

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

**Facility Monitoring Report:
Columbia Girls Secure Center
Claverack, NY**

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and

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May 30, 2013

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

I. INTRODUCTION

This is the tenth 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 for Girls (Columbia) on February 5-7, 2013. As noted in the first monitoring report, the Monitoring Team consists of two Monitors, Dr. Marty Beyer, who is responsible for the Mental Health paragraphs of the Settlement Agreement, (hereafter referred to as the MH Monitor) and Dr. David Roush, who is responsible for the Protection from Harm paragraphs (hereafter referred to as the PH Monitor).

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

A. Tryon Girls

On June 8, 2011, Governor Andrew Cuomo announced the closure of Tryon Girls Center and the reduction in the capacity of Finger Lakes Residential Center from 135 beds to 109 beds. The Monitoring Team maintained an ongoing dialogue with Home Office regarding the status of the girls displaced by the closing of Tryon Girls. Dr. Beyer monitored the transfer activities including treatment plans, staffing plans, and the status of operations at the destination facilities, Taberg Residential Center for Girls (Taberg) and Columbia Girls Secure Center (Columbia). The Office of Children and Family Services (OCFS) provided brief transition plans for 12 girls moved on August 31, 2011 from Tryon Girls Limited Secure to Taberg that summarized each girl's presenting problems and treatment while at Tryon.

On September 2, 2011, the Monitors requested an opinion from Home Office regarding questions about how the Tryon Girls closure applied to the Definition Section of the Settlement Agreement. Specifically, Paragraph 36 states that "Tryon Girls shall mean the Tryon Girls Center, located at 881 County Highway 107, in Johnstown, New York, or any other facility that is used to replace or supplement Tryon Girls." Discussions between OCFS legal counsel and DOJ attorneys resulted in an agreement to designate Taberg and Columbia as facilities that qualify for monitoring under the Settlement Agreement. The Home Office has continued to prepare six-month progress reports that include Taberg and Columbia. The first monitoring visit to Columbia occurred on November 29 through

December 1, 2011, the second Columbia visit was on June 26-28, 2012, and this report reflects the outcomes from the third Columbia visit on February 5-7, 2013.

B. 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 February 6, 2013, there were 12 girls at Columbia: 10 juvenile offenders/youth offenders and 2 juvenile delinquents. Since the monitoring visit six months previously, six girls remained; five girls were released (including one who had been in custody for three years) and another was about to be released. At the time of the site visit, several residents who had been fennered after serious incidents at Taberg and Lansing remained at Columbia.

The 12 girls ranged in age from 15½ to 19½; 8 were over 16. They had been at Columbia (or Tryon) from 1 day to 777 days (4 had been at Columbia less than 2 months; 5 had been there almost a year to almost 2 years). The 12 girls were committed for: Murder (1), Attempted Murder (1), Assault (3), Robbery (3), Burglary (2), Petit Larceny (1), and Parole Violation (1).

All but two of the girls have psychiatric diagnoses: Anxiety (4), Major Depression (2), Depressive Disorder (2), Dysthymic Disorder (2), ADHD (2), Adjustment Disorder (1), Expressive-Receptive Disorder (1), PTSD (by history; 1); Bipolar (by history; 1). Eleven of the girls are also diagnosed with Conduct Disorder; the twelfth girl had just arrived. Five of the girls are prescribed psychiatric medication: Remeron (2), Seroquel (1), Trazodone (1), Lexapro (1), Ritalin (1) and Benadryl (2).

C. 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 Secure Center for Girls (Draft), the report from the Quality Assurance and Improvement (QAI) Bureau, in advance of the monitoring visit.

2. Use of Data

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

A data integrity check revealed no discrepancies between the numbers of restraints in the CSU Restraint Log versus of the number of Post-Restraint Examinations conducted by the health clinic. These comparisons confirm the findings of the QAI Report, but they covered a somewhat different period of time.

3. Entrance Interview

The entrance interview occurred on February 5, 2013 and included the Monitoring Team and OCFS representatives, including key staff members from the facility. The meeting provided an opportunity for introductions, informal discussion of institutional goals and objectives, an overview of the assessment process, a review and discussion of assessment instruments, and the scheduling of the remaining assessment activities. Those in attendance included: David L. Bach, Quality Assurance Director; Sandra Carrk, Project Manager; Diane Deacon, Assistant Deputy Counsel; Dr. Patricia Fernandez, Assistant Director for Treatment; Edgardo Lopez, Settlement Coordinator; Anne Pascale, Chief of Treatment Services; Anita Sapio, Facility Director; R.J. Strauser, Acting Assistant Facility Director and YC2; and Monique Thomas, Assistant Counsel.

4. Facility Tour

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

5. On-Site Review

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

6. Staff Interviews

The Monitors interviewed 18 Columbia staff. In addition to group meetings with staff, the MH Monitor interviewed a Youth Counselor (YC), two clinicians, two nurses, and the psychiatrist. PH Monitor conducted interviews with 6 Youth Division Aides (YDA), one Youth Counselor, one Administrator on Duty (AOD), one Facility Director, two nurses, and one Acting Assistant Facility Director (AAFD). Perceptions of safety were very high both on the part of staff regarding their own safety and their perceptions of youth safety.

7. Resident Interviews

The MH Monitor interviewed three (3) girls, and the PH Monitor interviewed seven (7) girls with an average age of 17.4 years old. Six (6) youth participated in a standard interview and responded to the same questions. Interviews occurred in areas with reasonable privacy from staff. The Monitors selected the youth for interviews.

8. Exit Interview

The exit meeting occurred via conference call at 12:30 PM on February 8, 2013. The exit meeting was originally scheduled for February 8, but Winter Storm Nemo changed everyone's plans. Home Office staff and the Monitors travelled Thursday evening, which was ahead of the storm. As a result, a conference call was used as a substitute for the exit interview. During the call, 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 call was a time for questions, clarifications, and explanations of events and impressions before the draft report went to both Parties. Those participating by phone included: David Bach, QAI Director; Jim Barron, Director Labor Relations; Merle Brandwene, Director Program and Management Support; Matt Carpenter, Executive Assistant to Division of Juvenile Justice and Opportunities for Youth (DJJOY) Deputy Commissioner; Gladys Carrion, Commissioner; Sandra Carrk, Project Manager; Erin Cassidy, Executive Assistant to Executive Deputy Commissioner; Dr. Michael Cohen, Medical Director; Diane Deacon, OCFS Counsel; Myra DeLuke, QAI Specialist; Dr. Pat Fernandez, Assistant Director for Treatment; Felipe Franco, DJJOY Deputy Commissioner; Dr. Joan Gerring, Psychiatrist; Larry Gravett, Director SIU; Renato Guanga, Bureau of Training; Alan Kafowitz, Bureau of Training; Alyssa Lareau DOJ Attorney; Edgardo Lopez, Settlement Agreement Coordinator; Beth McCarthy, Bureau of Training; David Nasner, Bureau of Behavioral Health Services (BBHS) Special Projects Coordinator; Ines Nieves, DJJOY Associate Commissioner; Anne Pascale, Chief of Treatment Services; Sheila Poole, Executive Deputy Commissioner; Lee Prochera, OCFS Deputy Counsel; Anita Sapio, Facility Director; Beverly Sowersby, Facilities Manager; R.J. Strauser, Acting Assistant Facility Director; Jill Swingruber, Deputy Counsel; Monique Thomas, Assistant Counsel; and Dr. Joe Tomassone, Chief of Treatment Services.

D. Preface to Protection from Harm and Mental Health Findings

The New York Model has been fully implemented at Columbia. The DAS and phase system are in place, each resident has a mentor, and each phase requires a certain number of mentoring contacts. Staff are actively involved in support teams and Mental Health Rounds. Programs include individuals from the community providing a variety of activities at Columbia including music therapy, pet therapy, arts and crafts, and the Sister-to-Sister faith-based program on Sundays. In the future Columbia hopes to add fitness instruction, cosmetology, and a parenting class. Monthly incentive trips, such as visits to historic places in the community, are occurring. Even with these improvements, staff report that it continues to be a challenge to keep girls motivated when they remain at Columbia for years.

Five new YDAs were hired since the previous site visit.

Only 17 restraints had occurred in six months, most of them in November when two new fennered youth arrived.

Before this site visit, the QAI Bureau completed a thoughtful review at Columbia, which the Monitors discussed with them. The QAI team observed staff employing the New York Model and their report commended Columbia for fostering an environment conducive to successful programming, consistent decline in restraints to almost none, a YC's thorough contact notes, and the Assistant Director for Treatment's leadership and relationships with youth.

II. PROTECTION FROM HARM MONITORING

Columbia continues to be the DOJ facility that best exemplifies the OCFS reforms in response to the Settlement Agreement. The use of the New York Model and CPM appear to be effective, and the continuous quality improvement mechanisms in place at Columbia provide assurances that these program elements will continue to get better. Additionally, the QAI process, including the report, serves as a valuable external or third party perspective on programs and services.

The data provided by Home Office suggested a substantial reduction in restraints at Columbia following the January through March 2012 anomaly addressed in the last Monitoring Report. The recovery began around the time of the June 2012 monitoring visit, and the data suggest a return of youth safety to a level similar to that experienced during the November 2011 monitoring visit. While there are many factors that contributed to the difficulties experienced during the first several months of 2012, the return to a safe, structured, and orderly environment confirms the statements of staff that they are committed to make the New York Model successful and that they are capable of working with the most difficult youth in the system.

The YDA and the YC staff appeared to do their jobs effectively. There were also many staff members identified by youth as being competent and effective. Youth and staff relations seemed positive. All youth could name multiple staff members to whom they could go in times of distress. Again, when asked what these staff members do differently, listening and approachability were two critically important characteristics.

Safety continues to be a strong characteristic of the Columbia facility. Youth and staff both have positive perceptions of safety; the number of restraints has remained consistently low since the last monitoring visit, and the use of de-escalation seems to be a common element of how staff respond to the emotional difficulties of youth.

There were fewer complaints by youth regarding problem staff during this visit, but the relationships between youth and staff are not without room for growth according to most youth. Each girl asked for greater input into the rules for daily life on the units. While they acknowledged existing avenues for input, their request was for more opportunities for input. Many youth also expressed concerns about consistency, stating that they believed the facility could improve through greater staff consistency.

Veteran staff remain somewhat more resistant to the new program than some of the newer staff. Remnants of the traditional system where staff believed they should be more confrontational still exist, but the shift towards a more supportive approach was evident.

YDA staff talked of greater teamwork and cooperation. One staff member described the situation at Columbia as increasingly therapeutic with fewer power struggles between youth and staff.

The youth identified problems with their ability to get phone calls in accordance with policy and procedure and the extra phone calls earned through the incentive system. These logistical problems have the potential of creating conflicts that could lead to restraints. Staff also identified phone calls as a source of problems for the youth and stated that the issue could be resolved quickly by some minor changes in the schedule. Facility administration issued a revised set of guidelines for phone calls on February 14, 2013.

