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:
Taberg Residential Center for Girls
Taberg, NY

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INDIVIDUAL FACILITY MONITORING REPORT:

TABERG RESIDENTIAL CENTER FOR GIRLS

Taberg, NY

I. INTRODUCTION

This is the fourth 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 Taberg Residential Center for Girls (TRC) on February 7-9, 2012. As noted in the previous monitoring reports, 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 Needed, 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 and Columbia Secure Center for Girls.

In an August 22, 2011 memo, the Monitors presented their concerns about the adequacy of mental health services and the capacity of Taberg and Columbia to insure protection from harm during the high-risk transition period. On August 25, 2011, Acting OCFS Deputy Commissioner Franco responded with information about staffing, transition, and treatment at Columbia and Taberg.

OCFS provided brief transition plans for 12 girls moved on August 31, 2011 from Tryon Limited Secure to Taberg that summarized each girl's presenting problems and treatment while at Tryon. The 12 limited secure girls who moved to Taberg ranged in age from 13-17. They had been at Tryon 13-379 days, with half there less than three months and five between 3-6 months. Almost all the girls were described as aggressive and having trauma histories; four had been placed in psychiatric hospitals; eight of the 12 girls were taking psychiatric medication.

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.

B. Facility Background Information

TRC is a 23-bed limited secure facility with two units in one building. It formerly housed a male juvenile facility. One unit, with ten beds, is now the only mental health unit for girls in New York State; admission to that unit is done by a statewide Mental Health Unit committee. The other unit, consisting of 13 beds, is the only limited secure program for girls in the state (Lansing is a nonsecure facility that accepts limited secure girls).

Taberg opened for girls on August 31, 2011 when 12 girls moved from Tryon. Annsville, a nonsecure juvenile facility next door to Taberg, and Tubman, a girls program, also closed. TRC has a blended staff, with a third from Taberg Boys, a fifth each from Annsville and Tryon, and a quarter new and from elsewhere. It appeared that other than the minority of staff who had previously worked at Tryon and Tubman, many staff did not have experience working with girls and had limited training about girls.

It is astonishing that OCFS would have combined displaced staff from different facilities with no opportunity for team building, learning the New York Model or having a shared understanding of the unique needs of this group of girls prior to the facility opening. The new TRC staff were expected to meet the needs of a transplanted, complex group of girls who had been characterized as "out-of-control" in what some staff called a toxic environment at Tryon. It is remarkable that staff, whose ranks were dangerously diminished because of injuries, and who had mandated double shifts, struggled to keep the girls safe over four chaotic months and remained committed to turn things around with new leadership.

The girls at TRC have had a tumultuous history, with substantial change in their population with in a few months. The day of the move from Tryon (8/31/11), the first Taberg resident was fennered to Columbia after a staff member was injured. The next day, on 9/1/11, 11 girls at Taberg were involved in a "group disturbance." Police were called, one girl went to jail, three girls went to the hospital for mental health assessment, and a staff member was injured. A month later, on 10/3/11, eight girls at Taberg were involved in a "group disturbance." Police were called, and one girl went to jail. A month later, on 11/6/11, four girls at Taberg were involved in a cafeteria disturbance, one girl was taken to jail, and a staff member was injured. A month later, on 12/6/11, a girl injured a staff member, went to jail, and was sent to Columbia. On 12/12/11, nine girls at Taberg were involved in a "group disturbance." Police were called, two YDAs went to the hospital with concussions, two girls were fennered to Columbia, and another girl went to jail. By the time of our site visit, only three of those nine girls remained at Taberg. On 12/21/11, police were called, two girls went to jail, and on 1/10/12 one of them was fennered to Columbia. On 1/17/12, a girl went to jail for injuring a staff member.

On February 7, 2012, there were 15 girls at Taberg, nine on the mental health unit (Unit 12), and six on Unit 13 (three additional girls listed in the Taberg population were at the Oneida County Jail at the time of our visit). The 15 girls ranged in age from 13 to 17. They had been at Taberg/Tryon from 13 days to 784 days. They were committed for: Assault (4), Robbery (1), Weapon Possession (1), Stolen car (1), Harassment (1), Menacing (1), Grand Larceny (1), Criminal Mischief (2), Stolen property (2), and Petit Larceny (1). Of the original 12 girls moved from Tryon on August 31, 2011, only five girls remain at Taberg. Since their admission to Tryon, they have been in custody for lengthy periods (one longer than two years, two almost a year, and two longer than eight months—although one of them was discharged home from Taberg and returned a few weeks later). Six of the 12 have moved to Columbia and one is in jail and likely to move. Two girls admitted after Taberg opened have left by transitioning to aftercare or a residential program.

All but three of the Taberg girls are prescribed psychiatric medication. Although more girls on the MHU have an Axis I diagnosis, three girls on Unit 13 are diagnosed with anxiety disorder and one with mood disorder. Girls on both units are prescribed similar psychiatric medication: [Trazodone (2 on MHU, 4 on Unit 13); Seroquel (5 on MHU), Abilify (3 on Unit 13), Prozac (3 on MHU), Zoloft (1 on MHU, 1 on Unit 13), Zyprexa (1 on MHU), Clonidine (1 on MHU), Remeron (1 on Unit 13), Tenex (1 on MHU), Vistaril (2 on MHU), Aderall (1 on MHU), Intuniv (1 on MHU), Lamictal (1 on MHU), Vyvanse (1 on Unit 13), and Benadryl (3 on MHU)].

The MH Monitor and the PH Monitor met together with two staff groups on the first day of the Taberg site visit. These meetings were informative both about the commitment of staff to the girls and the struggles staff have faced since the facility opened for girls. "Taberg before the girls ran smoothly" and "girls are so different from boys" were comments heard in both meetings. But when staff described the girls as disrespectful and out-of-control, staff who had worked at Tubman commented, "that comes from the toxic environment of Tryon they brought with them rather than being girls' nature." Staff described being demoralized when their former facilities closed, and then experiencing burnout because they had to operate with only "15 out of 33 YDAs." As one staff commented, "We're totally frustrated. We feel unsafe. We're in survival mode. We need help in here fast. We need to work together." Education staff said they had never been in a facility where residents could refuse to go to school; they missed the consistency of the same YDAs accompanying youth to school--at Taberg staff had to remain on the unit with girls who did not attend. They were glad that attendance has improved with the new school incentive program. Staff talked about safety, structure and working with girls through trusting relationships, which they thought, was undermined when staff could not establish control on their units. They expressed a desire to "learn to be proactive to prevent problems," but successfully using their new de-escalation techniques had been challenging. The New York Model was described as "one more requirement" for worn out staff; some who felt confident about their Sanctuary skills thought instead of implementing something new, they should rely on what they knew.

It was commendable that Taberg staff are working hard to achieve two safe, stable, caring units, know teamwork among all staff is essential to achieving safety and stability, view relationships as the key to effectiveness with girls, and recognize control and

punishment will not achieve safety, stability or help girls recover from trauma. Taberg staff want to avoid the tendency in unstable facilities for the argument that "safety trumps treatment" when youth act out. This is a false dichotomy since an integrated treatment program makes safety possible, and youth who feel safe are easier to guide. With a population of traumatized youth, crisis prevention is much more difficult without a safe environment where trauma recovery and emotional regulation are being learned. Stable relationships and a calm environment are key ingredients of the New York Model.

Achieving trauma-responsive, relationship-driven, culturally competent, and strengths-based teamwork to meet girls' needs is difficult with a population as troubled as the girls at Taberg. All of the girls experienced repeated trauma from some combination of sexual abuse, physical abuse, loss of important people, and exposure to domestic violence, parental substance abuse, and community violence.

This is a critical point for Taberg in becoming a facility that meets these troubled girls' needs. New leadership and the transfer of aggressive Tryon girls began stabilizing Taberg in late January, and the promise of 15 additional YDAs helped staff morale. The New York Model implementation training and intensive coaching of New York Model practices must occur soon at Taberg.

C. Assessment Protocols

The assessments used the following format:

1. Pre-Visit Document Review

The Monitors submitted a list of documents for pre-visit and 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.

A conference call on January 23, 2012 with the Home Office staff assigned to the Settlement Agreement provided the Monitors and the DOJ attorney with an update on the status of Taberg, including a list of concerns about staffing, safety, injuries to staff, and incidents that resulted in sending girls to the local county jail. Additionally, Home Office staff reported a problem regarding the absence of data on some physical restraints. Between August 31, 2011 and November 30, 2011, no restraint information had been entered into the ARTS system. The discovery of this problem resulted in changes in the leadership at Taberg and raised several serious concerns during the monitoring that are addressed below.

2. Use of Data

The Office of Children and Family Services (OCFS) has a good management information system with access to a wide range of data. A further review of the system and its capabilities allowed for the development of Excel spreadsheets that Home Office provides regularly to the Monitors that includes facility-based incident data and the semi-annual Performance-based Standards (PbS) data. The Monitors also received the OCFS second Six-Month Progress Report on the MAP on December 20, 2011.

3. Entrance Interview

The entrance interview occurred on February 7, 2012 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: Merle Brandwene, Director, OCFS Management and Program Support; Sandra Carrk, OCFS Project Manager; Lori Clark, Acting Director; Diane Deacon, OCFS - Legal; Kathy Fitzgerald, BBHS –SW Supervisor; Alyssa Lareau, DOJ; Edgardo Lopez, Settlement Agreement Coordinator; Denise Passarello, QAU Specialist; Theresa Peck, Health Services NA I; Beverly Sowersby, DJJOY – Facilities Manager; Joseph Tomassone, BBHS Chief of Treatment Services; and Suzanne Tulino, Assistant Director.

4. Facility Tour

Walkthroughs of the facility followed the entrance interview. The Protection from Harm facility tour was more extensive and included a general inspection of all usable spaces. The facility tour used copies of fire evacuation floor plans on an 8 ½" x 11" format.

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 document shipment to the Monitors and the on-site assessment.

The MH Monitor observed a treatment team meeting, Rounds, a DBT meeting, a Sanctuary education group and met with the clinicians. The MH Monitor reviewed eight girls' records (five from the MHU and three from Unit 13).

The on-site review of physical restraint videos revealed a significant problem. The quality of the Taberg surveillance camera system, including visual acuity and fluidity of motion, is so poor that there is very little confidence in video evidence to confirm or deny allegations of wrongdoing. Reliance upon stationary camera videos appears to be part of the OCFS accepted practice of reviewing uses of force and physical restraints. The fact-finding activities, which informed some of the Settlement Agreement paragraphs, used adequate video images; and the absence of specific references to the quality of video surveillance imagery in the Settlement Agreement is likely a result of an adequate video documentation capacity in the four original facilities. Now we have a newly added facility with an inadequate video surveillance system, which alters substantially the presumption of adequate video documentation. Also, the poor quality of the video could undermine SIU investigations and the integrity of its findings.

6. Staff Interviews

The Monitors interviewed 17 TRC staff. In addition to the two group meetings with staff, the MH Monitor interviewed a YC, a YDA, a clinician, a school staff person, and a nurse individually. The PH Monitor interviewed six Youth Development Assistants (YDAs), one Acting Facility Director, one Assistant Facility Director, one Nurse Practitioner, two nurses, and one Youth Counselor 2.

Seventy-one staff were employed at Taberg at the time of the visit. Forty-four were YDAs; the rest included YCs, clinicians, administration and staff from medical, school, kitchen.

7. Resident Interviews

The Monitors interviewed eight (8) girls. The MH Monitor interviewed four girls individually, two from each unit, and the PH Monitor also interviewed four different girls individually, two from each unit. One of the PH Monitor's interviews lasted less than 10 minutes due to the girl's inability to focus on the questions. She behaved incoherently, but said she was tired due to her medications. Interviews occurred in areas with reasonable privacy from staff. The Monitors selected the youth for interviews.

