reflect diversity in interpreting symptoms that is likely to play a significant role in achieving diagnostic agreement.

The New York Model is a strengths/needs-based trauma responsive approach that is not a traditional medical model, and symptoms of depression, anxiety, emotional dysregulation, and substance abuse associated with trauma are addressed without being driven by diagnosis. If traumatized adolescents typically have a mixture of anxiety and depression, diagnosis may be less informative than tracking of symptoms by the psychiatrist and other clinicians and noting the efficacy of medication and other interventions in reducing the symptoms presented by each resident.

The Columbia psychiatrist indicated that that the majority of delinquent youth have ADHD, combined with anxiety and depression. Consequently, frequently residents' symptoms are treated with a combination of a stimulant and an anti-depressant with anti-anxiety benefits. At Columbia, the teachers complete the Vanderbilt scale on all residents, and half have ADHD. The psychiatrist uses two other inventories as part of her assessment of anxiety and depression and also measures severe mood dysregulation with the Affective Reactivity Index.

The QAI Review commended Columbia for IIPs, mental health assessments and Integrated Assessments all completed in a timely way in the records reviewed. In the records reviewed by QAI, 92% of the psychiatric variables measured scored within standards, although it was recommended that the Psychiatric Diagnostic Evaluation have all items completed.

FUTURE MONITORING

The MH Monitor will continue to review documentation of Columbia's completion of thorough Integrated Assessments and clinical contact notes, and ongoing efforts to arrive at consistent diagnoses.

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

49a. Create or modify and implement policies, procedures and practices to require that any psychotropic medication is: prescribed only when it is tied to current, clinically justified diagnoses or clinical symptoms; tailored to each youth's symptoms; prescribed in therapeutic amounts, as dictated by the needs of the youth served; modified based

on clinical rationales; documented in the youth's record with the name of each medication; the rational for the prescription of each medication, and the target symptoms intended to be treated by each medication.

COMPLIANCE

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

In practice, the Psychiatric Contact Note links diagnosis with the medication prescribed, followed by a current symptom checklist. The requirement of 49a is to state "the target symptoms intended to be treated by each medication." The MH Monitor observed the Columbia psychiatrist explaining the rationale for prescribing particular medication to treat a resident's symptoms.

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

COMPLIANCE

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

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

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 Columbia records.

On Site Observations Regarding Paragraph 49a-c (8/13)

On August 20, 2013, seven of the Columbia girls were prescribed psychiatric medication:

Generalized Anxiety Disorder, ADHD, Conduct Disorder Clonidine

Conduct Disorder, Rule Out ADHD	Clonidine
Dysthymic Disorder	Remeron, Benadryl
Major Depressive Disorder	Trazodone
Generalized Anxiety Disorder	Remeron
Generalized Anxiety Disorder	Clonidine
Insomnia	Benadryl

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 Columbia records.

The MH Monitor observed documentation of diagnosis, symptoms, dosages, and administration of psychiatric medication in the individual records at Columbia. For example, in a recent Psychiatrist Contact Form, the resident's five-pound weight loss in two weeks was documented and led to discontinuing the stimulant. She had complained about dizziness and the nurse was instructed in the contact form to take her sitting and standing blood pressures.

In the review of the 43 youth prescribed psychiatric medications at the three DOJ facilities in July, 2013 described above, overall 49% of the residents of the three facilities were prescribed psychiatric medication (43 of 87) as compared to 43% (36 of 83) in January, 2013. The MH Monitor found divergent medication practices among the four psychiatrists and one NPP at Columbia, Finger Lakes, and Taberg. Finger Lakes continued to have a much lower percentage of prescription of psychiatric medications (36%) in comparison to Columbia (67%), and Taberg (75%). Even given the small numbers analyzed, there are noteworthy different rates of prescribing medications. The most commonly prescribed psychiatric medications by facility were: Columbia-Remeron (25%) and Adderall (25%); Finger Lakes-Seroquel (25%) and Clonidine (20%); and Taberg-Seroquel (33%) and Trazodone (27%). Comparing January and July 2013, the percentage of youth prescribed Seroquel (23%), Clonidine (16%) and Risperdal (14%) remained the same in the three facilities combined and the percentage of youth prescribed Trazodone decreased (from 27% in January 2013 to 16% in July 2013). At Columbia, the use of Trazodone dropped from 50% to 13%, while the use of Remeron increased from 18% to 25% and Adderall from 9% to 25%. At Finger Lakes, the use of Seroquel and Clonidine remained the same from January 2013 to July 2013. At Taberg, the use of Trazodone remained the same (27%) while the use of Seroquel increased from 8% to 33% and the use of Clonidine dropped from 25% to 20% and Risperdal 25% to 13% from January 2013 to July, 2013. There has been national attention to reducing the prescription of Seroquel in facilities because of the dangers of abuse after return to the community.

