
ALBERT J. SOLNIT CHILDREN'S CENTER SOUTH CAMPUS

✧ Independent Consultant Review ✧

Monthly Report of Findings & Recommendations

September 20, 2018



Prepared by



I. Overview

This monthly report of findings and recommendations covers the consultation provided to Solnit Center South PRTF by Dr. Michael Hoge and Dr. David Klein from August 27, 2018 to September 18, 2018. It is a follow-up to the initial report submitted on August 27, 2018.

Once again, the Independent Consulting Team thanks Superintendent Michelle Sarofin, the leadership team, and management staff for their strong support and assistance with the consultants' work over the past month. They continue to be responsive, flexible, and forthcoming and their participation has been much appreciated.

There are many skilled and dedicated staff working within the PRTF and elements of the program that are functioning adequately. However, the many areas of concern detailed below, when taken as a whole, raise serious concerns about the overall operation of the PRTF, the potential impact of the numerous problems on the care of youth, and why so many issues have remained either unidentified or unaddressed by the PRTF.

II. Findings & Recommendations

FOCUS AREA ➤ POLICIES AND PROCEDURES AND RELATED STAFF TRAINING & SUPERVISION

Mandatory Training

Activities Conducted by Consultants:

- Observation of Leadership Meeting.
- Review of data on training completion.
- Discussion with facility trainers.

Findings:

Subsequent to the critical incidents and sentinel event, there have been several instances where procedural changes have created a need to retrain. After struggling with a "read and sign" approach, the organization developed a PowerPoint to support classroom-based training lasting approximately one hour. The training covers a large number of policy changes. The process of conducting this training with staff is ongoing as of the date of this writing (9/18/2018).

In the Leadership Meeting/Rounds on 8/28/2018, discussion occurred once again about how to get staff to the PowerPoint training on new policies and procedures, which was occurring that day. It was stated that none of the 1st shift residential staff had yet received this new training, though it was discussed a week ago in this meeting and offered to staff last week. A list existed of those staff who needed to receive this training, but it was not available at the meeting. In the Leadership Meeting/Rounds on

9/4/2018, frustration was expressed about the perceived struggles with implementation of training, as an announcement was made that post-training tests already administered would have to be re-administered because, in the haste to train staff, a miscommunication had occurred within Leadership about the nature of the testing process.

A spreadsheet was obtained on 9/18/2018 with the current status of training of all staff at the PRTFs. Approximately 65% of staff had been trained (51 of 78) and properly tested, but 7 of those who had been tested had failed, so 34 of 78 staff had yet successfully completed training. In discussions with the senior manager responsible for training, it became clear that the PRTF had not identified the date by which this training of all staff would be completed.

The strategy for completing the training process was described as: (1) reviewing staff on duty on a daily basis and providing relief so untrained staff could complete training; (2) having a trainer come to work early (late during 3rd shift) once weekly to facilitate training of third shift staff, and (3) arranging overtime, as needed, to have staff available to relieve others who required training. It is noted that staff were trained on each of the first 3 days of the initiative, but no staff were trained on the next 5 days, so implementation has been uneven.

Recommendation: Since this training pertains to high priority policy changes involving the safety of the youth, an organized plan should be developed prior to the day of training regarding staff assignments and coverage so that CSWs and other staff can be trained in the revised policies and procedures using the new training materials. The plan should have a clear and achievable date for expectation of completion.

Staff Competence

Activities Conducted by Consultants:

- Discussion of staff performance and disciplinary issues with Director of Residential Care.
- Discussion of staff performance and disciplinary issues with the Superintendent.
- Discussion of CSW performance with a clinician.

Findings:

During the course of the review, the team met with and observed numerous staff members who appeared competent, compassionate and committed to the work. Some stood out as remarkably talented and as natural leaders within the PRTF.

In a previous report, a member of the Barrins team reported observing the Lakota Unit CSUS (residential supervisor) screaming at a youth. In a meeting subsequently held with a Director of Residential Care, she commented that the CSUS on Lakota “has his hands full” with three difficult CSWs. In a case review by the Barrins team held on the Lakota unit during the week of August 27th, the clinician for the case was asked about the CSWs on the unit. She acknowledged that there were issues with the CSWs. When pressed, she said their behavior with the youth was “mostly appropriate.”

These findings were discussed with Superintendent Sarofin. She acknowledged that there were personnel problems among CSWs, some of whom have been employed on that unit for a long time. She

described that disciplinary action was underway with a CSW Lead on the unit, who the facility hopes to dismiss or demote due, in part, to unauthorized activities with youth. Reportedly, there have been delays within Central Office HR in rendering a decision on this personnel matter.

Related to staff competence, the team observed a specific clinician present a clinical case on three separate occasions. During one case the clinician struggled to describe the youth's psychiatric history, past psychiatric treatment, precipitants for the admission, and the treatment goals. The clinician's performance in the two other cases was acceptable and unremarkable. Senior leaders of the PRTF acknowledged that the employee has performance issues that are being addressed through the process of intensive supervision.

Recommendations:

- DCF Central Office should prompt HR to render a decision on the pending disciplinary CSW issue on the Lakota unit.
- The management team should develop a comprehensive plan for addressing CSW, CSW Lead, and CSUS performance on Lakota that includes potential actions such as: increased supervision, staff coaching, additional training, counseling, increased observation of staff performance, and potential reassignment of selected staff to different units.

