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 eleventh 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 (Taberg) on March 19-21, 2013. As noted in the first monitoring report, the Monitoring Team consists of two Monitors, Dr. Marty Beyer, who is responsible for the Mental Health paragraphs of the Settlement Agreement, (hereafter referred to as the MH Monitor) and Dr. David Roush, who is responsible for the Protection from Harm paragraphs (hereafter referred to as the PH Monitor).

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

The Settlement Agreement (Paragraph 61b) provides for *ex parte* communications as an ongoing way for the Monitors to gather information. The Settlement Agreement further stipulates (Paragraph 62d) that the Monitors will provide a draft report to the Parties following the monitoring visit. The Monitors construe the designation of a draft report in advance of a final report to mean that the draft report and the comments provided by each Party are still part of the investigative processes associated with the monitoring visit. Therefore, the Monitors note that statements in a draft report are not final, and they are not wedded to draft report statements. The Monitors acknowledge the option to modify and clarify initial impressions and statements regarding compliance in advance of a final report. Furthermore, the Monitors' draft and final reports do not pertain to any other matter than the *United States v. the State of New York and the New York State Office of Children and Family Services.*

A. Tryon Girls

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

Girls Limited Secure to Taberg that summarized each girl's presenting problems and treatment while at Tryon.

On September 2, 2011, the Monitors requested an opinion from Home Office regarding questions about how the Tryon Girls closure applied to the Definition Section of the Settlement Agreement. Specifically, Paragraph 36 states that "Tryon Girls shall mean the Tryon Girls Center, located at 881 County Highway 107, in Johnstown, New York, or any other facility that is used to replace or supplement Tryon Girls." Discussions between OCFS legal counsel and Department of Justice (DOJ) attorneys resulted in an agreement to designate Taberg and Columbia as facilities that qualify for monitoring under the Settlement Agreement. The Home Office also updated the six-month reports on the MAP to include Taberg and Columbia. The first monitoring visit to Taberg occurred on November 29 through December 1, 2011, the second visit occurred August 20-23, 2012, and this report reflects the outcomes from the third Taberg visit on March 19-21, 2013.

B. Facility Background Information

Taberg is a 23-bed limited secure facility for girls with two units in one building. Another building contains a gymnasium, library, learning center and classroom. One unit, with ten beds, is the only mental health unit for girls in New York State; a statewide Mental Health Unit committee does admission to that unit. The other unit, consisting of 13 beds, is the only limited secure program for girls in the state.

Taberg was a male juvenile facility, and it opened for girls on August 31, 2011 when 12 girls moved from Tryon. Staff originally came primarily from Tryon, Taberg Boys, Annsville, and Tubman; during 2012 many staff left, a large percentage were new and creating a cohesive staff team was a challenge for more than a year. Now all the Youth Division Aid (YDA) positions are filled, the strong leadership of the Acting Director has been continued with the promotion of the Assistant Director to Director. Both the staff and the residents are benefitting from stability and their cohesive teams.

On March 19, 2013, there were 20 girls at Taberg, ten on the mental health unit and ten on the generic unit. None of the original Tryon girls remain at Taberg; several were fennered to Columbia and at least one is still there. Only two girls at Taberg were there during the monitoring visit six months previously. Half the girls at Taberg arrived in the ten weeks prior to this site visit.

The 20 girls ranged in age from 12 to 17. The immaturity of the 12-year old, the 13-year old and the 14-year old was a significant challenge, especially in a facility where more than half the girls were 16 and 17—serving this wide range of developmental needs is likely to be a continuing difficulty in a facility that is the only limited secure program for girls and has the only mental health unit for girls in the state. The 20 girls had been at Taberg from 12 days to 229 days; this average length of stay of 97 days is a week shorter than the Taberg average in the last site visit, even though twice as many Taberg girls as previously had been there four months or longer on this visit. A surprising pattern at Taberg is that girls appear to arrive in clumps, with 2-4 girls frequently arriving within a week of each other: this must cause unit destabilization and significant culture change repeatedly at Taberg.

The 20 Taberg girls have been sentenced for: Assault (7), Criminal Mischief (3), False Report (2), Obstructing Justice (2), Petit Larceny (2), Burglary (1) Menacing (1), Possession of a Firearm (1), and Resisting Arrest (1). At least five were there following a probation violation.

All but two of the 20 girls have psychiatric diagnoses, and most have more than one: ADHD (1), Anxiety (4), Aggression (1), Depression (1), Major Depression (1), Mood Disorder (5), Mood Instability (3), PTSD (4), PTSD/Anxiety (1), Impulsivity (4), Irritability (1), Insomnia (6), and Insomnia/Anxiety (2). Two girls are diagnosed with Conduct Disorder. One girl who had just arrived had no diagnosis.

Seventeen of the Taberg girls are prescribed psychiatric medication: Abilify (3); Benadryl (2), Celexa (1), Clonidine (1), Clozapine (1), Concerta (1), Effexor (1), Elavil (1), Haldol (1), Intuniv (5), Lamictal (1), Lithium (1), Melatonin (1), Prozac (1), Risperdone (2), Seroquel (8), Trazodone (5), Trileptal (2), Wellbutrin (2), Zoloft (3), and Zyprexa (1). Despite the reduction of prescribing Seroquel at the other two girls DOJ facilities because of female side effects, Seroquel is still prescribed to almost half of the Taberg population for mood disorders, depression and PTSD.

Twenty-three girls were discharged from Taberg between 8/1/12 and 2/28/13. The average length of stay of 15 of those girls at Taberg was 7 months (six girls moved to Columbia and Lansing and two other girls with unusually short stays were excluded).

C. Assessment Protocols

The assessments used the following format:

1. Pre-Visit Document Review

The Monitors submitted a list of documents for on-site review. The Monitors worked with OCFS to make the document production and review processes more efficient, especially ways to make the transportation of documents easier for Home Office without compromising the quality of information provided. The Monitors also received the *Pilot Program Review: Taberg Residential Center for Girls* (Draft), the report from the Quality Assurance and Improvement (QAI) Bureau, in advance of the monitoring visit.

2. Use of Data

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

Facility Director Suzanne Tulino continues to track restraint data on a daily basis. Her charts revealed an interesting and persistent pattern that may reflect a natural phenomenon associated with congregate living arrangements for teenage girls. Again, a further analysis of these data and the probable causes warrant additional investigation.

A data integrity check revealed no discrepancies between the numbers of restraints in the Central Services Unit (CSU) Restraint Log versus of the number of Post-Restraint

Examinations conducted by the health clinic. There were several discrepancies in the number of restraints in the CSU Restraint Log and the number of Post-Restraint Examinations (PRE) in the monthly summaries of clinic activities for the same period of time. These were, however, situations where only one PRE was required of a youth who had been involved in multiple consecutive restraints. As a result, these multiple restraints were appropriately counted as one event because it required a single PRE by medical.

No mention was made in the Report or during the visit of the substantial data discrepancy between the rate of restraints reported to PbS during the October 2012 data collection and the rates reported by Home Office for the same month. Further investigation is needed since PbS involvement implies a high level of data integrity assurances. Home Office reported that QAI looked into the discrepancies and concurred. Restraint data were under-reported in PbS for October 2012 by both Lansing and Taberg. At Taberg, the information did not include non-RIR restraints into PbS. Both facilities were informed of the issue so that it will not be repeated.

3. Entrance Interview

The entrance interview occurred on March 19, 2013 and included the Monitoring Team and OCFS representatives, including key staff members from the facility. The meeting provided an opportunity for introductions, informal discussion of institutional goals and objectives, an overview of the assessment process, a review and discussion of assessment instruments, and the scheduling of the remaining assessment activities. Those in attendance included: Sandra Carrk, Project Manager; Lori Clark, QAI; Andre Cuda, Social Worker; Scott Diego, Youth Counselor 1 (YC1); Paul Piersma, Administrator On Duty (AOD); Edgardo Lopez, Settlement Coordinator; Monique Thomas, Assistant Attorney; and Suzanne Tulino, Facility Director.

4. Facility Tour

Walkthroughs of the facility followed the entrance interview. The Protection from Harm 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 documents prepared for the Monitors and the on-site assessment. The MH Monitor observed two support team meetings, two Mental Health Rounds, a DBT group, a Sanctuary group, a Triad substance abuse group, met with the clinicians/coaches, and reviewed seven residents' records.

6. Staff Interviews

The Monitors interviewed 20 Taberg staff. In addition to group meetings with staff, the MH Monitor interviewed a nurse, a psychiatrist, a clinician, and a Youth Counselor (YC). The PH Monitor interviewed seven (7) YDAs, one Facility Director, one OCFS Facility Manager, two nurses, one facility trainer, and four Youth Counselors 1. Of the seven (7) YDA staff members who participated in interviews, six were from the 3-11 pm shift; the average age was 35.6 years old with 5.4 years of experience; and 86% were male.