A. Use of Restraints

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

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

- i. Where emergency physical intervention is necessary to protect the safety of any person;*
- ii. Where a youth is physically attempting to escape the boundary of a Facility;
or*
- iii. Where a youth's behavior poses a substantial threat to the safety and order of the Facility.*

COMPLIANCE

COMMENT: Multiple aspects of restraints are included here. They are undue restraints, policy and procedure outlining the circumstances when restraints are appropriate, and a prohibition against the use of restraints as punishment, to name a few. The 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 had a working knowledge of the new policy and the physical restraint approach. Staff again provided accurate answers to the questions about these policies and procedures. The responses were consistent with the intent of the Settlement Agreement.

Several outcomes supported compliance: (a) the Restraint Packet reviews (including video reviews) and the reports from youth and staff confirmed the absence of unnecessary restraints or restraints that do not comply with exceptional circumstances; (b) the same information sources provided no evidence of the use of unauthorized restraint techniques; (c) the same information sources along with interview data from knowledgeable YDA staff and supervisors indicated that avoidable restraints were minimal,

if at all; and (d) the numbers of restraints and injuries (ARTS Master Ad Hoc with Staff Names List from June 1, 2012 through January 15, 2013) permitted a larger sampling of Restraint Packets, which strengthened the confidence or accuracy of this finding.

One girl proposed an alternative perspective, claiming that the reason for the reductions in physical restraints was that the girls had decided that they would no longer surrender their power to staff by allowing staff to escalate youth's behaviors to the point of a restraint. This might be construed as the use of "radical acceptance."

Further, the State shall:

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

COMPLIANCE

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

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

COMPLIANCE

COMMENT: The policy and procedures exist; the training on the policies and procedures has occurred; and staff and resident interviews were consistent with the policy and procedures. Interviews with direct care and health care staff revealed a working knowledge of conditions, circumstances, and plans that limit the restraints to youth due to heightened risk of physical or psychological harm. In most instances, staff recited information in the residents' IIPs and seemed quite cognizant of the nature and extent of the limitations. The reviews of Restraint Packets contained no indications of a violation of this paragraph.

41. c. *If face-down restraints continue to be used, create or modify and implement policies, procedures, and practices to require that staff utilize them only in emergencies when less restrictive measures would pose a significant risk to the safety of the youth, other youth, or staff. In addition:*
- i. *Face-down restraints shall be employed for only as long as it takes to diffuse the emergency, but in no event shall a youth be restrained in a facedown position for more than three (3) minutes.*

- ii. *Trained staff shall monitor youth for signs of physical distress and the youth's ability to speak while restrained.*
- iii. *Medical personnel shall be immediately notified of the initiation of a facedown restraint position, and the youth shall be immediately assessed by medical personnel thereafter. In no event shall more than 4 hours lapse between the end of a facedown restraint incident and the assessment of the involved youth by medical staff.*

COMPLIANCE

COMMENT: The policy and procedures exist; the training on the policies and procedures has occurred; and staff and resident reports are consistent with the policy and procedures. Policy 3247.12 describes a "transitional hold" that moves a youth from a supine restraint to a prone position for the purposes of applying handcuffs. In response to the question about when a face-down (prone) restraint is permissible, new Columbia staff responded that a prone restraint is not allowed and that the "transition hold" is not really a prone technique because they only move a youth to her side if the application of handcuffs is necessary.

Previously, the Bureau of Training demonstrated and reviewed for the PH Monitor the new, proposed handcuffing strategy, which would eliminate the need to use the "transitional hold" that exposes a youth to a facedown or prone position during the administration of the handcuffs. The procedure was a slight modification of the two-person seated restraint as the point of departure for the new procedure. Staff at Columbia were not aware of the new technique, which meant that it had not been approved and implemented at the time of the monitoring visit. The new approach represented a creative alternative to the transitional hold.

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

COMPLIANCE

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

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

COMPLIANCE

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

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

COMPLIANCE

COMMENT: Training continues to be a strength. Mr. Renato Guanga provided another thorough presentation of training records from STARS and assembled the materials in a training notebook that had both individual staff training files and the attendance data for each designated training session.

The training materials revealed that all but three staff were up-to-date on is the CPM, the CPM refresher, first aid, and CPR. The three who were not up-to-date had been on extended sick leave/workers comp and were scheduled for the next available training session. Five (5) new staff members had not received the training on the New York Model, but they were scheduled for the next available training session and given priority for those groups with limited enrollment. 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: The policy and procedures exist; the training on the policies and procedures has occurred; and staff and resident reports are consistent with the policy and procedures. No evidence existed of the use of prohibited physical restraint holds, especially "hooking and tripping" and chokeholds.

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

COMPLIANCE

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

Also, even though the rate of injury-to-youth has decreased since the problems of January through March 2012, the injury-to-youth rates offer support for the widespread contention that CPM is a far safer physical restraint strategy. While there may be increasing evidence to support the claim of CPM as safer than the previous system, there is also evidence to support increased safety for staff as indicated by OCFS data.

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

COMPLIANCE

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

Regarding Restraint Packet 415798, Ms. Dickerson should be commended for the quality of her Activity Report. It is typed, which makes it legible. Next, it is precise in its descriptions of what happened. Ms. Dickerson describes who, what, when, where, and how but she does not attempt to answer why questions, leaving these types of inferences to the treatment staff. The specificity of her behavioral descriptions is very good. For example, in describing the youth's behaviors before the assault, Ms. Dickerson writes, "(her) fists were balled up, her body was tense, and her body language was aggressive."

Recommendation: From the perspective of the Facility Administrator's Review, it would be better for YDA staff to refrain from describing their verbal interactions with youth as "counseling." It is okay for YDA staff to describe their interactions with youth in terms consistent with the New York Model or to simply refer to the interactions as "talking to" a youth. Part of the problem stems from use of force practices in other jurisdictions where staff use the phrase "I counseled the youth" as a euphemism for giving the youth a directive to stop any inappropriate behaviors and to warn or threaten the youth that force will follow immediately if the misbehaviors do not stop. Language is an important part of the New York Model and emotional regulation whether the language is external or internal. The same applies to documentation.

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

COMPLIANCE

COMMENT: The policy and procedures exist; the training on the policies and procedures has occurred; and staff members report a practice that is consistent with the policy and procedures. 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.

The Therapeutic Intervention Committee (TIC) seems to be the system of review by senior management outlined in this paragraph according to Home Office. The TIC has mandatory attendees that include the Facility Director or designee, Clinical, Assistant Director, AOD, YDA, YC, Medical, Kitchen, Maintenance, Recreation, Spiritual (if on staff),

Education, and youth (for last agenda items only). Additionally, the documentation provided by Home Office included minutes from seven (7) TIC meetings.

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

COMPLIANCE

COMMENT: The policy and procedures exist, and there is a practice in place. Throughout the monitoring process, this paragraph has become more important because of the “review” and “evaluate” functions contained in this weekly practice. The Facility Administrator review becomes a critical part of the feedback needed to continue the evolution and improvement of CPM and the New York model. With the advent of Quality Assurance, it provides another perspective on the types of staff behaviors that are exemplary or in need of improvement. Similarly, reviews of the physical restraints provide an additional opportunity to raise issues related to the prevention of unnecessary restraints. While an unnecessary restraint may more appropriately fall under Paragraph 42b regarding the least amount of control needed to resolve the situation, the current paragraph has evolved to the point where some of these auxiliary issues are more relevant here. Therefore, much of the narrative for this paragraph identifies issues that affect the nature and extent of physical restraints.

Because of concerns expressed in previous reports about the Facility Administrator’s review of Restraint Packets and videos, Home Office clarified the policy on “Documented Instruction.” Staff informally viewed documented instruction as a disciplinary or formal corrective action, so there seemed to be a hesitancy to use it in a way consistent with the PH Monitor’s interpretation of the Settlement Agreement paragraph. Paragraph 42e is the Facility Administrator’s opportunity to review this new and important procedure (CPM) and to provide a learning tool as a safeguard for youth and staff. That is, it requires Facility Administration to identify the types of behaviors that fit the policy, procedure, and training and also mandates Facility Administration to make learning opportunities for those staff members who have difficulty implementing the new techniques effectively. From the Monitors’ perspective, the purpose of documented instruction in this paragraph is to create multiple and ongoing opportunities for staff to learn and practice effective implementation of CPM techniques, especially de-escalation.

Five (5) Restraint Packets were selected for review for this monitoring visit. The selection process focused on those where the ARTS Master List suggested some level of problem, such as a protracted restraint, an injury, or a referral to SCR. In that sense, the sample provided information about how Columbia staff addressed some of the most difficult situations.

The Facility Administrator’s Reviews conducted by Matt Carpenter for previous monitoring visits were generally quite thorough and accurate. Additionally, his approach was transparent and led to productive discussions about restraint problems and their solutions. Currently, AAFD Strauser has the responsibility for the reviews, and his

evaluations and assessments appear to be equally as competent. AAFD Strauser also brings to the assessment process strong practical and training experiences with the use of CPM.

The finding of compliance for this paragraph derives from the thoroughness and responsiveness of the Facility Administrator's Reviews as determined by the PH Monitor. Additionally, QAI notes the same level of rigorous review of Restraint Packets and videos. This does not mean that this paragraph is without areas for growth and improvement. Instead, there appears to be a good system in place to identify and address issues surrounding the proper implementation of CPM.

Restraint Packet 394398

This is a situation where the youth was charged with an assault on a staff member by hitting the staff member with a [REDACTED] racket. The event also resulted in allegations by the youth that a staff member punched her. SCR accepted the case; the investigation findings are pending.

The documentation indicated an escalation of the youth's behavior. The recommendations in the IIP did not prove effective or maybe they were not implemented effectively. Either way, the assaultive behavior appeared to happen after the decision by the YDA and the AOD to cancel recreation. In one of the Activity Reports, another YDA wrote that the youth followed the announcement of the cancellation by saying, "If integration is over I'm getting mine." The youth's statement says, "If I have to go back to the unit, I am going to pop off." The youth's statement seemed to have been interpreted by the aforementioned YDA as a threat by the youth that the termination of the recreation would result in her getting recreation or a workout by aggressive behavior toward anyone in the vicinity, including or perhaps specifically staff. In light of the history behind the Department of Justice involvement, the documentation of a youth indicating that a staff assault will be a substitute for recreation warrants special attention. In particular, it would have been helpful to know (a) what the AOD and YDA were thinking regarding the consequences of cancelling recreation, (b) how they explained the decision to residents, (c) what staff considered to reduce the chances that cancelling recreation would provoke this reaction, and (d) whether this resident's unique characteristics were factored in when anticipating her likely reaction and reducing the chances of it.

The video also raised concerns about the nature and extent of order and structure at Columbia (see Paragraph 44g). Despite the quality of the video (which may have been a function of the PH Monitor's viewing software), it appeared that the youth has a badminton racket in her right hand but she was not playing badminton; she walked around gym in what appeared to be an agitated fashion and seemed to point the racket in a menacing fashion at staff while talking at them; and she was observed hitting it against the wall in an inappropriate fashion. It is difficult to know if staff responded verbally; however, the youth's behaviors appeared to escalate.