8. Exit Interview

The exit meeting occurred on February 9, 2012. The Monitors expressed their appreciation for the cooperation and hospitality of the TRC and OCFS staff. The Team then highlighted areas of importance and concern, but not findings. The exit meeting was a time for questions, clarifications, and explanations of events and impressions before the draft report went to both Parties. Those in attendance included: Edith Abete, YDA 2; Gale L. Asch, SWII; Karen Best, Office Assistant; Merle Brandwene, Director, OCFS Management and Program Support; Sandra Carrk, Project Manager; Susan Cheeburrish, Psychiatry; Lori Clark, Acting Director; Alison Clark, Teacher IV; Janice Curren, PAC; Dave De La Osa Cruz, YC 1; Kathy Fitzgerald, BBHS; William Gilman, LCSW-R, LMSWII; Scott Hecox, Superintendent of Facilities Security; Anthony Hough, DJJOY Associate Commissioner; Alyssa Lareau, DOJ; Edgardo Lopez, Settlement Coordinator; Marie Mastracco, Psychologist 2; Kelly Miller, Education Coordinator; Ruth E. Mosher, RN Nurse II; Ines M. Nieves, Associate Commissioner; Denise Passarello, QAU; Michelle Randall, Teacher; Patricia Randall, Secretary I; Amy Redmond, YCI; Melinda Rivera, BBHS Counseling Liaison; Rebecca Roberts, YC 1; Beverly Sowersby, Facilities Manager; Dr. Joe Tomassone, BBHS; Suzanne Tulino, Assistant Director; Jane Werham, Nurse II; and Bruce Warcup, YDA III. Those participating by telephone included: John Canino; Larry Gravett, SIU; Pam Kelly, Training; Anne Pascale; Sheila Poole, Acting Executive Deputy Commissioner; Lee Prochera, Legal; Lou Renzi; Kathryn Shelton, Acting Executive Deputy Commissioner Executive Assistant; Jane Utting, QA; and Iren Valentine, BBHS.

D. Preface to Protection from Harm and Mental Health Findings

Three important factors qualify the Taberg Residential Center for Girls (TRC) report. First, the operations at Taberg had been in existence less than 160 days at the time of the monitoring visit. The briefness of the TRC operations limits the Monitors' ability to make compliance decisions based on patterns of systematic behaviors. Compliance determinations require more time and evidence to avoid claims that the programs and conditions at TRC might be intermittent or temporary.

Second, and in addition to the newness of the TRC program, Settlement Agreement Paragraph 58 allows the Office of Children and Family Services (OCFS) 23 months (until approximately July 2012) to develop and implement its designated reforms. As such, this report narrative describes programs and services that are still "in progress" or fully "in transition." Therefore, Settlement Agreement paragraphs where, for example, policy and

procedure are not yet permanent but are operational and guide daily practice in a fashion consistent with the Settlement Agreement may be described as Partial Compliance or Compliance Pending in the anticipation of the full implementation of the OCFS reforms.

Third, the Monitors encountered a series of circumstances that obscured a clear look at programs and services related to the Settlement Agreement. Issues such as staff shortages and staff transitions meant that most interactions, observations, and document reviews were altered by variables that often diverted attention away from the intent of the Settlement Agreement. Beyond these qualifiers, the TRC monitoring visit had more positives than had been anticipated given the description of the status of operations on the January 23 conference call.

Because the Settlement Agreement includes a sustainability requirement that compliance must be maintained for a year, the newness of the Taberg operations, and the presence of variables that can be resolved, the compliance determinations in this report are tentative.

II. PROTECTION FROM HARM MONITORING

The shortage of YDA staff at TRC negatively affects the protection from harm paragraphs. A primary concern from the aforementioned Monitors' meetings with staff was the relatively small number of YDA staff available to work the shifts. One staff member captured the sentiments of the group by saying, "We don't need help, we need YDAs!" Another YDA rated youth safety much higher than staff safety during an interview with the PH Monitor. When asked about what was needed to improve staff safety, the response was to get new staff working more quickly. The pressing staff concerns translated into too few available staff and too much time needed to replace them.

There are many factors that go into the determination of staffing adequacy for any given facility. One reliable approach includes an analysis of the coverage and assignment patterns (sometimes referred to as the staff scheduling strategy) as described by an administrative staff member. The Taberg Administrator on Duty (AOD) explained the YDA staff assignments and posts. Using the National Institute of Corrections (NIC) staffing formula and the information provided by TRC administration regarding allocated positions, vacancies, and leave usage as of February 3, 2012, an estimate of the gap between the number of YDA staff needed to fill the schedule versus the availability of staff to work those shifts revealed that TRC was operating between 58% and 65% of its intended staffing capacity. Described below are examples of how operating a facility with this low a percentage of staffing capacity affects various Settlement Agreement paragraphs.

Two female staff members expressed concerns about the safety of male coworkers working with this population of girls. Specifically, they cited examples where female residents attempted to exploit male staff members sexually by making sexually provocative comments and gestures, by exposing themselves to male staff members, and by touching male staff members inappropriately during physical restraint. These comments were in response to concerns expressed by female staff members regarding the low number of female staff available on any given shift. Their perspective was that an increase in the number of female staff members per shift would be beneficial in the reduction of sexually

inappropriate behaviors by female residents. Another staff concern was the complaint that Home Office had provided no specialized training for TRC staff about how to respond to sexually inappropriate behaviors by girls.

The Monitors note Home Office's objections to discussions of gender and sexual misconduct as inappropriate for these reports. We agree that these topics warrant a separate discussion, but they make their way into reports not because we believe they have bona fide occupational qualification (BFOQ) implications but because of the connections to uses of force and protection from harm. These connections exist outside the boundaries of the Settlement Agreement until staff and youth raises a questions and concerns about them, including Home Office actions under Settlement Agreement, i.e., the March 5, 2012 Paragraph 73 notification.

The repeated concern expressed by staff about gender and safety issues might better be explained in terms of staff supervision, particularly as it relates to privacy. The research on sexual misconduct includes violations of privacy and boundary issues as precursors to larger problems. Where a predominance of males work the living unit shifts in an all girls facility, staffing considerations should include privacy and safety for girls with trauma histories. The necessity for security-related observations of girls in the living unit may include times when it would be better if female staff members were responsible for direct supervision. The anxiety resulting from opposite sex supervision that invades privacy can lead to embarrassment, humiliation, arousal, and re-traumatization of the youth, which can contribute to acting out behaviors. One generally accepted safeguard is the assignment of a female YDA to each shift. The implication is not that the shift be staffed entirely by workers of the same gender as the youth on the living unit. For January 2012, TRC staff scheduling records indicated that there were four shifts with zero female YDA staff members working.

A. Use of Restraints

Multiple factors influence the use of restraints and Protection from Harm. Not every factor is mentioned in the Settlement Agreement, but Paragraph 57a invites the Monitoring Team to identify issues and concerns that emerge during the monitoring that are related to compliance.

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.

COMMENT: The Crisis Prevention and Management (CPM) policy and procedure 3247.12 fulfills the requirement that OCFS create a new set of requirements on the use of restraints. OCFS lists the policies covering Paragraph 41 as PPM 2081.00, PPM 3247.13, and PPM 3247.14. During staff interviews, all staff had a working knowledge of the differences between the new policy and the approach to physical restraints before the DOJ Settlement Agreement and appeared to understand the circumstances under which restraint can be used.

With policy and procedure in place, the compliance challenge becomes the assessment of the new practice, which generates many questions. Do the changes associated with CPM and the New York Model affect undue restraints? Does current practice contribute to a reduction in the rate of restraints as compared to the old model? Does the continued implementation of the new CPM model contribute to a progressive or incremental reduction in the ongoing rate of restraints? Is there a mutually agreed upon benchmark for restraints that will serve as one indicator of compliance?

In the absence of mutually agreed upon QA mechanisms, outcomes measures, and quantitative data, compliance decisions default to the expert opinions of the monitors. Currently, compliance decisions include the PH Monitor's understanding of relevant research, evidence-based best practices, and direct experiences with similarly situated institutions and agencies external to the named facilities, in conjunction with Home Office perspectives and clarifications.

The CPM policy and procedure, PPM 3247.12, sets forth the expectation that all restraints under new system will be limited to only exceptional circumstances, and this requires verification. Implicit in the logic of the New York model and CPM is that the combination of these two approaches will reduce the number of exceptional circumstances, reduce the number of the more restrictive uses of force, and increase effectiveness of the de-escalation and less restrictive alternatives. Therefore, one measure that the practice complies with the policy and procedure is that the rate of restraints will go down. So, are the rates of restraints changing? If so, are they increasing or decreasing? To answer these questions, there needs to be a reliable measure of restraints.

Table 1 contains the best available rates of restraint events and injuries to youth for four selected months preceding the monitoring visit. The data do not yet support a finding of compliance due to the newness of the program and the inability to establish a pattern of restraint practices. To use restraint data as one measure of compliance, there also needs to be agreement about the Home Office data. While the process is close to resolution, the data were not useable for the Taberg assessment.

Table 1 contains the rates of restraint events and injuries to youth and staff for the two months (December and January) preceding the monitoring visit. Rates convert the incident frequencies to occurrences per youth per 100 bed days. The use of rates allows better intra- and inter-facility comparisons, especially when resident populations differ.

Taberg staff indicated that the integrity of the December and January data is better as a result of the increased scrutiny on data collection. All of the data are from the restraint logbook maintained in CSU, which correspond nicely to the post-restraint examination numbers reported monthly by the infirmary.

Table 1. Restraint and Injury Rates for the Two Months before the Taberg Monitoring Visit

Incident	December 2011 Rate	January 2012 Rate
All Restraint Events	18.75	12.60
Escorts	8.13	2.44
Seated/Supine	10.63	10.16
Youth Injury	1.25	0.20
Staff Injury	0.51	0.33

Table Notes:

1. "All Restraint Events" includes every restraint entry in the restraint log. The January rate shows a 33% decrease.
2. "Escorts" includes single and team-standing escorts as identified in the restraint log. Escorts represent a better intervention outcome than a seated or supine physical restraint, and escorts showed a 70% decrease between December and January.
3. "Seated/Supine" includes all restraint activities where a youth is placed on the floor. This category is the total escorts subtracted from all restraint events. The rates between December and January showed only a 4% decrease, which questions the TRC assertions that the rates of restraints are dropping substantially. While an argument can be made in support of that perspective given the 33% decrease in all restraint events, these data imply that the reduction has occurred largely because of fewer escorts, while the more difficult and risky restraint practice of taking a youth to the floor shows only a slight decrease.
4. "Youth Injury" is an injury associated with a physical restraint. While the restraint logbook entries are a rough estimate of injuries, there is an 84% reduction in the recording of an injury to youth associated with a physical restraint event. The January rate suggests improvement in the application of the CPM techniques.
5. "Staff Injury" is any injury associated with a restraint as entered in the restraint log. This too is an estimate based on supervisor or staff judgment. As with the other restraint categories and the youth injury category, staff injury rate decreased (by 36%) between December and January. This, too, is a sign of progress but warrants continued attention.

Regarding "practices that limit the use of restraints to exceptional circumstances," there is insufficient evidence to support this "limiting" requirement. Based on the perceptions of various TRC staff along with the PH Monitor's experience with juvenile facilities and the research regarding critical incidents, the rates of restraint are too high, meaning they are well beyond an acceptable level. Further, the inadequacies of the video surveillance system, discussed more below, mean that this important element of restraint

documentation is insufficient to support or refute the assertions by staff that restraints are limited to exceptional circumstances.

Further, the State shall:

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

PARTIAL COMPLIANCE

COMMENT: The policy and procedures are established, and the training on the policies and procedures has occurred. At question now is the verification of the practice; however, the quality of the video documentation is insufficient to support or deny the requirement that staff only employ a minimum amount of physical control. To illustrate, the leadership charged with reviewing the videos was unable to determine the identity or the gender staff member in one video. Described below is a review of multiple restraint incidents, including an assessment of the written documentation and the videos. As is noted below, there are multiple questions about the amount of force necessary due to the lack of staff.

Home Office notes that the approved CPM curriculum provides that staff must use only that amount of force necessary to bring a situation under control. Therefore, when done in a single person application, the CPM requirements are not violated. However, multiple examples exist in Restraint Packet videos where a single staff member has difficulty staying within the CPM guidelines to bring a situation under control. In these situations, one of two things occur, either the staff member releases the youth (fails to secure the youth) and waits until additional staff arrived or the staff member uses additional force that may be in excess of the amount taught in training in order to secure the youth. In these situations, reference is made to a single staff member application a physical restraint requiring multiple staff members. In situations where a restraint requires multiple staff due to the nature of the youth's behavior, situations frequently happen where a single staff member has to use a level of force that sometimes appears to be greater than the amount described in the CPM training in order to maintain control. With the implementation of any new physical restraint strategy, there needs to be careful consideration of those situations where the strategies presented in training are difficult to implement. Issues such as these should be part of the quality assurance program as it relates to continuous quality improvement.

As will be discussed below, there is some evidence that supports the staff's comments that they use only the minimum amount of time in restraints necessary to stabilize the situation. In one particular video, staff struggled to restrain a youth and then had to apply handcuffs, but calmed the youth, removed the handcuffs, and released her from restraints within seven minutes. This is an example of a use of force that appears to have spent the minimum amount of time necessary to restore safety and to stabilize the youth.

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. Staff generally knew the information in the IIP and seemed quite cognizant of the nature and extent of the limitations.

The nursing staff explained the process of creating a restriction on the use of physical restraints for particular youth. They initiate the process, which is contained in the youth's IIP. The discussion focused primarily on obesity and Dr. Michael Cohen's requirement that obesity be defined by a BMI of 30 or more. The nurses explained the health problems associated with physical restraint and obesity.