7. Resident Interviews

The Monitors interviewed eight (8) girls; the MH Monitor interviewed two girls, and the PH Monitor interviewed six (6) girls with an average age of 15.3 years old. Interviews occurred in areas with reasonable privacy from staff. The Monitors selected the youth for interviews.

8. Exit Interview

The exit meeting occurred on March 21, 2013. The Monitors expressed their appreciation for the cooperation and hospitality of the Taberg and OCFS staff. The Monitors then highlighted areas of importance and concern, but not findings. The exit meeting was a time for questions, clarifications, and explanations of events and impressions before the draft report went to both Parties. Those in attendance included: David Bach, QAI Director; John Campbell, YDA II; Sandra Carrk, Project Manager; Susan Cheblowski, Psychiatrist; Lori Clark, QAI; Dan Comins, Facility Manager; Andre Cuda, Social Worker; Valerie C., Youth - Amethyst; Scott Diego, YC1; Dave DeLaOsaCruz, YC1; Mark Ebensperger, YDA 3; Joy I., Youth - Opal; Jasmine J, Youth - Amethyst; Edgardo Lopez, Settlement Coordinator; Doris M., U-Amethyst; Monique O., Youth - Opal; Jewell D., Youth - Opal; Denise Passarello, QA Specialist; Paul Piersma, AOD; Brian Radley, YC1; Sam Spina, YDA; Monique Thomas, Assistant Attorney; Dr. Joseph Tomassone, Chief of Treatment Services; Suzanne Tulino, Facility Director; Bruce Warcup, YDA; Jane Wenham, RN; and Rob Williams, AD. Those in attendance via telephone included: Erin Cassidy, Executive Assistant to Executive Deputy Commissioner; Diane Deacon, Legal; Myra DeLuke, QAI Specialist; Felipe Franco, DJJOY Deputy Commissioner; Larry Gravett, Director, Special Investigations Unit (SIU); Tony Hough, DJJOY Associate Commissioner; Regina Jansen, DOJ Attorney; Pam Kelly, Director, Bureau of Training; David Nasner, Bureau of Behavioral Health Services (BBHS) Sanctuary Specialist; Jennifer Utting, QA Specialist; and Iren Valentine, Director, BBHS; and Regina Jansen, DOJ Attorney.

D. Preface to Protection from Harm and Mental Health Findings

The New York Model has been implemented at Taberg. Staff are actively involved in support teams and Mental Health Rounds and the Daily Achievement System (DAS) and phase system are in place.

The opening of the Annesville Annex as a Taberg arts and vocational area is an eagerly anticipated addition to the program for girls. Program enhancements included off-grounds apple picking, sledding and movies (all without incidents) as well as a successful beading company. Taberg recently hired a new Assistant Director for Program and a new social worker; they are continuing to recruit for the Assistant Director for Treatment (vacant since October, 2012). The Director reported that having sufficient staff has strengthened unit team functioning, allowed for coverage for increased YDA participation in Mental Health Rounds and support teams, and made scheduling training easier.

Before this site visit, the DJJOY Quality Assurance and Improvement (QAI) Bureau completed an in-depth review at Taberg, which the Monitors discussed with them. The QAI team observed staff employing the New York Model and their report commended Taberg for developing a team atmosphere and the consistent leadership from the past Acting Facility Director and the newly appointed Director. The QAI review of Taberg also

commended the facility for monthly individual supervision of YDAs by Unit Leaders (YCs). YCs receive monthly individual supervision by the Assistant Director for Program (this position was unfilled at the time of the QAI review, but the new Assistant Director for Program attended the Monitors' closeout at Taberg and was scheduled to begin soon) who is supervised by the Facility Director. A clinician was commended for convening a monthly staff meeting that encourages communication among all staff, especially collaboration among YDAs and clinicians. A YDA was commended for active participation in support teams and supporting residents.

There are increased programs and activities, which reduce the amount of idle time and boredom.

The institutional climate has improved. Some of this improvement was attributed to personnel issues, including the addition of new line staff, AODs, and the appointment of Ms. Tulino as the Facility Director.

One veteran YDA described the differences at Taberg as being the result of more administrative support, a greater ability to have input, more appreciation and support expressed by administration, more de-escalation, and regular training.

The New York Model has strong endorsement by youth as a program that provides them with useful and valuable tools to address their problems. In the exit meeting, six (6) youth attended, and one of them made a powerful statement of appreciation to staff for the good job they have done in helping her.

Relationships between youth and staff continue to improve. Over the past two monitoring visits, line staff and leadership have emphasized the importance of the relationship between youth and staff and have discussed ways that Taberg works to improve these relationships. Until this visit, there were a number of youth who did not believe that the relationships between youth and staff were improving. Even though middle-management staff maintained that there are still a few staff members at Taberg who should be working elsewhere, youth were more positive about relationships with staff during this visit.

II. PROTECTION FROM HARM MONITORING

Youth perceptions of safety have improved in some areas. The PH Monitor's youth interviews affirmed the Entrance Meeting statements of staff that substantial progress has continued, but they are not yet satisfied with all of the outcomes. Of the youth who participated in interviews, they had an average safety rating of 7.9 in response to the question, "On a scale of 1-10 with 10 being the highest, how safe are you in this facility?" This was a slight increase in comparison to the previous monitoring visit. Conversely, only 33% of the youth interviewed indicated that they had feared for their safety in the last six months, whereas that percentage was 14.3% during the previous visit. The inconsistent safety perceptions still seemed influenced by peer violence (within the last 6 months,

66.7% reported they had been beaten up[1] or threatened with being beaten up), and this was an increase from the 42.9% from the previous monitoring visit. Conversely, 50% indicated that they had been involved in a fight within the past 6 months, a drop from the 71.4% from the previous monitoring visit. The aggressive and sometimes volatile behaviors of some of the youth at Taberg directly affect youth perceptions of safety.

Staff perceptions of safety were good. No staff member expressed any noteworthy concern or fear for his or her safety. Staff also rated youth safety as good. Of the staff who participated in interviews, they had an average safety rating of 9.5 in response to the question, "On a scale of 1-10 with 10 being the highest, how safe are you in this facility?" They rated youth safety at 9.3 on the same question. According to staff, a major factor in youth safety is how safe staff perceive themselves to be.

Youth persisted in talking about gender issues as safety concerns especially when discussing use of force because of the way they believed it influences physical restraints. For example, two of the 6 girls interviewed stated that they needed to have a female staff member present to help them de-escalate. Both youth named the same female staff member; but when pressed about what happens when that particular staff member was not working, the responses were that it was easier for them to regain emotional regulation with a female staff member. The comments suggested that some of these restraints could be avoided.

Administration acknowledged mixed reactions by girls to having a predominance of men in the key daily life positions (both Taberg YCs are men, and the majority of YDA staff are men). Because men are more likely to hold youth accountable according to administration, they become the "bad guys." However, youth trauma histories and the sometimes use of sexuality to influence adult behaviors play a big role in youth and staff relationships, and administration believes it takes longer for men to develop relationships with female youth. Male staff were aware of the issue. They viewed Ms. Tulino as knowledgeable about working with girls, and they seemed to have confidence in her decision-making about job performance issues. When youth were asked about staff members they could go to in times of crisis to discuss personal issues, the list did not exclude male staff members. While not in the majority, many male staff members were credited with strong, healthy, and helping relationships with girls. The Sanctuarian of the Month for March was a male YDA.

A. Use of Restraints

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

41. Use of Restraints. The State shall require that youth must not be subjected to undue restraints. The State shall create or modify policies, procedures, and practices to require that the use of restraints be limited to exceptional circumstances, as set forth below, where all other appropriate pro-active, non-physical behavioral management techniques have been tried and failed and a youth poses a danger to himself/herself or

[1] As a point of clarification, the term "beaten up" is taken directly from of the semi-annually administered Youth Climate Survey used by participating agencies in the Performance-based Standards Project. See Question 22 under the Safety and Security section.

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.

PARTIAL COMPLIANCE

COMMENT: Multiple aspects of restraints are included here in addition to two conditions for the use of restraints "where all other appropriate pro-active, non-physical behavioral management techniques have been tried and failed and a youth poses a danger." During staff interviews, all staff had a working knowledge of the new policy, the physical restraint approach, and the exceptional circumstances. Staff again provided accurate answers to the technical questions about these policies and procedures.

An important element of compliance is verifying that practice routinely reflects policy, procedure, and training, particularly that "all other appropriate pro-active, non-physical behavioral management techniques have been tried and failed and a youth poses a danger." However, at Taberg, too many unauthorized and avoidable physical restraints remain despite substantial improvements in restraint-related activities. Factoring into this determination are (a) the Home Office-supplied data, (b) reviews of Restraint Packets, and (c) reviews of restraint videos, along with an understanding of restraint practices and the challenges presented by Taberg youth. Supplementing this perspective are comments from knowledgeable Taberg staff who understand CPM and who (a) discussed the continued existence of avoidable restraints, and (b) described situations where better decision-making by staff could avoid physical restraints. Knowledgeable staff also indicated that Taberg continues to make progress at identifying and correcting avoidable restraints. No one made the argument that Taberg was where it should be with respect to its use of restraints.