When staff interventions occurred, the youth's behavior continued to escalate; and she maintained possession of the [REDACTED] racket throughout the process. AAFD Strauser noted correctly that the youth had a [REDACTED] racket and was also on gym restriction. He wrote, "follow-up with staff." Home Office provided the follow-up memo

since documentation of this type is not part of the Restraint Packet. This issue applies directly to the staff supervision concerns outlined in Paragraph 44g.

On several occasions, the AOD appeared to lean forward to get his face closer to the face of the youth. This approach does not appear to be part of the approved CPM technique, and no mention of this unapproved technique appeared in the Video Review Form.

Finally, the staff member involved in administering the standing restraint appeared to implement the technique appropriately and effectively. There did not seem to be any use of excessive force.

Restraint Packet 388598

The video agrees with the documentation in the VRF by AAFD Strauser. The AOD's behavior was a cause for concern on the one hand. Granted, the classroom is small and the amount of space restricted, but it does appear that the AOD blocked the youth's egress from the room. The Restraint Monitor Report indicated that time away was attempted in adherence to the IIP. The video did not support this statement. In this regard, Documented Instruction seemed appropriate.

To the AOD's credit, each time he was seen interacting with the youth, his arms were extended from the sides of his body with his palms facing the youth. In the absence of audio, it was difficult to tell whether his verbal interactions with the youth contributed to her escalation, but his behavior did not initially show any signs of aggression or anger.

Regarding the Crisis Prevention and Management (CPM) Request for Documented Instruction, AAFD Strauser asked for a review of the interactions that may have escalated the overall situation. Specifically, overall de-escalation techniques associated with the crisis were listed as the focal point of the Documented Instruction. There was confusion and disagreement about the de-escalation instruction. Instructor McNary wrote, "Specifically, if he was the target of the youth's anger, he should have allowed youth some space to move out of the classroom. The use of proximity may not have been helpful in the de-escalating the youth." How does allowing the youth more space and movement correspond with the use of proximity? Proximity for some residents can be provocative, and they feel less safe. Getting too close and blocking the youth's way out may trigger the youth from past victimization. The AOD behavior mentioned above (p. 13) regarding Restraint Packet 394398 applies here also.

Parenthetically, this was the same behavior from the same individual that proved to be an excellent de-escalation strategy with a different large and violent girl in a crisis situation witnessed by the PH Monitor during the previous monitoring visit in June 2012. In comparison, the difference in the two situations is the physical space. In this instance, the amount of room for movement by both the staff member and the youth was greatly constricted, whereas the June incident occurred in the dayroom where both youth and staff had a greater range of motion and, perhaps, the youth did not feel "trapped." The review of this Restraint Packet tended to confirm the earlier Home Office conclusion that the technique of "proximity" seems to be viewed more as an invasion of personal space by youth; therefore, it appears more likely to escalate than de-escalate behaviors. Concerning Documented Instruction, the recommendation would be that administration, trainers, and

coaches use this situation, where a behavior that was exemplary in one circumstance became questionable in another, as a point of departure for discussions about the continuous improvement of CPM techniques.

Restraint Packet 415798

The Youth Physical Restraint Staff Debriefing Report form for Youth B.X. indicated that the interventions were ineffective. There is nothing in the documentation to indicate some kind of follow-up regarding how to make the interventions more effective.

The video appeared to be consistent with the documentation. AAFD Strauser noted that the staff member and the youth fell to the floor in a seated position. This resulted in the use of a technique that was not part of training, even though it appeared to be an appropriate adaptation of the technique given the physical plant restrictions. AAFD Strauser noted the need for a follow-up with training. There was no documentation in the Restraint Packet of what occurred as a result of this referral to training. Home Office provided information that the trainer also viewed the video with AAFD Strauser and determined that follow-up training was not needed because staff did the best they could given the circumstances.

Echoing the sentiments in the lead paragraph, the review process provides a “check and balance” on CPM, allowing each facility to analyze the implementation of the restraint process based on actual events and to implement and create educational responses that enable staff to enhance their skills and abilities. One likely outcome is an adjustment to the CPM strategies as more information becomes available about how staff implement it. Applying the concept of a chain analysis (the assumption that complex behaviors chain or have a sequential characteristic), the recommendation is that these administrative review processes continuously expand the analysis of de-escalation or the ability of staff to disrupt the chain before it gets to a physical intervention. When a pre-restraint problem results from staff escalation and a restraint follows, the restraint is an inappropriate use of force. If an inappropriate escalation of the youth’s behavior by staff results in a technically perfect restraint, it should be categorized as an unnecessary restraint or an excessive use of force and referred, at a minimum, for Documented Instruction.

42. f. Train direct care staff in conflict resolution and approved uses of force that minimize the risk of injury to youth. The State shall only use instructors who have successfully completed training designed for use of force instructors. All training shall include each staff member’s demonstration of the approved techniques and require that each staff member meet the minimum standards for competency established by the method. Direct care staff skills in employing the method shall be periodically re-evaluated. Staff who demonstrate deficiencies in technique or method shall be re-trained at least every six months until they meet minimum standards for competency established by the method. Supervisor staff who are routinely involved in responding to incidents and altercations shall be trained to evaluate their subordinates’ uses of force and must provide evaluation of the staff’s proper use of these methods in their reports addressing use of force incidents.

COMPLIANCE

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

C. Emergency Response

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

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

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

NOT APPLICABLE

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

COMPLIANCE

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

QAI looked at different variables as new ways to demonstrate staff effectiveness in the use of CPM and, ultimately, the reduction in the number of physical restraints. One strategy was to compare the monthly number of Code Yellows with the number of Code Whites. The rationale was that a Code Yellow identified a problem where a restraint was possible if de-escalation did not work. If the de-escalation were effective, there would be no need for a Code White, so the number of Code Whites should be fewer than the number of Code Yellows. Even though the method is fraught with numerous problems, four (4) of the six (6) months that QAI looked at these numbers the frequency of Code Whites was less than Code Yellows.

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

COMPLIANCE

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

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

COMPLIANCE

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

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

COMPLIANCE

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

D. Reporting and Investigation of Incidents

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

- i. Inappropriate use of restraints;*
- ii. Use of excessive force on youth; or*
- iii. Failure of supervision or neglect resulting in:*
 - (1) youth injury; or*
 - (2) suicide attempts or self-injurious behaviors.*

COMMENT: The walkthrough of the physical plant looks for potential risks of harm to youth regarding injuries, suicide behaviors, and self-injurious behavior (44.iii.2), knowing that an agency cannot eliminate all physical plant related risks of harm. During the November 2011 visit, potential risks were noted during the physical plant tour with administration, but did not make their way into the report since there was reason to believe that administration would mitigate the potential risks for harm. The November concerns were about suicide risks in the bathrooms and the tension between privacy versus safety when girls use their bathroom and showers. Conversations with administration resulted in a simple agreement that Columbia would change its supervision practices for a youth's use of the bathroom to include regular auditory responses from the girls when visual observations were inappropriate.

During the June 2012 monitoring visit, the PH Monitor discovered an incident where a youth on suicide watch was restrained in the bathroom. While the situation was somewhat different, it drew attention to the lack of any changes in the policies and procedures regarding the November 2011 concern about auditory responses from the girls when visual observations were inappropriate. In the interim, a suicide gesture at another facility prompted physical plant changes to be made in the bathroom(s) at Columbia in order to make pipes less accessible. A due diligence review of these modifications at Columbia prompted a discussion about supervisory practices while girls are in the bathroom.

Recommendation: The November 2011 policy and procedure change recommendation did not occur because Home Office did not agree. Since the current practice remains a problem, it is recommended that OCFS provide an alternative acceptable to the Monitors.

To this end, the State shall:

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

COMPLIANCE

COMMENT: Interviews with staff and youth yielded similar results. No one commented about a reluctance or fear of retaliation when faced with the need to report another worker regarding an alleged incident of and inappropriate use of force or suspected abuse. Some concerns remain about a previous incident and the implication by one staff member that a different staff member was reluctant to offer information against a co-worker.

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

COMPLIANCE

COMMENT: There was no review of SIU reports of investigation on this monitoring visit. However, meetings with the SIU director and one investigator occurred before the monitoring visit at Columbia. Their explanation of the criteria for prioritizing facility investigations warrants continued monitoring and discussion, but the prompt determination of an appropriate level of contact between youth and staff seemed to be ingrained in practice. The review of allegations against staff members resulted in the discovery of a quick and responsive determination of levels of contact.

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

COMPLIANCE

COMMENT: The policy and procedures exist, and staff and resident interviews were consistent with the policy and procedures. The key issue here was the safeguarding 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.

Interviews with the health clinic staff revealed an understanding of the policies and procedures, their professional obligations, and what appeared to be a trusting and helpful demeanor. Nurses appeared to understand their mandatory reporting requirements, and they described a post-restraint examinations (PRE) procedure that allows the examination to occur with a reasonable amount of privacy. The procedure for conducting the PRE in the clinic had changed since the last monitoring visit. A decision had been made to move the exam table to a position in the exam room such that the transporting and/or supervisory YDA had a direct line of sight to the youth during the PRE. The explanation for the change had to do with safety for clinical staff. It is recommended that the Medical Director or his designee review the changes to make sure that they meet the confidentiality issues in this paragraph.

Recommendation: Regarding Restraint Packet 415798, the Post Physical Restraint Health Report indicated that a "confidential exam was done." While it is important to note that a confidential exam was completed, it would be better if there were some additional narrative about the exam setting that described how the confidentiality was achieved. Given the change in the clinic's post physical restraint exam practices at Columbia, the need for additional documentation is important. (See Paragraph 42c regarding documentation.)

44. d. *Create or modify and implement policies, procedures, and practices to require that all allegations of staff misconduct described above are adequately and timely investigated by neutral, trained investigators and reviewed by staff with no involvement or personal interest in the underlying event.*
- i. *Such policies, procedures, and practices shall address circumstances in which evidence of injuries to youth, including complaints of pain or injury due to inappropriate use of force by staff, conflicts with the statements of staff or other witnesses.*
 - ii. *If a full investigation is not warranted, then the reasons why a full investigation is not conducted shall be documented in writing. In cases where a youth withdraw an allegation, a preliminary investigation shall be*

conducted to determine the reasons for the withdrawal and, in cases where it is warranted, a full investigation will be conducted.

COMPLIANCE

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

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

PARTIAL COMPLIANCE

COMMENT: The expectation of prompt and appropriate corrective measures is an important part of compliance, even though most of the variables affecting this paragraph are controlled by Home Office and are, therefore, systemic. This paragraph should become part of a different approach for monitoring that reviews the concepts of prompt and appropriate corrective measures from a systemic perspective. There was nothing in the Columbia documentation regarding the two employees who received discipline to indicate that there has been any improvement in the prompt administration of disciplinary action. In both instances, the time between the event and the Notice of Discipline or a disciplinary action was approximately one year.