41. c. If facedown 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. Facedown 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.

PARTIAL 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. Consistent with Settlement Agreement paragraph 41.c.i., which states, "Facedown restraints shall be employed for only as long as it takes to diffuse the emergency, but in no event shall youth be restrained in a face down position for more than three (3) minutes," interviews with staff and youth confirmed the elimination of facedown restraint practices as a primary

strategy in a restraint process that requires staff to place a youth on the floor for increased safety. In response to the question about when a facedown (prone) restraint is permissible, most TRC staff responded that a prone restraint is no longer used. The follow-up question to these staff inquired about the application of the "transitional hold" as taught in the CPM training. Answers to this follow-up question were consistent. Staff did not consider the "transitional hold" as a prone technique because they only move a youth to her side if the application of handcuffs is necessary. The responses indicated a clear understanding of the concerns about facedown restraints expressed in the Settlement Agreement paragraph.

OCFS prohibits facedown or prone restraints by policy, which is consistent with the CPM strategy. However, evidence still exists of the recent use of facedown or prone restraint techniques at TRC. The review of videos confirmed at least two uses of a facedown technique that did not fit the "transitional hold" definition. This finding is qualified by the very poor resolution of the videos, but enough evidence was visible to conclude that the youth in these instances were facedown. A contradiction exists, for TRC staff appear to understand CPM policy, procedure, and philosophy, but CPM is quite new and requires more staff than the old strategy required. The circumstances surrounding the full acquisition of the new physical restraint skills combine with staff shortages to aggravate the situation.

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 psychiatric medication for restraint purposes. Resident and staff interviews and direct observations provided no evidence of the use of psychiatric 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.

PARTIAL COMPLIANCE

COMMENT: The policy and procedures are established; the training on the policies and procedures has occurred; and staff reports are consistent with the policy and procedures. TRC administration maintains a list of staff members and the status of their training.

Deborah Pete provided a review of the STARS system for the verification of staff training participation and hours. Regarding CPM, three (3) YDA staff members had not successfully completed the training and were ineligible to participate in a physical restraint. One of the three (3) individuals had been assigned to an office position, having no direct contact with youth and, therefore, not having any physical restraint responsibilities. The other two (2) YDAs had not completed the training, so there needed to be a notification to other staff that these two (2) staff members were ineligible to participate in physical restraint.

Staff schedule records indicated that one of the two (2) staff members had worked a shift just before the monitoring visit. To determine if there has been a restriction on this staff member's authorization to participate in a restraint, the AOD was asked how this special status would have been communicated to other staff. The response was that restrictions would be noted in the log in CSU. A subsequent review of the CSU log revealed no special notification of the staff member's restriction on participation in physical restraint on the previous days in question when he worked. However, there was a highlighted CSU log entry from earlier that same day indicating that the individual was not to participate in physical restraints until he had successfully completed the CPM training.

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.

PARTIAL 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. The video review contained one instance of what may have been some form of chokehold or head lock takedown, but the resolution on the video was so poor that a determination could not be made to affirm or deny the application of a prohibited technique. It is the inability to confirm or deny allegations of improper restraint techniques due to substandard video that undermines the confidence that staff are implementing CPM techniques as trained.

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.

PARTIAL COMPLIANCE

COMMENT: The policy and procedures are established, and the training on the policies and procedures has occurred. Staff and resident reports are mostly consistent with the policy and procedures. The PH monitor understands that the CPM techniques were taken largely from, and reviewed by, staff of the New York State Office of Mental Health, and the repeated references to staff injuries in conjunction with the application of CPM techniques comes from staff institutional staff at all levels. These comments are not intended at all at second-guessing are not intended question the selection of and development of CPM. Instead, least amount of force issue in this paragraph has

implications for staff and youth as generated by staff perceptions and reports and confirmed by direct observation. That said, the TRC rates of injuries to staff associated with physical restraints are too high to support an argument that to support a least amount of force necessary argument, and these high rates of injuries to staff are a concern expressed by TRC infirmary staff. Three (3) of the four (4) nurses completed the CPM training, but exercised their option out of the physical technique testing. When asked about the appropriateness of the techniques for application to adolescents, all nurses said that the techniques look unsafe, and they particularly identified possible injuries to staff in the areas of shoulders and knees.

TRC staff injuries from physical restraints relate to compliance. Injured staff are frequently unable to perform their job duties fully, including the safe and effective implementation of physical restraints; and injured staff often take some form of leave while recuperating from injury. Therefore, increased staff injuries predict a reduced staffing adequacy, which is one of several factors that have an empirical relationship with physical restraints. All staff absences including those resulting from staff injuries have a negative effect on unit management, teamwork, continuity, and program consistency. Based on anecdotal evidence from direct observations in several of the named facilities, there appears to be a direct positive relationship between staffing variables (program continuity, teamwork, effective communications, and staff consistency) and improved safety outcomes for youth, including fewer uses of force. Again, the focus is on use of force and youth safety, and these staff injury fluctuations represent QA challenges, especially when more information is needed regarding the strength of other influences on the rates of physical restraints, such as changes in the resident population, changes in social and spatial density, and staff fatigue as measured by the rate of mandations.

The number of staff injuries and their relationship to the Settlement Agreement are in this report largely due to the comments and observations of YDA and other DJJOY staff. Anecdotal evidence is not only important, but most can be constructive and helpful. One source of information that supports and sustains compliance determinations includes the responses from youth and staff about current conditions that are consistent with the other sources of information.

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

PARTIAL COMPLIANCE

COMMENT: The policy and procedures exist, and the training on the policies and procedures has occurred. However, evidence of a corresponding practice that includes documentation (written and video) and staff reports was severely compromised by the failure of the previous TRC administration to adequately and promptly report the uses of force and physical restraints from August through November 2011.

Most TRC staff know about the "incomplete files" incident. Estimates are that approximately 400 restraint packets were incomplete and never reported. TRC administration places the number at 365. Since November, efforts to reassemble the files have been successful for all but approximately 44 incidents, where there is missing documentation or a file apparently was never started. If the 365 incidents is an accurate

number of events and if the corresponding documentation can be reassembled for 321 incidents, the missing 44 represent a 12% margin of error. This is unacceptable regarding documentation of a central protection from harm issue.

The PH Monitor acknowledges the actions of OCFS by issuing a facility-wide memorandum pertaining to the integrity of records and referred this matter to the State Inspector General. The State Inspector General referred the matter back to OCFS' Special Investigations Unit, which will pursue the investigation. We agree that the circumstances surrounding this restraint documentation problem warrant a thorough investigation, but still would have preferred preferably by an investigative agency external to OCFS, with a report of findings that is shared with the Monitors. There is reason to suspect that other TRC staff members have information about what happened, and it is important to guarantee their confidential cooperation in any investigation of this serious incident, especially when an employee may fear being subjected to disciplinary action for supplying information to an investigator.

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.

PARTIAL COMPLIANCE

COMMENT: The policy and procedures exist, and the training on the policies and procedures has occurred. Staff intend to follow this procedure for all instances of restraint, but additional time has been spent on updating and correcting the aforementioned incomplete restraint packets. 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 and followed by a Home Office review.

This Paragraph, along with Paragraphs 41, 41.a., 41.c., 42.b., 42.c., 42.e., 42.f., and 44, have been affected adversely by the transition at TRC, the problems associated with the restraint reporting incident, and especially the substantial obstacle to accountability created by an inadequate security camera system.

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

COMPLIANCE PENDING

COMMENT: Serious problems exist that compromise the TRC's ability to conduct the reviews called for by the Settlement Agreement.

Regarding the capacity to conduct an adequate investigation, surveillance cameras provide an important source of information in the evaluation of a physical restraint incident or any use of force or abuse investigation. Without an audio record of the event, the video evidence becomes critical in conjunction with the incident report documentation in determining what exactly happened. The absence of audio limits the ability to come to a

better finding, so coherence between what the incident report states and what the reviewer sees on the video becomes important in determining compliance with the Settlement Agreement regarding the proper application of the restraint technique and the prohibition against certain restraint techniques. At this time, the camera resolution produces a video that is of extremely poor quality. For example, when reviewing a video of a physical restraint of a youth, one TRC administrator was unable to determine if the staff member in the video implementing the restraint was a male or female. The quality of the video cameras prevents TRC administrators and Home Office staff, including the Special Investigations Unit staff, from seeing with sufficient clarity enough information to substantiate many of the allegations of abuse or inappropriate uses of force.

During the site visit, the PH Monitor directly observed part of a restraint that occurred in the corridor near the CSU. By the time the PH Monitor arrived on the scene, the youth was already in a seated restraint with three (3) staff members actively engaged in the restraint. Based on an earlier review of the CPM techniques, it appeared that the staff members were applying the techniques correctly. A fourth staff member was present because of the need for a towel to be placed between the youth and the staff member holding her legs. She had spit on the staff member before a towel was present.

Based on the disruption that preceded the physical restraint and prompted the PH Monitor to leave an interview, there was a question about the nature and extent of the verbal de-escalation used by the staff member before the restraint. Knowing that there was no audio, a request was made to view the incident video from the two camera positions. Only one camera view was available, and, again, the resolution was so poor that no determination could be made about the verbal de-escalations (certain de-escalation techniques are associated with identifiable physical behaviors or actions by staff). Furthermore, the video did not have sufficient clarity to know if the staff members applied the restraint techniques appropriately.

A review of several restraint packages and the corresponding video yielded the following:

1. Incident date: December 24, 2011; Situation: Restraint of Youth A.

The incident report begins with a description of four (4) girls who were involved in "horse playing." The report states that the staff member "addressed" the issue. There was no description of any action or consequence or whether or not the "horseplay" ceased.

The video review that occurred at TRC during the monitoring visit also included behavior identified by administration as "horseplay." The December 24, 2011 event resulted in a physical restraint, which followed an incident of "horseplay" among several girls. The behavior of staff on the video did not give the impression that he addressed the "horseplay" behavior; however, without audio, there is no way of knowing for certain. The "horseplay" behavior continued. Pursuant to Paragraph 73 of the Settlement Agreement, Home Office informed DOJ Attorney Lareau of a recent incident of "horseplay" that resulted in an injury to a youth, who was accidentally struck in the ear. She was taken to Rome Hospital for examination where she was diagnosed with blood in the ear.

Borrowing from the New York Model and its Chain Analysis, "horseplay" is an inappropriate behavior that often leads to problems associated with use of force and injury.

To the extent that "horseplay" is linked to physical restraints and injuries, as documented in Restraint Packets and other information, there is a need for documented instruction with any YDA who does not address this behavior. This is not "rough and tumble play," but it is frequently a boundary violation that is a precursor of more serious misbehavior.

The video shows a restraint that occurred in the corner of the unit near the door to the cafeteria. It is difficult to identify the staff members involved. At the height of the restraint, seven (7) staff members appear to be involved. Based on the quality of the video, it is difficult to identify the behaviors that qualified as de-escalation. Furthermore, it is nearly impossible to evaluate the application of the restraint techniques given the poor resolution and the distance from the event.

2. Incident date: January 17, 2012. Situation: Restraint of Youth B.

Note: The quality of the reproduction of the incident report provided to the PH Monitor is extremely poor. The duplication appears to have come from a copy machine with a toner problem. It is largely unreadable. Additionally, based on what can be determined from the part of the page that is readable is that the behaviors leading up to the fight occurred off camera.

The lack of resolution on the video makes it impossible to determine the de-escalation techniques that may have been used or to evaluate the use of the physical restraint techniques. The video is jerky in its delivery of the scenes, and the lack of fluidity creates a distorted movement that prevents the evaluation of staff actions in real time. This video neither affirms nor denies the statements in the incident report.

3. Incident date: December 21, 2011. Situation: Group Disturbance

The image at 11:24:49 shows three (3) staff members involved in what appears to be a restraint near the divider of the classroom. In this frame and in the following frames, there is a pair of white tennis shoes that do not appear to belong to staff. The tennis shoes are pointed toes down, implying that the wearer of the shoes is facedown.

At 11:26:15, another restraint occurs between a staff member and a girl, and the restraint appears to be a takedown with the girl going to the floor face first and the staff member on top of her, face down. In both instances, staff move as quickly as possible to regain control and move the resident into a seated position.

At 11:27:22, a male staff member has a youth in a standing restraint with a female staff member standing very close to the youth, face-to-face. It is difficult to determine what type of de-escalation technique this might be.

4. Incident date: January 26, 2012. Situation: Group Disturbance

At 08:16:40, the video shows a restraint of a girl by one male staff member, which starts with the girl going to the floor in a supine position, but the staff member is unable to maintain control, so he changes his restraint hold. This resulted in what appeared to be a facedown or prone position with the staff member on top of her to regain control. Both staff and youth appeared to be face down. The struggle continued.