This finding takes into account the QAI Report, but the information reviewed during this monitoring visit was not the same restraint materials that QAI reviewed nor did this visit include a quality assurance check by the PH Monitor of the QAI restraint review process that informed its findings.

Further, the State shall:

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

COMPLIANCE

COMMENT: The policy and procedures are established; the training on the policies and procedures has occurred; and limited evidence of a corresponding practice includes

documentation (written and video), staff reports, and resident reports that are consistent with the policy and procedures. Again, OCFS policies comply with the Settlement Agreement. Taberg administration was familiar with policy and procedure that limit the circumstances when the use of restraints is necessary, and staff continued to provide accurate answers to the questions about policies and procedures related to CPM. The responses were consistent with the intent of the Settlement Agreement.

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.

PARTIAL COMPLIANCE

COMMENT: The policy and procedures exist; the training on the policies and procedures has occurred; and staff and resident interviews were consistent with the policy and procedures. Interviews with direct care and health care staff revealed a working knowledge of conditions, circumstances, and plans that limit the restraints to youth due to heightened risk of physical or psychological harm. In most instances, staff recited information in the residents' IIPs and seemed quite cognizant of the nature and extent of the limitations.

The reviews of multiple Restraint Packets contained violations of this paragraph. Regarding Restraint Packets 392699, 402000, and 409600, the documentation confirmed supine restraints occurred when the IIPs prohibited them. The number of incidents suggested more than an isolated example.

41. c. If face-down restraints continue to be used, create or modify and implement policies, procedures, and practices to require that staff utilize them only in emergencies when less restrictive measures would pose a significant risk to the safety of the youth, other youth, or staff. In addition:

i. Face-down restraints shall be employed for only as long as it takes to diffuse the emergency, but in no event shall a youth be restrained in a facedown position for more than three (3) minutes.

ii. Trained staff shall monitor youth for signs of physical distress and the youth's ability to speak while restrained.

iii. Medical personnel shall be immediately notified of the initiation of a facedown restraint position, and the youth shall be immediately by assessed by medical personnel thereafter. In no event shall more than 4 hours lapse between the end of a facedown restraint incident and the assessment of the involved youth by medical staff.

COMPLIANCE

COMMENT: The policy and procedures exist; the training on the policies and procedures has occurred; and staff and resident reports are consistent with the policy and procedures. The QAI Report found 98% of the Restraint Packets in its review to be meeting

the standards regarding the prohibition on facedown restraints. The one incident that received discussion as not meeting the OCFS standards was based on video that neither confirmed nor ruled out a facedown restraint. Similarly, the Restraint Packet reviews for this monitoring visit revealed no instances of facedown restraints.

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

COMPLIANCE

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

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

COMPLIANCE

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

Regarding Restraint Packet 417498, one YDA Activity/Incident Report stated, "The nurse came into the room and gave her [the youth] some medication to help her calm down that was ordered from the doctor that was on grounds." In the Activity Report filed by the Facility Director, she wrote, "Dr. Chebowski came in and offered her [the youth] Seroquel. She agreed and was given the meds and was compliant." In the absence of additional documentation, there are several questions: Was the youth taking Seroquel on admission? Was she due a dose at or around the time of the physical restraint? This was the first instance of the use of Seroquel to "help calm down" as a p.r.n. and the first instance of the use of medication referenced in a physical restraint packet during these monitoring experiences.

Home Office provided additional information from an immediate investigation by BBHS following the initial discussion of the reference to Seroquel. Their findings indicated that the medication was used after the youth was released and not during the restraint, so this would not be an example of the use of medication in a physical restraint. Moreover, the medication was offered by the treating psychiatrist who has knowledge of the youth and who was on-site at the time.

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 authorized to utilize restraints.

COMPLIANCE

COMMENT: Training continues to be a positive program element. Printouts from the STAR system for (a) CPM, (b) first aid, CPR, and AED, (c) CPM Refresher #1, (d) CPM Refresher #2, and (e) the New York Model were provided by Sean Allen, the BOT trainer

assigned to Taberg, and reviewed line-by-line with him. Regarding the status of employees with up-to-date CPM training, only one staff member did not have up-to-date training regarding CPM refresher training; and he was a new staff member currently attending the Academy. Regarding First Aid and CPR training, five (5) staff members were not up-to-date due to Worker's Comp leave.

Training continues as one of the strengths in the implementation of the Settlement Agreement. Staff also received a large number of training hours annually. The files of three (3) staff members were selected at random to check their 2012 training hours totals. The staff member with the lowest number of 2012 training hours had in excess of 167 hours training, which far exceeded expectations.

In response to the attention to the role of the Restraint Monitor, Taberg held a Restraint Monitor training (2 hours) on February 7, 2013. Trainer Allen forwarded to the PH Monitor copies of the Restraint Monitor Training Lesson Plan and PowerPoint slides.

B. Use of Force

42. Use of Force. In order to adequately protect youth from excessive use of force at the Facilities, the State shall:

42. a. Continue to prohibit "hooking and tripping" youth and using chokeholds on youth.

COMPLIANCE

COMMENT: The policy and procedures exist; the training on the policies and procedures has occurred; and staff and resident reports are consistent with the policy and procedures. No evidence existed of the use of prohibited physical restraint holds, especially "hooking and tripping" and chokeholds.

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

PARTIAL COMPLIANCE

COMMENT: The logic of the New York Model states that the use of its principles by youth and staff should increase emotional regulation in the face of problems and crises and, thereby, mitigate the practices governing uses of force. This does not imply that the New York Model will eliminate the need for an occasional use of force or physical restraint, and the Monitors have never suggested that it should. However, if the logic of the New York Model has some validity, then the application of these principles by youth and staff should increase the likelihood that only the least amount of force necessary would apply. Conversely, if staff failed for whatever reason to apply an individualized New York Model strategy for assisting the youth in calming herself and reestablishing emotional regulation, then it would seem that the use of force under these circumstances would have been more than the least amount needed if the staff member followed treatment recommendations as outlined in the youth's IIP and other safety plans, according to the New York Model. From the PH Monitor's perspective, this appears to be the case in the following Restraint Packet reviews.

Regarding Restraint Packet 408307, the Incident Reports described the youth as refusing to comply with the directive to move her things from one room to another. Upon the ultimatum that if she did not move her things, the YDA would do so for her, the youth went into her room and closed the door behind her. According to one Incident Report, she began to kick and punch the door several times, but stopped upon redirection. When this happened, the YDA opened her door and "began to speak to her in a calm manner using Direct Appeal." What followed was described as an assault on the YDA by the youth, throwing books and punches at the YDA. There was no video verification since all of this occurred in her room.

The IIP issued November 2, 2012 by Dr. Fisher and reviewed by YC Radley on January 4, 2013 lists three strategies under the Crisis Prevention and Management Plan, the first two being "Venting" and "Time Away from the Problem but staying on the unit unless there is available staff to take off unit," respectively. Under the Youth Generated Sanctuary Safety Plan, the three skills are "Time Away Journaling," "Pleasant Imagery about Home," and "Thinking about Going to Mall with Brother." There was nothing in the IIP about "Direct Appeal."

Staff are expected to know the IIP, but for most YDAs the important information is the section that refers to Prohibited Physical or Mechanical Interventions. So the question here becomes one related to the relevance of the Crisis Prevention and Management Plan and the Youth Generated Sanctuary Safety Plan for determining the appropriate de-escalation strategies for CPM. The IIP contents should provide guidance to YDAs regarding all appropriate pro-active and non-physical alternatives, their choice, and their uses with CPM de-escalation techniques. Therefore, because these techniques were not used or in some cases violated, the youth did not have the opportunity to use her individualized techniques to calm herself and regain emotional regulation. If the YDA had followed the IIP, restraint might have been avoided; and the implementation of an avoidable restraint would seem to violate this paragraph's expectation that the least amount of force apply.

Venting and Time Away are strategies that often appear to be contrary to safety and security and sometimes strain the relationship between treatment and security staff. As the Monitors have tried to indicate previously, this is a false dichotomy but nonetheless a real tension in most facilities. The documentation in this Restraint Packet provides some support that the youth was attempting to follow her safety plan. She did some venting and protesting, but at the point of an ultimatum, she went into her room (time away from the problem) and did stop kicking and banging on the door. At this point, the IIP would seem to imply that there should have been some time afforded the youth for these strategies and skills to take effect. The problem seemed to escalate when the YDA unlocked her room door and went into the room. Without audio, it is difficult to know what verbal behaviors occurred; however, the YDA's decisions to unlock the door and enter the room are sufficient to warrant a recommendation that Home Office review with DOJ facility leaders the appropriate circumstances for a staff member to unlock a youth's door and enter her room.