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

COMPLIANCE

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

The Restraint Packet reviews contained documentation by staff that multiple different interventions proved to be ineffective. Because there was no additional explanation or investigation, the source of the ineffectiveness remains a question. It might have been that de-escalation techniques were not applied or implemented correctly or it might be that the techniques were implemented properly and proved to be ineffective. Either way, resolution of these concerns is important for the continued growth of the New York Model and CPM as a safeguard for Protection from Harm issues. For example, regarding Restraint Packet 394398, on several occasions, the staff member appears to lean forward to get his face closer to the face of the youth. This approach does not appear to be part of an approved CPM technique; however, the behavior was not noted on the VRF nor was there documentation that the behavior was referred for consideration by training or the IDT.

Regarding Restraint Packet 415798, the Youth Physical Restraint Staff Debriefing Report form indicated that the interventions were ineffective. There was nothing in the documentation to indicate some kind of follow-up regarding how to make the interventions more effective.

Regarding Restraint Packet 404598, the YDA involved indicated that she used supportive touch as approved on the IIP, but this technique did not work. This comment appeared in AAFD Strauser's Administrative Review of Physical Restraint form, but there was no further documentation regarding the nature and extent of follow-up.

Additionally, there has been no resolution to an issue raised in the previous monitoring report regarding the absence of clarity in the protocols for situations where youth have released themselves from a CPM hold. For example, in Restraint Packet #31588, the video review included good examples of staff using supportive touch to move the youth gently away from the restraint area in two (2) instances. Yet, the youth broke away from a staff restraint, and there was no mention of the larger question, if and how the restraint continues from this point.

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

PARTIAL COMPLIANCE

COMMENT: At the facility level, an isolated but substantial issue was the adequate supervision of staff. This paragraph does not suggest that staff will always do what is appropriate; instead, it suggests that appropriate action will be taken when staff the supervision of staff is inadequate. Two examples of the failure to provide instruction and guidance to staff about the nature and extent of their supervision of youth are discussed here.

Regarding RIR F122405, this is the Reportable Incident Report of the assault on a [REDACTED] YDA by Youth M.I. with a [REDACTED] racket. The administrative review noted that the youth in question had a [REDACTED] racket while on gym restriction. There was a cursory note about follow-up, and Home Office provided the follow-up memo to one of the YDAs involved in the physical restraint of the youth. However, the supervision of staff issues that are in question here did not apply to the physical restraint. Neither did the IAB or SIU investigations apply. The issue in this instance has two parts. First, the video showed the AOD as present during part of the resolution of the incident. Yet, the documentation did not include any notation or comment that addressed with the AOD the oversight that occurred on his shift that permitted a youth on restriction to be in the circumstances shown on the video. Next, no information was available at the time to suggest any follow-up or concern about the length of time that the youth possessed the badminton racket or any guidance and instruction to those staff members involved about how to handle the situation according to OCFS policies and procedures.

Next, regarding Restraint Packet 415798, a substantial concern was the reason why Youth B.X. was able to assault Youth T.Z. There was nothing in the documentation to suggest that the two girls were having problems. Even if there had been issues between the two such that an assault might have been anticipated, the video showed youth behaviors and levels of agitation were sufficient warnings that there should have been

follow-up about various ways that staff could have acted so as to reduce the likelihood of the assault. Independent of this information, concerns remain about an inadequate environmental scan, the poor positioning of staff in the dayroom, and an explanation as to why Youth B.X. had unimpeded access to Youth T.Z. for an assault.

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.*

COMMENT: These factors are mostly systemic and apply to Home Office.

One measure of determining and appropriate level of fitness to work in a juvenile justice facility is to develop a common set of characteristics of those staff who demonstrate a high level of competency working with youth as indicated by both youth and staff and to identify characteristics of those who do not work well with youth, again, basing this on the perspectives of youth and staff. The assumption has been that concerns about the effectiveness of staff will become a greater priority as concerns about the excessive use of force subside and as the effectiveness of the therapeutic effects of the New York Model increase.

III. MENTAL HEALTH MONITORING

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

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

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

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

COMPLIANCE

The New York Model and training comply with the requirements of 46a, and 46a is being implemented into practice at 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 of the NY Model Implementation is being developed with guidance from BBHS staff, and the QAI report is now organized to reflect a youth's progress through the program. The QAI review examined residents' records for integrated assessments, psychiatric evaluations, support plans, diagnoses, psychiatric contact notes, medication, family outreach, suicide response, substance abuse services and transition plans.

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

COMPLIANCE

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

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

PARTIAL COMPLIANCE

Through support teams (formerly treatment teams) and Mental Health Rounds, Columbia staff are complying with 46c on an individual basis, but full compliance requires facility-wide to regularly assess the effectiveness of interventions.

The new mental health sections of JJIS comply with 46c (these were not yet in place to be observed at Columbia). The MH Monitor was provided with an impressive JJIS demonstration at Home Office on February 5, 2013. JJIS is the OCFS' Juvenile Justice Information System, a comprehensive automated system used to track youth in OCFS custody, including but not limited to case management, movement histories, legal histories, and administrative/billing. Reception diagnostic information, Integrated Assessment, IIP (Individual Intervention Plan), Facility Initial Mental Health Assessment (FIMHA) (which includes mental status exam and results of suicide risk assessment), contact notes (by psychiatrists and other clinicians, as well as facility and CMSO case managers), Integrated Support Plan (with updated diagnosis), and Transition Plan are all included on JJIS. By propagating from one document to another, the new forms reduce the work of entering information and integrate all the forms. Drop-down boxes guide data entry. As soon as a resident is admitted, prompts are sent to the team about due dates and ongoing reminders assist in the timely flow of documents. JJIS is designed to capture how a strengths-based, trauma-responsive approach is being implemented with each resident. The JJIS may be the most advanced documentation of juvenile justice teaming in the country: it is an elegant communication system that is clinically sophisticated and thoroughly 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.

When these sections of the JJIS were developed, forms were revised to fit emerging best practice as the New York Model evolves. The IIP is being reduced to a more effective single page document (expected in April 2013). The Integrated Assessment has been simplified. The support plan has been strengthened. A discharge summary is being developed (expected July 2013). The forms require monthly clinical updates that will reflect notes from Mental Health Rounds. JJIS not only provides current information on each resident's progress and efforts being made to enhance interventions, but also offers the opportunity for stronger clinical supervision of staff and can serve as the basis for Quality Assurance monitoring.

The Assistant Directors for Treatment of the four DOJ facilities and social work supervisors have recently been provided with the JJIS demonstration. The JJIS designers are developing a demonstration to be brought to each facility not only to instruct in the use of the JJIS but also provide examples of writing goals that reflect the resident's aspirations and the staff's assistance in clarifying the steps to achieve them. Coaching will also be provided to support teams to strengthen support plans. A JJIS technical manual is being developed (expected summer, 2013), to be complemented by a BBHS clinical procedural guide. A crucial next step will be to ensure that this documentation system includes all the non-clinical staff involved in the resident's progress and fully reflects the teamwork necessary for his/her success. For example, educational testing results will be reflected in the Integrated Assessment, but the JJIS could also result in monthly updates in the academic progress of the residents, including new assessment results, recent achievement scores, passing Regents, and new IEPs, and what educational and other staff are doing to support that progress.

Continued monitoring of the facility's use of information to regularly assess the effectiveness of interventions for all residents will continue to be monitored to determine full compliance.

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

PARTIAL COMPLIANCE

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

On Site Observations (Regarding Paragraph 46a-d) (2/13)

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.

The Columbia Assistant Director for Treatment captured how the New York Model has infused the entire program with the term "Surround Sound" and the idea that throughout every day the residents hear New York Model messages and receive support to learn skills of emotional regulation from all staff. Columbia staff continue to work diligently to achieve trauma-responsive, relationship-driven, culturally competent, and strengths-based teamwork to meet their residents' complex needs.

As they refine their implementation of the New York Model, Columbia staff have debated "what functional behavior looks like." They are pleased that now there are "very few school refusals because the New York Model exposes kids to doing well in several areas—some have passed Regents they had failed more than once. One resident came in feeling that she was worthless and she didn't care. She didn't believe she could complete anything. Today she is taking the GED. There has been a lot of school success. The teachers have changed the school environment—teachers being involved in all aspects of treatment has made a big difference. School attendance is expected. We don't say, 'You're bad' but 'What can we do to help you go to school today?'"

The MH Monitor observed thorough discussions of two residents at Mental Health Rounds led by the psychiatrist: QG, an 18-year old with a 1-3 year sentence for a 2010 [REDACTED] arrived at Columbia in October, 2012 after multiple placements [REDACTED]. Her Integrated Assessment reported daily use of marijuana. Her [REDACTED] to whom she was close died [REDACTED] and two friends had died in the previous year. Her diagnosis was Adjustment Disorder with depressed mood, Cannabis Abuse and Conduct Disorder. The goals in her support plan (1/24/13) were: Goal #1 Learn to use mindfulness. YDAs will use single step directions and encourage mindfulness. The psychiatrist will explore Traumatic Brain Injury. Goal #2 Achieve passing grades in all class. Ask for extra help from teachers for work she finds difficult. The school will review for special education services. Teachers and others will redirect and remind her of her goal. Goal #3 Work on improving communication skills with her mother. Use DEARMAN when talking with her mother. Listen to her mother's feedback without becoming defensive. Her therapist wrote lengthy contact notes regarding individual therapy. Her YC wrote detailed contact notes regarding mindfulness and helping her with her letter to the Parole Board (which could release her in [REDACTED] 2013 or she would remain at Columbia until she is 20). Another clinician's contact notes described her learning about accepting direction and their family counseling over the phone and during a visit. The reason for discussing her at Mental Health Rounds was to get a better understanding of her cognitive deficits. She wants her GED but she has to do a lot of remedial work to raise her low skill levels. She gets easily distracted, and does well with 1:1 work, especially with the cook. The psychologist explained that she has problems with basic arithmetic and her verbal comprehension skills are very low. Even though she appears to be articulate, it is hard for her to understand mindfulness and other abstract concepts. The psychiatrist and nursing staff worked persistently to obtain [REDACTED] hospital records for her head injury when she was hit by a car, lost consciousness, had a skull fracture, and was in intensive care for days. She was out of school for a month, did not go to rehab and did not get a Traumatic Brain Injury disability or IEP. The psychiatrist presented QG's memory, attention, visual-perceptual and motivation problems that are typical of TBI and explained that it is not surprising that following a closed head injury she would have behavior problems as a result of these cognitive impairments. The psychiatrist

presented a helpful explanation of cognitive rehabilitation for TBI. She proposed that (1) QG receive a speech/language evaluation; (2) the speech/language specialist begin working with her individually several times a week, (3) the speech/language specialist explain her cognitive limitations to staff; and (4) her IEP be delayed until the evaluation occurs.