In the DOJ facilities in July, 2013, Seroquel was being prescribed to 25% of Finger Lakes and 33% of Taberg residents prescribed medication for Mood Disorder, PTSD, Mood Dysregulation, Anxiety Disorder, Adjustment Disorder and Conduct Disorder. Trazodone was being prescribed for Insomnia, Major Depressive Disorder, Depression and PTSD Clonidine was being prescribed for Anxiety Disorder, ADHD, PTSD, Depression, Insomnia, and Conduct Disorder Risperdal was being prescribed for ADHD, Mood Disorder, Disruptive Behavior Disorder, and Conduct Disorder

FUTURE MONITORING

The MH Monitor will continue to review documentation of Columbia's tracking diagnoses, symptoms and efficacy and side effects of psychiatric medications.

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

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

COMPLIANCE

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

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

COMPLIANCE

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

On Site Observations Regarding Paragraph 50a-b (8/13)

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

FUTURE MONITORING

The MH Monitor will continue to review documentation that Columbia staff are adequately trained about mental health and informed about residents' medications.

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

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

COMPLIANCE

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

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

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

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

COMPLIANCE

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

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

Nursing staff at Columbia described practices that comply with 51b.

51c. A medical refusal form shall be completed each time a youth is scheduled to receive medication and refuses. In addition to the date and time, youth's name and prescribed medication which the youth is refusing, the form shall include an area for either the youth or a staff person to record the youth's stated reason for refusing medication, an area for the youth's treating psychiatrist to certify that s/he has reviewed the medication refusal form, and signature line for the refusing youth.

COMPLIANCE

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

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

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

COMPLIANCE

The MH Monitor observed signed medication refusal forms in Columbia 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 Columbia residents' support teams that complies with 51e.

FUTURE MONITORING

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

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

COMPLIANCE

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

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

FUTURE MONITORING

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

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

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

COMPLIANCE

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

Support teams at Columbia exemplify New York Model implementation.

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

COMPLIANCE

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

53c. Require that the youth is present at each treatment team meeting, unless the youth is not physically located in the Facility during the meeting or the youth's presence is similarly impracticable, and that, if applicable, the youth's treating psychiatrist attend the treatment team meeting a minimum of every other meeting.

COMPLIANCE

Support team meetings at Columbia comply with 53c.

The Parties interpret 53c to mean (a) the psychiatrist has input at support team meetings through their contact notes and communication between the psychiatrist and clinicians during Mental Health Rounds and informally and (b) the psychiatrist will attend support team meetings when their participation is clinically indicated for a specific resident. The NPP participated in the observed support teams at Columbia, which complied with 53c, although it was a new practice and she did not have current psychiatric input to provide in the discussion.

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

COMPLIANCE

Columbia Integrated Assessments and clinical evaluations describe the effects of trauma on residents' thinking and behavior and are part of planning interventions and the residents' support plans. 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.

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

COMPLIANCE

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

"Goal Writing and Support Plans in the New York Model" (4/13) provides helpful and specific guidance for goal writing to maximize the motivation and engagement of youth

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

COMPLIANCE

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

On Site Observations Regarding Paragraph 53a-f (8/13)

In July 2013, OCFS revised the IIP form to make it clearer. It is a simpler form, focusing on what staff will do to calm the youth, as well as the prohibited and approved physical interventions for the youth. The BBHS Facility Clinical Procedures described the process of arriving at the IIP: "The clinician will work with the youth to determine what de-escalation techniques used by staff will be most helpful to the youth given the possibility of difficulty with emotion regulation." Columbia started using the form in JJIS in September 2013, and the MH Monitor reviewed an IIP on the new form for one of the residents interviewed at Columbia during the site visit. The MH Monitor observed a change of shift meeting during which modifications in girls' IIPs were discussed.