Regarding Restraint Packet 421198, the youth's IIP indicated that the first skill under the Youth Generated Sanctuary Safety Plan is "mediate with resident afterwards," suggesting that the time for reasoning or talking or encouraging cooperation is following

the emotional dysregulation. The Activity Reports did not indicate staff responsiveness to the IIP. The situation was further complicated by a restraint that resulted in the youth and staff member falling to the floor and the youth's head hitting the floor.

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; the training on the policies and procedures has occurred; and intermittent evidence of an occasionally sufficient corresponding practice included documentation (written and video), staff reports, and resident reports that were consistent with the policy and procedures. However, documentation problems existed, which need correction.

The documentation and reporting of all uses of force are important. Before an assessment of whether the documentation answered the questions of who, what, when, where, and how, the official record must minimally be legible. Restraint Packets 392398, 392699, and 402000 contained sections of the documentation that were deemed illegible.

Regarding the Video Review Form (VRF) for Restraint Packet 374987, under the area with checkboxes for additional action, the "Notify Facility Manager" box was checked. There was no further explanation.

In Restraint Packet 421198, one incident report indicated that the youth "then walked to her room to lay down with this writer and Nurse Leonard." This was likely not the intended description of what happened.

In Restraint Packet 408307, the documentation indicated that the staff member unlocked the youth's room door only once. The video showed the YDA unlocking the door twice. Conversely, Restraint Packet 408307 was a good example where the documentation offered a clear distinction between how to implement the New York Model at the shift or daily living level. The facts seemed to indicate that there was a behavioral contract about school attendance with the youth's compliance allowing her to remain in what must have been a highly desirable room for her. The Incident Reports begin with the notification to the youth that she has not fulfilled the terms of the contract and, therefore, will be moved from her present room to a different room. This appeared to be the triggering event.

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

COMPLIANCE

COMMENT: The Therapeutic Intervention Committee (TIC) seems to be the system of review by senior management outlined in this paragraph according to Home Office. The TIC has mandatory attendees that include the Facility Director or designee, Clinical, Assistant Director, AOD, YDA, YC, Medical, Kitchen, Maintenance, Recreation, Spiritual (if on staff), Education, and youth (for last agenda items only). Additionally, the documentation provided by Home Office included minutes from several TIC meetings.

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

PARTIAL COMPLIANCE

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

Throughout the monitoring process, this paragraph has become more important because of the "review" and "evaluate" functions contained in this weekly practice. The Facility Administrator review becomes a critical part of the feedback needed to continue the evolution and improvement of CPM and the New York Model. With the advent of Quality Assurance, it provides another perspective on the types of staff behaviors that are exemplary or in need of improvement. Similarly, reviews of the physical restraints provide an additional opportunity to raise issues related to the prevention of unnecessary restraints. While an unnecessary restraint may more appropriately fall under Paragraph 42b regarding the least amount of control needed to resolve the situation, the internal quality assurance and staff development aspects of this paragraph include issues that affect the nature and extent of proper physical restraints.

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

Restraint Packet 402000

In the Administrative Review of Physical Restraint completed by Matthew Cole, the youth indicated that that she was restrained because, "staff thought I was going after another staff." In the Youth Debriefing Report completed by Mr. Piersma, the youth indicated that she was upset because "[a YDA was] taking items from my room." In the Use of Physical Restraint Staff Debriefing Report, Cole recommended conflict resolution explained as follows: "(illegible) with [the YDA]." Under Section 8, "Suggestions for Improvement to Avoid Recurrence," Cole also wrote, "[the YDA] to get AOD permission to remove youth's personal belongings."

There was an issue here about the YDA behavior, its appropriateness, and the role it played in precipitating the event. However, no other comments in the Restraint Packet addressed its resolution. If the failure of staff to use discretion regarding operational and routine activities were the precipitating event for a youth's emotional dysregulation, regardless of the youth's current ability to calm herself, the restraint might be classified as an avoidable restraint; but the situation warranted a coaching opportunity for the YDA through Documented Instruction.

In Restraint Packet, the VRF indicated Documented Instruction for two individuals due to placing the youth in seated or supine restraints were prohibited by the IIP. Documented Instruction was scheduled and occurred the following day.

Restraint Packet 408307

If there is a need for Documented Instruction when YDAs do not follow the Prohibited Physical or Mechanical Interventions on the IIP, it would seem consistent that the failure to follow the items on the youth's Crisis Prevention and Management Plan and the Youth Generated Sanctuary Safety Plan would also warrant Documented Instruction. Nothing in the documentation recommends Documented Instruction with regard to the YDA's failure to use the strategies listed on the two safety plans.

With the youth out of the restraints and sitting in a chair talking to the AOD and Ms. Tulino, the video shows the YDA in a commonly used position -- standing up, feet apart, arms crossed in front, and looking down at the youth. If there is body language that reflects the principles of the New York Model, it should be discussed in relationship to this example.

Restraint Packet 417498

The documentation described a physical and mechanical restraint that occurred in an administrator's office on February 7, 2013. The documentation appeared appropriate. There was good description of the situation, and it appeared consistent across reports. There was follow-up in the form of a "Red Flag" meeting and an IIP review due to "extensive trauma history," and the justification for mechanical restraints seemed appropriate. Several concerns emerged from the documentation:

1. There was no video. Because the restraint occurred in an office, space was also limited, which increases the likelihood of injury to youth and staff. Based on CPM training, all staff should be aware of this risk. The documentation indicated that there was time for staff to engage in de-escalation activities even though they did not prove to be effective. What was missing from the Restraint Monitor Report was something that went beyond the environmental safety observations (the Restraint Monitor identified the desk, file cabinet, printer, chairs as items removed from the office) and explained why there was no attempt to move the youth out of the office and in the hallway where there was more room. However, in Restraint Packet 408307, the VRF appropriately recommended Documented Instruction on the need to remove the youth from her room before implementing the restraint. These inconsistencies in the application of D.I. need resolution.

2. When the Monitors expressed concerns about the misuse of the de-escalation technique of Proximity as an invasion of the youth's personal space and, hence, an escalator

of misbehavior, Home Office immediately addressed the concern and redefined the issue of a staff member's placement in the environment relative to the youth as "Positioning." Positioning appears to have replaced Proximity as the way that YDA explain the reason why they moved closer to the youth prior to the initiation of a physical restraint. As part of what is supposed to be a de-escalation strategy, video evidence suggested that once more the technique sometimes appears to violate the youth's personal space, rendering the strategy ineffective for de-escalation. The original concern remains: In the midst of highly charged emotional events that have the high probability of a physical restraint, a few instances remain where staff appear to be engaged in a power struggle with the youth and violate the youth's personal space in an attempt to intimidate cooperation (see discussion of Restraint Packet 421198 below).

Restraint Packet 421198

The documentation raises several important issues regarding CPM and the review of Restraint Packets.

Consistency in the implementation of the program structure provides a situational regularity that supports a youth's emotional regulation. Therefore, when the structural regularity changes and emotional dysregulation occurs, there needs to be more explanation provided in the Restraint Packet to further describe the link between the New York Model and CPM. For example, one incident report stated that the youth was "angry over not being able to go to the library to watch a movie because Unit 13 is currently occupying it. When we (staff) restructured program, to go to classroom number 1 to watch the movie." The Activity Report suggested that staff changed the schedule or routine, but there was no explanation as to why a change was made. Because the documentation suggested a causal relationship between changing the activity and the youth's emotional upset, it is important to understand the reason why the change occurred so that there can be specific feedback to the treatment team about the circumstances surrounding the restraint and a clearer approach to helping administration identify and reduce potentially avoidable restraints.

The video showed the YDAs attempting to use Positioning trying to have the youth in an area of the dayroom relatively free from obstructions. The problem was that staff (and there were enough staff members present to have prevented her return to the area with couches and chairs) somehow allowed the youth to return to an area where it was not environmentally conducive for restraint. Additionally, there was nothing in the Restraint Monitor Report to indicate that the positioning strategy could have been implemented more effectively by keeping the youth in an open area of the dayroom.

At 00:19 on the video, it appeared as if the youth's allegation that staff were "in her face" was true. The video showed a staff member with his face very close to the youth's face as they walked from one side of the dayroom to another.

The location of staff, other youth, and dayroom furniture prevented a clear view of what happened. Missing was the video from the camera at the opposite end of the dayroom. It was unclear why this perspective was missing.

Regarding the VRF, Documented Instruction needs to be an automatic response when a staff member fails to administer or use a CPM technique correctly, even if the attempt was appropriate. The video showed more than one failure to apply a technique in

such a way that it prevented injury. More importantly, the nature of the fall and the seriousness of the youth hitting her head on the floor necessitated Documented Instruction.

Restraint Packet 409600

The documentation confirmed a supine restraint when the IIP prohibited it. Hence, the recommendation for Documented Instruction was appropriate, but another issue arose from this Restraint Packet. In one Incident Report, the lead YDA wrote, "[the youth] decided to flip over a table. I went to place [the youth] in a restraint but she plopped her body to the ground." The report indicated that a kick by the youth also followed, but it was not visible on the video.