At 08:17:48, two (2) other female residents are restrained. One of them is also facedown with a female staff member on her back and another female staff member

holding her legs. The third resident is in the process of being restrained by two (2) male staff members. The first resident still appears to be facedown.

At 08:18:37, there appear to be seven (7) staff members in the area. The third girl is in a standing restraint with a single staff member. One of the two (2) staff members has released himself from the standing restraint that appears to have worked effectively. Both of the other girls are still facedown now with two (2) staff members on each, one on the torso and the other on the legs.

At 8:19:40, handcuffs have been successfully applied to the first youth who now appears to be on her side.

At 8:21:06, the second girl is in a seated position. The first girl is still on her side and in handcuffs.

At 8:23:34, the first girl is released from cuffs after being in a seated position for a couple minutes.

The documentation for this event is incident number F120119. The report names five (5) girls and six (6) staff members. The documentation gives the impression that the "first girl" mentioned above is youth C. Three (3) different staff members filed an incident report on their observations of the restraint event with Youth C. The narratives identify a "single person" physical restraint that ends up on the floor. One of the reports states, "They both stumbled to the ground." None of the three (3) reports mentions the words "supine" or "prone" in the descriptions of the restraint. Descriptions of the restraint techniques are missing.

The reports do not mention the application of the "transition hold" for the application of handcuffs. There is no explanation for the apparent use of the prone position. To the credit of staff, the restraint of Youth C lasted only seven (7) minutes and handcuffs were applied within three (3) minutes and removed within four (4) minutes. The video shows Youth C talking or interacting with staff following her release from the restraint.

The video review raises questions about the use of what appeared to be a prone restraint. Staff were referred for documented instruction regarding this restraint. Another indicator of insufficient staffing is an incident report filed by the cook who participated in the restraint. TRC administration acknowledged the use of CPM-trained but non-YDA personnel in restraints.

5. Strength and Agility

The physical size and strength of some TRC girls present a problem for staff regarding the effective and appropriate use of the CPM restraints. While not every girl is large, many of the youth on the restraint videos were large girls, and in some instances were as large or larger than the female staff. This raises concerns about the strength and physical agility of staff. One TRC girl confirmed a perspective from other OCFS female residents that the presence of male staff adds to safety because many female staff either cannot restrain larger residents or are afraid of them. One male YDA stated that he is "singled out" to do restraints because of being large. If female staff defer to male staff in situations requiring physical restraint, this places male staff at greater risk of injury and

abuse allegations. It also presents a potentially re-traumatizing situation when male staff members restrain girls who have an abuse history.

Most of the male staff interviewed said they have experienced an abuse allegation and an investigation. All were unsubstantiated. While male staff say that an abuse allegation is "just part of the job when working with violent and troubled girls," all agreed that an investigation is difficult to endure and troubling to think about because a substantiated finding can affect his family, his role in the community, and his career options.

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. Supervisory 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: The training on the policies and procedures occurs regularly, and the evidence of a corresponding practice from the STARS system is consistent with the requirements of this paragraph. The records also show that staff members who require retraining for any number of reasons generally receive 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.

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.

PARTIAL COMPLIANCE

COMMENT: The policy and procedures exist (PPM 3246.02 and PPM 3247.13), and the new Crisis Response and Radio Communications policy and procedures were distributed to staff on January 25, 2012 with an implementation date of January 30, 2012. Confusion existed among YDA staff about the proper procedure to call for assistance. Three (3) YDA staff members said that the proper procedure was to "push the red button on the radio." This is the "push the pin" practice referenced in Paragraph 43. a. No YDA interviewee identified all of the call for assistance color codes (Code Yellow = personal safety, Code Blue = medical, Code Green = security, Code Gray = mental health issues, and Code White = restraint in progress), but all could identify "white" as a restraint in progress.

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

PARTIAL COMPLIANCE

COMMENT: The policy and procedures exist (PPM 3246.02); the training on the policies and procedures has occurred; and staff reports are consistent with the policy and procedures. Time constraints on this on-site assessment did not allow for the verification the documented appropriateness of the response. It will be part of the next TRC monitoring visit.

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

PENDING REVIEW

COMMENT: The local operation practice (LOP) exists as the emergency response plan. It was not included in the review during this visit, but it will be part of the next TRC monitoring visit.

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 TRC staff's successful completion of the training. A random check of the total 2011 training hours for four (4) YDAs produced the following totals: 110, 97.75, 111.5, and 123.75. In all cases, the total training hours exceed the agency expectation.

D. Reporting and Investigation of Incidents

These paragraphs refer largely to the activities of the Special Investigations Unit (SIU). Recently, a separate monitoring visit to the Home Office reviewed these paragraphs. Most of the comments below reflect aspects of the current reporting and investigative process as they relate to the responsibilities of the individual facility staff. Compliance implications relate more to Home Office activities in these areas than to the local facility implementation.

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.). The expectation that an agency can eliminate all related physical plant risks of harm is unrealistic. Instead, potential risks are noted with administration during the tour and make their way into the report when there is reason to suspect that staffing patterns and/or supervisory practices are not adequate to mitigate the potential risks for harm.

TRC has the same floor plan as Columbia. These facilities have nearly identical physical plants, and because of the newer construction, the physical plants have relatively fewer risks of harm. One concern was the tension between privacy versus safety when girls use their bathrooms and showers. Additionally, all of the bathroom door windows on Unit 12 were covered on the inside with paper towels. Due to concerns about possible suicide risks associated with the bathrooms, enforcement of the policy regarding the removal of items on the bathroom windows that obstruct vision needs to be enforced.

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 PENDING

COMMENT: Home Office determines the policies, procedures, and practices that govern prompt and appropriate corrective measures. In the interviews with staff, they seemed confident in the investigation process and in the new TRC administration. They did not express any fear of a breach of confidentiality or retaliation. However, further review of this paragraph did not occur during this monitoring visit.

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 PENDING

COMMENT: Paragraph 44.b. is a function of departments external to TRC. The review of this paragraph did not occur during this monitoring visit.

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 are consistent with the policy and procedures. The key issue here is 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, allegations of excessive use of force, and injury complaints.

The review of the infirmary was very positive and informative. The lead nurse (RN 2) and the regional nursing supervisor discussed the manner in which a post-restraint examination is conducted. The arrangement of the infirmary and the use of a radio during the examination provides for sufficient auditory confidentiality. However, a problem existed due to the location of the youth in the direct line of sight of the supervising YDA. Following a discussion of the concerns about this arrangement, nursing staff made an immediate change in their procedures so as to eliminate the direct line of sight between the youth and the YDA.

In a discussion with all four (4) nurses, they indicated a good understanding of the process for filing a child abuse complaint with SCR. Additionally; they had a good understanding of the health requirements for conducting an assessment of the youth while in restraints.

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 withdraws 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 PENDING

COMMENT: The SIU conducts investigations while new and updated policy and procedure work their way through the review and approval process. The review of this paragraph did not occur during this monitoring visit.

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

PENDING REVIEW

COMMENT: Home Office determines the policies, procedures, and practices that governing prompt and appropriate corrective measures. Further review of this paragraph did not occur during this monitoring visit.

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 3247.13, and PPM 3456.00); the training on these topics has occurred as documented in STARS; and staff descriptions of the training are consistent with the policy and procedures.

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

PENDING REVIEW

COMMENT: At the facility level, the Monitors are aware of no concerns about the adequacy of staff supervision of current TRC staff. Further review of this paragraph did not occur during this monitoring visit.

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.

PENDING REVIEW OF HOME OFFICE

III. MENTAL HEALTH MONITORING

An impressive amount of work on policies and New York Model training materials has occurred in recent months. For the ten mental health paragraphs of the Settlement

Agreement, four policies have not been finalized (PPM 2801.00 "Training Requirements for DJJOY Staff," PPM 3247.60 "Suicide Risk Reduction and Response," new policy on Facility Admission Process, and an update on the integration of PPM 3443.00 "Resident Rules" in the New York Model) and one training curriculum and protocols related to developing uniform working diagnoses for mental health professionals have not been completed. The MH Monitor cannot assess compliance until the policies are finalized, staff are trained using new curricula and the staff demonstration of consistent application of the training and adherence to the policies 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:

a. 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.

b. 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.

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

d. 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

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

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

The Daily Achievement System (part of the New York Model) complies with the requirements of 46d, and implementation is beginning at TRC.

The OCFS 6-Month Progress Report, 12/20/11 reported that TRC staff completed CPM training and New York Model training. The BBHS Chief of Treatment Services and BBHS Social Work Supervisor are working with TRC staff to implement the NY Model.

What the MAP referred to as a new policy on Case Management of Juvenile Delinquents Placed in the Custody of OCFS is no longer planned as a policy. What was to be

the content of that policy—including treatment teams and substance abuse treatment—are being incorporated into training curricula. The New York Model implementation training includes the new integrated assessment, the new treatment plan, and how to utilize both in the new treatment teams.

The MH Monitor reviewed the draft policy 2801.00 "Training Requirements for DJJOY Staff." Direct care staff (YDAs, recreation staff, and YCs) are required to have a minimum of 200 hours of training within the first year of employment and 40 hours each year thereafter. In addition to various safety topics, annual required refresher training includes: Crisis Prevention and Management (CPM), Suicide Risk Reduction and Response, Psychiatric Medications and Psychiatric Disabilities and Trauma Informed Care. The policy does not provide any details about supervisory training, although the role of supervisors as coaches of expected practice is endorsed: "Supervisors are required to supervise and evaluate the work of their staff and provide communication, mentoring and coaching to improve and increase employee's skills and capabilities." The New York Model, Sanctuary, and DBT are not mentioned in "Training Requirements for DJJOY Staff." While some of the required training topics in the policy comply with the Settlement Agreement, these would be in addition to the New York Model training.

The MH Monitor reviewed the 8/11 curriculum for five-hour training for direct care staff entitled "Mental Health for DJJOY Youth: Disorders, Interventions and Management Basics." It reviews the psychiatric diagnoses common among delinquent youth and describes specific interventions, written with little mental health jargon, which will be useful with youth with each diagnosis.

The MH Monitor was provided with a summary of Mental Heath Units (MHU) in DJJOY facilities, which provide intensive mental health treatment for youth with serious emotional disturbance. Residents are eligible for MHUs when they have a DSM-IV, Axis 1 diagnosis (other than or in addition to Conduct Disorders, Disruptive Disorders NOS, Oppositional-Defiant Disorders, Intermittent-Explosive Disorder, Attention-Deficit Hyperactivity Disorder, Adolescent Anti-Social Behavior, or Substance Abuse) and exhibit serious and persistent symptoms that cause significant functional limitations. Admission to the Taberg MHU is managed by the Girl's Mental Health Committee, composed of the OMH clinicians on the MHU, OMH liaison, OCFS Crisis Coordinator, OCFS Chief of Treatment Services, and a representative from Classification and Movement. The Committee meets formally twice monthly and as necessary for expedited admissions. If a Taberg Unit 13 resident's needs could be more effectively met on the MHU, the clinician could contact the OCFS Crisis Coordinator or the Chief of Treatment Services and complete the MHU referral form for the Committee.

There are two policies and staff practices the MH Monitor is waiting to review to determine full compliance with 46 a, b, and d. It is unclear what OCFS is implementing to comply with 46c.

State Report on Progress (12/20/11)

1. Create the New York Model

   Completed June 2011.

2. Create new policy on Case Management and Treatment Team Processes

"This policy is drafted but the content is different than originally intended. New tasks will be provided to address the remedial measures in the upcoming revised MAP."

3. Modify PPM 2801.00 "Training Requirements for OCFS Operated Facility and Day Placement Staff" and PPM 3443.00 "Resident Rules."

2801.00 Renamed Training Requirements for Division of Juvenile Justice and Opportunities for Youth Staff "has been implemented as at the DOJ facilities. Pending discussion with unions."

3443.00 Resident Rules "This policy is being evaluated for integration with NY Model."

4. Create new policy related to Facility Admission Process.

"The Non-Secure and Limited Secure version is drafted and ready to submit to DOJ. Secure version in progress."

5. Revise orientation curriculum

Completed March 2011.

6. Plan for training and train staff in the implementation of the NY Model, including the facility admission process, case management, and treatment team processes.

NY Model training was completed at Lansing 10/27/11, Columbia 12/14/11 and Taberg 12/22/11 and will be completed at Finger Lakes 6/19/12. The full training schedule is being developed. Treatment team planning is being implemented at each facility.