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

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

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

The MH Monitor observed two exemplary support team meetings at Columbia. The first observed support team would have made an excellent training video to demonstrate support team practice. [redacted] is a 19-year old who has been at [redacted] and then Columbia since [redacted] for assault. Her diagnosis is Generalized Anxiety, Conduct Disorder and Cannabis Abuse; she is not prescribed medication. Participants in her support team meeting included her therapist, the Assistant Director of Treatment, the substance abuse clinician, both YCs, the nurse, the PNP and the BBHS Director of Treatment; the CMSO participated by videoconference. The team discussed her continuing anxiety about the future and her difficulty accepting that when she is released in seven months she will not be living with her mother. She arrived at the team meeting and demonstrated good understanding of her goals. Each member of the team told her how they will help her achieve her goals. The CMSO plans to work with Parole on housing and a mentor, but [redacted] and other team members thought the CMSO was going to be prepared at this meeting to move forward with housing and education plans. [redacted] is worried about being homeless and showed her disappointment in the CMSO. As she said, "Planning for life is very hard." [redacted] wants to go to college and may now be motivated to get her GED and start community college at Columbia before her discharge. Her support plan (8/8/13) said she "will spend more time in therapy focusing on release planning because her attention has shifted to her future. She has been demonstrating appropriate skills when she is frustrated. She talks about how she got into trouble because she did not like things being taken away from her or being told "no" and she worried a lot about someone hurting her or her family. She is working hard to pass her Regents." Goal #1 was that she will plan for her living arrangements and her academic future, and each staff person's role in assisting her was clearly spelled out. Goal #2 was that she will use her DBT skills. Her family goal was to be able to communicate with her mother more because she gets upset when she cannot reach her mother by phone.

The second observed support team was a 14½-year old at Columbia for robbery, her first offense. Her Integrated Assessment was thorough. Her [redacted] died of [redacted] when she was an infant and her [redacted] died when she was small; she witnessed her [redacted]'s murder when she was [redacted]; her [redacted] was incarcerated; her [redacted] died when she was [redacted]; and her older [redacted] died in when she was [redacted]. Her tested IQ was 70, and she was reading at the 5th grade level and doing math at the 4th grade level. Her psychiatric evaluation noted symptoms of PTSD including helplessness, intense distress at exposure to cues, increased arousal, impaired sleep, irritability, and difficulty concentrating. Her original diagnosis was Reactive Attachment Disorder, Dysthymia, and Rule Out PTSD. Her current diagnosis was Generalized Anxiety Disorder, Dysthymic Disorder and Conduct Disorder, although the most recent psychiatric contact note indicated that she had a Major Depression with severe ruminations and was anxious about leaving, so the psychiatrist increased the dose of Lexipro. A comment on her DAS was "Emotional and anxious about discharging soon. She used her safety plan well." She was unhappy that her mother did not want her to return home, and that ACS was planning discharge to [redacted]. She required considerable 1:1 support because she was highly anxious and got easily frustrated, but her goals did not reflect the trauma connection with her behavior. Her Goal #1 was to accept directives without showing resistance (by using radical acceptance and mindfulness). Her Goal #2 was to use self-soothing techniques to help her manage her emotions (and deal with her placement extension). A thorough list of interventions was described. In the month before the site visit, she had individual therapy three times, individual counseling with her YC four times, saw the psychiatrist three times, attended two DBT groups and was discussed at Mental Health Rounds. Participants in her last support team meeting before discharge were her therapist, the Assistant Director of Treatment, the substance abuse clinician, both YCs, her YDA mentor, the nurse, the PNP and the BBHS Director of Treatment. Staff members were frustrated that it took so long to find out from ACS which RTC she was going to; she is anxious about not knowing how many residents she will be living with, if she will be sharing a room, and whether she can bring her crochet (a big soother for her); Columbia staff had tried but been unable to arrange a videoconference with the RTC. She told her team, "I learned how to use manners; patience—you can't get what you want right now; it's hard to open up--I used to avoid feelings; but I could not avoid staff; I learned not to hurt people who are helping me; I said 'No' to everything, but now I'm saying 'Yes;' I'm on top of my school work. Thank you for helping me." Each team member told her how proud they were of her, how much she has accomplished since she arrived four months ago, and their wishes for her when she leaves. Her YDA encouraged her to give staff at her new placement a chance and to look for someone like him, or others on her support team who she could trust. It was a tearful meeting, and she went around the table and hugged everyone.