The documentation indicated that the staff considered flipping over a table as one of the exceptional circumstances set forth in Paragraph 41. Flipping over a table may have constituted destruction of property in the eyes of the staff member. These appear to be the rationales for the initiation of a use of force. It is recommended that this video receive additional review by QAI and Home Office regarding the PH Monitor's concern that the information available in the Restraint Packet, including the video, could have been interpreted differently and the restraint avoided.

Had staff exercised Martin's time and distance strategy, the youth would have had to move in order to hit or kick, thus providing behavioral evidence of aggression and an intent to assault. The trajectory of the New York Model suggests that the staff member's pursuit of a restraint might be unnecessary, and the likelihood exists that the restraint could have been avoided. Even in the absence of the New York Model philosophy or strategy, pursuing a youth who is in a submission position seems to be a questionable practice. The interaction between the New York Model and CPM recommends a recalibrating of what is acceptable, what is imminent, and what is necessary to protect the safety of youth and staff. Here is an example where a better integration of treatment and security might have resulted in a different approach to the situation and, likely, have resulted in a different outcome without a physical restraint.

Also, of the Restraint Packets reviewed for this visit, one YDA was the target of two youth assaults. This was the YDA whose body language on previous videos appeared authoritarian and confrontational. The recommendation is additional evaluation and, perhaps, a referral to training and to New York Model leaders for some clarification, coaching, or Documented Instruction regarding body language implications.

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

provide evaluation of the staff's proper use of these methods in their reports addressing use of force incidents.

COMPLIANCE

COMMENT: Training remains a strength of the Protection from Harm Paragraphs. The training on the policies and procedures seemed to have occurred regularly, and the evidence of a corresponding practice from the STARS system was consistent with the requirements of this paragraph. Training records showed that staff members who required retraining for any reason received the training in a timely fashion. Interviews with staff confirmed the staff member's understanding of the training and an awareness of his or her status regarding completeness of the training requirements. Staff members knew when re-training events would occur and in what activities they were permitted to participate. See comments for Paragraph 41f.

C. Emergency Response

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

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

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

NOT APPLICABLE

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

COMPLIANCE

COMMENT: The policy and procedures exist (PPM 3246.02 and PPM 3247.12); the training on the policies and procedures has occurred; and staff and resident reports are consistent with the policy and procedures. All staff confirmed with acceptable accuracy the call for assistance procedures based on the color code indicators.

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

COMPLIANCE

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

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

COMPLIANCE

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 Taberg staff's successful completion of the training.

D. Reporting and Investigation of Incidents

These paragraphs refer largely to the activities of the Special Investigations Unit (SIU). 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.

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

i. Inappropriate use of restraints;

ii. Use of excessive force on youth; or

iii. Failure of supervision or neglect resulting in:

(1) youth injury; or

(2) suicide attempts or self-injurious behaviors.

To this end, the State shall:

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

COMPLIANCE

COMMENT: Interviews with staff yielded consistent results. No one commented about a reluctance or fear of retaliation when faced with the need to report another worker regarding an alleged incident of an inappropriate use of force or suspected abuse, including nurses.

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

COMPLIANCE

COMMENT: Just as each DOJ facility is different, Home Office must apply a standard set of decision-making criteria regarding the prompt determination of the appropriate level

of contact between youth and staff based on the nature of the allegation and preliminary investigation findings. So far, that process appears to be implemented satisfactorily.

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 infirmary program represents a Protection from Harm strength. The policy and procedures exist, and staff and resident interviews were consistent with the policy and procedures. The key issue here was safeguarding a youth's opportunity for a candid conversation during a post-restraint examination (PRE) with a trusted, health care provider, so that she can then more easily provide confidential information regarding the use of force incident, any allegations of excessive use of force, and any injury complaints.

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

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

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

PARTIAL COMPLIANCE

COMMENT: The Special Investigations Unit conducts investigations, and the reviews of SIU investigations have revealed careful and thorough investigations, completed in a generally timely fashion. However, as the implications of the Settlement Agreement play out in the daily practice in the DOJ facilities, differences may exist regarding the nature and timeliness of the investigations. For example, of the Taberg investigations reviewed by QAI, all met the QA standards set by OCFS.

Parts of multiple restraints occurred out of the view of cameras or with staff members obstructing the camera's view. Some off-camera restraints are inevitable in locations where privacy concerns override video surveillance. However, off-camera restraints are problematic, and if an off-camera restraint occurs, the Administrative Review would do better not to treat them as routine.

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.

PARTIAL COMPLIANCE

COMMENT: Home Office determines the policies, procedures, and practices that govern prompt and appropriate corrective measures. Three (3) general classifications of outcomes contribute to the assessment of compliance with this paragraph. The first is whether or not a response occurred. The intent of the paragraph is that there will be a response to every finding. The second criterion is whether or not the response is prompt; meaning is there a reasonably short time between the event and the response to make the response meaningful. The third assessment is whether the response is appropriate for the nature and extent of the misconduct.

Monitoring identified two (2) important disciplinary cases pending resolution. One includes a staff member who is on administrative leave pending a request for termination. Another involved an alleged assault on a youth by a staff member, which is still in arbitration.

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

COMPLIANCE

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

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

PARTIAL COMPLIANCE

COMMENT: The problems surrounding documentation by Restraint Monitors revealed deficits in the adequate supervision of staff. In addition to the examples cited above regarding documentation problems with Restraint Monitors (Restraint Packet 417498, and Restraint Packet 421198), the QAI Report cited multiple instances where the Restraint Monitor was intermittently present, or not present, or an active participant in the restraint. The intent of the Restraint Monitor as a non-participating, proactive supervisor during restraint events is only intermittently fulfilled.

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.

NOT APPLICABLE

COMMENT: These factors are mostly systemic and apply to Home Office. One measure of determining an appropriate level of fitness to work in a juvenile justice facility is to develop a common set of characteristics of those staff who demonstrate a high level of competency working with youth as indicated by both youth and staff and to identify characteristics of those who do not work well with youth, again, basing this on the perspectives of youth and staff. The State has not implemented reasonable measures to make this determination. The assumption has been that concerns about the effectiveness of staff will become a greater priority as concerns about the excessive use of force subside and as the effectiveness of the therapeutic effects of the New York Model increase.

III. MENTAL HEALTH MONITORING

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

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

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

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

COMPLIANCE

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

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

The QAI review of the New York Model implementation is being refined with guidance from BBHS staff, and the QAI report is now organized to reflect a youth's progress through the program. The QAI review examined residents' records for integrated assessments, psychiatric evaluations, support plans, diagnoses, psychiatric contact notes,

medication, family outreach, suicide response, substance abuse services and transition plans.

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

COMPLIANCE

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

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

PARTIAL COMPLIANCE

Through support teams and Mental Health Rounds, Taberg staff are complying with 46c on an individual basis. Full compliance requires regularly assessing the effectiveness of interventions facility-wide, which is not the current practice.

The new mental health sections of the JJIS comply with 46c (these were not yet in place to be observed at Taberg). The MH Monitor was provided with an impressive JJIS demonstration at Home Office on February 5, 2013. JJIS is the OCFS Juvenile Justice Information System, a comprehensive automated system tracking youth in OCFS custody, including but not limited to case management, movement histories, legal histories, and administrative/billing. Reception diagnostic information, Integrated Assessment, IIP (Individual Intervention Plan), Facility Initial Mental Health Assessment (which includes mental status exam and results of suicide risk assessment), contact notes (by psychiatrists and other clinicians, as well as facility and CMSO case managers), Integrated Support Plan (with updated diagnosis), and Transition Plan are all included on JJIS. JJIS is designed to capture how a strengths-based, trauma-responsive approach is being implemented with each resident and tracks the diverse interventions of the New York Model. JJIS makes it possible to document practice according to the procedures that comply with several mental health paragraphs in the Settlement Agreement and allows for the regular assessment of the effectiveness of interventions required by 46c.

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

The Assistant Directors for Treatment of the four DOJ facilities and social work supervisors saw the JJIS demonstration. The BBHS Director of Treatment Services and the JJIS clinical coach are in the process of meeting with each facility to instruct in the use of the JJIS and also provide examples of writing goals that reflect the resident's aspirations and the staff's assistance in clarifying the steps to achieve them. They coached at Taberg in February 2013, on support plans, a support team meeting they observed and transition

planning, and will return in April. A JJIS technical manual is being developed (expected summer, 2013), to be complemented by a BBHS clinical procedural guide. A crucial next step will be to ensure that this documentation system includes all the non-clinical staff involved in the resident's progress and fully reflects the teamwork necessary for his/her success. Positive illustrations of educational services outside this Settlement Agreement but nonetheless important include educational testing results that are reflected in the Integrated Assessment and in JJIS as monthly updates in the academic progress of the residents, including new assessment results, recent achievement scores, passing Regents, and new IEPs, and what educational and other staff are doing to support that progress.

