Review of Sequel Programs

Washington State Department of CHILDREN, YOUTH & FAMILIES

Original Date: Nov. 30, 2020

Child Welfare Programs| Approved for distribution by Steve Grilli, Director of Child Welfare Programs

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CONTENTS

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BACKGROUND

Former Children's Administration and subsequently, DCYF has been placing youth in Sequel run programs since October 2013. In August/September of 2016, Connie Lambert-Eckle, then Director of Field Operations, and Doug Allison, then-Supervisor for the Adolescent and Education Unit in the Program and Policy division, toured Sequel's Clarinda and Woodward Youth Services programs in Iowa to learn more about Sequel programming and explore the possibility of opening Sequel facilities in Washington. While Sequel has not opened a facility in Washington, DCYF has used Sequel programs at several different locations in several different states over the last seven years.

In August 2018, Disability Rights Washington (DRW) notified DCYF of its concerns about Clarinda Academy in Iowa, as well as concerns related to other out-of-state intensive resource placements. As a result of the review of placements and programs at that time, recommendations included:

- Making changes to the template contract language requiring an incident report any time a physical restraint is used.
- Requiring DCYF staff to do an in-person visit to a facility DCYF had not used prior to placing youth in the facility.
- Completing in-person visits by DCYF staff at least every 6 months after placement.

DCYF also stopped referring Washington youth to Clarinda Academy and removed the remaining youth that were there.

In September 2018, DCYF sent teams of executive leadership representatives paired with regional caseworkers or program staff to every out-of-state facility with Washington state youth placed on Child Specific Contracts (CSC). These teams interviewed staff and youth in each program and completed a write-up using a form developed for this purpose. These forms were reviewed by the Intensive Resources program manager and the Supervisor of Adolescent and Education programs to have a separate review of the documentation, to ensure youth were safe and the programs were meeting the child-specific contract expectations. In addition, an out-of-state work plan was created with the goal of returning youth back to Washington state for placement. The work plan established policy and practice changes including:

- Requiring quarterly in-person visits by DCYF staff for all youth placed out of state on CSC.
- Developing additional guidance regarding monthly caseworker contact with youth placed in out-of-state facilities.
- Developing additional guidance for documenting and responding to critical incidents.
- Increasing review and oversight prior to placement in programs that Washington has not previously used to include an in-person visit, review of program restraint and behavior management policies, and licensing standards and history.
- Added the Director of Field Operations to the review process for all requests for out-of-state CSC.

This work plan was shared with DRW. At the time of the 2018 review, DCYF had approximately 78 youth in out-of-state facility placements. As of November 19, 2020, there was 16 youth (13 Washington State-dependent youth and 3 tribal youth) placed in out-of-state facility placements.

Since the concerns about Clarinda Academy were raised in 2018, there have been additional incidents that have occurred at different Sequel program locations. Sequel closed Red Rock Academy in Utah after an incident described as a riot occurred in 2019. Most recently, a non-Washington youth died as a result of being restrained at the Lakeside Academy program in Wisconsin. Sequel has closed that location as well. The staff involved in the

Lakeside Academy incident were fired (per Sequel), and as many as 10 have been criminally charged in the death. Washington did not have any youth placed at Lakeside Academy at the time.

As a result of the continued concerns, DCYF completed a desk review of the Sequel programs where Washington State youth were placed on CSC as of September 2020. At the time the review began, Washington had 10 youth placed in 4 Sequel programs. As of the writing of this report, there are 5 youth, 3 Washington State dependents and two tribal dependents, placed in four Sequel programs. These programs include:

- Mountain Home(TSI) in Mountain Home, Idaho, currently has 2 youth.
- Forest Ridge in Estherville, Iowa, currently has 1 tribal youth.
- Falcon Ridge in Virgin, Utah, currently has 1 youth.
- North Illinois Academy in Aurora, IL, currently has 1 tribal youth

Effective September 10, 2020, DCYF suspended new referrals to all Sequel programs. DCYF also had each assigned caseworker have a private conversation with youth placed in Sequel programs to ask them if they felt safe and assess their safety. Youth's placement in the programs was assessed for transition to a non-Sequel placement able to meet their needs, and the current status is included in the Review Summary section, below. A monthly field assignment was implemented to monitor the completion of monthly Health and Safety (H&S) contacts and visits. DCYF has identified a contracted provider in the state where youth are placed to complete monthly in-person H&S visits. The expectation for monthly contact by the caseworker with the youth was updated to prioritize virtual visits over phone contact when possible. These virtual visits or phone contacts are in addition to the in-person contracted Health and Safety (H&S) visits from the contracted provider in each state. Due to COVID, some in-person visits have not been able to occur. If a youth does not have an in-person contracted H&S visit, the caseworker is to complete two virtual visits.