On Site Observations (2/12)

Paragraph 46 of the Settlement Agreement requires an effective program to meet the needs of residents. OCFS has proposed a comprehensive program entitled the New York Model. The New York Model, and the policies and training to support it, are designed to build on the strengths of OCFS services and address weaknesses 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 New York Model is a composite of evidence-based practices that have been successful with delinquents elsewhere and have not previously been combined for such a comprehensive program. If research shows that the New York Model is effective in supporting youth to recover from trauma and change their behaviors, it has the potential to be influential in delinquency programming around the country.

The components of the NY Model include: the Sanctuary Model of Trauma-Responsive Care which, through its seven commitments, helps residents understand the links between past trauma and current emotions and behaviors; Dialectical Behavior Therapy (DBT) which is an evidence-based, skill-building approach using behavioral principles such as chain analysis, reinforcement, validation, and coaching; the SELF Model (Safety, Emotional Management, Loss, and Future) which emphasizes providing a safe environment so residents can understand their trauma and communicate their feelings

more effectively; the Daily Achievement System focusing on earning rewards based on progress in treatment; the treatment team; and community meetings to develop emotional intelligence, demonstrate social responsibility, use open communication, focus on the future, and learn from others.

The MH Monitor reviewed the PowerPoint for the Implementation of the New York Model. After a facility has had the 3-day New York Model training and CCM training, staff also require training in new policies (mental health, psychiatric medications and suicide) which will become part of Academy training in the future. In addition, the new 2-day New York Implementation training was piloted at Finger Lakes in early February, 2012 and will be provided at TRC soon to assist not only with putting the Daily Achievement System in place but also in implementing the Integrated Assessment and New York Model treatment teams. The New York Model Implementation PowerPoint is a comprehensive, practical and specific support for staff in a facility to implement IIPs, treatment teams, Red Flag meetings, Rounds, the Daily Achievement System, Chain Analysis, Egregious Behavior protocol, the Phase System and Sanctuary and DBT groups. The MH Monitor also reviewed the PowerPoint "Setting the Stage" included in the Implementation training, which presents vicarious trauma experienced by staff and self-care.

The MH Monitor reviewed the OCFS 2-page outline for a one-day gender-specific training provided to 27 Taberg staff in July 2011 (in addition to the Tryon staff transferred to Taberg who previously had the gender-specific training). The training provides an overview of the National Institute of Corrections program "Meeting the Needs of Juvenile Female Offenders" that emphasizes five "female responsive values:" inclusive; relational; restorative; societal influences; and multi-leveled. Some of the NIC's proposed values might assist staff, but they are presented in a programmatic way that ignores the typical needs of girls that must be addressed in a developmentally-sound, trauma-responsive program. What might be more useful would be to build a practical repertoire of staff responses by starting with the needs of the girls, such as: to be treated respectfully, to have some control over what happens to them, to be praised, to calm themselves, to be less reactive to threat, to express anxiety, fear and anger safely, to compensate for their disabilities, to feel their family and culture are valued, and to have relationships that continue. To meet girls' needs it is important that staff do not get angry, defensive, or controlling, engage in power struggles, or take girls' behavior personally. Girls sexualized behavior and girls' relationships with male staff also could be covered by this training. Training about girls must be tailored to fit in the New York Model and use the same terminology.

The MH Monitor reviewed a new description of the New York Model Individual Intervention Plan Implementation Guidelines. The IIP includes both the actions of staff "to assist the youth in managing a potential crisis situation" and the "Youth Generated Sanctuary Safety Plan" of self-soothing skills unique to each youth. IIPs are expected to change over time as the youth acquires problem-solving and emotion regulation skills. IIPs also indicate prohibited physical or mechanical interventions and approved physical interventions. These guidelines meet the requirements of the Settlement Agreement. The MH Monitor reviewed a new description of the NY Model Mentor Program, which "assists youth in engaging in the program and meeting their individual goals…Staff are assigned to

be youth mentors to provide guidance, direction, support, feedback, and encouragement to the youth by developing a focused and supportive relationship with the youth." Mentors meet with the youth weekly for a minimum of 15 minutes, complete weekly Mentor Reports and keep the Treatment Team informed of the youth's progress by attending Treatment Team, Rounds, and Red Flags, and communicating with the YC. Mentoring, as described, meets the requirements of the Settlement Agreement.

The MH Monitor reviewed a new description of the TRC Daily Achievement System designed to explain it to youth:

> "the DAS uses 'achievements' as counters for the skills and behaviors that will help you do well in your community…The skills and behaviors that you will get achievements for are the very same skills and behaviors that will help you be successful in your home school, get along better with peers in your community, help you with family relationships, and help you to stay out of placements in the future. There are many things that achievements can be used for, including: extra phone call minutes, using cards and the Wii during recreation periods, being able to read new and interesting magazines, being able to go to bed later…You need to manage your EMOTIONS [that] includes things like: You try to use your safety plan when you get upset; You listen to staff when they try to help you when you are upset; You use the skills from groups to try to solve problems and to help yourself feel better; You do not use verbal threats, swearing, cursing, or other inappropriate language to express your feelings. You accept LOSS (that] includes things like: You accept responsibility for your behavior; You do not blame others for your behavior; You accept being told "no", or that you have to wait for something that you want."

The DAS description is another New York Model component that meets the requirements of the Settlement Agreement.

Exhausted staff, a crisis atmosphere, and little opportunity to build an effective team combined to produce instability at Taberg which increased acting out among residents and interfered with the facility settling down enough to benefit from training. With a population of traumatized youth, crisis prevention is much more difficult without a safe environment where trauma recovery and emotional regulation are being learned. Stable relationships and a calm environment are key ingredients of the New York Model. Coaching of staff on promoting self-calming by girls and increase effective de-escalation so restraints can be avoided will require relieving the overload on YCs and clinicians so they can actively support skill strengthening and teamwork.

Staff want to implement the New York Model at TRC, but it has been delayed by the turmoil at the facility, the training not happening until six weeks before the site visit, a change in leadership three weeks before the visit, and significant staff shortages. There has been no Assistant Director for Treatment Services, and a long-term OMH therapist departed recently. As a result, practices such as behavior chains are not yet routinely used to help girls recognize what triggered them, what they felt, how they expressed their feelings and the outcome.

A key to implementation of the New York Model is a functioning team of coaches. A strong coaching team ensures that the New York Model becomes a way of thinking by staff and youth, rather than simply a clinical service. At the request of the MH Monitor the coaching team assembled for the first time and acknowledged the importance of having improved communication and clarification of roles in order to operate as effective coaches of the New York Model at TRC (the coaching team consisted of the three YCs, the three therapists, and school coordinator, supported by the BBHS Chief of Treatment Services and BBHS Social Work Supervisor). They agreed to have regular meetings as the coaching team—these meetings might include the Acting Director and Director of Program but would be for the explicit goal of refining their coaching of the New York Model, not for administrative purposes.

The MH Monitor reviewed a new description of the NY Model Facility Rounds Implementation Guidelines. Rounds provide a protected time to exchange information about the current functioning of youth as well as facility issues which may be affecting them. Through ongoing discussions of a youth's emotional state, behavior, and relationships, teams will develop a deeper understanding of the youth's unmet needs. Rounds include the psychiatrist and other mental health staff, YDAs, YCs, teachers, medical staff and others). This description of Rounds meets the requirements of the Settlement Agreement.

The MH Monitor observed outstanding Rounds led by Dr. Cattalani, one of the two Taberg psychiatrists. In one hour they reviewed all nine girls on the MHU. The psychiatrist sees each girl weekly and reported not only on medication issues but his concerns about her mental health. Staff made observations of progress and concerns on the unit, in school, and in therapy. The effect of the polarization on the MHU was blended in the individualized clinical discussions. The discussion was sophisticated and clearly guided practice, particularly for a recently-returned girl whose records were not yet at the facility so staff helping each other meet her needs was essential. In our debrief, the psychiatrist said he views Rounds as an opportunity to "let go of who is clinical and who is not." There was strong collaboration among the psychiatrist, three clinicians, YC, two nurses, and educational coordinator, and they commented that Rounds was team-building. They were disappointed that no YDAs were at Rounds because of staff shortages and reported that usually the Assistant Director for Program and Program Monitor attended and conveyed information to the YDAs. They commented that insights from Rounds can also be shared in log notes, the pre-shift briefing, and IIPs. It is essential that Rounds are seen as important at TRC so accommodations are made to free YDAs to participate. The approach to Rounds observed at TRC is effective. The NPP at Columbia has a different way of doing Rounds that may be effective there, but the emphasis on teaming and updating everyone on all the complicated girls on one unit works well at TRC.

The MH Monitor observed skilled leadership of a DBT group at TRC, with strong involvement of a YDA. The therapist did not focus attention on the three girls who did not participate in the group, and instead got the rest of the unit involved. They moved from a didactic presentation to two enjoyable group activities to demonstrate mindfulness by staying focused and avoiding judging. The therapist talked in the debrief about wanting all

the girls on the unit to participate, and the progress of girls who formerly did not participate now joining some of the time.

The Red Flag meeting convened on Unit 12 with more than 20 participants was beneficial. The reason for calling the meeting was the polarized unit. Staff used it as an opportunity to support girls in talking about what it would take for them to feel safe on the unit. Ultimately the girls told each other about the hurt feelings that had festered for days. One staff person described the meeting: "All that uproar was because girls thought other girls didn't like them." A safe unit offers girls a process for recovering from trauma by allowing her to say, "You are hurting me. I have been victimized before. I don't want to be hurt anymore." Staff guided the girls to use their skills of emotional regulation so they could be get better treatment without reacting aggressively. Hopefully, Chain Analysis was used after the Red Flag meeting with each girl to examine what provoked them and how they responded and how they worked things out differently at the meeting.

FUTURE MONITORING

When they are available, the MH Monitor will review:

- New policy on Facility Admission and Orientation
- Decision about whether PPM 3443.00 "Resident Rules" will continue to be used or will be integrated into the New York Model

The MH Monitor will discuss how the effectiveness of interventions will be regularly assessed (46c).

The MH Monitor will observe New York Model coaching and the implementation of treatment teams, Rounds, and the Daily Achievement System.

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:

a. 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].

b. 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.

c. 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.*

PARTIAL COMPLIANCE

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

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

The MH Monitor reviewed a 2/12 email updating a 2/11/11 Memorandum. The email was from Iren Valentine to Brenda Aulbach, Lori Clark, Annette Larrier, and Anita Sapio entitled "Contacting Mental Health Professionals Outside of Regular Work Hours." It identifies a clinician at Lansing, Finger Lakes, Columbia, and Taberg who should be contacted in the event of an emergency situation or a mental health crisis. The Memorandum indicates that "each of the facilities report having an established procedure in place," but the MH Monitor has not reviewed that procedure.

The MH Monitor reviewed Policy PPM 3243.33 entitled "Behavioral Health Services" which 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."

The MH Monitor reviewed Policy PPM 3243.34 entitled "Psychiatric Hospitalizations" which responds to the Settlement Agreement by describing steps to be taken by facilities when a resident requires an intensive mental health treatment setting.

There is one policy the MH Monitor is waiting to have finalized to determine full compliance.

State Report on Progress (12/20/11)

1. Review and modify if necessary policies: PPM 2801.00 "Training Requirements for DJJOY Staff," PPM 3243.33 "Behavioral Health Services," PPM 3247.13 "Use of Physical Restraint," PPM 3247.60 "Suicide Risk Reduction and Response" and PPM 3243.34 "Psychiatric Hospitalizations."

   PPM 2801.00 and the new restraint policy have been implemented as at the DOJ facilities. PPM 3243.33 is approved for implementation. PPM 3243.34 is approved for implementation. PPM 3247.60 is pending further revisions.

2. Plan for training and train staff in Crisis Prevention and Management

   CPM training was completed 5/20/11.

3. Plan for training and train staff in comprehensive mental health policies, including strategies to address mental health crises and standards and procedures for contacting a qualified mental health professional outside normal work hours.

   Mental health training is being scheduled.

On Site Observations (2/12)

Clinicians and unit staff at TRC expressed the desire to help girls calm themselves. Even when things seem peaceful, girls can get into an agitated state with little warning. Traumatized girls quickly become more anxious than they have the skills to manage, and effective crisis prevention involves supporting them to soothe themselves (so a restraint will not have to be considered). A trauma-responsive approach means understanding what works with each girl as she gets emotionally dysregulated and helping girls utilize their coping skills before they begin to escalate. This is an example of how important coaching for staff is in translating New York Model training into action.

While group and individual disruptive behavior at TRC may have reflected mental health crises of individual girls, the outcome was girls going to jail. None of them were apparently in such acute distress that psychiatric hospitalization was warranted, although the group disturbance on the first day TRC opened resulted in three girls having a mental health assessment at a local emergency room and being returned to the facility.