The second resident discussed at MH Rounds was MA, at 15½ [REDACTED]. She was at Lansing in 2011, was fennered [REDACTED] to Columbia and was discharged. As a child, she and her siblings were removed due to their mother's [REDACTED] use and later returned; her mother is in recovery. Her [REDACTED] who she was close to, died. She was placed by [REDACTED] as a teenager due to her behavior problems. Her challenges are her relationship with her mother and problems trusting others. Although she was initially aggressive on her first Columbia stay, she is bright, initiated phone therapy with her mother, and advanced to application phase. She went back to her mother in [REDACTED] 2012 with family therapy arranged. She had "a horrible three months with many problems with her mother," and was revoked to Taberg in 9/12. After she was fennered to Columbia [REDACTED] she announced, "This is where I feel safe." She has a constant low-grade depression and ruminates, but is not suicidal. She struggles to accept past loss and see how it continues to affect her. She is working on making decisions without being so affected by her emotions. She was Student of the Week [REDACTED]. She does not want to return home and would benefit from a step-down to RTF, but the waiting list is very long. She had no family visits during her first stay, even with offers to her mother of transportation; she has had no family visits and is not doing family therapy during this stay at Columbia. There is now a plan to review her for special education services, especially in math. The school staff want to push her into 10th grade Regents classes, but they have to convince her to have the self-confidence she can do them. She has a good relationship with several staff and also calls [REDACTED] Taberg. The psychiatrist encouraged each participant to contribute to the discussion and then said that MA at first had a diagnosis of ADHD, was prescribed medication, and continued to have behavior problems. She presented her as having underlying attachment problems and depression. Her diagnosis now is Severe Mood Dysregulation, and she is prescribed a combination of a stimulant and an antidepressant (plus Perphenazine to reduce anger). This was a thorough discussion of MA, but it did not include clear next steps for each participant to share with others and to consider for the next support team. The diagnostic discussion of MA's depression at Mental Health Rounds was noted in her support plan for her support team meeting later that same day.

The psychiatrist asked if there were other residents to discuss in the few minutes remaining of Mental Health Rounds. A YC requested an evaluation for PTSD for the newest resident who witnessed her [REDACTED] being shot and killed [REDACTED]. Afterwards she had easily triggered anger that resulted in [REDACTED] placing her; she ran away and stopped attending school. She had 2 psychiatric hospitalizations due to suicide threats [REDACTED] before she arrived at Columbia. Staff were encouraged to maintain close contact with her and further discussion would occur after psychiatric and psychological assessment.

In the debrief with participants in Mental Health Rounds, the thoroughness of the discussion was commended. There was an interest in making sure Mental Health Rounds ended with specific next steps for each resident presented and that participants take these

steps to all the staff who work with resident who were not present. Participants were enthusiastic about presenting Mental Health Rounds highlights and next steps at change of shift meetings.

The MH Monitor observed a DBT group at Columbia. The leader was well-prepared, the residents were actively involved, and one resident led the group with an engaging mindfulness game that staff and residents enjoyed. For long-stay residents who have done DBT repeatedly, Columbia might consider an advanced small group with new, real-life applications of DBT. Because of an inclement weather schedule change, the MH Monitor was involved in other activities instead of observing a Sanctuary group at Columbia as planned. The QAI Review included observation of several groups at Columbia and commented on the active participation of youth and the involvement of YDAs in some but not all groups.

A key to implementation of the New York Model is a functioning team of coaches. A strong facility coaching team ensures that the New York Model becomes a way of thinking by staff and youth, rather than simply a clinical service. The Assistant Director for Treatment, the Acting Assistant Facility Director, and the clinicians participated in a thoughtful exchange of ideas with the MH Monitor about coaching at Columbia and how to assist staff in using their relationships with youth effectively. The coaches summarized their progress since the last site visit including:

- “The best coaching is not planned. YDAs ask any of us for coaching. There is a lot of informal 1:1 teaching. Coaches say to staff, ‘You have the skills to deal with this.’ We coach staff to say to girls, ‘It’s a tension in life: You can do well and not get what you want. If you get upset, you do something about it.’ Encouraging kids to advocate for themselves means we have to prepare staff for how they can help kids do that, and then staff have to prepare youth. We do a lot of coaching staff in the moment, especially helping staff see how kids’ past experiences affect their worldview. As residents move through phases, they internalize self-control if staff can avoid rescuing them and instead coach them to use their own skills.”
- “We encourage AODs at the end of shift to compliment staff.” When one of the coaches is AOD, she described recognizing each staff person for something at the end of shift. “Appreciated staff means appreciated residents. ‘ In the moment you did a great job’ applies both to staff and residents.”
- Coaching mentors has become an important activity. “Mentoring relationships are going well—they are an opportunity for YDAs to use their skills. Mentors get to every team meeting and phase meeting and see how they fit into treatment. Administration has arranged more coverage on Thursday and allowed overtime so mentors participate. YDAs and residents recognize the importance of mentoring for moving up a phase. We don’t have to push the kids to get their mentoring sheets in anymore.”
- “Everyone is understanding the DAS message that ‘You can recover. One level does not wreck your whole day’. At the last staff meeting we walked everyone through examples of the DAS so there was better understanding of scoring.”

- “Even girls on Generalization Phase for months have had bumps in the road. Staff have gotten better at judging if engaged in treatment—not just showing up. This is a much higher bar. Girls are not necessarily moved up.”
- The coaches believe “it is important for staff to be allowed to switch schedules to fit their lives, which typically was not okay in the past. Staff would say, ‘OCFS cares about everyone else’s kids but mine.’ Flexible scheduling allows them to see their kid playing on a team. Some staff request double shifts and are happier with their schedule. We have very few staff calling in sick. Here everyone is respected, everyone is part of the team.”

The Columbia coaches described moving forward on monthly staff meetings and once/weekly shift meetings in order to do more coaching and teaching. They discussed options for clinical supervision of YDAs, including small group supervision or consultation at unit meetings or having the third clinical position they are trying to fill to provide clinical supervision.

The MH Monitor observed IIPs (Individual Intervention Plans) in the reviewed Columbia records; support plans indicate the IIP has been reviewed each month. The QAI review found that at Columbia consistently completed IIPs that contained realistic crisis management strategies.

The Columbia DAS is organized into five sections. The first four are the SELF approach and the fifth is the girl’s treatment goal; they were revised to reflect primary and additional goals:

Safety

Primary: Follows program norms and expectations

Additional:

- Uses Safety Plan
- Uses staff to help resolve conflicts
- Uses interpersonal effectiveness skills (DEAR MAN, GIVE, FAST)

Emotion Management

Primary: Expresses feelings in a safe and respectful way

Additional:

- Uses mindfulness skills (observing, describing, wise mind)
- Uses emotional management skills (distract, self-soothe, improve the moment)
- Gives words for feelings rather than acting out

Loss

Primary: Accepts directives, uses distress tolerance skills

Additional:

- Accepts current circumstances without denial or blaming others
- Makes attempts to understand the effect of past losses on present

Future

Primary: Shows (by actions) that she is working toward future goals

Additional:

- Identifies realistic plans for the future

- Demonstrates that she is working toward short and long-term goals

Treatment Goal (the individual's goals are stated)

In addition to its clarity in listing skills, a strength of the Columbia DAS is that nine out of the ten DAS reviewed by the MH Monitor had a different individual treatment goal listed. Furthermore, there is a clear connection between their most recent support plans and the treatment goal listed on the DAS—for example: T's listed treatment goal on her 2/1/13 DAS was "Continue to increase her ability to share emotions/feelings with others to avoid emotional crises" and the goal in her support plan was to "Learn to express herself without verbal aggression." Q's listed treatment goal on her 2/1/13 DAS was "Be mindful/aware of things that might frustrate her and be able to talk about them instead of withdrawing and avoiding them" and the goal in her support plan was to "Learn to use mindfulness." M's listed treatment goal on her 2/1/13 DAS was "Be mindful of her triggers to getting angry and use her safety plan to try to prevent problems" and the goal in her support plan was to "decrease incidents of verbal/physical aggression by using her head to make decisions, rather than her emotions."

There are two versions of the Columbia DAS form: one is for school days and one for non-school days. Each of the five areas are scored daily during six periods. Unlike DAS forms in other facilities, the Columbia DAS is also printed on the back in two sections: there is space for comments by 6-2 shift, 2-10 shift and 10-6 shift (the comments appeared only to be completed when the resident had not earned her point); the comments section seems to result in the scoring on the front of the sheet not having handwritten comments on them as in other facilities. The bottom has a Key to Terms: Interpersonal Effectiveness Skills (DEARMAN, GIVE and FAST) and Distress Tolerance Skills (DISTRACT with Wise Mind ACCEPTS; SELF-SOOTHE the FIVE SENSES; IMPROVE THE MOMENT).

On 2/3/13, all 11 residents in the facility achieved A level, with 8 having perfect scores for the day (although one resident had achieved 17 two days earlier with 0 for morning and afternoon program and another earned 10 points two days earlier, only getting 1s for afternoon and evening program--the comments said she had an assault, restraint and EBP that day). If the majority of residents have perfect or A level behavior, is it reasonable to ask whether the DAS should be made more challenging for residents?

The QAI Report found documentation for frequent clinical interventions. Clinicians and YCs both met with youth once or more a week, YCs made several contacts monthly with families, clinical and psychiatric contact notes are thorough, support plans were revised monthly by support teams, and CMSO was involved with those youth to be discharged to aftercare. The QAI Report included a youth survey reflecting Columbia residents' understanding of their support plan, safety plan, support team, DAS, and phase system.

FUTURE MONITORING

When they are available, the MH Monitor will review:

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

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

The MH Monitor will observe the consistency of DBT and Sanctuary groups and other therapeutic interventions and the progress being made by residents, particularly those frustrated by their long stays.

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

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

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

COMPLIANCE

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

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

Mental health staff at 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 2/12 email entitled "Contacting Mental Health Professionals Outside of Regular Work Hours" 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.

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 (2/13)

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

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

In the previous six months, only one Columbia resident was on a suicide watch (SW), [REDACTED]. The MH Monitor found inadequate documentation of her SW in her record. There is a note in the CSU log written by the CSU staff that the resident was taken off SW by the clinician but the note was not written by the clinician. This was documented in the QAI Review and the Columbia Assistant Director for Treatment discussed with the clinicians that they were responsible for writing the note in the CSU log and a contact note regarding the rationale for releasing her from SW.

FUTURE MONITORING

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

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

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

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

COMPLIANCE

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

QAI reviewed one or two Columbia records in which the initial mental health screening documentation was incomplete or not timely, but the records the MH Monitor reviewed, including the most recent admissions, complied 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 has been completed. A 2/12 memo describes the procedure for referral of youth to a committee for a mental health placement and complies with 48b.

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

PARTIAL COMPLIANCE

The Integrated Assessment form complies with 48c.