SEQUEL REVIEW PROCESS

The Sequel review was completed virtually due to the COVID-19 pandemic. The review included the following:

- Reviewed FamLink case notes for documentation of monthly contact by caseworkers.
- Contacted all youth at a Sequel program to explore whether they feel safe.
- Reviewed Sequel policy and procedures for new employee training, incident reporting, and physical intervention policies, including program-specific policy and procedure variations.
- Talked with facility licensors and reviewed copies of the last licensing review.
- Reviewed incident reports for Washington youth for July and August 2020.
- Verified the Joint Commission (JCO) accreditation status.

Summary of Review:

Policies and Procedures

Sequel has standardized policies and procedures that it utilizes across all of its programs. The policies have a local addendum at the end of each policy for local licensing variances that do not conflict with the Corporation's standard policies. Policies were well written and had all of the items one would expect to see, especially since all sites are accredited through JCO. These include trainings on trauma-informed care and training on physical intervention that reinforced the expectation that physical intervention and restraints should be the last resort to keep the youth and others safe. There were no obvious concerns noted in the policies that were reviewed. Historically, all Sequel programs had been accredited by one of the three national accrediting bodies, but at the end of 2019, Sequel brought all their programs under the JCO accreditation for consistency.

Review of Incident Reports

Available incident reports were reviewed for youth placed in each facility. Incident reports are used to document safety concerns or unusual incidents. Examples of some safety concerns are allegations of child abuse or neglect, safety plan not being followed by all parties, parent or child relapsing on drugs and/or alcohol, or new safety concerns not related to abuse or neglect. Some examples of unusual incidents include, but are not limited to: physical harm to self or others by the client, sexual assaults or age-inappropriate sexual behaviors, severe behavioral incident(s) outside the youth's ordinary baseline behavior, running away, incidents that require medical attention or hospitalization, or adverse reaction to food or medication. The CSC requires facilities to immediately notify the assigned DCYF caseworker and to provide written documentation within 24 hours for safety concerns or unusual incidents. Given the variety of incidents that are documented in the reports and the behaviors presented by the youth in placement, it is not unusual for incidents to occur. Summaries of the reports reviewed are included in the narrative for each program.

Northern Illinois Academy (NIA), Aurora, Illinois

Washington State had two dependent youth placed at NIA and assisted with the placement of one tribal dependent youth. When Washington youth were asked if they felt safe at NIA, they both reported they felt safe. The one tribal youth indicated that they did not feel safe at NIA. DCYF immediately notified the tribe of this information and the tribe made the decision to leave the youth at NIA.

All incident reports for the three youth for the last 60 days were requested for review. The tribal youth had 2 incident reports during this period. One DCYF youth had 8 incident reports, and the other youth had 9.

The youth that is a tribal dependent had two incidents that were reviewed. One incident required a physical intervention to stop them from assaulting a peer. The other incident did not require a physical intervention for assaulting a roommate. The roommate was moved and the youth was able to regulate their behavior. The tribe has elected to have this youth remain at this location after being informed about DCYF's concerns.

The first DCYF youth reviewed had eight incidents during the time frame that were reviewed. Of those, two required a staff escort of the youth for physically assaulting other youth and trying to run away from the program. Three incidents required no physical restraint and included the youth hitting their head on keys in the staff's pocket when the youth was attempting to horseplay with staff, verbal direction only, and using physical presence to interrupt behavior that included self-harm and assaulting staff. In three of the incidents, physical intervention was used twice because the youth was assaulting another peer, and once because the youth was hitting, kicking, and spitting on staff.