Staff Stress, Burnout, & Secondary Trauma

Activities Conducted by the Consultants:

- A meeting was held with senior managers on staff stress, burnout and secondary trauma.
- Discussions with varied staff members were held about job satisfaction and burnout within the PRTF.

Findings:

A meeting with managers was held to discuss staff stress, burnout, secondary trauma, and the interventions used to prevent or address these issues. Sources of problems were identified as: the emotional intensity of the work; the challenges presented by youth and families; fear of youth AWOLs; organizational stress; a patient's recent death; mandatory overtime; layoffs and program closures; the move from a residential to more medical model; and the periodic intensity of staff dissatisfaction, which is a stressor for managers and supervisors.

Staff members echoed the sources of stress, burnout and secondary trauma mentioned by managers. To those they added the negative effect of program closures, such as CJTS, and the impact on staff who were relocated to other programs, such as the PRTF. They also described selected members of the staff who they viewed as "burned out", marking time in the program until eligible for retirement.

Interventions reported in use by managers to address these issues include: one-to-one support; giving an employee a break from the work or unit; additional training; increased supervision; convening meetings with staff to discuss these problems; the facility's Wellness Program; and periodic luncheons for staff. The problems related to stress, burnout and secondary trauma that were described, as well as the preventative interventions being taken to address them, seem typical of psychiatric facilities.

Recommendation: The managers participating in this discussion suggested that the types of prevention and intervention activities with staff stress, burnout and secondary trauma should be intensified. It is recommended that the facility develop a formal, ongoing plan to monitor and address these issues amongst its workforce.

FOCUS AREA ➤ STAFFING

Staff ratios

Activities Conducted by Consultants:

- Review of staffing schedules and discussion with CSUS staff.
- Observation of staffing ratios in milieu.
- Discussions with CSW staff.

Findings:

Staffing levels were more than adequate on Labor Day on all shifts, with all prescribed staffing ratios met or exceeded, allowing for several programming options. In fact, a CSW went home voluntarily early in the day shift because there was a RN, two CSWs, and two LPNs on duty for 5 girls (2 others were on pass and not expected to return during the shift). In the other cottage, the number of staff exceeded the number of girls and all staff chose to remain. As explained by CSUs and others, few staff scheduled to work on a “premium” holiday (6 per year) choose to take the day off given the rate of pay. With one cottage closed and most staff from that cottage scheduled to work in other cottages, staffing was more than ample, despite absences for Worker’s Comp and FMLA. Staff continue to show awareness of staff/resident ratios inside and outside the cottages, and awareness the observational challenges posed by the different designs of the cottages (Lakota as opposed to Kiwani and Quinnipiac).

Several staff have expressed a sense that many of the long-term staff are staying for the benefits (retirement, wages, time off), rather than for the intrinsic value of the work with children, noting that the system has strong incentives to remain in employment. In addition, staff cited the perceived undesirability of options for transfer, leading to an aging workforce. Some have stated that the changes in the system, with reduction of hospital beds and elimination of correctional facilities, have resulted in transfers of staff to the PRTF from other settings that emphasized client control, rather than engagement. Some stated that they are sometimes called to an emergency physical intervention and find staff from outside the unit taking the lead on the intervention as the regular staff from the unit remain on the periphery. This reportedly occurs even though regular unit staff are more familiar with the youth and would in theory be able to manage the situation effectively.

In other discussions, praise was offered for some longer-term staff who have devoted their lives to children with no discernible loss of enthusiasm over time, and demonstrated wisdom and breadth of knowledge that can be associated with experience.

A CSW staff member queried in Lakota was unfamiliar with the clinical assessments in the record, was unable to distinguish the Psychiatric Admission Note from the Psychosocial Assessment, and was unable to locate the “overflow” part of the record, even suggesting that it did not exist, despite the fact that over one month of progress notes were missing from the active record (an LPN was able to locate the “overflow”).

A CSW staff member was unfamiliar with the youth's discharge plan in terms of whether or not the goal was for her to return to her aunt's home, which would be useful information when interacting with the youth, who at the time was with her aunt on pass, scheduled to return later in the day, and who was planned for discharge with her aunt during the following month.

One of the CSUSs present on Labor Day was also the person who provides the Life Skills Program, which has been noted to be significant in the treatment of several of youth, especially older adolescents who may be entering the workforce in the reasonably near future. She noted that she had been absent for significant periods of time lately (two periods of Worker's Compensation and one vacation totaling 8 weeks), and that in her absence, the program operates at a very reduced level, because no one is trained to provide the program and/or no one is interested in doing so.

Recommendations:

- As described above, develop and implement a plan to address burnout in the workforce.
- Several staff have commented on the typical absence of CSWs from the Treatment Planning meetings, a challenge exacerbated by stricter adherence to staffing ratios. It is recommended that a mechanism be developed to include CSWs in the Treatment Planning process or, at a minimum, to educate them about the treatment plan.
- Develop a plan that allows the Life Skills program to continue in the absence of the CSUS.

Overall Staffing

Activities Conducted by Consultants:

- Discussion of PRTF staffing with senior managers, Solnit Center HR director, and representatives of DCF Central Office HR.
- Review of staffing data.
- Discussion of staffing data with Superintendent Sarofin.