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

- (a) a thorough trauma history, symptoms of trauma and how trauma appears to be affecting the resident's behavior,
- (b) evidence of learning disabilities and how they appear to be affecting the resident's behavior,
- (c) results of the Adolescent Alcohol and Drug Involvement Scale (ADDIS) and history of substance use, and how it may be related to trauma, learning and social problems.

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

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

PARTIAL COMPLIANCE

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

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

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

COMPLIANCE

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

On Site Observations (Regarding Paragraph 48a-e) (2/13)

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

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

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

"Mental health rounds occur weekly, the purpose is to identify and address acute treatment-related issues for particular youth in a team format. In addition to the review of acute issues, rounds will be used to discuss both the progress and challenges for individual youth. The rounds will include members of the mental health team: the psychiatrist, the psychiatric nurse practitioner (if applicable), the clinician, the case manager, a

representative of the direct care staff, and representatives from education and medical. The clinician will write a short summary note of the discussion on each youth presented and record this note in the youth's mental health chart. Mental health rounds will assist in integrating the psychiatric and behavioral health services of each youth into a broader holistic understanding of the youth and the family" (page 3).

"The psychiatrist and nurse practitioner participate in the weekly mental health rounds and contribute information about diagnosis (es), medication, benefits and side effects. Consensus of team members is achieved during these meetings, with resultant modification of treatment parameters by all participants according to the team discussions. The Axis I primary diagnosis may change as treatment progresses and more information about the youth becomes available" (page 7).

"If the clinician does not participate in the [psychiatric visit with the youth], they will meet with the psychiatrist prior to the youth's session to communicate regarding treatment issues and progress. The treating clinician and the psychiatrist (with input from the mental health rounds team) will develop a single working diagnosis, which is reflected in JJIS and in the Treatment Plan. The treating clinician is also responsible for communicating any and all changes to the youth's treatment (including medication changes, expected outcomes of medication changes, potential side effects, etc.) to the treatment team following the youth's psychiatric visit." (page 8).

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

An example of the importance of documenting an evolving diagnostic formulation is TK, a 16-year old YO at Columbia for a burglary who arrived [REDACTED] weeks before the site visit. The psychiatrist saw her on 1/24/13, and the psychiatric contact note indicated symptoms of irritability and worry. The psychiatrist diagnosed Generalized Anxiety Disorder, Dysthymia, and Conduct Disorder and prescribed Lexapro for depression and anxiety and discontinued Bupropion because it was ineffective (she had arrived at the facility taking Seroquel). However, the support plan dated the same day had her former diagnosis, Bipolar (by history) and Conduct Disorder and did not include the addition of Lexapro and discontinuing of Bupropion. Although evaluation indicated that she had experienced no trauma other than police brutality [REDACTED] over which she filed a lawsuit for her head and back injury), her history showed parent divorce, moving back and forth between parents, an abortion [REDACTED] and her mother struggling with a chronic illness. She described herself as a good girl who wanted to see what it was like to be bad when she got involved with burglary. She preferred to spend time with staff and

became agitated and impatient with her peers. The goals in her support plan were “Use radical acceptance to prevent her from acting out her anger,” including diary cards to identify situations that create anger, and “Get passing grades in school.” The contact notes reflected her therapist discussing with her mentor how to help with her anger and where in the past it comes from. Staff consensus about what their interventions intend to address, consistent with a consensus diagnosis, should be apparent in the support plan.

Another example was a Columbia resident whose 2/13 support plan listed a different diagnosis from a 1/13 psychiatric contact, and the psychiatric medication roster prepared for the MH Monitor provided a different diagnosis. While it is expected that, given their changing symptoms, adolescents’ diagnoses may also be in flux and psychiatric medication may not be effective and medications changed, documentation of the symptoms that everyone is working on should be consistent.

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

DEPRESSION 27% of youth prescribed medication (12)

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

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

MOOD 27% of youth prescribed medication (12)

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

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

ANXIETY 23% of youth prescribed medication (10)

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

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

INSOMNIA 32% of youth prescribed medication (14)

| | |
|----------|---------|
| Columbia | 17% (1) |
|----------|---------|

| | |
|--|---------|
| Finger Lakes | 11% (2) |
| Lansing | 75% (6) |
| Taberg | 42% (5) |
| ADHD 23% of youth prescribed medication (10) | |
| Columbia | 33% (2) |
| Finger Lakes | 17% (3) |
| Lansing | 13% (1) |
| Taberg | 33% (4) |

Many more youth were diagnosed with depression at Columbia (67%), Mood Disorder at Taberg (50%) and Finger Lakes (33%), and Anxiety Disorder (50%) at Lansing, as compared to the other facilities. Although divergent diagnoses among the individual youth in the four facilities are expected, these discrepancies appear to be larger than likely would be accounted for by population variation. In a follow-up discussion with the Columbia psychiatrist, she indicated (a) depression, mood problems, and anxiety are within the same cluster of diagnoses and (b) what matters is diagnostic consensus among the clinicians at the facility where the resident is being treated (even if the same consensus might not be reached if the resident was placed elsewhere. Nevertheless, the differences above show diversity in interpreting symptoms that is likely to play a significant role in problems with achieving diagnostic agreement.

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

It is a significant dilemma that while the New York Model is a strengths/needs-based trauma responsive approach that is not a traditional medical model, how can OCFS address symptoms of depression, anxiety, emotional dysregulation, and substance abuse associated with trauma without being driven by diagnosis? Furthermore, if traumatized adolescents typically have a mixture of anxiety and depression, then diagnosis may be less informative than tracking of symptoms by the psychiatrist and other clinicians and noting the efficacy of medication and other interventions in reducing the symptoms presented by

each resident. OCFS wants to avoid pathologizing youth (which can occur when there is an emphasis on diagnoses), but to clarify the extent of serious emotional problems across facilities requires the capacity to analyze the symptoms of all youth, not just the diagnoses of youth who are prescribed medication by the psychiatrist. This would necessitate psychiatrists contributing to diagnoses or symptom clarification for youth not being prescribed medication and an effective process of discussing diagnoses or symptom reduction not just at Mental Health Rounds but also as refinements are made in support plans and during teams.

FUTURE MONITORING

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

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

The MH Monitor will review additional psychiatry guidelines.

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

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

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

PARTIAL COMPLIANCE

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

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

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 the Columbia records.

On Site Observations (Regarding Paragraph 49a-c) (2/13)

On February 6, 2013, five of the 12 girls at Columbia were prescribed psychiatric medication:

| | |
|--|--------------------|
| Major Depression; Generalized Anxiety Disorder; ADHD | Trazodone; Ritalin |
| Insomnia; PTSD (by history) | Benadryl |
| Major Depression; Generalized Anxiety Disorder | Remeron |
| Bipolar (by history) | Seroquel; Lexapro |
| Dysthymia; Generalized Anxiety Disorder | Remeron; Benadryl |

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

An OCFS draft document requires that "the psychiatrist will use no more than three psychotropic medicines in his/her treatment of a youth. At presentation, the number of

medications may be greater, but needs to be tapered to no more than three. If the psychiatrist can justify the usage of more than three medicines, then it is important to discuss this usage with the Chief Psychiatrist. The psychiatrist will use no more than one medicine per class, i.e., one antipsychotic, antidepressant, mood stabilizer. If the psychiatrist can justify the usage of more than one medicine per class, then it is important to discuss this usage with the Chief Psychiatrist.” None of the Columbia residents are prescribed three psychiatric medications.

The QAI Report found that the psychiatric contact notes at Columbia documented discussions between the psychiatrist and youth regarding their medications, symptoms, and side effects. On the youth surveys, four residents indicated they were taking medications, they knew what they were and why they were taking them, and their side effects had been explained to them. About half the staff surveyed knew why the youth were taking psychiatric medication. The QAI Report found that the psychiatric contact notes often left the lab findings section blank (although the psychiatrist had reviewed and signed the lab results). The QAI Report recommended a schedule for lab exams.

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

One Columbia resident has a diagnosis of Insomnia, two are prescribed Benadryl, and an unknown number of residents who are not receiving medication have sleep problems. The MH Monitor recommends that sleep-enhancing skill building be incorporated into the New York Model and implemented in groups and individually by evening shift staff, supported by the youth’s team. Traumatized youth have to learn how to put themselves to sleep without substances, which requires feeling safe and trusting that staff will take care of them. Not only may bedtime remind them of night fears, but they miss home and the familiarity of sleeping with family members so going to bed may accentuate their loneliness. Given the importance of sleep to emotional regulation, more attention to self-soothing strategies for sleep is a priority.

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

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

- 25% use of Risperidal (antipsychotic) at Taberg and 17% at Finger Lakes and none at Columbia and Lansing

Trazodone is being prescribed for Anxiety Disorder, Dysthymic Disorder, Major Depressive Disorder, Depression, and Insomnia. Seroquel is being prescribed for Mood Disorder, PTSD, Mood Dysregulation, Generalized Anxiety Disorder, Anxiety Disorder, Dissociative Disorder, and Conduct Disorder. Clonidine is being prescribed for Anxiety Disorder, ADHD, Bipolar Disorder, Mood Disorder, and Impulsivity. Risperidal is being prescribed for ADHD, Conduct Disorder, and Mood Disorder.

FUTURE MONITORING

The MH Monitor will review additional psychiatry guidelines.

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

The MH Monitor will review consistency of recording laboratory results at Columbia. The MH Monitor will observe discussions of efficacy of medication at Columbia Mental Health Rounds and support teams.

The MH Monitor will continue discussions of consistency in diagnostic and medication practices with the clinicians.

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

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

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

COMPLIANCE

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

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

practical nurses, Facility Administrators, and Deputy Administrators. All other staff at the Facilities shall be required to complete a minimum of one (1) hour of competency-based training on psychotropic medications and psychiatric disabilities annually for the term of this Agreement.

COMPLIANCE

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

On Site Observations (Regarding Paragraph 50 a-b) (2/13)

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

FUTURE MONITORING

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

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 comply 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 one Columbia resident's support team that complies with 51e.

On Site Observations (Regarding Paragraph 51a-e) (2/13)

The MH Monitor observed documentation in a Columbia record when a resident refused psychiatric medication. There was understanding that if a resident refuses psychiatric medication, the psychiatrist meets with the youth to clarify why (and why the youth is refusing and what the psychiatrist has done to address the side effects and/or other reasons for refusal should be included in the Psychiatric Contact Note) and these issues are discussed in support team. However, the QAI Report found that although the medication refusal forms were reviewed by the psychiatrist, some had not been discussed either with the youth's legal guardian or in the support team.

FUTURE MONITORING

The MH Monitor will continue to review documentation of medication refusal at Columbia and the practice of support team discussion of medication refusal by residents.