The MH Monitor reviewed the draft policy 3247.60 "Suicide Risk Reduction and Response." Two levels of Enhanced Supervision Status are used to maintain the safety of youth who experience suicidal ideation or who exhibit suicidal gestures or attempts. Suicide Watch (SW) requires 1:1 supervision; at no farther than arm's length distance; entries in the unit logbook describing the youth's mood and attitude are made every 15 minutes. When the youth is asleep, staff sit at the bedroom doorway. Personal Safety Watch (PSW) requires arm's length supervision during the time when the youth is awake; entries the Unit logbook describing the youth's mood and attitude are made every 30 minutes. When the youth is sleeping, staff must establish visual contact every 15 minutes unless otherwise specified by a clinician. Supervision requirements for SW and PSW do not diminish during any aspect of program including showers and hygiene. In addition to staff training, suicide risk reduction in the physical plant, and mental health screening at admission, within 72 hours of admission every youth is assigned a clinician who assesses suicidal ideation or intent. Clinicians do a mental health evaluation to determine when the youth is ready for modification or removal from enhanced supervision status with a safety plan to be included in the youth's Individual Intervention Plan and communicated to staff directly and via unit log entries. This suicide policy complies with the Settlement Agreement.

The documentation of daily contacts with girls being observed for suicidal thoughts by the clinician on the Taberg MHU were unusually thorough. Not only did the clinician complete the daily brief mental status exam or special precaution evaluation for each girl, but he also provided supportive counseling (often more than once a day) and carefully documented it in her record.

FUTURE MONITORING

When it is approved and implemented, the MH Monitor will document that all the elements of revised PPM 3247.60 "Suicide Risk Reduction and Response" are followed with residents.

The MH Monitor will interview trainers and staff who participate in the mental health training.

The MH Monitor will observe coaching of staff on using safety plans to calm youth, 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:*

    a. *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.*

    b. *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.*

    c. *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.*

    d. *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.*

    e. *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.

PARTIAL COMPLIANCE

The new Integrated Assessment format complies with 48a, d, and e.

Mental health staff at TRC were observed complying with 48d.

Some resident records demonstrate compliance with 48a, c, and e.

The MH Monitor reviewed "The NY Model: Treatment Team Implementation Guidelines" (described below), including the Integrated Assessment and Treatment Plan.

There is one policy to be finalized and one training curriculum to be reviewed for the MH Monitor to determine full compliance, as well as a discussion among treating clinicians regarding consistent diagnostic practices.

State Report on Progress (12/20/11)

1. Modify policies: PPM 2801.00 "Training Requirements for OCFS Operated Facility and Day Placement Staff," PPM 3243.33 "Behavioral Health Services," PPM 3247.13 "Use of Physical Restraint," PPM 3243.34 "Psychiatric Hospitalizations" and PPM 3247.60 "Suicide Risk Reduction and Response."

   PPM 2801.00 has been implemented as at the DOJ facilities. PPM 3243.33 is approved for implementation. PPM 3243.34 is approved for implementation. PPM 3247.60 is pending further revisions and review/approval by unions.

2. Identify assessment instruments.

   Form OCFS-1448 Admission Screening Interview completed October 2011.

3. Plan for training and train staff in comprehensive mental health policies and standards.

   Training is being schedule.

   Orientation of Form OCFS-1448 to be scheduled at the facilities.

4. Formalize committee for mental health transfers.

   Completed 6/9/11

5. Update Memorandum of Understanding with Office of Mental Health.

   Completed 1/4/11.

6. Communicate and implement policy and procedures to qualified mental health professionals.

   In progress.

7. Plan for training and train mental health professionals on protocols related to developing a uniform working diagnosis(es) and comprehensive mental health policies and standards.

   Protocol in development.

   On Site Observations (2/12)

Six of the girls at TRC are diagnosed with Generalized Anxiety Disorder, six with Mood Disorder, one with PTSD, one with Bipolar Disorder, one with Depression, two with ADHD and six with insomnia. Cannabis Abuse and Alcohol Abuse were prominent in at least half the girls' histories.

Shortly before the site visit, an Office of Mental Health (OMH) clinician who moved from the Tryon MHU to the Taberg MHU was asked to leave TRC while being investigated regarding a suicide watch for a girl. After she left, the mental health files of three girls were missing at TRC. There was no indication from the records reviewed by the MH Monitor that there were other inadequacies in note-taking by clinicians. Meanwhile the other OMH clinician is carrying all nine of the girls on the Taberg MHU. MHUs are staffed by OMH, and, due to downsizing of the workforce statewide, the OMH hospital that has oversight of the MHU at TRC is having difficulty filling the vacancy. Given the acuity of the girls on the Taberg MHU and risks of deterioration from an unstable unit, OCFS recruiting a skilled trauma therapist to fill the vacancy on the unit appears urgent.

FUTURE MONITORING

When it is approved and implemented, the MH Monitor will document that all the elements of revised PPM 3247.60 "Suicide Risk Reduction and Response" are followed with residents.

The MH Monitor will review:

- Completed OCFS-1448 forms in records.
- Training curriculum for mental health professionals on protocols related to developing uniform working diagnoses
- The MH Monitor will interview trainers and staff who participate in the mental health training and discuss consistency in diagnostic practices with the 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:

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

medication; the rational for the prescription of each medication, and the target symptoms intended to be treated by each medication.

b. 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.

c. 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.

PENDING REVIEW

Given the complex requirements of 49 a, b and c, the MH Monitor will engage an adolescent psychopharmacology expert subcontractor to assist the MH Monitor with her review of compliance with the psychiatric medication section of the Settlement Agreement.

Policy PPM 3243.32 entitled "Psychiatric Medications" addresses the requirements of the Settlement Agreement: prescribing, informed consent, medication administration, clinical monitoring, reporting, and training.

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."

The MH Monitor reviewed the training curriculum entitled "Introduction to Psychiatric Medicine" which is designed to inform direct care staff at DJJOY facilities about the principals of psychiatric treatment with medicine, about the side effects and complications that may occur with psychiatric medicines, and about their roles in relation to that treatment. This training includes: Principles of Treatment with Psychiatric Medicines, Diagnoses Treated with Psychiatric Medicines, Classes of Drugs Used to Treat Mental Illness, Side Effects of Psychiatric Medicines, and The Role of Direct Care Staff.

The MH Monitor reviewed the one-page "Prescription of Psychiatric Medicines" by Dr. Gerring (1/12):

> The psychiatrist makes the decision to prescribe a psychiatric medicine on the basis of his/her psychiatric evaluation, the clinician evaluation, and staff input. The psychiatrist discusses benefits and side effects of the medicine with the guardian to obtain verbal informed consent; the psychiatrist and clinician discuss benefits and side effects with the youth to obtain consent. Written consent form explaining benefits and side effects are mailed to the guardian for signature. The psychiatrist chooses medicine with attention to diagnosis, symptoms, and past medication history. He orders the medicine in the orders section of the facility medication chart. According to the intensity of disorder, the psychiatrist will interview the youth at regular intervals, with input from the clinician, nursing, and other staff, monitor benefits and side effects, continue, adjust or change medicines, and discuss these adjustments with the youth and family. The psychiatrist will write a note into JJIS for each patient encounter.

State Report on Progress (12/20/11)

1. Modify policies: PPM 3243.32 "Psychiatric Medications" and PPM 3243.33 "Behavioral Health Services."

   "Approved for implementation."

2. Plan for training and train qualified health professionals in prescribing and monitoring practices related to psychiatric medication.

   "Curriculum in development."

On Site Observations (2/12)

The MH Monitor observed documentation of diagnosis, symptoms, dosages, and administration of psychiatric medication in the individual records at TRC. The Psychiatrist presented medication and medication changes for each girl in Rounds.

The one-page Psychiatrist Contact Form completed on each girl by Dr. Cattalani is both thorough and easy to review. It provides an opportunity for once weekly checks by the psychiatrist of a list of 24 symptoms, her diagnosis, a record of side effects, a record of blood work and weight and blood pressure, and a decision about any change in medication. He types it after seeing each girl so it is legible and allows for a comparison in symptoms week after week. For example, for a girl reviewed in Rounds, despite the frustration of still having no records 3 weeks after admission, Dr. Cattalani indicated on the contact form that Mood Disorder and PTSD were being considered as diagnoses: "Engaging, socially appropriate and articulate She believes she needs to be back on some kind of medication for her "mood switches" which she describes as sudden periods of dysphoria, impulsivity and some aggression. Given her struggles with weight and glucose intolerance, I suggested that a return to an antipsychotic was not the best idea and that perhaps a trial with Tenex might be a better choice. She agreed and we called her mom, discussed risks and benefits and she agreed to a trial."

FUTURE MONITORING

An expert review to determine appropriateness of medications for diagnoses and whether correct dosages and standard monitoring of effects are the practice at TRC will be completed in the future.

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.

a. 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.

b. 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

State Report on Progress (12/20/11)

1. Modify policies: PPM 2801.00 "Training Requirements for OCFS Operated Facility and Day Placement Staff," PPM 3243.32 "Psychiatric Medications" and PPM 3243.33 "Behavioral Health Services."

   PPM 2801.00 has been implemented as at the DOJ facilities. PPM 3243.32 is approved for implementation. PPM 3243.33 is approved for implementation.

2. Plan for training and train staff on psychiatric medication and psychiatric disabilities.

   "Mental Health training is being scheduled. Psych Meds curriculum in development."

On Site Observations (2/12)

Other than the Rounds discussion described above and an interview with one of the TRC nurses regarding medication, there was no opportunity for observation of staff understanding of medication.

FUTURE MONITORING

The MH Monitor will interview staff about their understanding of psychiatric medication.

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

a. 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.

b. 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.

c. 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.

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

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

COMPLIANCE

Policy PPM 3243.32 entitled "Psychiatric Medications" and Policy PPM 3243.15 entitled "Refusal of Medical or Dental Care by Youth" cover the requirements of the Settlement Agreement.

The curriculum for the one-hour training for nurses entitled "Refusal of Psychiatric Medication" covers the requirements of the Settlement Agreement.

State Report on Progress (12/20/11)

1. Modify policies: PPM 3243.15 "Refusal of Medical and Dental Care by Youth and PPM 3243.32 "Psychiatric Medications"

   PPM 3243.15 implemented. PPM 3243.32 is approved for implementation.

2. Plan for training and train staff on psychiatric medications, including refusal of treatment

   "Medical staff training on refusal of treatment is completed."

   "Psych Meds curriculum in development."

3. Educate youth on refusal of medical protocols.

   "Ongoing."

On Site Observations (2/12)

The MH Monitor observed documentation in girls' individual records that numerous girls at TRC had refused psychiatric medication, and it was reported that if a girl does not want to take her medication, the medical staff's practice is to ask about her reasons and counsel her about making a wiser decision. If they cannot persuade her to take her medication, she is asked to write her reason on the medication refusal form, which is reviewed by the psychiatrist. Medication refusals were discussed at Rounds.

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.

PARTIAL COMPLIANCE

There is a training curriculum the MH Monitor is waiting to review to determine compliance.

State Report on Progress (12/20/11)

1. Modify policy: PPM 3243.32 "Psychiatric Medications"

   PPM 3243.32 is approved for implementation.

2. Plan for training and train qualified mental health professionals on psychiatric medications, including informed consent requirements

   "Informed consent is being obtained by qualified prescribers at all four facilities."

   "Psych Meds curriculum in development."

On Site Observations (11/11)

Informed consent forms were in the TRC records reviewed by the MH Monitor.

FUTURE MONITORING

When it is available, the MH Monitor will review the training curriculum for qualified mental health professionals on psychiatric medications

The MH Monitor will 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:

a. 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.

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

c. 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.

d. 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.

e. 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 of 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.

f. 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.

PARTIAL COMPLIANCE

Mental health staff at TRC were observed complying with 53b and c with their first treatment team consistent with the New York Model.

The TRC staff will soon begin using the new integrated assessment and new treatment plan form routinely, and will require assistance from the BBHS Chief of Treatment Services and BBHS Social Work Supervisor to improve their skills in writing treatment goals with the young person.

What the MAP referred to as a new policy on Case Management of Juvenile Delinquents Placed in the Custody of OCFS is no longer planned as a policy; instead, New York Model implementation training includes the new integrated assessment, the new treatment plan, and how to utilize both in the new treatment teams.

The MH Monitor reviewed "The NY Model: Treatment Team Implementation Guidelines" (12/9/11 from the OCFS Bureau of Behavioral Health Services). It is a 9-page document, with attachments of the Integrated Assessment with guidance for what should be included in each section and a copy of the new treatment plan.

> "Each youth will have a Treatment Team meeting every 30 days from the date of admission. Each youth's Treatment Team would include the following members: the youth, representative(s) of the youth's family or youth's community-based caretaker, the youth's facility case manager (FYC), the youth's community case manager (CYC), the mental health clinician, the psychiatrist (if applicable), a childcare staff (mentor if available), representative of the medical, education, recreation, spiritual, and the vocational departments of the facility, as well as any other community resources that have been (or will be) engaged in the support of the youth and their family. The team will engage the youth and family in a discussion of their goals and how the team can assist the youth and family in attaining those goals (in light of their strengths and needs)."