Findings:

It was very difficult to understand staffing and vacancy data for the PRTF as all HR systems combine data on Solnit South - PRTF with the Solnit South Inpatient units. A specific request was forwarded to DCF Central Office HR by the Barrins team to generate reports that were specific to the PRTF on the South campus only, but the data returned by HR comingled PRTF and inpatient staffing. Superintendent Sarofin made a personal effort to hand calculate totals on selected staffing variables for the Barrins team to review.

The following should be considered tentative approximations of staffing and vacancy levels and should be further vetted by the PRTF to ensure accuracy:

- There are an estimated 175 employees at the PRTF-
 - 137 treatment personnel
 - 38 in administrative, custodial, and maintenance categories
- From August 2015 through August 2018 there were 16 "separations" from the PRTF:
 - 8 resignations
 - 4 retirements
 - 4 moves to other agencies

- With respect to vacancies there are:
 - 15 vacancies among treatment staff positions that are being refilled.
 - 13 vacancies among newly established positions
- 3 treatment staff are out on Worker's Compensation
- 5 treatment staff are out on FMLA or other forms of leave

The team's interpretation of these data are as follows:

- There are a large number of positions for the Solnit Center PRTF. Staffing appears more similar to typical hospital levels than to non-hospital programs.
- The frequency of separations appears low.
- Excluding newly established positions, approximately 17% of positions are vacant or occupied by employees out on leave.
- There are 8 vacancies among CSWs, which is a significant percentage of the CSW workforce. Senior staff indicated that the percentage of these vacancies is high due to a change in DCF and state procedures related to recruitment and hiring.
- Mandating staff to work overtime and reassigning inpatient staff to cover the PRTF have been widely reported as current practices that put a strain on the organization's workforce.

Recommendations:

- DCF and the Solnit Center should refine HR systems to separately track and report data for the PRTF South separately from other Solnit programs.
- Once accomplished, HR data should be monitored through a quality improvement program, benchmarking with other DCF units, and implementing initiatives to minimize the frequency and duration of vacancies.
- The PRTF should work with DCF HR and the Solnit HR office to search for ways to reduce the length of time that vacant positions remain unfilled.

FOCUS AREA ➤ CLINICAL SERVICES

DBT Treatment

Activities Conducted by the Consultants:

- Review of cases.
- Discussion of DBT training with a Director of Residential Care.

Findings:

A case was reviewed on Lakota with clinician Beata Munoz, LCSW. The youth was initially admitted to Natchaug Hospital after an overdose of K2 and bath salts. She was admitted to Solnit PRTF as a step down from that unit, unable to return home. The admission was deemed appropriate by the clinician, and the Barrins consultant agreed with that assessment. The course of PRTF treatment had not been marked by any untoward events. Family treatment had been a key element of the treatment. The youth had just turned 18 and DMHAS has accepted future treatment responsibility for the patient, but had not yet clarified the service plan.

This youth was deemed appropriate for DBT Committed, but it took six weeks from admission to start in this modality. There were notes by the clinician in the chart documenting her discussions with the youth about the benefits of DBT Committed.

The case of a recently discharged youth was reviewed on the Quinnipiac Unit with clinician A.W., LCSW. The admission occurred in November of 2017, but Ms. W. did not become responsible for the case until May of 2018 when the youth was moved from another unit because of an attack on her by two other PRTF youth. The youth had no history of psychiatric hospitalizations and came to the PRTF from respite foster care, while waiting for a foster placement. When no placement materialized, the biological mother agreed to reunification and the youth was discharged home. During her stay, the youth was often emotionally dysregulated and experienced considerable interpersonal conflict. Parent-child problems and trauma were considered major problem areas for this youth. Family sessions were held routinely. DBT Committed, which was appropriate for this youth, was not put in place until 6 months after admission.

On a related note, the Director of Residential Care who oversees training, indicated that DBT training for all staff will begin in October.

Recommendations:

- As previously recommended, the management team should shorten the time between admission and start in DBT Committed for those youth appropriate for this group.
- A specific plan and timeline should be developed for training all staff in DBT principles and practices.

Substance Abuse Treatment

Activities Conducted by Consultants:

- Review with clinicians of cases involving substance abuse.
- Discussion of substance abuse treatment in the PRTF with the Director of Operations.

Findings:

The program has a relatively limited emphasis on substance use disorders from both diagnostic and treatment perspectives. Compared to other mental health diagnoses, the amount of data collected regarding substance use in the diagnostic assessments is limited, and the clinical treatment for these problems is minimal.

The Solnit Center Director of Operations was interviewed regarding substance use among youth and the approach to managing this issue within the PRTF. He noted that youth with primary need for substance abuse treatment are considered inappropriate for admission. Among youth for whom substance use is a secondary concern, the PRTF will often “defer” treatment until the PRTF stay is concluded and the youth has returned to the community. Participation in an NA group at the Solnit Hospital is possible for some youth. On several previous occasions the PRTF paid for youth to receive treatment during the day at the Rushford Center, but this compromised youth involvement in the PRTF program and community. The PRTF was considering adoption of the Seven Challenges treatment model that was in use at CJTS. There is now the possibility that the PRTF could be included in the ACRA model (Adolescent Community

Reinforcement Approach), which is being implemented in outpatient and residential programs across the state with DCF support.

Youth #7 - Lakota (clinician – BM, LCSW):

The youth was initially admitted to Natchaug Hospital after an overdose of K2 and bath salts. She was admitted to Solnit PRTF as a step down from that unit. The youth participated in an NA group conducted at the Solnit Center Hospital. This was appropriate, but insufficient treatment, given the nature of the youth's substance use.