52. *Informed consent. The State shall revise its policies and procedures for obtaining informed consent for the prescription of psychotropic medications consistent with generally accepted professional standards. In addition, the State shall require that the information regarding prescribed psychotropic medications is provided to a youth and to his or her parents or guardians or parson(s) responsible for the youth's care by an individual with prescriptive authority, such as a psychiatric nurse practitioner. This information shall include: the purpose and/or benefit of the treatment; a description of the treatment process; an explanation of the risks of treatment; a statement of*

alternative treatments, including treatment without medication; and a statement regarding whether the medication has been approved for use in children.

COMPLIANCE

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

On Site Observations (2/13)

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

FUTURE MONITORING

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

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

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

COMPLIANCE

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

The support team practices at Columbia comply with 53a.

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

COMPLIANCE

Mental health staff at 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.*

PARTIAL COMPLIANCE

Support team meetings 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. It seems unlikely that there could be a six-month interval between monitoring visits when the psychiatrist's participation in some support teams was not clinically indicated. If the psychiatrist never participates in support teams, the facility is not in compliance with 53c. Although the Columbia psychiatrist's contact notes, discussions at Mental Health Rounds, and informal communication with staff are utilized at support teams, there are times the psychiatrist's participation in a support team would be important.

However, the psychiatric coverage issue is more than attending support teams. If more residents required psychiatric medication than currently and/or the consensus diagnosis process included all the residents in a facility (not just those prescribed psychiatric medication), more psychiatry hours would be necessary. OCFS does not have a formula to calculate number of necessary psychiatry hours based on population.

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

PARTIAL COMPLIANCE

Columbia Integrated Assessments, clinical evaluations, and Mental Health Rounds reflect an understanding of the effects of trauma on resident's thinking and behavior. But typically the resident's support plan does not include trauma. For some residents, the clinical contact notes indicate trauma work by the resident. This may be considered private between the resident and one or two clinicians and not something they want discussed with their team and/or family. Hopefully, the more support plans reflect both the resident's views and the staff's understanding, trauma will become a safer topic in the process of residents changing their thinking and behavior.

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

PARTIAL COMPLIANCE

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

A youth worksheet has been developed to help residents state their goal, the steps to their goal, and what adults can do to help them with each step and can help in the

development of the support plan with the resident and to assist the resident in preparing to speak up at the support team meeting.

Consistently strong support plans—including building from the Integrated Assessment, clear goals based on the resident’s aspirations with the addition of staff expertise, and all team members’ interventions (not just clinicians) stated specifically--is being monitored to determine full compliance.

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

COMPLIANCE

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

On Site Observations (Regarding Paragraph 53a-f) (2/13)

The MH Monitor observed two Columbia support team meetings. MA’s (described above) support team was convened by her therapist with two YCs, another clinician, a YDA, a nurse, and 3 teachers. Because of downsizing CMSO in NYC, she had no aftercare worker. Everyone on the team actively participated and reported her progress, including being Student of Week. She is working on self-calming, and her YC and YDA check-in with her daily. She did not achieve a phase advancement and decided get the required substance abuse assessment in the hope she will make it the next time. Participants on the team were reminded that although she appears mature, everyone has to remember she is only 15 (but the team was not coached on the immature thinking and identity that are typical of adolescents her age). Offering an Alateen group for residents with family with alcohol and drug problems was suggested to meet her needs. When MA arrived, she stated her goals herself. Her mother was on the phone and was vocal, and asked MA what she thought her strengths were. This meeting represented real progress because it was the first one her mother agreed to participate in, after a long period of not being in touch with her daughter. The teachers praised MA directly and her mentor commended her progress on decision-making, while other team members reported on her progress to her mother. MA said later she was happy with the meeting and felt supported by team members and her mother. The team meeting was one step toward improving mother-daughter communication. Her updated support plan reported a review of her safety plan and IIP with no changes and a change in medication. She “has continued to improve her functioning over the past 30 days...consistently worked on her goal of making more rational decisions. She has been observed tolerating distress in various instances, being willing to quietly do things that she does not want to do...she has been reluctant to attend substance abuse treatment groups due to her family’s history of substance abuse, but completed substance abuse assessments and started attending groups.” After the discussion that morning in Mental Health Rounds, the support plan was updated, noting that she “appears to have Dysthymic Disorder and there was agreement about this diagnosis and it has been changed. But she says that she is not depressed, just does not get along with her mother.” Her strengths were listed as being very bright and articulate; she has developed positive and functional social skills; she wants to determine where she is going to live; she wants to finish school.” Goal#1: MA will

decrease incidents of verbal/physical aggression by using her head to make decisions, rather than her emotions. Her target objectives are using mindfulness to observe her emotions and describe how she is feeling, becoming aware of the connection between her emotions and actions, and reporting on those incidents when she is able to make positive/rational decisions. The psychiatrist has worked with her to identify medications she will take. Counseling is helping her use wise mind, rather than emotion mind and make decisions. Her YC will continue to check in daily to help her review her behavior and consequences and use her coping skills. YDAs and other staff (especially her mentor) can help MA recognize when she is letting her emotions govern her decision-making. Goal #2 MA will pass her classes by attending class daily, if feeling tempted to skip class, use mentoring and/or positive self-talk and attempting to complete all assigned work. The psychiatrist talked with her about focusing on classwork and she decided to increase her dose of Ritalin. Counseling is helping her think of ways to refocus herself in the classroom with help of staff and teachers. By using positive reinforcement teachers will redirect and encourage MA to complete her class assignments. Her mother states she is accepting the fact that MA does not want to come home and wants to step down to a lower level of placement. This is an exemplary support plan that might serve as a sample in future coaching in other facilities.

TB's support team was convened by her therapist with two YCs, another clinician, a YDA, a nurse, and 2 teachers. TB is a 19-year old JO who has been at Columbia for more than a year of [REDACTED] sentence [REDACTED]. She was described as making progress, including achieving Student of Week for two weeks, but struggling. The initial part of the team meeting was more of a review of her support plan rather than a sharing of ideas about what might meet her needs more effectively. Her 2/7/13 Integrated Support Plan concluded: "TB continues to increase her participation in groups on the unit. She is participating in individual counseling. TB's ability to manage her frustration with residents and staff has increased over time." Her dealing with her emotions about her [REDACTED] friend's leaving Columbia [REDACTED] weeks before was described in her support plan. The relevance of her learning from her reaction to her friend's departure for the likely experience of losses in the future is not reflected in her support plan. Her diagnosis in her support plan was Sleep Disorder Related to Insomnia, PTSD, Conduct Disorder, Depressive Disorder (by history), Mood Disorder (by history), and Language Disorder. "TB acknowledges that she has been through traumatic experiences [REDACTED] and these affected her crime: 'I was angry.' She wants to complete high school and college, pursue a career in the fashion industry, [REDACTED]. She hopes to be released on parole, live with her grandmother and provide for her siblings. Goal #1 Learn to express herself without verbal aggression. Demonstrate the ability to use mindfulness by role-playing situations that could occur in the secure setting. Use her DEARMAN skills to help her to express her emotions. The psychiatrist will help her with sleep. Her therapist will review how she uses mindfulness and role-play challenging situations to practice DEARMAN skills. Her YC will remind her to be mindful. Teachers will use selective focus, redirect TB and discuss her negative behavior after class." There was nothing listed in the plan for the YDA and Mentor to do, and the interventions for Rec and Voc were "same as education." Goal #2 Verbalize how she is working on not allowing other peers' misery (arguing, cursing, being loud) affect her. Practice using radical acceptance. Use her safety plan and walk away if

she is struggling. Diary cards to identify emotions. The only staff roles described are mental health and YC, not for other staff.

Columbia staff are writing specific treatment goals and specific steps to support the resident's goals explicitly connected to the skill building of the New York Model. As the Columbia Assistant Director for Treatment indicated, "We continue to work on how we write goals, but even clinicians have trouble. Goals have to be (1) observable—how do we know you're improving; and (2) in the resident's words, with small accomplishable objectives. If we don't write clear goals, it is a big problem." The observed support teams at Columbia showed the caring and inclusive way staff communicate with residents and include the family. Aspects of support teams requiring improvement are (a) getting behind the resident's behaviors to the unmet needs driving them and designing ways each staff can help the resident meet those needs with more acceptable behaviors; (b) incorporating the Integrated Assessment findings into the team discussion and support plan; and (c) making connections between the resident's goals at Columbia and success in the community.

QAI found that almost all surveyed staff indicated they had received enough training in dealing with youth with mental health issues and two-thirds said they were active members of support teams. QAI identified two concerns in the Columbia support plans: (a) the goals and objective were too broad, and (b) the role of each staff person on the team in providing specific support to the resident in working on that goal was not consistently recorded.

Instead of a formal curriculum for teaching staff how to complete the new JJIS support plans, OCFS is providing in-person system walk-throughs and continued coaching by BBHS. JJIS Support Plan Coaching facility staff has begun. Coaching will be to sit with Clinicians, YC's, Teachers, and Medical staff at their computers to guide them through the new form. On 2/1/13, the new Integrated Support Plan was released in JJIS. On 2/21/13 BBHS Director of Treatment Services and the JJIS clinical coach had their first coaching session (at Taberg); they sat in on a support team and provided the clinicians feedback about the meeting and walked them through creating a support plan on JJIS. The coaching team will return in 3/13 to Taberg to do the same with case managers, teachers and medical staff. Lansing staff were trained, Finger Lakes staff are scheduled in March, and Columbia will be scheduled. All support team members who enter information into JJIS will have to complete the mandatory on-line HIPAA and information security training.

FUTURE MONITORING

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

The MH Monitor will continue to observe Columbia support team meetings.

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

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

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

PARTIAL COMPLIANCE

OCFS is using Innervisions for substance abuse prevention education at Columbia, but is looking for a new program on total well-being including substance abuse education.

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

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

PARTIAL COMPLIANCE

OCFS is using Triad for substance abuse treatment at Columbia.

Like the process of becoming trauma- responsive, learning to meet the needs behind substance abuse is important for all staff, not just clinicians. A necessary element of coaching on New York Model implementation is ensuring that each resident integrates DBT skills learned in substance abuse treatment with those learned in DBT group and the coping skills learned through SELF. This will require strong communication in support teams and Mental Health Rounds among the therapist, substance abuse clinician, YCs, YDAs and the rest of the team on how to support each resident's individual progress in self-calming at Columbia and how she can use these skills to avoid substance use and manage her family's substance abuse in the community.

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

On Site Observations (Regarding Paragraph 54a-b) (2/13)

The MH Monitor observed a substance abuse group at Columbia. The leader was well-prepared but the residents made it clear they did not want to be there. Their YDAs were not involved but two clinicians participated. In the debrief afterward, staff commented that a few months ago the residents were actively participating but a few had become discouraged by their long stays which had affected the unit's dynamics negatively.

The substance abuse clinician appeared to be fully integrated on the Columbia team, providing individual counseling for several residents as well as substance abuse groups on each unit using the Triad curriculum designed for girls. She completes the AADIS assessment of substance abuse with each resident at admission. She actively participated in Mental Health Rounds and support teams, commenting on residents' development of DBT skills not just in a substance abuse context.