The records reviewed by QAI met standards in core programming which was an improvement from the previous QAI review. QAI reviewers commended the amount of support one resident received: when the clinician was not working, she called in to the facility to check on the youth. The clinician meets with the youth weekly or more often at the residents' request. The resident denied trauma, but QAI noted strategies for developing coping skills to address her anxiety. Her support plan had realistic, measurable goals including goals transferable to the community. For another resident, QAI noted that her

clinician met with her at least weekly and contact notes gave a detailed description of how this youth's crises were managed, how family connections were being made and attempts to engage her [redacted] in her treatment. For another resident, the QAI reviewer noted that evidence of the team implementing a trauma-responsive approach was observed in Mental Health Rounds and support plan meetings. For other records, the QAI reviewer noted that the support team used the Integrated Assessment to account for the youth's trauma history, its impact and strategies for developing coping skills and that the diagnoses informed service plan goals. The QAI review commended Columbia for residents reporting they were encouraged to share their thoughts in support team meetings and having input into their goals.

FUTURE MONITORING

The MH Monitor will continue to review documentation of Columbia's support plans and support team meetings.

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

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

COMPLIANCE

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

Columbia is providing InnerVisions groups for residents.

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

COMPLIANCE

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

Columbia is providing Triad groups for residents.

The Columbia substance abuse clinician is providing individual therapy, including relapse prevention assistance, for residents with a substance abuse diagnosis.

On Site Observations Regarding Paragraph 54a-b (8/13)

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

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

skills learned in substance abuse treatment with those learned in therapy and DBT and Sanctuary groups. Strong communication at Columbia in support teams and Mental Health Rounds among the clinicians, YCs, and YDAs and the rest of the team result in supporting each resident's individual progress in self-calming and relying on these skills to avoid substance use in the community.

It was a complicated civil services process for Columbia to hire the substance abuse clinician permanently from her temporary position; while waiting, she worked as a YDA which she and her colleagues felt had been beneficial in several ways. At the time of the site visit, she had resumed her full-time substance abuse clinician position.

The MH Monitor observed a Triad group at Columbia. The substance abuse clinician began with yoga and a high-energy presentation of self-soothing. The substance abuse clinician is actively involved on the Columbia units and in support teams. If a resident has substance abuse problems, her need for treatment is documented in the Integrated Assessment and included in her support plan. The substance abuse clinician is the individual therapist for girls with substance abuse problems, although it is expected that all the clinicians will include substance abuse work into treatment to fit the resident. The substance abuse clinician does a Relapse Prevention Plan with all girls with a substance abuse diagnosis as they are getting ready to leave.

FUTURE MONITORING

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

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

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

COMPLIANCE

The Continuity of Care Plan complies with 55a.

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

COMPLIANCE

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

The revised Discharge Summary includes sections on Background Information, IIP, Progress Toward Goals (with goals), Medication, Diagnostic History, and Discharge Summary and complies with 55b.

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 (8/13)

Six girls were discharged from Columbia between 1/24/13 and 7/12/13. Three were 16, one was 17, one was 18, and one was almost 20 when they were released. One had been at Columbia for three months, two for four months, one for seven months, one for nearly a year and one for 20 months.