How the facility uses the QAI, TIC, pre-shift briefings and information from residents' progress to regularly assess facility-wide effectiveness of interventions for all residents will continue to be monitored to determine full compliance.

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

PARTIAL COMPLIANCE

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

On Site Observations Regarding Paragraph 46a-d (3/13)

Paragraph 46 of the Settlement Agreement requires an effective program to meet the needs of residents. OCFS is implementing the New York Model, and the policies and training to support it, to build on the strengths of OCFS services and address limitations of past programming. OCFS does not have to implement the New York Model to comply with Paragraph 46, but OCFS is choosing to comply with Paragraph 46 with the New York Model.

Taberg staff continue to work diligently to achieve trauma-responsive, relationship-driven, culturally competent, and strengths-based teamwork to meet their residents' complex needs. Their dedication to teaching residents emotional regulation was apparent. All the girls at Taberg have long histories of trauma and troubled behavior, and some of the most challenging girls are proud of their progress.

The two observed MH Rounds at Taberg were conducted differently, although in both all ten girls on each unit were reviewed, the discussions were productive, the psychiatrist actively participated, and the nurse managed the meetings. One MH Rounds went into detail about current symptoms, diagnosis, and coordination of staff interventions with the YC taking a lead. The other MH Rounds focused on future planning, with the psychiatrist leading; in the process, the girls' trauma histories were described and the YDAs said their actions would change as a result of what they learned that they had previously not known. It was troubling both that the YDAs had not been informed about important details about the girls and that the future outlook for the girls was so discouraging. The

shortage of clinicians at the facility was apparent in the discussions. For at least one girl with severe problems with her mother, working on a trauma narrative seemed to be necessary, but it appeared that her therapist was not providing trauma treatment. In the debrief with participants in Mental Health Rounds, they described the benefits of having YDA involvement. The idea of alternating Mental Health Rounds (and DBT groups) from morning to afternoon so both YDA shifts could participate was considered. The QAI review commended Taberg for good communication on treatment issues and progress at Mental Health Rounds: "All of the youth were discussed in great detail with input from each participant adding insight to youth's behavior, progress, family and residential challenges, as well as their future plans."

The MH Monitor observed a DBT group and a Sanctuary group at Taberg, and the residents were actively involved. The use of dyads, each with a staff person for support, in the safety discussion in the Sanctuary group was effective. In the debrief, they discussed staff consistently helping with role plays in the group.

A key to implementation of the New York Model is a functioning team of coaches. A strong facility coaching team ensures that the New York Model becomes a way of thinking by staff and youth, rather than simply a clinical service. Since the last site visit, Taberg has been without an Assistant Director for Treatment, social worker, and Assistant Director for Program, which reduces the capacity of the coaching team. The Taberg coaches are overextended, trying to keep up with clinical responsibilities and also guiding staff. Their goal is to "be on the floor" as much as possible, encouraging the use of DBT skills in one-on-one interaction of staff with residents. Their coaching also emphasizes staff modeling skills of coping with anger. The Taberg coaching team—especially with the addition of new staff—requires more guidance from BBHS. The QAI interviews of Taberg staff included comments about improvements in the program as clinical staff became more involved.

The MH Monitor observed IIPs (Individual Intervention Plans) in the reviewed Taberg records; support plans indicate the IIP has been reviewed each month. The QAI review commended the Taberg IIPs for being detailed, individualized and updated.

The MH Monitor recommends that the Taberg team consider adapting the Columbia DAS for a skill-based approach more consistent with the New York Model since the Taberg DAS remains the same rule and compliance oriented checklist as it was at the previous site visit six months ago:

Demonstrates Safety: Non-violent/Follows program rules and norms

- Wears Safety Plan
- Attends school, group, meals
- Seeks help from staff to remain safe
- No physical aggression or horseplay
- No kicking, punching, breaking objects, throwing food, spitting
- No verbal threats

Manages Emotions: Uses skills to avoid conflicts or problems

- Uses skills to manage emotions (ART, problem solving, DBT skills)
- No verbal threats, racial slurs, swearing, inappropriate sexual language

- Participates in community meetings

Deals with Loss: Accepts circumstances

- Accepts responsibility for behavior
- Accepts being told "no" or having to wait
- Does not engage in blaming others

Works toward the Future: Plans for the future

- Attends school daily; is not disruptive in class
- Participates in community meetings—engages in goal setting
- Attends group sessions

Shows Effort: Beyond simple compliance with program; is active, not passive

- Raises hand and asks questions
- Completes assignments
- Volunteers for tasks
- Actively engages program

The Taberg DAS is limited by not including an individual goal of the resident. OCFS noted that facilities have successfully implemented DAS when they use Effort as the fifth criteria of achievements, and that incorporating an individual's goal is the highest standard. A separate, and the primary, concern raised by the MH Monitor about the Taberg DAS is that it is rule-oriented as compared to the Columbia skill-based DAS.

The Taberg DAS is scored on the above five areas five times daily (6-10 PM, 10 PM-6 AM, 6 AM-10AM, 10 AM – 2 PM, 2 PM-6 PM). Since most residents sleep from 10 PM – 6 AM, it weakens the DAS to be scored on these areas overnight—it would make the DAS more valid to make the time periods similar to the DAS at other facilities by including awake times with night times.

The DAS for five residents from the two units—all of whom were described in Mental Health Rounds as having significant challenges in the program—were reviewed for the week prior to and during the site visit. During two days, B received 24 points both days, J received 24 points one day and 12 the other, K received 20 points one day and 19 the other, and M and D each received 21 points one day and 20 the other. These high DAS scores may show progress by these residents, but also reflect inflation by the overnight scores and perhaps a DAS that is not sufficiently challenging for residents.

The QAI Report commended frequent and well-documented clinical interventions at Taberg. Clinicians and YCs both met with youth, YCs made contacts with some families, clinical and psychiatric contact notes were thorough, support plans were revised monthly by support teams, and the CMSO was involved in support teams. Concerns raised by QAI were family involvement, progress updates from support team members, and the support team taking into consideration the impact of trauma and development of coping skills for trauma. The QAI Report included a youth survey reflecting Taberg residents' understanding of their support plan, safety plan, support team, and DAS.

FUTURE MONITORING

When they are available, the MH Monitor will review:

- New policy on Facility Admission and Orientation

- Revised PPM 3443.00 "Youth Rules"

The MH Monitor will review whether Taberg has adequate clinical staffing and coaching capacity.

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

The MH Monitor will observe the consistency of DBT and Sanctuary groups and other therapeutic interventions and the progress being made by residents.

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

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

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

COMPLIANCE

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

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

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

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

COMPLIANCE

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

47c. Require that any youth who experiences a mental health crisis and resorts to maladaptive coping strategies, such as self-injurious behavior, is referred for mental health services following the resolution of the immediate crisis. A qualified mental health professional shall develop a crisis management plan in conjunction with the youth and his or her other mental health service providers. The crisis management

plan shall specify methods to reduce the potential for recurrence through psychiatric treatment, treatment planning, behavioral modification and environmental changes, as well as a strategy to help the youth develop and practice positive coping skills. Such services shall continue throughout the duration of the youth's commitment to the Facility.

COMPLIANCE

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

On Site Observations Regarding Paragraph 47a-c (3/13)

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

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

Eight Taberg residents were on Suicide Watch in the six months before the site visit, five of whom had numerous watches.

Although the QAI review of Taberg noted one record where a youth had poor documentation of the mental health assessment to determine that the youth required a Suicide Watch and that a clinician did a safety plan or documented that the youth was approved to go off suicide watch after four days, the MH Monitor reviewed two Taberg records where repeated Suicide Watch documentation by the clinician was thorough.

FUTURE MONITORING

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

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

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

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

COMPLIANCE

Taberg records reflect that residents are seen soon after admission by a mental health professional who completes the ISO-30 and begins the Integrated Assessment. Youth who arrive on psychiatric medication or who are referred to the psychiatrist by facility staff are seen soon thereafter, documented in a psychiatric evaluation or psychiatric

contact note. The MH Monitor observed completed and timely Integrated Assessments in the Taberg records that demonstrated compliance with 48a.

The QAI review of Taberg found untimely initial screening because the OCFS-1448 screening form that should be completed within an hour of arrival was not in youth records, although records showed that the youth met with a clinician within 72 hours of admission. The QAI review of Taberg found that the ISO-30 was completed in the initial clinical contact. The QAI review of Taberg found that some Integrated Assessments were completed within a month of admission and one was thoughtful and detailed, the other two were incomplete. The records the MH Monitor reviewed, including a recent admission, complied with 48a.

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

COMPLIANCE

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

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

PARTIAL COMPLIANCE

The Integrated Assessment form complies with 48c.