Youth #1 - Lakota (clinician - MW, LCSW), 16-year-old who was 15 during the course of treatment:

The Psychosocial Assessment noted “[youth] reports a history of alcohol and marijuana use. The frequency, intensity and duration of this use is unknown, however, due to inconsistent reporting by [youth]. At times, she indicates experimental use, and at other times daily use is indicated. This will be continued (sic) to be assessed and explored in treatment”. There was little evidence that it was later explored but progress notes for the first 4 months of her stay could not be located. In the Primary Clinician Discharge Summary, it was noted under Reason for Admission that her referring clinician reported “remarkable decompensation” that included smoking marijuana.

The entry in the Psychiatric Admission Note for “Substance Use History” was “Details are unclear. [Youth] is said to have history of cannabis use. She also reports Tobacco use.” The Psychiatric Discharge Summary indicated that “[Youth] is said to have history of Cannabis use.” There was no mention of substance use in the initial diagnosis or any updated diagnoses, including the discharge diagnoses.

Substance use was not ignored in the treatment plan, however; she was assigned to attend Seeking Safety group in the initial treatment plan and in all updates, with one of the goals to address “urges to use substances.” She was not assigned to attend the on-campus weekly NA meeting.

Youth #2 - Lakota (clinician - MW, LCSW), 14-year-old:

There was an event during her stay where she returned from a pass and spoke about getting high, eventually denying that she had done so. The report was considered serious enough to have her vital signs taken to assess whether there was drug use, yet there was no order for a urine toxicology, despite the availability of such testing.

Youth #3 - Lakota (clinician - BM, LCSW), 13-year-old girl:

The extent to which substance use was mentioned in both the initial Psychosocial Assessment and RN Assessment was “alcohol/marijuana” with no specificity regarding the amount or frequency of use, age at first use, duration of use, or recency of use. In the Psychiatric Admission Note, the information under Substance Use History was “History includes reports of use of alcohol twice a week and Cannabis twice a week,” which is not insubstantial use for a 13-year-old girl. When the clinician described the youth's history, the first presenting problem she mentioned was alcohol and marijuana use, yet substance use was not mentioned in the Psychiatric Admission Note in the

sections for Reason for Referral or the History of Present Illness and Pertinent Information, and Preliminary Diagnoses only mentioned "History of" Alcohol and Cannabis Use. There was no evidence presented or implied that use had ceased, and in discussion, the clinician indicated that use was present prior to the hospitalization that preceded admission to the PRTF.

Options for substance use treatment, as identified by the clinician for this youth included:

- a. Participation in a NA group weekly led by a clinician from the hospital on Solnit South. Youth #3 participated 2-3 times before refusing to continue. The clinician could find no evidence of a progress note from the group leader despite the fact that clinicians are expected to write notes after every group, and her assumption was that there was no note because the group leader worked at the hospital and not at the PRTF. The clinician also had no awareness of the youth's participation in that group other than what she was told by the youth.
- b. Referral (done by the clinician) to the Seeking Safety group, which has a curriculum that includes discussion of smart choices regarding substances. Seeking Safety is one of three options to which youth can be referred during that time period in the weekly schedule, and this youth was referred to a different option regarding trafficking, which was clinically relevant to the girl's treatment but prevented her from participating in the Seeking Safety group.

Thus, the youth received essentially 2-3 hours of clinical group services regarding substance use during the course of treatment.

Recommendations:

- Enhance the amount of programming for substance use disorders.
- Consider obtaining consultation to assist with curriculum development.
- Provide training for staff regarding the prevalence of substance use in the population served and the interaction of substance use with other diagnoses.
- All Solnit clinicians who provide clinical groups to PRTF youth should write progress notes in the youth's PRTF medical record.

Approach to Trauma

Activities Conducted by Consultants:

- Meeting with Solnit Director of Operations and two clinical supervisors to discuss youth trauma.
- Review of clinical cases.

Findings:

The facility approach to the issue of trauma appears to be well conceived. Senior managers describe the care provided at the PRTF as "trauma informed". They assume that almost every youth treated at the PRTF has experienced significant trauma and they described in detail the various types of trauma that are common in the lives of youth admitted to this program. All staff are to receive training in a trauma informed approach. As a treatment model and basis for staff training, the facility uses the ARC (Attachment, Self-Regulation, Competency) framework and an ABCD (Attachment, Belonging, Competency, Doing for Others) milieu model. A major objective of the PRTF's approach is to ensure that frontline staff understand the following: the nature of trauma; how it influences the lens through which PRTF youth view the world and react to it; and the importance of managing their affect as caregivers,

engaging in consistent responses to the youth, and maintaining routines with the youth. Other interventions with youth involve the Love 146 and Seeking Safety groups, which center on education and development of coping skills. Clinicians determine how to approach trauma in individual treatment but, in general, there is an assumption uncovering or exploratory treatment focused on trauma is generally not appropriate in this acute care setting. It may occasionally be a focus of within family work that centers on reunification.

There was evidence in almost every case presentation that trauma histories were recognized. The potential role of trauma in effecting a youth's current behavior was frequently noted. The impact of trauma on possible reunification or placements was often explicitly discussed or outlined in the record. Other than one very inappropriate action of a frontline staff member with a youth, which was previously documented, staff interactions with youth seemed appropriate. The content of individual therapy and family therapy, as documented in the medical records, also seemed appropriate from a trauma perspective.