The second DCYF youth had nine incidents that were reviewed. Five of the incidents reviewed had no physical interventions. They either had staff presence or verbal de-escalation. The youth during these incidents was trying to assault a peer, using foul language towards female staff, trying to incite a riot, or had run or was trying to run away from the program. Four of the incidents had a physical intervention. In three of the incidents, physical intervention was used due to assaulting/fighting with peers. In the fourth incident, the youth was assaulting staff and causing property damage to the facility. Staff applied an inappropriate restraint on the youth. CPS and law enforcement in Illinois were involved. Staff was placed on administrative leave, and the Illinois Department of Healthcare and Family Services opened an investigation on the incident.

There is a video of this incident and a copy of it has been requested more than once. DCYF has not received a copy of the video, and on October 29, 2020, we received the following email response to our request for a copy of the video:

> *"Dear Mr. Campbell,*
>
> *We are in receipt of your October 8, 2020 request for video submitted to Jarrett Shoemaker. We respectfully disagree with the analysis that the video in question constitutes either an "l. Incident report[s] involving the youth. . ." or "h. Medical care provided to youth."*
>
> *We believe that the video files are best described as something akin to peer review records—i.e. we use video to confirm the details of description of events from both students and staff; and to evaluate, adapt, and train on trauma informed care. As such, the video files are outside the designated record set as defined in 45 CFR section 164.501. Given this analysis, we have concluded that the video does not fall into required reporting per our contract.*
>
> *If you would like to schedule a call to discuss further, we would be pleased to allocate some time to do so.*
>
> *The responsibility and trust that Washington has imparted on Sequel to serve its youth has not gone unnoticed. We look forward to building on our relationship and strive to assist our partners whenever we can."*

While reviewing incident reports for NIA, there were also two separate references to incidents happening when staffing ratios fell below the minimum standards. As a result of the incident of inappropriate restraint, and the two incidents of self-documented out-of-ratio compliance, DCYF decided to return all DCYF youth placed at NIA to Washington and no longer place youth in that facility. Increased monitoring of each youth at NIA was put into place until the youth could be moved. The victim of the incident/assault moved back to Washington state on September 30, 2020. The other state-dependent youth returned on October 22, 2020. A DCYF staff stayed in Illinois beginning October 6, 2020, and met with the youth in-person weekly until he returned. The tribal youth remains there. DCYF has notified the tribe of our concerns and that we will no longer place youth there. The tribe at this point has said it wants its youth to remain there.

As DCYF has stopped placements at NIA and returned youth to Washington, Illinois licensing and CPS were not contacted. Due to the difficulties in obtaining the video of the incident, DCYF is exploring revisions to contract language that would require facilities to provide recordings of incidents involving Washington State youth.

Falcon Ridge, Virgin, Utah

DCYF has one youth at Falcon Ridge. When the youth at Falcon Ridge was asked if they felt safe, they confirmed they did feel safe. This youth did not have any incident reports during the period from July to September. This youth reports wanting to enter extended foster care and remain in Utah after they turn 18 years old in early 2021. The facility is taking them to tour colleges in the area.

Falcon Ridge is accredited by the JCO. On October 1, 2020, DCYF spoke to Utah licensor, Kelley Anderson. Mr. Anderson has been a licensor in Utah for over 15 years and has monitored Falcon Ridge during those 15 years. Per Mr. Anderson, Falcon Ridge has not had any major licensing or CPS findings since at least August 2018. He last did an on-site review in October of 2019. There were no findings and therefore was not a report written at that time. The previous year, there were minor violations, mostly around not reporting minor non-safety related items within 24-hours. There was a change in the law about reporting these incidents, and the violations occurred as the providers worked to follow the new requirements. He said they are doing well with this at this

point. He also had access to the CPS investigations for the last two years and did not find any concerns from those investigations.

Mr. Anderson was asked about any concerns with Sequel as a whole. He had none. He mentioned that he believed that Sequel was being progressive with implementing UKERU into their programs in an attempt to reduce the need for physical interventions. UKERU is a method of trauma-informed care that uses blocking pads in an attempt to not need hands-on physical intervention. Mr. Anderson was scheduled to complete his next licensing review in October 2020. He relicenses facility-based programs every year. Mr. Anderson spoke very highly of this program saying that it has been a well-run program for years. Based on the available information, there were no concerning patterns at this facility.