It appeared that all but one of the Columbia residents had a history of substance abuse. Sometimes substance abuse was noted in an Integrated Assessment, but not reflected in the support plan. For example, TK whose Integrated Assessment described her use of marijuana [REDACTED] and alcohol [REDACTED] but it was not reflected in her goals or diagnosis of Generalized Anxiety Disorder, Dysthymia, and Conduct Disorder for which she was prescribed Lexapro and Seroquel. The goals in her support plan were "Use radical acceptance to prevent her from acting out her anger," including diary cards to

identify situations that create anger, and “Get passing grades in school.” The contact notes reflected her therapist discussing with her mentor how to help her with her anger and where in the past it comes from.

The long-term importance of effective substance abuse treatment is exemplified by a 19-year old resident who arrived at Columbia in [REDACTED] 2012 from [REDACTED] where she was sent for violating her parole [REDACTED]. She had been released from Tryon on [REDACTED] just as it was closing and relapsed. The biopsychosocial assessment completed by the substance abuse clinician revealed a lot of loss—her grandmother who she was close to died, she does not see her father, her cousin was killed, one brother is hospitalized f [REDACTED], and another is incarcerated. The father of her 3-year old died [REDACTED]. She used [REDACTED] before she was placed at Tryon and after she left—she said everyone she knew used it. Nevertheless, this substance abuse problem was not described in her Integrated Assessment. Her diagnosis was Depression with anxiety, Adjustment Disorder with depressed mood and Cannabis Abuse. She will likely require individual time with the substance abuse clinician to identify specifically the skills that will help her avoid relapse in the community and help in practicing those skills at Columbia.

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

The QAI Report found that at Columbia all youth receive substance abuse treatment and education, the substance abuse clinician administers a drug/alcohol screen for all youth as they arrive, and progress notes indicate a connection between DBT skills and substance abuse issues.

FUTURE MONITORING

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

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

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

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

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

COMPLIANCE

The Continuity of Care Plan complies with 55a.

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

PARTIAL COMPLIANCE

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

The Discharge Plan (still being developed) will be reviewed for compliance with the "other services" in 55b.

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

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

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

COMPLIANCE

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

On Site Observations (Regarding Paragraph 55a-c) (2/13)

The MH Monitor reviewed the one-page Mental Health Continuity of Care Plan and the Transition Plan for a girl who was released during the site visit. TH is a 16-year old JD at Columbia for almost a year for a 2010 assault; she was fennered [REDACTED]. Her father was incarcerated; she lived with her mother [REDACTED], and returned to her father and paternal grandmother in 2010. She started having behavior problems in school when she was 10. She had been diagnosed with Bipolar Disorder, but at Columbia the conclusion when she was removed from high medication doses was that she did not meet Bipolar diagnostic criteria and showed depression symptoms. She was reading and doing math at an elementary school level, had a borderline IQ, and testing at Columbia found she had a

language disorder significantly impairing her ability to comprehend others and to express her ideas. Her Integrated Assessment was completed soon after her placement, and identified physical and emotional abuse, including abandonment by her parents and that she used substances to cope with her emotional pain and hopelessness. Her 1/13 support plan indicated diagnoses of Adjustment Disorder and Conduct Disorder, but the psychiatrist indicated diagnoses of Major Depression, Generalized Anxiety Disorder, and Conduct Disorder (she is prescribed Remeron). She was accepted at a residential program [REDACTED] but decided instead to be released to her father despite their difficulty communicating with each other that was evident on their last videoconference. A referral to [REDACTED] was made after that support team meeting. The support team notes by her case manager were thorough. She hopes to complete high school; although she is reluctant to go to treatment in the community, she wants to continue on an anti-depressant. The goals in her support plan were "She will practice expressing her feelings in a nonjudgmental manner" and "She and her father will be honest about weaknesses in their relationship and will develop options to problem-solving when they are having difficulty." Her previous support plan focused on the goal of using radical acceptance to do tasks she did not want to complete ("Will follow directives and accept them even if they are not what she wants to do; will attend individual sessions with her therapist whether she wants to or not; will accept program as written and not the way she'd like it to be"). In an interview with TH [REDACTED], she said she had problems adjusting from "the old program" to New York Model and "the points." She described what she learned at Columbia as, "Get yourself together—just have to think about the future and brush things off. I have to help myself." She described one staff person as "calming me down when I'm mad and reminding me I need my education." One wonders how her father will deal with her since she says she doesn't want help in community and just wants to be left alone in her room at home.

TH left Columbia [REDACTED]. She had an OCFS Mental Health Discharge Summary indicating that her admission diagnosis was Conduct Disorder and her discharge diagnosis was Conduct Disorder and Borderline Intellectual Functioning. Her diagnosis did not reflect the effects of trauma on her behavior, despite the Discharge Summary description of trauma "which has determined her interpersonal effectiveness skills as well as her inability to express her thoughts and feelings. She often appears withdrawn, extremely sad and exhibits hopelessness when discussing goals or her future. She experiences nightmares and is frightened. She believes she acts out for no reason. She initially refused to attend groups or individual therapy. She cautiously developed a relationship with her therapist and began to talk about her painful history." The Discharge Summary described her "blossoming," including more insight into her behavior, making an effort in school, showing a sense of humor, and wanting to develop positive relationships with her parents and siblings. The Discharge Summary indicated that she would have a [REDACTED] worker in the community, the school she would attend and that she would have individual therapy, substance abuse treatment, and continue psychiatric medication in the community. TH's Transition Plan had nearly identical wording to her Discharge Plan except it indicated she was diagnosed with Conduct Disorder and Major Depressive Disorder and was treated for depression with Remeron. TH's Continuity of Care Plan listed her appointments for individual therapy and medication management in one community

agency and substance abuse treatment in another. Despite her history of difficult relationships with her parents, no family therapy with her father was scheduled. None of the three reports makes a reference to trauma treatment. Although TH's Discharge Plan provides a more thoughtful clinical analysis than the Transition Plans the MH Monitor has reviewed, her Discharge Summary did not offer a bridge from her achievements at Columbia to a support plan for her team in the community. Columbia staff work with youth to develop excellent support plans, which should guide the resident continuing to use her skills to achieve her goals in the community.

The Transition Plan screens comply in part with the Settlement Agreement by including information about all aspects of the youth's services in the community. However, two important functions of a Transition Plan are: (1) Providing specific guidance for a resident's family, school and other providers about her needs and how each of them can support her distress tolerance, self-calming and interpersonal effectiveness skills (including how, specifically, she can make use of her Safety Plan and other New York Model skills in the community); and (2) Identifying her team in the community to help the young person reach her goals and giving each team member (youth, family, OCFS staff, service providers) the telephone number and address of each person/service on the youth's community support team. A transition plan should define how a resident's treatment plan and gains in the facility will continue in the community: if, for example, one of a youth's goals in the facility was "Learn how to manage frustration," then in the last support team meeting before re-entry, important supporters in the community would have been present or on tele/video conference so they understood their role in helping the youth tolerate frustration in the community. Just as the youth and everyone on her team at the facility use her support plan to assess progress and refine supports, OCFS should help the youth, her family and service providers be able to rely on her transition plan as her support plan in the community. All the residents in the four DOJ facilities are receiving individual therapy and individual counseling and are participating in DBT and Sanctuary groups and most are participating in substance abuse treatment groups. The Settlement Agreement wording does not limit the need for a continuity of care plan to youth prescribed psychiatric medication; it includes all residents with the terms "mental health issues" and "receiving substance abuse treatment" in the facility. The Settlement Agreement wording "referrals to mental health *or other* (emphasis added) services when appropriate" requires continuity of care planning for all OCFS residents. This could include, in addition to referrals to therapy, medication management and substance abuse treatment on the Continuity of Care plan, referrals to B2H services, YAP services, mentoring services, and educational services. Referrals for these services are important for transition plans for all youth, not just those requiring medication management in the community. Some residents have a goal of discontinuing psychiatric medication before they are discharged, and they might be at greater risk of return to the facility than those residents who have a Continuity of Care plan for follow-up by a mental health provider in the community. Through the New York Model OCFS has implemented the integrated assessment and integrated support plan, and hopefully, a revised Discharge Plan format could become an integrated transition plan that includes all elements of a youth's successful re-entry to the community without violating HIPAA.

FUTURE MONITORING

The MH Monitor will review the Discharge Plan in JJIS.

The MH Monitor will review transition plans and continuity of care plans of recently released residents.

IV. DOCUMENT DEVELOPMENT AND QUALITY ASSURANCE

56. *Document Development and Revision.* Consistent with paragraph 68¹ of this Agreement, the State shall create or modify policies, procedures, protocols, training curricula, and practices to require that they are consistent with, incorporate, address, and implement all provisions of this agreement. In accordance with paragraph 68 of this Agreement, the state shall create or modify, as necessary, other written documents – such as screening tools, handbooks, manuals, and forms – to effectuate the provisions of this Agreement. The State shall submit all such documents to the United States for review and approval, which shall not be unreasonably withheld.

PENDING REVIEW

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

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

PARTIAL COMPLIANCE

COMMENT: A positive element of the monitoring process has been the creation and implementation of the Quality Assurance and Improvement (QAI) Bureau. The Monitors received the *Pilot Program Review: Columbia Residential Center (Draft)* or the QAI Report for 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 to discuss the FLRC report. Attendees included David L. Bach, QAI Director; Sandra Carrk, Project Manager; Lori Clark, QA Specialist; Diane Deacon, Assistant Deputy Counsel; Myra DeLuke, QA Specialist; Edgardo Lopez, Settlement Agreement Coordinator; Denis Passarello, QA Specialist; and Monique Thomas, Assistant Counsel. The high-quality QAI reports are becoming an important resource for ongoing OCFS assessment of compliance with the Settlement Agreement.

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.

The critical and yet-to-be-developed aspect of QAI is a recommendation, and approval by the Monitors, of Protection from Harm and Mental Health performance metrics to safeguard residents. More dialogue is needed with Home Office about the role of QAI in the development and use of indicators that will automatically activate individualized, incident-specific, facility-specific, and time-limited safeguards for the protection of youth similar to the ways that immediate and prescriptive supervisory and programmatic changes occur for youth who are deemed to be a suicide risk or a medical risk.

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

COMMENT: No corrective action recommendations exist as a result of the Columbia 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

Program development occurs in stages. As safety increases through the reduction of disruptive and harmful behaviors for youth and staff, such as those resulting in physical restraints, more time is available for program implementation and refinement, which carries with it a whole new set of challenges. As programs mature, staff strategies evolve in response to the improved capacity to meet the needs of youth. Quality Assurance-driven measures of effectiveness reveal discrepancies within the staff teams; and as these discrepancies are resolved, program consistency increases. Consistency is an important Settlement Agreement ally. It is a core element of structure, regularity, and order and provides both physical and emotional safety for vulnerable youth whose developing emotional regulation will be continually tested.

Columbia is the facility with a good implementation of the New York Model. The performance metrics support multiple findings of compliance.