Recommendations:

No recommendations are offered as trauma histories among youth are assessed and well documented by PRTF staff and the trauma informed approach to care appears to be appropriate for the setting and length of stay.

Program Participation:

Activities Conducted by Consultants:

- Record review
- Clinical tracers and discussion with clinicians
- Interview with Superintendent

Findings:

Youth #4 (Quinnipiac – clinician AW, LCSW) has consistently attended less than 50% of therapeutic groups and school classes. She has also not been able to participate in the typical amount of individual therapy with her clinician. As a result, the clinician has adapted individual sessions so they are briefer and occur in settings tolerable to the youth, sometimes with the clinician meeting the youth near the television, where she tends to gravitate, rather than outside or in a private room, where she is less comfortable. The clinician has also developed what she identified as a behavior modification system to encourage attendance in school and group activities and to encourage the youth to take a shower. The plan was an attempt by the clinician to address an instance where an aspect of the treatment plan was ineffective.

The behavior modification system was developed to be simple and easily understood, which made it cognitively suited to the youth. Moreover, youth input was reportedly obtained in developing reinforcers, although no documentation could be found of youth input. Unfortunately, the program has thus far been ineffective in modifying behavior. Also, the program is not understood by staff and is not well implemented by staff. Finally, records of the youth's performance on the behavioral modification system have either been destroyed or are missing.

Significant findings relative to the behavior modification system are described below:

- a. Regarding the system, the treatment plan for the youth states on 6/14/18, 7/17/18 and 8/14/18 that "Amanda will develop..." such a system. Treatment plan language was never modified from the future to the past tense when the plan was developed. No evidence could be located in the record to identify when the plan actually was developed, but the clinician was confident it was well before the last treatment plan entry, and possibly before the prior entry.
- b. A sheet to track progress over two weeks (a two-sided sheet with one week on each side) was developed. The sheets are not kept in the record, and in fact, sheets from time periods prior to the current period could not be found. Staff believed they had been thrown out, despite the fact that rewards are to be earned based on cumulative performance, which makes retention of previous records necessary.
- c. The sheet for the current week was reviewed and it was blank, despite the fact that the day of the review was Wednesday and the tracking starts on Monday. An LPN reported the sheet was blank because there was no school during the week, but according to the instructions on the sheet, the absence of school should have been scored for each class period (a "partial" credit as if the youth were excused) and credit for attendance in groups and taking a shower could have been scored. The clinician remarked that she had presented the program in both the morning shift meeting and the afternoon inter-shift meeting, but staff were not implementing the program correctly, for which she identified two possible causes: (1) with the assiduous effort to maintain proper staffing ratios in the cottage, it was not uncommon for only supervisors and clinicians to be in the shift meetings, so perhaps staff responsible for the program were not educated in the implementation; and (2) with the current staffing demands, the number of staff working outside of their normal assignment is high, so the group working with the youth was not as cohesive as they might otherwise have been.

These deficits were considered to be serious, as there was limited written evidence of the behavior modification program implementation either in the treatment plan or progress notes.

As noted in previous reports, participation in clinical activities is not required, and some youth refuse groups more regularly than others or walk out of groups while the group is in session. Although there is not a point/privilege system in place, there are incentives to attend groups, including the privilege of a weekly off-ground activity (seemingly in place in one cottage but not elsewhere), and "stores" available for participation in rehabilitation and DBT groups. Many of the staff were unaware of this incentive system within the DBT program. It is also noted that in Quinnipiac there is a special Friday lunch to reward group participation.

Conflicting information about whether or not there is an incentive or behavioral system linked to participation in the clinical group program was further explored. Through discussion with a clinician in the DBT program, it was clarified that there is an incentive system in DBT Committed that rewards youth for continued participation and completion of DBT homework. This system is designed to maintain active youth participation in DBT Committed. It is not a system that appears to motivate youth to initially join DBT Committed groups.

In a discussion with the Superintendent, she indicated that she held a recent meeting with staff to discuss how the clinical groups might be expanded, and whether there are sufficient incentives for youth to participate in clinical groups or counterproductive rewards for youth who decline participation (e.g., more TV time).

Recommendations:

- The treatment plan format encourages cutting and pasting, which can lead to failures to address changes when they occur. A different format is highly recommended.
- Although the behavior modification tracking sheets are not a typical part of the record, they are important indicators of progress, or lack thereof, and they should be maintained in the record.
- The breadth of problems with the behavior modification system suggests that it receive special attention in a formalized way. Perhaps, any instance of a behavior modification system should require a documented weekly meeting with the clinician, nursing, and direct care staff (at a minimum) with documentation of staff training and youth progress.
- Staffing issues, e.g., posting, hiring, filling vacancies, reducing reliance on overtime and staff from other locations, need to receive prioritized attention.
- As previously recommended, the PRTF management team should develop a plan to strengthen the clinical program and build a unit culture and system of incentives that creates expectations and rewards for participation in clinical care.

Strong Teens Curriculum

Activities Conducted by the Consultants:

- Discussion of the curriculum with the school principal.
- Review of the Strong Teens curriculum.