The MH Monitor reviewed the Discharge Summary (8/26/13) for [redacted], a 14 ½-year old discharged a few days after the site visit after four months at Columbia whose last support team the MH Monitor observed. Her diagnoses were Generalized Anxiety Disorder, Dysthymic Disorder, and Conduct Disorder and she was prescribed Lexapro and Remeron. The section "Reasons for Admission to Mental Health Service" provided a summary of her history. The "Course of Treatment" section was "[redacted] was able to share painful information with her clinician, express her emotions without over- reacting and manage frustration without demonstrating inappropriate behaviors. She acquired patience which she stated at her last support team meeting was very difficult for her to do until she came to Columbia. This writer established a close and trusting relationship with [redacted]. She said this was the first time she was able to do this in a facility. [redacted] engaged in the New York Model program and successfully advanced to the Learning phase." This thoughtful description would be helpful to future treatment providers. OCFS discharge summaries would be strengthened if they also included: the resident's goals (translated from facility goals to community goals), what triggers her and how to intervene early when she begins to feel anxiety, her primary skills and the importance of prompting her to use them, and educational status including ability levels and skills targeted in the IEP. The MH Monitor reviewed the one-page Mental Health Continuity of Care Plan for [redacted]'s transition to residential treatment in [redacted], NY. Her medications were listed, and she had an appointment for psychiatric services and mental health treatment in the residential facility; substance abuse treatment and family therapy were listed as not needed.

The MH Monitor reviewed the Discharge Summary for [redacted], a 19 ½-year old discharged in July, 2013 after seven months at Columbia. Her diagnoses were Adjustment Disorder with Depressed Mood and Cannabis Abuse. The "Reason for Admission to Mental Health Service" section provided history. The course of her treatment was summarized: "[redacted] was able to establish supportive relationships with staff and peers during her placement at Columbia. She advocated for herself when she was pursuing phase advancement. She applied for online employment with her clinician and did research for support services to help her return to the community. She was able to make connections to her past behaviors and how they impacted her current consequences. She was setting limits for her siblings over the phone with the hope she would be helpful to her family. She demonstrated loyalty and concern for her mother by calling daily and speaking to her grandmother who was taking care of [redacted]'s mother." The Discharge Summary section was

"[redacted] will complete her GED exam at a community vocational tech school in (hometown). She has completed employment applications online. She was referred to a job readiness program to find employment and to learn interviewing skills." These summaries would be helpful to future treatment providers. OCFS discharge summaries would be strengthened if they defined how a resident's support plan and gains in the facility will continue in the community and included specific guidance for a resident's family, school and other providers about how they can support her distress tolerance, self-calming and interpersonal effectiveness skills and listed the telephone number and address of each person/service on the youth's community support team. The MH Monitor reviewed the one-page Mental Health Continuity of Care Plan for [redacted]'s release out-of-state to her mother. Surprisingly, the Continuity of Care plan included no referrals for services, despite the benefits of therapy with [redacted] at Columbia. It indicated, "No psychiatric services are needed. She needs educational and employment services at this time. Her mother is in poor health and is not interested in family therapy. The facility psychiatrist does not suggest psychiatric services. [redacted] did not score high enough to warrant substance abuse services."

The QAI review commended Rochester and Buffalo CMSOs for working with the JO/YO population transitioning out of Columbia even though they are not designated juvenile offenders.

FUTURE MONITORING

The MH Monitor will continue to review documentation that Columbia Discharge Summaries and Continuity of Care plans support the continuation of the resident's progress in the facility in the community.

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.

COMPLIANCE

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

57. Quality Assurance Programs. The State shall create or modify and implement quality assurance programs consistent with generally accepted professional standards for

[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.

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: Columbia Girls Secure Center* (Draft) also referred to as the QAI Review of Columbia before the monitoring visit and then had an opportunity to discuss its contents and findings before the Columbia 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 on August 20, 2013 to discuss the Columbia report. Attendees included David L. Bach, Director QAI; Sandra Carrk, Project Manager; Lori Clark, Quality Assurance Specialist; Diane Deacon, Asst. Deputy Counsel OCFS; Myra DeLuke, Quality Assurance Specialist; Edgardo L. Lopez, Settlement/Agreement Coordinator; Robert MacGiffert, Assistant Director QAI; Jennifer Mack, Assistant Facility Director LRC/QA; Anne Pascale, Chief of Treatment Services; Denise Passarello, Quality Assurance Specialist; Michael Rotolo, Quality Assurance Analyst; Hilda Saltos, Quality Assurance Analyst; Jennifer Utting, Quality Assurance Specialist. The high-quality QAI reports are becoming an important resource for ongoing OCFS assessment of Settlement Agreement issues.