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

(a) a thorough trauma history, symptoms of trauma and how trauma appears to be affecting the resident's behavior,

(b) evidence of learning disabilities and how they appear to be affecting the resident's behavior,

(c) history of substance use and how it may be related to behavior, including results of the Adolescent Alcohol and Drug Involvement Scale (ADDIS) when it has been completed with the resident.

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

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

PARTIAL COMPLIANCE

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

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

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

COMPLIANCE

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

On Site Observations Regarding Paragraph 48a-e (3/13)

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

One resident's Integrated Assessment reviewed by the MH Monitor was weak, resulting in an inadequate support plan. [redacted], a 17-year old who arrived at Taberg a month before the site visit, has a lengthy history of nine previous failed placements. In 2008 at age 13, she was admitted to [redacted] two years later she went to [redacted], and at age 16 she returned to [redacted] a few months later she went to [redacted] was hospitalized, and ended up at [redacted] she was again released to [redacted]

[redacted], was hospitalized, and returned to [redacted] a few months later; she was discharged to [redacted] and returned to Lansing less than a month later, two months prior to her arrival at Taberg. Her 4/3/13 Integrated Assessment at Taberg was inadequate: sections were not completed, and Trauma History and Family History were blank; specialized treatment needs only included "Youth has a history of marijuana use. Youth is assigned to the Mental Health unit." Her vulnerabilities were "Mother committed suicide. Father is a sex offender. She has a history of self harm." Clinical treatment needs were left blank. Her support plan was also weak. Her only goal was "To work on impulse control" with one objective "Recognize and verbalize how feelings are connected to misbehavior." Only three staff interventions were listed: individual therapy and medication management with the psychiatrist, her therapist making a connection to her father as a release resource, and her YDAs encouraging her to apply DBT skills to control impulses. Her family goal was "Successful working through unresolved issues in connection with the lack of family involvement between [redacted] and her father" for which family therapy sessions were the intervention. Her diagnosis on her support plan was Mood Disorder and Conduct Disorder, although the facility medication list indicated a diagnosis of Anxiety/Rage Reaction for which Abilify was prescribed. Both the assessment and support plan reflect a significantly underpowered intervention for this troubled resident.

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

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

"Mental health rounds occur weekly, the purpose is to identify and address acute treatment-related issues for particular youth in a team format. In addition to the review of acute issues, rounds will be used to discuss both the progress and challenges for individual youth. The rounds will include members of the mental health team: the psychiatrist, the psychiatric nurse practitioner (if applicable), the clinician, the case manager, a representative of the direct care staff, and representatives from education and medical. The clinician will write a short summary note of the discussion on each youth presented and record this note in the youth's mental health chart. Mental health rounds will assist in

integrating the psychiatric and behavioral health services of each youth into a broader holistic understanding of the youth and the family." (Page 3)

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

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

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

An example of the importance of documenting an evolving diagnostic formulation is [redacted] When asked how [redacted], a resident on the MHU, who was previously diagnosed with PTSD and bipolar disorder and had trauma symptoms could have recently had a diagnosis change to no psychiatric diagnosis (Conduct Disorder only), the psychiatrist responded that the treatment facility she will step down to will get the message that they are supposed to treat her trauma-related symptoms and are not treating a girl who is bipolar but has relationship problems, social skill deficits, and is hypersexualized and reactive. The psychiatrist expressed this intention, but one wonders how the treatment facility will understand that after leaving Taberg, trauma treatment was necessary. It seems likely a PTSD, depression and/or anxiety diagnosis as the result of trauma would more effectively convey her needs and clinical priorities to the next program and CMSO.

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

DEPRESSION 27% of youth prescribed medication (12)
(Including Depression NOS, Major Depressive Disorder, and Dysthymic Disorder)

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

MOOD 27% of youth prescribed medication (12)
(Including Mood Disorder, Mood Disorder NOS, and Mood Dysregulation)

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

ANXIETY 23% of youth prescribed medication (10)
(Including Anxiety Disorder, Anxiety NOS, and Generalized Anxiety Disorder)

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

INSOMNIA 32% of youth prescribed medication (14)

Columbia	17% (1)
Finger Lakes	11% (2)
Lansing	75% (6)
Taberg	42% (5)

ADHD 23% of youth prescribed medication (10)

Columbia	33% (2)
Finger Lakes	17% (3)
Lansing	13% (1)
Taberg	33% (4)

Many more youth were diagnosed with depression at Columbia (67%), Mood Disorder at Taberg (50%) and Finger Lakes (33%), and Anxiety Disorder (50%) at Lansing, as compared to the other facilities. Although divergent diagnoses among the individual youth in the four facilities are expected, these discrepancies appear to be larger than likely would be accounted for by population variation. The former Chief Psychiatrist indicated that depression, mood problems and anxiety are within the same cluster of diagnoses and that what is necessary is diagnostic consensus among the facility staff where the resident is being treated. Nevertheless, the differences above reflect diversity in interpreting symptoms that is likely to play a significant role in achieving diagnostic agreement.

This analysis appeared to show movement away from Conduct Disorder being diagnosed in OCFS, in recognition that trauma-related depression, anxiety and emotional dysregulation are primary in residents. An email to the Assistant Directors for Treatment from the BBHS Chief of Treatment Services expressed this concern about the value of diagnoses other than Conduct Disorder in guiding interventions: "Our total statewide population (including secure) is below 550 youth. Every youth who has any other possible service option is being served elsewhere. The remaining youth are the most complex, multi-challenge youth (and families) in the State of New York. They have extremely high

levels of substance abuse, trauma, attachment problems, mood disorder, self-regulation issues, etc. Their diagnoses should facilitate a deeper understanding of their behavior based on their developmental experiences as well as their current presentation. It is difficult to imagine that Conduct Disorder would be the primary focus of intervention for our youth. To reduce their diagnostic complexity to Conduct Disorder can actually impede their recovery. Our diagnoses should clearly reflect the mental health issues of our kids."

The New York Model is a strengths/needs-based trauma responsive approach that is not a traditional medical model, and symptoms of depression, anxiety, emotional dysregulation, and substance abuse associated with trauma are addressed without being driven by diagnosis. If traumatized adolescents typically have a mixture of anxiety and depression, diagnosis may be less informative than tracking of symptoms by the psychiatrist and other clinicians and noting the efficacy of medication and other interventions in reducing the symptoms presented by each resident. OCFS wants to avoid pathologizing youth (which can occur when there is an emphasis on diagnoses), but to clarify the extent of serious emotional problems across facilities requires the capacity to analyze the symptoms of all youth, not just the diagnoses of youth who are prescribed medication by the psychiatrist. This would necessitate psychiatrists contributing to symptom clarification for youth not being prescribed medication and an effective process of discussing diagnoses and symptom reduction not just at Mental Health Rounds but also as refinements are made in support plans and during teams.

The QAI review commended Taberg for having an updated working diagnosis and support team agreement regarding diagnosis, reflected in girls' records. The QAI review of Taberg found that in all records reviewed, the Psychiatric Evaluation contained a complete review of symptoms, but in two information about the youth's history was missing.

FUTURE MONITORING

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

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

The MH Monitor will review additional psychiatry guidelines.

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

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

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

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

PARTIAL COMPLIANCE

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

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

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

PARTIAL COMPLIANCE

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

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

Generally accepted practice is that no more than three psychiatric medications and no more than one medication per class will be prescribed. During this site visit, several Taberg residents were prescribed four psychiatric medications, as described in more detail below. The MH Monitor will discuss the management of this practice further with OCFS before determining compliance.

49c. Require that the results of laboratory examinations and side effects monitoring are reviewed by the youth's psychiatrist, if applicable, and that such review is documented in the youth's record.

COMPLIANCE

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

Forms to track laboratory findings and side effects comply with 49c and were completed in Taberg records.

On Site Observations Regarding Paragraph 49a-c (3/13)

On March 19, 2013 18 of the 20 girls at Taberg had one or more psychiatric diagnoses and 17 were prescribed psychiatric medication:

Anxiety/Rage Reaction-Abilify
Anxiety-Effexor; Impulsivity-Lamictal and Intuniv; Insomnia/Anxiety-Trazodone
Major Depression-Seroquel, Zoloft, and Trileptal
Mood Disorder-Haldol; Insomnia-Benadryl
Mood Disorder-Intuniv; Impulsivity-Zyprexa; Mood/ADHD-Risperdone
Mood Disorder-Abilify; Depres-Wellbutrin; Impulsivity-Intuniv; Insomnia-Melatonin
Mood Disorder-Trileptal; Anxiety-Clonidine and Wellbutrin; Insomnia-Benadryl
Mood Instability-Seroquel (2)
Mood Instability-Seroquel; Insomnia-Trazodone
Mood Instability-Seroquel and Risperdone; Impulsivity-Concerta
PTSD-Celexa; Anxiety-Abilify
PTSD-Zoloft; Insomnia/Anxiety-Trazodone
PTSD-Seroquel; Insomnia/Anxiety-Trazodone
PTSD-Prozac; Mood Disorder-Seroquel; Irritability-Intuniv; Insomnia-Trazodone
PTSD/Anxiety-Zoloft and Seroquel; Aggression-Intuniv; Insomnia-Elavil
Conduct Disorder-Lithium and Clozapine

The MH Monitor inquired about the list above, and it was confirmed that aggression, anger, rage reaction, impulsivity, and mood instability are symptoms, not diagnoses. These symptoms can be a criterion of more than one diagnosis. It might be clearer to consistently use either symptoms or diagnosis in individual support plans and the facility psychiatric medication list. On the psychiatric contact notes, Mental Health Rounds discussion, and support plan, the psychiatrist describes the symptoms observed and how they are being treated with medication and other interventions. If the psychiatrists find the symptom checklist on the psychiatric contact note to be limiting, they could suggest that more be included to reflect mood instability, anxiety, anger, and others that are underrepresented on the list.