Findings:

A *Strong Teens* group is offered to youth at the school on a once weekly basis when the school is in session. The curriculum was provided by the school principal and reviewed by a Barrins consultant. *Strong Teens* is a social and emotional learning curriculum that can be taught by non-clinical or clinical personnel. For youth in the PRTF it is taught by a Pupil Services Specialist and a teacher. While described by a number of staff members as a clinical intervention, it is best conceptualized as a psycho-education curriculum.

The curriculum's authors maintain that it is designed for healthy teens, as well as those with emotional problems. The author's state that it is appropriate to use in the educational program of a residential facility. Recommended delivery is one 45-50 minute session per week for 12 weeks. The sessions cover topics such as understanding emotions, dealing with anger, conflict resolution, and positive thinking. The authors have made efforts to evaluate the effectiveness of the curriculum, including one recent study conducted in a residential treatment facility for girls.

Recommendation:

No recommendation is offered, as this is an appropriate psychoeducational intervention for delivery in this setting with this population.

Discharge planning:

Activities Conducted by Consultants:

- Record reviews.
- Clinical tracers and discussion with clinicians.

Findings:

Youth #1 was discharged after 5+ months at the PRTF. She had been living with her maternal aunt, grandmother and two brothers prior to admission, and the initial plan was to return home. Four months into her stay, on 7/2/18, the RN wrote that she was “eager to return to grandmother.” Nevertheless, over the next three weeks, there were notes regarding exploration of foster care, therapeutic group home, and residential care, with ultimate placement at Waterford Country School’s residential program. Less than one week before her visit to Waterford, she self-injured. She did not respond to a knock on the PRTF bathroom door and was found face down on the floor, subsequently stating she was not ready to leave the PRTF. The youth subsequently became excited by the prospect of placement and expressed embarrassment about her previous reactions, and she was discharged to the residential program slightly less than two weeks later. The clinician, RN, and psychiatrist all had documented their input in the record regarding treatment and discharge planning.

Youth #2 is expecting to return to her aunt, with whom she has lived in the past. She was also eager to begin spending more time with her mother. Her aunt had some hesitation about a return, and there was some concern that the youth might expect more from the relationship with her mother than was realistic. There have been several passes with the aunt, a supervised visit at Solnit occurred with the mother, and some pass time was spent with other family members. The clinician has worked closely with the youth and with her aunt, addressing behavior on pass and managing expectations. The plan remains for the youth to return to her aunt in October after 4 months in the program.

Youth #5 will probably be discharged to return to her family despite the fact that DCF is reportedly likely to substantiate neglect. Mother, for whom alternative childcare is a challenge, has often brought two children to family sessions, a younger brother described as very active, perhaps hyperactive, and a much younger (1-2 years old) brother who is medically fragile with a feeding tube. This has created a less than ideal situation for family therapy. In addition, the mother has refused to allow the clinician to divulge any information to DCF beyond clinical updates regarding the youth in care. Despite these challenges, rather than setting limits that might disrupt the treatment process, the clinician has moved the setting of family therapy to a large room to accommodate the brother’s activity level and has engaged with the family within the constraints noted in the hopes of developing a clinical alliance that will benefit the youth and family. She has reviewed her decision-making regularly within the process of clinical supervision.

Youth #6 was reported to have had a turbulent childhood, initially living with both biological parents, then with paternal grandmother because her mother engaged in substance use, then with father and stepmother, then with stepfather and mother, as mother was sober and had filed for visitation and custody. At some point, father was reportedly selling and using drugs and was incarcerated. The youth resented both parents for their absences from her life, but wanted relationships with both, and both are reportedly now sober. Family sessions were held with mother, some of which were held telephonically because mother had a high-risk pregnancy, and contact with father was re-introduced and facilitated by mother. The youth had several visits, then passes with her mother, had visits from her father, and she visited him while she was on pass with her mother. In addition, the patient’s outpatient clinician saw her on several occasions prior to discharge to facilitate transition to aftercare.

Recommendations:

- There are no recommendations as clinical staff are recognized for their efforts in these cases. The youth served at Solnit are often complex, not only clinically, but in terms of the challenges associated with placement. For many, placement with family is not feasible, and there may be a history of unsuccessful placements in foster homes and group homes, multiple hospitalizations, and behaviors that make them difficult to place from the PRTF. Nevertheless, discharge planning in these cases was considered to be a strength:
 - In the case of youth #1, although there were several indicators that the discharge plan might be more than the youth could tolerate, staff worked closely with her to assess the appropriateness of the disposition and to prepare her for discharge.
 - In the case of youth #2, discharge planning was comprehensive and well-planned.
 - In the case of youth #5, although it is unclear whether the strategy is optimal, the clinician is recognized for her thoughtful and consultative approach to care.
 - In the case of youth #6, the clinician is recognized for coordinating family and community resources in the best interest of the youth.

Independent Status

Activities Conducted by Consultants:

- Record review
- Clinical tracers and discussion with clinicians

Findings:

Youth #6 was discharged after shortly more than 3 months in the program. During her time in the program, she participated actively in many aspects of the program, including school, was DBT-committed, and made full use of various therapies. Approximately two weeks before discharge, with MD order, she accomplished the level of Mobility status identified as "Independent Status," which occurs infrequently. By policy, youth on Independent Status "...may move unsupervised...on grounds...and within buildings on the East Campus," and "do not require direct staff supervision for...periods of time...up to 60 minutes" The status "is designed to promote autonomy and responsibility and to help prepare youths for functioning outside of a facility setting." The MD order was written as "Discontinue standard observation. Start Independent status."