Forest Ridge, Estherville, Iowa

At the time of the review, there was three youth placed at Falcon Ridge. Currently, DCYF has no youth at this program and there is one tribal dependent youth there. When all three youth were asked if they felt safe at Forest Ridge, all three said that they did feel safe. This agency is accredited by JCO as well.

There were 11 total incident reports reviewed for the 3 youth. It was noted as part of the review that the reports could be more detailed.

The first Washington State youth had 4 incident reports. One of those was for giving themselves a tattoo with a paperclip. Three incidents involved physical intervention for assaulting staff. Two incidents required physical intervention that started as a standing position and ended with the physical intervention in a seated position, and the third was a standing restraint that ended in a supine hold. In one of the instances, staff were trying to prevent the youth from running away and putting themselves into an unsafe situation. In two of the incidents, the staff used Ukeru pads in an attempt to not have to use physical intervention. Ukeru is a system of using blocking pads for youth to take some of their energy out on. This youth has returned to Washington state.

The second youth reviewed only had one incident report for the time period for finding ibuprofen that another youth had taken from a medication box and put into this youth's room. This youth found the medication and reported it to staff. This youth has returned to Washington state.

The third youth was tribal dependent youth who had six physical interventions that were due to self-harm behaviors and assaulting staff and peers. In four of these incidents, the staff tried using the Ukeru blocking pads prior to using a hands-on physical intervention. The youth also had one self-harm incident in which no holds were used, only the Ukeru pads.

The licensing report identified two founded findings on two former employees from late 2018 and early 2019. In two separate incidents (two different staff members) two clients made allegations of sexual abuse. Those staff were fired and Iowa CPS made founded findings on them.

On September 25, 2020, DCYF spoke with Dixie Dupey, Licensor in the Iowa Department of Inspections and Appeals. Ms. Dupey is a Health Facility Inspector. She has been in her current role for 15 years and has been the licensor for Forest Ridge during the 15 years. She had very positive things to say about the program and the facility. She has no concerns about safety at this time. When asked about the two founded findings on the staff, she said the agency was very proactive in the reporting and suspended the staff immediately. The facility and cottages took the incident very seriously and provided everything in a very timely manner. Ms. Dupey noted that there was a period of time in late 2018 and early 2019 when there was a rash of CPS and licensing intakes from girls in the program alleging sexual abuse. Ms. Dupey said that one of the founded reports was due to inappropriate touching (no intercourse). Ms. Dupey believes that the agency had terminated both employees

prior to the completion of the investigation. Only these two reports were founded. Ms. Dupey also reported that Forest Ridge tends to over-report and report things that they are not required to report. Forest Ridge's licensing was moved from a three-year cycle to a one-year cycle because of the founded findings. This is consistent with a change in the law in Iowa just prior to these incidents that required them to go to a one-year cycle. At the time of the discussion, Ms. Dupey was getting ready to do an on-site monitoring review. She said that COVID has made in-person reviews difficult. Ms. Dupey provided contact information for the Iowa CPS investigator Kelley McKeever. On September 28, 2020, DCYF talked with Mr. McKeever on the phone. He stated he had worked in his current position for 23 years. Mr. McKeever stated that he did not do every single CPS investigation at Forest Ridge but did the "lion's share" of them. He shared very similar information as Ms. Dupey. He also did not have any current concerns about safety at this facility. He noted that "today is today and that may change tomorrow" with any new intake that may come in. DCYF followed up on this statement, and he said that you never can predict what the next day will bring. At the time of the call, he had no concerns. From the information available for review, there were no concerning patterns at this facility.

Mountain Home (TSI), Mountain Home, Idaho

At the time of the review, DCYF had four youth placed at Mountain Home. Currently, however, there are two Washington State youth placed at the facility, one who had been there and one who was placed in early September. Washington State youth in this program are there primarily to participate in sexually aggressive youth (SAY) treatment. When all four youth were asked if they felt safe at Mountain Home, all said they felt safe. Of the four youth that had been there, one youth had four incident reports, one youth had seven incident reports, one youth had two incident reports, and one youth had 11 incident reports.

The first youth had four incident reports, all of which required a physical intervention. One was for attempting to assault a peer. The other three were for assaulting staff and doing property damage. In one of the staff assaults, the youth charged staff with a broken broom handle. This youth has returned to Washington state.