QAI has proposed a quality assurance strategy that could lead to an expedited finding of compliance for the Protection from Harm paragraphs when fully developed and implemented. In its efforts to assist the facility in the appropriate use of physical restraint interventions, Home Office developed performance metrics through the efforts of many DJJOY staff members, especially the significant assistance of Dr. Rebecca Colman, Director of OCFS' Bureau of Strategic Planning and Policy Development. QAI reviewed with the Monitors the development of these restraint metrics and how they will be linked to graduated response protocols and action plans. More importantly, this QAI initiative recognizes the paradigm shift that occurred in juvenile corrections nearly two decades ago and is consistent with generally accepted professional standards. These critical performance metric restraints safeguards require more time for implementation and verification, but they have the potential to change the monitoring strategies in such a way that expedites agreement among the Parties about compliance.

The Monitors' endorsement of the new protocols is that they satisfy the need for a reasonable, logical, and coherent policy, but there is not yet information about the performance of the new protocols. Once evidence exists that the protocols work, compliance with this paragraph will exist.

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

COMMENT: No recommendations exist as a result of the Columbia monitoring 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 Columbia monitoring visit.

V. SUMMARY

The Monitors find the Protection from Harm Paragraphs 40-44 in substantial compliance with the Settlement Agreement at Columbia. Pursuant to Paragraph 77, Subsection d regarding "compliance with a portion of the agreement with respect to one or more facilities," the Monitors support an action or petition by Home Office to DOJ for the end of the Protection from Harm monitoring at Columbia.

Staff members describe Columbia as more proactive than reactive. The New York Model encourages staff in being supportive, hands-on, teaching oriented, and positive and to anticipate escalation and assist residents in calming themselves. Coaching is a great opportunity for YDA staff.

Staff noted that incentives are intact and delivered with greater consistency, thus increasing the effectiveness of the Daily Achievement System (DAS).

Staff noted the frequent occurrence of visitors at Columbia. While it is the source of pride that Columbia is seen as a leader in secure facility programs for girls, the frequency of visitations, tours, and Home Office assessments requires careful scrutiny to prevent them from becoming disruptive to the normal routine for youth and staff.

Change has occurred quickly and dramatically as a result of the Settlement Agreement. Columbia represents the best implementation of the New York Model and, for that reason, has the greatest number of sustained compliances. Several recommendations for continued strengthening of the New York Model integration with the YDA staff at Columbia include:

1. Continue to expand YDA staff involvement as providers of primary interventions to support residents in achieving their goals. This includes more, and more consistent, communication with YDA staff on all shifts and strengthening the YDAs' role in the TIC, support teams, and Mental Health Rounds. It might be helpful if Mental Health Rounds sometimes occurred in the afternoons to include the second shift.

2. Consider including a treatment staff member in the administrative review of Restraint Packets required by Paragraph 42 so that the determination of Documented Instruction and coaching can be enhanced through input from the New York Model perspective about alternative ways to resolve the still too frequent conflict between therapeutic problem solving versus rule following during conflict situations.

A. Addendum: Closure of Lansing Residential Center for Girls (LRC)

The Office of Children and Family Services (OCFS) closed the Lansing Residential Center for Girls (LRC) in August 2013, with all residents released as of July 15, 2013. On August 20, 2013, the Monitors submitted a memorandum to OCFS and the Department of Justice (DOJ) entitled "Girls Discharged in the Closure of Lansing Residential Center." The memorandum summarizes the findings of the MH Monitor's review of the discharge

process for the nine girls who were at Lansing when the closure decision was announced on May 28, 2013. The memorandum described the short length of stay for seven (7) of the residents, a lack of placement options for two (2) residents and insufficient preparation for re-entry success for five (5) residents because of the precipitous closing of Lansing. The memorandum also raised concerns regarding discharge planning that are applicable to other DOJ facilities. None of the girls discharged from Lansing in June or July 2013 were admitted to Columbia prior to this site visit.