Independent Status clearly conflicts with the current practice that all youth are visually observed no less frequently than every 15 minutes when at the PRTF. However, the clinician noted that in various meetings, it was made clear that the youth would be observed every 15 minutes, and progress notes regularly acknowledged that she was on Independent Status with 15-minute checks, seemingly a contradiction. The clinician also noted that Leadership has recognized the inconsistency of the status with current observation protocols and that the intention is to determine whether the status should continue to exist, and if so, in what form. The supervising psychologist agreed, and stated that there were currently no youth on Independent status.

Recommendation:

Leadership should determine whether Independent status can continue to be maintained in some form at the PRTF given current practices, and policies should be amended accordingly.

FOCUS AREA ➤ APPROPRIATENESS OF ADMISSIONS

Appropriateness of Admission of Current and New Patients

Activities Conducted by Consultants:

- Review of reason for admission of all current PRTF youth.
- Discussion of these cases with clinical staff.
- Review of new admissions with the Medical Director and Director of Nursing.

Findings:

The cases of all youth within the PRTF at the time the Barrins team began its consultation were reviewed. No instances were found in which a currently admitted youth was considered by the Barrins team as having been inappropriate or too high risk for admission to the PRTF. There were cases in which a PRTF level of care was not considered by the Barrins team to be clinically necessary. However, no other acceptable treatment or placement had been found for these youth. The PRTF does serve the function of an interim treatment environment while an appropriate community placement is arranged or family work is conducted to enable the youth to return home.

Two admissions occurring after the Barrins team began its consultation were reviewed to assess whether the admissions were appropriate. The first was review on August 23 and was discussed in a previous report.

The second new admission to the facility (Quinnipiac Unit) was reviewed on August 30th with the Medical Director, primary clinician (a post-doctoral psychology fellow), and the supervising clinician. The Director of Nursing was on leave and, thus, unavailable for this review. The PRTF admission criteria and the Beacon Health Options level of care criteria were reviewed with respect to this admission. These staff made the case that the youth fit admission criteria. However, it was later revealed that the PRTF had rejected the initial referral, which reportedly focused on the youth's "conduct disorder."

The youth was in the state's CSSD-operated detention center; a CSSD clinician had conducted an assessment and specifically recommended admission to the PRTF; and a judge had twice subpoenaed PRTF staff to appear in court to discuss why this youth was not being admitted.

It is the view of this consultant that the youth was not inappropriate for admission, certainly did not need a higher level of care, and may derive some benefit from the PRTF. The involvement of the judge seemed to be a decisive factor in the youth's admission to the PRTF.

The Provider Plan of Correction submitted July 30, 2018 states that "Referrals are to be reviewed weekly with the Medical Director and the Director of Nursing at Management and/or Triage Meeting." In the case described above, it was not clear if the Medical Director had been in meetings where this referral was reviewed prior to admission. He did receive notice of the admission one working day prior to

admission. Referrals are discussed weekly in a triage meeting, but the Medical Director indicated he is not always in attendance.

The facility does not appear to have a procedure in place to adhere to this element of its own corrective action plan.

Recommendation:

In order to ensure adherence to its own corrective action plan, a procedure should be implemented to guarantee that the Medical Director and Director of Nursing review a potential admission prior to a final decision to admit. A simple procedure would involve having the intake coordinator review pending admissions with the Medical Director and Director of Nursing and briefly document those discussions.

FOCUS AREA ➤ REVIEW OF 5 RECENT SERIOUS INCIDENTS

Activities Conducted by Consultants:

- Record review for 5 youth involved in critical incidents.
- Review of selected documents and reports.
- Discussion with Superintendent.
- Interviews with selected staff.

DOB	DOA	DOD	DPH report	Identifier	Event
9/11/2001	2/6/2018	6/28/2018	7/27/2018	Resident #1	Hanged self at Solnit
2/23/2004	9/6/2017	12/28/2017	N/A	N/A	Hanged self at home
7/29/2003	10/25/2017	7/15/2018	7/27/2018	Resident #3	Choked self at Solnit
1/17/2001	12/1/2017	3/15/2018	4/9/2018	Resident #1	Overdose at Solnit
4/17/2002	3/5/2018	3/22/2018	4/9/2018	Resident #2	Choked self at Solnit

Findings: Reviews are in progress.

Recommendations: Pending completion of reviews.

FOCUS AREA ➤ MEDICAL RECORD REVIEW FOR REQUIRED DOCUMENTATION

Pre/Post Pass Risk Assessment:

Activities Conducted by Consultants:

- Record review
- Clinical tracers and discussion with staff

Findings:

Two clinicians separately stated that a clinician assessment can substitute for a nursing assessment prior to a family pass, one stating that she believed the policy states that “a licensed person” can do the pre-pass assessment, and she believed that prior to the expansion of nursing staffing, clinicians sometimes provided the assessments because nurses were not promptly available.

The policy *Youth Care: Therapeutic Visit* states that “Pre- and post-visit nursing assessments shall be performed and documented in the youth’s medical record.” It does not endorse or prohibit pre-pass assessments by others, but it does not identify such assessments as a substitute for the nursing assessment.

However, in every case reviewed, a nursing assessment was found prior to and subsequent to a pass. No instance of a clinician assessment in place of a nursing assessment was found. No evidence of a violation of the policy was found.