The second youth had seven incident reports that were reviewed, all involving physical intervention. Two of the physical interventions were due to preventing self-harm. Four incidents were for assaulting staff. In the incidents involving staff assault, the youth also was damaging property or attempting to run away. The last incident required a physical intervention to prevent the youth from fighting/assaulting a peer. This youth has returned to Washington state.

The third youth that was reviewed had two incident reports. One required physical intervention for threatening peers and then shoving staff. The other incident report was documenting an assault by a peer on the youth. This youth has returned to Washington state.

The fourth youth had eleven incident reports that were reviewed. Two incidents involved a physical intervention due to trying to incite a riot and then assaulting staff. Two incidents involved a physical intervention for trying to run and then assaulting staff. Two incident reports involved physical intervention because youth assaulted staff. In one incident, the youth assaulted staff during a self-harm episode. Three incidents required a physical intervention due to arguing with and then assaulting peers. One incident was for hitting a peer while horse playing. The remaining incident was consensual sexual contact with a peer on October 7, 2020. The sexualized behavior is being investigated by Idaho CPS and Licensing. Information provided from an internal review from Mountain Home indicates that staff could have been better positioned on the floor for supervision and that refresher training would be given to all staff as a reminder. It appears that there was enough staff on the program from Sequel's self-report. DCYF will continue to monitor the outcome of the Idaho CPS investigation. This youth remains at this program.

In a recent in-person H&S visit with the youth placed after the review process had started, that youth reported to the DCYF employee that Mountain Home staff were on their phones when supervising youth. The DCYF employee asked the Executive Director about this, and he explained that there was a policy that staff were not to be on their phones but it did sometimes occur, and when it did it was addressed by management. In addition, although outside the timeframe of this review, there was also an incident of youth touching each other during group in December 2019. Issues of supervision were identified as an area of concern related to that incident.

The licensing review did not show any concerning patterns. DCYF talked with licensors Sandi Frelly and Kelle Johnson for Mountain Home on October 15, 2020. Both licensors shared they could not provide details, but that overall they had no concerns with Mountain Home. They stated that they had just completed a virtual licensing review of Mountain Home in October 2020 and had no concerns. DCYF requested a copy of the licensing report from Sequel Programs the same day. As of the writing of this report, DCYF had not received the document. The licensors stated that they were aware of the incident from October 7 when they did their review. DCYF asked if this changed any of the information that they had shared about Mountain Home, and both said it did not. Both of these licensors cover all of the facility-based licenses in Idaho. This location is in good standing with JCO.

RECOMMENDATIONS RELATED TO PLACEMENT IN SEQUEL PROGRAMS

Based upon this review of Sequel programs and the incidents that have occurred since 2018, the following are recommendations related to the use of Sequel programs:

- It is recommended that DCYF not use Sequel programs for placement and actively work to transition youth in those programs to another program or placement able to safely meet their needs as soon as one is located based upon:
    - Significant incidents regarding youth safety at different Sequel programs over the last two years with the closure of two facility locations.
    - Concerns regarding the supervision of youth at Mountain Home Academy in separate incidents.
    - Significant incident at NIA and failure to provide a copy of the video of the incident involving a DCYF youth.
- If new safety concerns arise, then DCYF should move the youth immediately.
- Continue to pursue the video of the incident at NIA. DCYF AAGs might need to take legal action to get a copy of the video.
- Continue to monitor CPS investigation at Mountain Home for the October 7, 2020 incident. The most recent request made to Idaho CPS was October 27, 2020. Assess the program for continued placement of current youth based upon the outcome of the investigation.
- Complete DCYF weekly in-person visits with youth at Mountain Home Academy as allowed by COVID restrictions that may be in place until youth have left Mountain Home. Quarterly in-person visits will continue for youth at other facilities.
- Continue monthly video conferencing for youth placed in the programs until all youth have moved. If COVID prevents contracted in-person health and safety visits, video conferencing will occur twice per month.
- Continue to monitor contracted Health and Safety monitoring reports each month until all youth leave Sequel facilities.
- Revise language in the out-of-state child-specific contract to include copies of any videos of incidents.