A discussion of strengths orients the treatment team in a strengths-focused direction to establish a sense of hopefulness and capability. If a youth's struggles with a lack of skills get in the way of their stated goal, a clear link can be made between them. Treatment Team members can then discuss what supports and services they have to offer to assist the youth in overcoming the identified obstacle and moving closer toward their goal. The question the Team Members ask themselves is "What do I have to offer this youth and their family that will help get them closer to their stated goal?" "The NY Model: Treatment Team Implementation Guidelines" meets the requirements of paragraph 53 of the Settlement Agreement.

The MH Monitor reviewed a new description of the NY Model Phase Advancement Worksheets. Any member of the Treatment Team can call a meeting to discuss Phase Advancements, and these can be discussed at Rounds, Shift Exchange, Red Flags, Treatment Teams, and Log Entries. The skills the youth must learn in order to advance are clearly spelled out.

State Report on Progress (12/20/11)

1. Create new policy on Case Management and Treatment Team Processes

The new policy is renamed Case Management of Juvenile Delinquents Placed in the Custody of OCFS. "This policy is drafted but the content is different than originally intended. New tasks will be provided to address the remedial measures in the upcoming revised MAP."

2. Modify treatment plan documents

   Integrated Assessment form completed July 2011.

   Integrated Treatment Plan completed July 2011.

   New York Model Treatment Team Implementation Guidelines completed 10/20/11.

3. Plan for training and train staff on case management and treatment team processes

   "Instruction and implementation on treatment team processes provided by Bureau of Behavioral Health Services in progress: Lansing completed 10/25/11; Finger Lakes starting 12/6/11; Columbia completed 11/15/11; Taberg to be scheduled."

On Site Observations (2/12)

The MH Monitor observed a treatment team at TRC that was their first effort to use an approach more like what is expected in the New York Model. The YC skillfully led the meeting that included the therapist, the school coordinator, a YDA and a nurse and her aftercare worker and grandmother on the phone. The 15-year old was admitted to TRC about three weeks before the site visit (she had been in custody for a month before). She has a significant trauma history including physical and sexual abuse, death of parent, eviction, and death of friends. Her placement at TRC followed getting out-of-control in the courtroom, and she was diagnosed with PTSD, Oppositional Defiant Disorder, and marijuana and alcohol dependency. She told the Taberg psychiatrist she did not want medication. She was described as anxious, and it was noted that she gets aggressive when she feels overwhelmed. Her YC presented the girl's strengths and asked, "What goals do you have?" She responded, "To control my mouth" and "To not get as frustrated." Her grandmother said she "hopes she gets well so she can come home. We love her. We want her home. We also want peace in our home." Her therapist said the girl is working with staff to see when she is being triggered so she does not respond with uncontrollable anger. The BBHS Chief of Treatment Services encouraged staff to offer what they could do to help her with her goals of controlling her mouth and not getting so frustrated. They told her they could help her work on compromise to reduce frustration and help her take 5-minute breaks before something got too frustrating. They reviewed her IIP techniques of time away and venting. The treatment team actively included the girl and her grandparent. The team gave her positive feedback about what she is doing well.

For this resident, the MH Monitor reviewed the first Integrated Assessment at TRC. It contained a summary of educational background, past trauma and family problems, including psychiatric history. The recommendation section listed five needs—but they were services (not needs), not unique to her, and geared toward clinicians and education (e.g., "individual and family counseling" and "substance abuse counseling" are not needs).

The diagnostic formulation described her denial and emotional numbing (in part through substances) to cope with her trauma history. If the question was asked, what needs would be met by individual or substance abuse counseling, the answer might be "She needs to express her sadness and anger from past trauma." By writing specific needs like this in recommendations section of the Integrated Assessment, the service and provider column would include a variety of staff meeting that need (therapist providing counseling, drug counselor teaching about the risks of numbing with substances, teacher allowing Time Away, YDAs helping with self-soothing, and YC helping plan for responding to family and peer substance abuse in the community).

Learning how to write specific treatment goals based on needs behind each girl's behavior is the challenge of the new treatment plan. The MH Monitor discussed with TRC staff their commonly used single generic goal in most treatment plans: "Comply with the rules and expectations on the unit, school and general community environment of facility." Compliance is a challenge for the girls, but it is not useful as a treatment goal. A vague goal results in a generic plan of "see the psychiatrist and participate in DBT for all girls. Using her ideas, if her treatment goal were stated, "To not get as frustrated," it is much clearer what staff will do to help her meet this goal and in the process she would engage in treatment and connect her frustration to the anxiety from trauma that she avoids.

The clinicians discussed the MH Monitor's observation that several of the girls' treatment plans only addressed mental health interventions (things a therapist would do with her). But an integrated treatment plan states needs behind behavior that can be met by all staff differently, much of which will not be therapy.

How treatment teams at TRC actively engage residents in defining their own goals is crucial because generic services have not been effective. Four girls' multiple placement histories exemplify inadequate goals and services:

• Taberg is the 8th facility placement for a 15-year old who has been back and forth from the Bronx to facilities for more than 18 months (MTFC 5/10, Tryon 5/10, Brentwood 7/10, Tryon 7/10, Aftercare 12/10, Tryon 1/11, Aftercare 2/11, Tryon 4/11, Aftercare 6/11, McQueen 11/13, Lansing 12/11, and Taberg 12/11.

• A 14-year old has been has in custody more than 18 months (except for 2 months on aftercare): Tryon 6/10, Tubman 6/10, Lansing 8/11, Tryon 2/11, Brentwood 6/11, Aftercare 8/11, and Taberg 10/11.

• Now 16, one girl has been in custody more than 2 years: Tryon 12/09, Tubman 1/10, Tryon 8/10, Taberg 8/11, McQueen 11/11, and Taberg.

• After commitment in 5/10, spending more than a year in a residential program (including six runaways and two weeks in a psychiatric hospital), placement at McQueen, placement at Brentwood, return to McQueen, and arriving at Taberg, one girl is now 17, in the jail, in custody more than 18 months, and at risk of adult prison.

It is essential that each of these girls' treatment teams help her figure out what has to change for her to end this pointless revolving door and make the most of her strengths so she can be successful. Figuring out the unmet needs behind their behaviors to make

sure each girl is an active player in getting her needs met requires a specific, needs-driven treatment plan explicitly connected to the skill building of the New York Model.

FUTURE MONITORING

The MH Monitor will interview trainers and staff involved in "The NY Model: Treatment Team Implementation Guidelines" training.

The MH Monitor will review treatment plans and observe treatment team meetings

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

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

    b. *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

The MH Monitor reviewed the 3-page 1/12/12 OCFS Bureau of Behavioral Health Services plan outline for all facilities to have a substance abuse prevention and treatment program. Youth going to limited- and non-secure facilities are assessed for chemical dependency at reception (using the SNAP and GAIN-Q). The Substance Abuse Workgroup is identifying an instrument for assessing chemical dependency for the secure facilities. OASAS is developing standards for chemical dependency treatment at OCFS DJJOY facilities with the goal that OASAS will certify OCFS facilities to provide substance abuse services. At Taberg, Columbia, Finger Lakes, and Lansing, OCFS has or will hire a clinician to provide individual chemical dependency treatment and group treatment using a curriculum that relies on DBT and Sanctuary.

The MH Monitor reviewed the curriculum for the DBT for Substance Abuse training which DJJOY used to train 3 staff from Taberg, 3 staff from Columbia, 4 staff from Lansing and 4 staff from Finger Lakes in February, 2012 to meet the requirement for substance abuse treatment in the Settlement Agreement.

The MH Monitor reviewed the 2-day agenda for "Dialectical Behavior Therapy: Treating Clients with Borderline Personality Disorder & Substance Use Disorders" planned for February 2012. It included topics such as: Structuring the Treatment Environment, Dialectical Abstinence in DBT-SUD, Structuring the Individual Therapy Sessions, Chain Analysis and Task Analysis in DBT-SUD, and Working with Families in DBT-SUD.

The 1/12 plan outline and the DBT and Addictions training demonstrate progress in complying with the Settlement Agreement. Neither provide a clear explanation accessible to all staff of how substance abuse fits into delinquent behavior and will be treated in the New York Model while youth live in a drug-free environment but will return to peer and family substance abuse. Like the process of becoming trauma-responsive, learning to meet the needs behind substance abuse is important for all staff, not just clinicians. This understanding must come out of the training so it can be coached in daily practice. Furthermore, it is crucial that treatment teams support youth confidence that they will

continue to use the skills learned in the facility when they return to the community so substance use does not contribute to re-offending.

The 1/12 plan outline acknowledges the challenge posed by the OASAS requirement that youth must consent to treatment and many refuse if not court-ordered. The Substance Abuse Workgroup is considering ways to increase voluntary participation, presumably by involving youth in identifying their goals and what it will take to achieve them in the integrated assessment, treatment plan and treatment team process.

The MH Monitor is waiting to review OASAS standards for chemical dependency treatment at Taberg, Columbia, Finger Lakes, and Lansing, OASAS certification of the facilities to provide substance abuse services, and details of the individual chemical dependency treatment and group treatment using the New York Model by OCFS clinicians at the facilities.

The section of PPM 3243.33 entitled "Substance abuse interventions and treatment" does not address the connection between the NY Model and such treatment, including the applicability of DBT and Sanctuary skills.

State Report on Progress (12/20/11)

1. Develop collaboration with NYS Office of Alcohol and Substance Abuse Services (OASAS)

   "Based in part on comments made by the DOJ Monitors, OCFS is reconsidering the manner in which we will meet this remedial measure, which may not involve collaboration with OASAS."

2. Modify PPM 3243.33 "Behavioral Health Services"

   "Approved for implementation."

3. Create new policy on Case Management and Treatment Team Processes (to include substance abuse services)

   New policy renamed Case Management of Juvenile Delinquents Placed in the Custody of OCFS. "This policy is drafted but the content is different than originally intended. New tasks will be provided to address the remedial measures in the upcoming revised MAP. Substance abuse services are incorporated in the integrated treatment team process"

4. Plan for training and train staff on case management and treatment team processes, including substance abuse services

   "Instruction and implementation on treatment team processes provided by Bureau of Behavioral Health Services in progress: Lansing completed 10/25/11; Finger Lakes starting 12/6/11; Columbia completed 11/15/11; Taberg to be scheduled."

5. Plan for and provide, with the support of OASAS, substance abuse treatment, prevention and educational services to youth commensurate with their needs

   "Based in part on comments made by the DOJ Monitors, OCFS is reconsidering the manner in which we will meet this remedial measure."

On Site Observations (2/12)

Substance abuse, particularly daily marijuana use, is a widespread, often trauma-related problem among youth that is influential in delinquent behavior. Most of the girls at TRC have significant substance abuse histories.

FUTURE MONITORING

When they are available, the MH Monitor will review:

- Description of substance abuse treatment and education services in the facilities that complies with 54 a and b, including OASAS certification of the facilities to provide substance abuse services.
- Revision of PPM 3243.33 addressing the connection between the NY Model and such treatment.
- Presentation of chemical dependency services in the New York Model utilizing DBT and Sanctuary and in the context of the new integrated assessment, treatment plan, and treatment team process.

The MH Monitor will observe substance abuse treatment being provided to residents and their substance abuse being addressed in treatment plans, treatment teams and through coaching of staff in the New York Model.

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, who 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:*

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

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

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

PARTIAL COMPLIANCE

The MH Monitor reviewed the curriculum for the one-hour training for nurses entitled "Psychiatric Medications at the Time of Release" and it explains the policy required by the Settlement Agreement: 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.

The MH Monitor reviewed the Transition Plan screens from the OCFS Juvenile Justice Information System dated February 2012. These indicated that iLinc Training scheduled in 2-1/2 hour blocks would be offered several times per week between 3/8/12 and 4/25/12. The 2-page computerized Transition Plan form has ten sections: (1) identifying information, including family, CMSO (aftercare), community service provider, attorney, other important adults, supportive peer resource; (2) housing; (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.

State Report on Progress (12/20/11)

1. Modify policies: PPM 3243.32 "Psychiatric Medications" and PPM 3243.33 "Behavioral Health Services."

   "Approved for implementation."

2. Create new policy on Case Management and Treatment Team Processes

   New policy renamed Case Management of Juvenile Delinquents Placed in the Custody of OCFS. "This policy is drafted but the content is different than originally intended. New tasks will be provided to address the remedial measures in the upcoming revised MAP."