Evidence was consistently found of documented contact (or attempted contact) by the clinician with the family or other responsible party on the first working day following a pass, which is considered to be a strong clinical practice.

Recommendation:

Clarify for staff the requirement for nursing assessments prior to and subsequent to each pass.

Administration of the C-SSRS/Suicide Risk Assessment:

Activities Conducted by Consultants:

- Record review.
- Clinical tracers and discussion with staff.

Findings:

Solnit has adopted the Columbia-Suicide Severity Rating Scale to assess suicide risk at various significant points during the course of care, most notably upon admissions or in response to self-injurious behavior.

Youth #3 had an incident identified as self-harm, including scratching herself and punching a wall. Medications were adjusted, and the incident was addressed as an instance of change in clinical condition with a treatment plan addendum and additional support and monitoring ordered, and later discontinued. This was all documented with assessments. However, a C-SSRS was not completed, despite the fact that the policy *Youth Care Precautions: Self Harm Precautions* states that “If a staff member observes that a youth has...engaged in self-injurious behavior...the Registered Nurse will...complete the...C-SSRS.” Although the clinician noted the self-harm behavior was relatively minor, which appeared to be the case (the youth attended an off-grounds activity later on the same day), it was identified as self-harming behavior and was addressed properly in the record as self-harming behavior in other prescribed ways.

Also, there was no documented evidence that Youth #3 was placed on constant observation despite the fact that the policy *Youth Care Precautions: Self Harm Precautions* states that “Any youth that has engaged in a self-injurious behavior...will be maintained on constant observation...pending assessment.”

In contrast, after youth #4 expressed suicidal ideation, proper assessments occurred, including the C-SSRS; the frequency of observation was increased per doctor's order; good evidence existed of communication with the physician; orders were clearly written; and discontinuation of those orders was clearly written and justified. Hence, the problem is not pervasive.

For youth #5, the initial administration of the C-SSRS by the RN had 4 positive responses, all reported for the youth's lifetime and none for the more recent past. There were no further administrations of the C-SSRS, which the clinician believed was consistent with policy, which states "If the C-SSRS registers no positive answers, no further action is necessary." However, positive answers were registered, albeit not for recent time periods, and the policy also states "If the C-SSRS registers positive answers on questions 1, 2, or 3, the nurse will notify the treating psychiatrist," which did not occur despite the fact that a positive answer was registered for question 1 (Wish to be Dead) for the Lifetime rating.

Administration of the C-SSRS Attachment 3 often does not occur in a manner consistent with instructions on the form when the youth denies suicidal ideation. The instructions state "Ask Questions 1 and 2. If both are negative, proceed to "Suicidal Behavior" Section," which would mean that Questions 3-5 would not be completed and the subsequent section, Intensity of Ideation, would not be completed. Nevertheless, when the answers to question 1 and 2 are negative, questions 3-5 are frequently completed, and the Intensity of Ideation section is often completed, even though the content of those questions is illogical in the context of negative answers. In another case, when the Intensity of Ideation section is appropriately left blank, the rater did not proceed to the "Suicidal Behavior" section and complete it.

It is noted that regular use of the C-SSRS is relatively new at Solnit South, and staff may not have developed the habits that facilitate its use.

Recommendations:

- Prioritize compliance with C-SSRS administration and documentation of the implementation of constant observation.
- Measure compliance with C-SSRS administration and documentation of the implementation of constant observation as part of the QI/RM process.
- Leadership should review and clarify the policy regarding administration and discontinuation of administration of the C-SSRS
- Staff who administer the C-SSRS should be retrained after the policy is clarified.

Psychosocial Addendum:

Activities Conducted by Consultants:

- Record review
- Clinical tracers and discussion with staff
- Discussion with Supervising Social Worker and Psychologist

Findings:

In the record of youth #2, a Psychosocial Addendum was completed rather than a comprehensive Psychosocial Assessment. A clinician explained that when a youth is admitted directly from the Solnit

South hospital unit, a brief Addendum is acceptable with updated information. Unfortunately, the more comprehensive Psychosocial Assessment was not found in the Psychosocial section of the record where the Addendum was located, and it could not be located elsewhere in the record by the clinician. The Supervising Clinician suggested that the original Assessment might be found in the PRTF "overflow" chart in the Abstracts section, and it was. They were unable to locate a policy that describes the practice of generating an Addendum. The original Assessment was generated approximately 100 days before the Addendum.

Recommendations:

- Develop a policy to govern the Psychosocial Addendum, defining the conditions under which an addendum is acceptable and where the original Assessment can be located in the PRTF record.
- Locate the original Assessment be located next to and directly behind the Addendum for ease of reference.

Authorization of restraint:

Activities Conducted by Consultants:

- Record review.
- Discussion with Superintendent.

Findings:

The policy *Youth Care: Emergency Safety Interventions – Physical Interventions* defines Licensed Independent Practitioner (LIP) as "any practitioner permitted by State law and facility policy as having the authority to independently order restraint or seclusion." However, the required facility policy does not exist. According to several staff and the Superintendent, the psychiatrists, APRNs, and pediatricians can order restraint, and by exclusion, other LIPs cannot, e.g. psychologists, licensed clinical social workers. Therefore, a practice exists, but a policy governing that practice does not.

Recommendation: Develop a policy that matches the practice.