3. Plan for training and train facility and community based staff on case management and treatment team processes, to include transition planning

   "Transition planning for youth with mental health needs has been implemented using the Continuity of Care plan, which incorporates the components of this remedial measure."

On Site Observations (2/12)

The MH Monitor requested copies of documents from the files of six former TRC girls admitted to Columbia after the December 2012 site visit. No Continuity of Care plans were included nor any indication that the Taberg clinicians sent treatment summaries to Columbia. Just because a youth is fennered from the jail to Columbia should not exempt the former facility staff from completing a Transition Plan.

The new Transition Plan screens comply in part with the Settlement Agreement by including information about all aspects of the youth's community transition. However, if a purpose of the transition plan is to be a single reference point for each person involved (youth, family, OCFS staff, service providers) then it should include the telephone number and address of each person/service. Second, substance abuse recovery support services are not specifically listed. Third, the training for the plan indicated that the last section is to identify if a youth is in immediate danger of serious harm, but for all youth, their Sanctuary safety plan could be written on the transition plan as a reminder of what the youth learned to do to calm him/herself (to be used in the community); it would be easier for the youth to follow if it were formatted like the safety plan list that the youth wears around his/her neck in the facility. Fourth, 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 treatment 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. Finally, the OCFS Mental Health/Psychiatric Medication Continuity of Care Plan contained the details of about medications and the name and

telephone of outpatient provider and dates of scheduled appointments, and these are missing from the new Transition Plan screens.

The necessity of an effective, comprehensive transition plan that is specifically designed to ensure that a resident's gains in the facility continue in the community is exemplified by a 14-year old resident who was admitted to Tryon in 4/11, moved to Taberg in 8/11, was released on aftercare in 1/12 and returned to Taberg five days later.

The MH Monitor has not yet reviewed actual transition plans that included all elements of a youth's successful re-entry to the community.

FUTURE MONITORING

When they are available, the MH Monitor will review transition plans in records.

The MH Monitor will interview staff who were trained on the new Transition Plan through iLinc training.

The MH Monitor will observe residents working with staff on transition plans that connect their successes in the facility with their plans in the community and review transition plans for youth.

IV. DOCUMENT DEVELOPMENT AND QUALITY ASSURANCE

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

PENDING REVIEW

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

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:

PENDING FURTHER REVIEW

COMMENT: In a meeting with the Home Office staff assigned to the Settlement Agreement, a discussion occurred about the Quality Assurance (QA) Paragraph 57. Home

[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.

Office staff confirmed that a director has not been hired but that could be remedied soon. Currently, the quality assurance department includes an assistant director and five (5) quality assurance specialists. A quality assurance consultant from Connecticut has been hired to work with the division. The delay in the full implementation of quality assurance programs means that there are issues that continue to receive oversight by the monitoring.

At the facility level, there were no indications of a QA presence through a set of QA guidelines, specific data collections, or routine inspections of operations. The new policy on quality assurance is still pending; therefore, the program itself is also pending. See page 21 of the December 2011 "6-Month Progress Report." The QA unit is responsible for monitoring the reportable incidents that require DOJ notification per the Settlement Agreement, for providing support to the DOJ facilities to prepare for monitoring visits, for performing oversight of OCFS facilities' usage of the Performance-based Standards System (PbS), and for developing a quality assurance instrument to measure compliance with the remedial measures.

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: Three quality assurance related problems arose from the TRC visit. They are:

1. The shortages of available YDA staff at TRC negatively affect Protection from Harm and programs.

The Settlement Agreement does not directly make "staffing adequacy" an issue. That said, this monitoring visit, along with some of the other recent monitoring visits, raise questions as to whether various factors, including staff absences due to worker's compensation, family medical leave and administrative leave along with limitations on staff contact with youth during investigations, are impacting the facilities' ability to have the full complement of staff necessary to implement the remediation policies on a day-to-day basis. OCFS has agreed to review the impact of these factors on facility staffing and determine whether any adjustments in staffing patterns or other staffing procedures may be needed.

The staffing factors should include a working definition of "staff adequacy" and mechanisms that TRC administration can use to ensure that all shifts are filled and that overtime is at an acceptably low level. Other related concerns are ways to (a) adjust staff coverage and assignments based on variations in the number of youth and the needs of youth, including one-on-one suicide observations and identification of residents who may require additional staff for the safety of themselves and others, (b) reduce or moderate the use of leave hours by YDA staff that affects work availability, and (c) expedite the YDA hiring process for "DOJ facilities" that experience staffing problems associated with the need to fill staff vacancies.

2. The recent failure to guarantee that critical, physical restraint and use of force data and records are appropriately gathered and documented constitutes a serious breach in quality assurance.

Needed from Home Office are greater assurances that the problem has been effectively resolved and that systems are in place to prevent its recurrence. Referring the

issue for investigation is an important first step, but the Monitors continue to have concerns about the appropriateness of an internal investigation. In addition, the Monitors and DOJ need to know that Home Office will share with us the outcomes of the investigation and will implement any remedial actions necessary as a result of the findings. Additionally, while we concur with OCFS' removal of two administrators, questions still exist about the efficacy of that move regarding deterrence against a repeat of the behavior. Furthermore, there must be additional procedural safeguards in place to prevent a recurrence. This, too, may be an issue for quality assurance, but in its absence, greater specificity is needed. Finally, question remains as to whether the Restraint Packet information was never done, misplaced, or destroyed. Answers to these questions are essential and could have more serious implications.

3. The existing surveillance camera system is of such poor quality that the resolution of video documentation hampers the investigation of incidents and undermines confidence in investigative or review conclusions about what happened. This degrades the integrity of the investigation system.

The inadequacies of the TRC camera system are described on page 5 of this report. The poor quality of the video undermines the SIU investigations and the integrity of its findings. The larger issue here is Paragraph 44 and the confidence in abuse investigations related to acceptable video evidence, which does not exist at Taberg.

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: Home Office committed to expanding quality assurance development to address these and other issues related to compliance. Discussions between the Monitors and Home Office staff resulted in a decision by DJJOY to meet this summer to review quality assurance mechanisms and compliance issues. This commitment and the formalization that accompanies quality assurance mechanisms supply a reasonable assurance that the resolution of these issues has priority status. QA and Home Office agreed to work collaboratively with the Monitors in the development of quality assurance mechanisms. The review of these quality assurance products and the status of the resolution of the aforementioned issues will be critical parts of future monitoring.

V. SUMMARY

A primary challenge for TRC is the newness of the programs and operations. The monitoring occurred only five months after the move to the Taberg facility, and there have been substantial changes since then. These changes include new leadership and changes in staff roles and responsibilities. Home Office and the new TRC administration point out that while things are not where they want them to be and while they have a long way to go in the area of program development and safety, most TRC staff members believe that positive indicators exist and they bode well for future and continued improvements.

Several factors affected the Monitors' ability to render a complete assessment of the TRC programs and services. The resolution of these problems, as outlined in paragraph 57

and other locations within the report, will permit an assessment of the level of compliance in six months.

Appendix A

List of Documents Reviewed for Taberg Residential Center for Girls

1. Complete set of current policies, procedures, and practices.
2. Current floor plans or diagrams (on 8.5 x 11" format) of living units and other program space in each of the facilities, including information regarding segregation and disciplinary units, and other special management units.
3. Current program descriptions, including daily and weekly schedules for youth by living units, including mental health program activities and schedules (i.e., groups, other therapeutic activities).
4. Current rated capacity (including the capacity breakdowns by living units) and current census by facility and living unit.
5. A current organizational chart of each facility, including the names, gender, and titles of all employees, including supervisors, mid-managers, and upper level managers.
6. Total staffing for the mental health program(s) according to program, and specifying the job category or discipline, including all contract personnel.
7. Facility reviews including, monitoring reports, accreditation reports, audit reports, and other reports prepared for or by facility management or external entities since August 1, 2010.
   A. Fire Safety Reports – Annual, Semi-Annual, Monthly (consistent with statutory inspection intervals by the state or local fire marshal).
   B. All existing Facility Director's reports to DJJOY executive staff regarding an accurate and complete account of incidents involving the use of physical restraint as entered into the Automated Restraint Tracking System (ARTS).
8. List of all youth on any level or type of personal safety watch, specifying the date, length of time, and precipitating cause since August 31, 2011.
9. Incident reports or youth grievances regarding use of force, injury, and sexual misconduct since August 31, 2011.
10. A list or log of all youth who were injured (requiring more than on-site first aid) or who were transported to an emergency room or other off-grounds medical facility for medical or mental health treatment, including the source and date of the injury, and a description of the injury or condition for which treatment was sought, particularly youth on the mental health caseload who appear on this list since August 31, 2011.
11. List of all youth seen by medical following a physical restraint incident since August 31, 2011.
12. List of youth who were admitted to a psychiatric facility, the precipitating cause, and the length of each youth's stay at the psychiatric facility.

13. Use of force reports since August 31, 2011, including a list of youth who were restrained, specifying the date, precipitating cause, and method of restraint (i.e., physical, mechanical, chemical).

14. List of all youth who received a psychiatric, substance abuse, or other mental health intervention, including diagnosis and date and type of treatment.

15. List of youth taking psychotropic medication, identifying the medication, dosage, and the condition it is treating.

16. A list of staff who are or who have been in the process of any corrective action or discipline as a result of disobeying laws, regulations, or OCFS policies or procedures regarding the supervision of youth.

17. A list of staff who are or who have been on administrative leave or no-contact status pending the outcome of any investigation or injury.

18. A list of incidents that have been referred to social services agencies, the local police, or other State or County law enforcement authorities.

19. Complaints from parents, guardians, attorneys, or other interested third parties regarding use of force or fear of safety, including sexual misconduct, and the status of the complaint.

20. Civil complaints or criminal charging documents alleging professional misconduct against staff or facility administrators, and the results of those complaints or charges.

21. Reports of investigations involving allegations of abuse, neglect, or mistreatment.

22. Description of all physical plant improvements since January 1, 2009, including any changes to the interior and exterior visual surveillance systems.

23. List of employees who have not satisfactorily completed CPM training and who are not authorized to perform a physical restraint.

24. Training records from the STARS system for each staff member in the facility indicating the training session or experience completed.

25. Youths' institutional records.

26. An alphabetical list of juveniles held at the facilities for the first day of the site visit, including names, ages, admission dates, living units, housing classifications, detaining offenses, and any personal safety watch alerts.

27. Any list or log of youth grievances indicating the type, date, and outcome of each grievance.

28. Any list or log of youth discipline indicating the type, date, and outcome of each disciplinary event.

29. Incident reports, use of force reports, disciplinary infraction reports, and disciplinary hearing reports.

30. Any digital video surveillance camera recordings of specific incidents, especially

those prepared for the Facility Director's review of physical restraint as defined by PPM 3247.17.

31. Any manual and electronic housing unit logs.

32. State of New York laws, rules, and regulations regarding confidentiality for adolescents.

33. State of New York Child Health Care Standards.

34. State of New York Child Abuse/Maltreatment law(s), including mandatory reporting.

Appendix B

List of OCFS Staff Who Contributed Information

Edith Abete, YDA 2

Gale Asch, SWII

Dan Bareiss, Cook

Keely Bennett, YDA 3

Karen Best, Office Assistant

Merle Brandwene, Director OCFS Management and Program Support

Mike Capparello, YDA3

Sandra Carrk, OCFS Project Manager

Dr. Susan Cheeburrish, Psychiatry

Lori Clark, Acting Director

Alison Clarke, Teacher 2

Janice Curren, PAC

Diane Deacon, OCFS Legal

Dave DeLaOsaCruz, YCI/AOD

Kathy Fitzgerald, BBHS –SW Supervisor

William Gilman, LCSW-R, LMSW2

Scott Hecox, Supervisor of Security of Facilities

Anthony Hough, DJJOY Associate Commissioner

Jason Kneezle, YDA3

Erin Kornbluth, YDA 3

Donna Leonard, RN 2

Edgardo Lopez, Settlement Coordinator

Dr. Marie Mastracco, Psychologist 2

Kelly Miller, Education Coordinator

Ruth Mosher, RN

Ines M. Nieves, Associate Commissioner

Denise Passarello, QAU Specialist

Theresa Peck, Health Services NA 1

Debra Peete, Training Supervisor

Michelle Randall, Teacher 2

Patricia Randall, Secretary 1

Amy Redmond, Youth Counselor 1

Melinda Rivera, BBHS Counseling Liaison

Rebecca Roberts, YC 1

Amy Scribner, Teacher

Debra Skinner, Teacher 2

Beverly Sowersby, DJJOY – Facilities Manager

Samuel Spina Jr., YDA 3

Andre Testamark, YDA3

Dr. Joseph Tomassone, BBHS Chief of Treatment Services

Suzanne Tulino, Assistant Director

Bruce Warcup, YDA3

Jane Wenham, RN