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

The most recent support plan of one resident listed a diagnosis of Conduct DO (by history), Polysubstance dependence, R/O PTSD. However, the facility roster gave her

diagnosis as PTSD (for which she was prescribed Prozac), Mood Disorder (Seroquel), Irritability (Intuniv), and Insomnia (Trazodone).

An OCFS draft document requires that "the psychiatrist will use no more than three psychotropic medicines in his/her treatment of a youth. At presentation, the number of medications may be greater, but needs to be tapered to no more than three. If the psychiatrist can justify the usage of more than three medicines, then it is important to discuss this usage with the Chief Psychiatrist. The psychiatrist will use no more than one medicine per class, i.e., one antipsychotic, antidepressant, mood stabilizer. If the psychiatrist can justify the usage of more than one medicine per class, then it is important to discuss this usage with the Chief Psychiatrist." Three Taberg residents are prescribed three psychiatric medications and five are prescribed four psychiatric medications:

Seroquel, Trileptal, Zoloft
Intuniv, Risperdone, Zyprexa
Concerta, Seroquel, Risperdone
Effexor, Intuniv, Lamictal, Trazodone
Abilify, Intuniv, Melatonin, Wellbutrin
Benadryl, Clonidine, Trileptal, Wellbutrin
Intuniv, Prozac, Seroquel, Trazodone
Intuniv, Elavil, Seroquel, Zoloft

The use of four medications and the use of medications from the same class by the Taberg psychiatrists was reportedly discussed with the former Chief Psychiatrist, but apparently modification did not result and no documentation of the rationale for not following generally accepted practice was apparent in the residents' records.

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

Nine Taberg residents are being prescribed medication for insomnia and an unknown number of other residents have sleep problems. The MH Monitor recommends that sleep-enhancing skill building be incorporated into groups and individually by evening shift staff, supported by the youth's team. Traumatized youth have to learn how to put themselves to sleep without substances, which requires feeling safe and trusting that staff will take care of them. Not only may bedtime remind them of night fears, but also they miss home and the familiarity of sleeping with family members so going to bed may accentuate their loneliness. Given the importance of sleep to emotional regulation, more attention to self-soothing strategies for sleep is a priority. OCFS responded to this concern with a 1/13 BBHS memo to clinicians encouraging them to assist their teams in increasing staff awareness and competency around the issue of sleep hygiene, with follow-up discussion planned during regular clinical meetings.

In the review of the 44 youth prescribed psychiatric medications at the four DOJ facilities on January 1, 2013 described above, the MH Monitor found divergent medication practices among the five psychiatrists at Columbia, Finger Lakes, Lansing and Taberg. Finger Lakes, the facility with the least amount of psychiatric coverage and the only boys facility, had a much lower percentage of prescription of psychiatric medications (32%) in

comparison to Columbia (55%), Lansing (67%) and Taberg (75%). Even given the small numbers analyzed, there are different rates of prescribing the three most common psychiatric medications (Note: the antidepressant Trazodone has the highest rate of prescription at the three girls facilities (Columbia and Lansing (50%) and Taberg (25%)), but is seldom prescribed at Finger Lakes because of a side effect experienced by boys):

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

In the DOJ facilities in January 2013, Trazodone was being prescribed for Anxiety Disorder, Dysthymic Disorder, Major Depressive Disorder, Depression, and Insomnia. Seroquel was being prescribed for Mood Disorder, PTSD, Mood Dysregulation, Generalized Anxiety Disorder, Anxiety Disorder, Dissociative Disorder, and Conduct Disorder. Clonidine was being prescribed for Anxiety Disorder, ADHD, Bipolar Disorder, Mood Disorder, and Impulsivity. Risperidal was being prescribed for ADHD, Conduct Disorder, and Mood Disorder.

The QAI review commended Taberg psychiatric progress notes for documentation of discussions between the psychiatrist and youth regarding prescription medications, medication benefits, and dosage changes and for contact between the psychiatrist and parent. The QAI survey of 10 Taberg residents found that five said they were taking medication and knew what they were and why they were taking them and four said they were helping them. In one record reviewed, psychiatric contract notes regarding parental contact were detailed and showed engagement of the parent. Of five staff respondents, two knew what psychiatric medications youth were taking and why; only one knew the potential side effects of youth medications.

FUTURE MONITORING

The MH Monitor will review additional psychiatry guidelines.

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

The MH Monitor will review consistency of recording laboratory results at Taberg.

The MH Monitor will observe discussions of efficacy of medication at Taberg Mental Health Rounds and support teams.

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

The MH Monitor will discuss with OCFS the practice of prescribing four medications to residents.

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

complete competency-based training on psychotropic medications and psychiatric disabilities.

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

COMPLIANCE

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

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

COMPLIANCE

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

On Site Observations Regarding Paragraph 50a-b (3/13)

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

The QAI review found that most of the Taberg staff who were interviewed did not know which youth were prescribed medication and what types of medications. QAI recommended that the Taberg administration develop a plan for disseminating information regarding which youth are on medications.

FUTURE MONITORING

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

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

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

COMPLIANCE

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

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

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

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

COMPLIANCE

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

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

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

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

COMPLIANCE

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

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

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

COMPLIANCE

The MH Monitor observed signed medication refusal forms in Taberg residents' records that comply with 51d.

51e. The youth's treatment team shall address his or her medication refusals.

COMPLIANCE

The MH Monitor observed documentation that medication refusal had been discussed in Taberg residents' support teams that complies with 51e.

On Site Observations Regarding Paragraph 51a-e (3/13)

The MH Monitor observed documentation in a Taberg record when a resident refused psychiatric medication. There was understanding that if a resident refuses psychiatric medication, the psychiatrist meets with the youth to clarify why (and why the youth is refusing and what the psychiatrist has done to address the side effects and/or other reasons for refusal should be included in the Psychiatric Contact Note) and these issues are discussed in support team. The QAI review found that the Taberg nurses notified (via email) psychiatric medication refusals to the resident's YC, clinician, psychiatrist, and AOD.

FUTURE MONITORING

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

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

COMPLIANCE

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

On Site Observations Regarding Paragraph 52 (3/13)

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

FUTURE MONITORING

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

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

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

COMPLIANCE

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

The support team practices at Taberg comply with 53a.

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

COMPLIANCE

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

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

COMPLIANCE

Support team meetings at Taberg comply with 53c.

The Parties interpret 53c to mean (a) the psychiatrist has input at support team meetings through their contact notes and communication between the psychiatrist and clinicians during Mental Health Rounds and informally and (b) the psychiatrist will attend support team meetings when their participation is clinically indicated for a specific resident. It is commendable that the psychiatrists at Taberg participate in support teams.

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

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

PARTIAL COMPLIANCE

Taberg Integrated Assessments, clinical evaluations, and Mental Health Rounds describe the effects of trauma on residents' thinking and behavior and are part of planning interventions. But typically the resident's support plan, a key aspect of the New York Model, does not include trauma. For some residents, the clinical contact notes indicate

trauma work by the resident. This may be considered private between the resident and one or two clinicians and not something they want discussed with their team and/or family. To meet the Settlement Agreement's requirement for "a strategy for developing coping skills [for trauma] by the youth," the effects of trauma on the resident's behavior must be part of staff assistance in the youth's development of goals. Hopefully, the more support plans reflect both the resident's views and the staff's understanding, trauma will become a safer topic in the process of residents changing their thinking and behavior.

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

PARTIAL COMPLIANCE

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

"Goal Writing and Support Plans in the New York Model" (4/12/13) provides helpful and specific guidance for goal writing to maximize the motivation and engagement of youth by "starting where they are" and beginning services with their goals. Strengths to build on to achieve their goals is stressed as an important part of writing support plans. This document guides staff in how to help youth develop goals by validating and breaking goals into components they can achieve. Staff are encouraged to ask the youth about outcomes they want to identify the reward for them for working toward their goal. Utilizing the examples of goals, objectives, supports/services/interventions in these guidelines will improve support plans. The one-page document Support Team Staff Notes walks staff through an analysis of their role in assisting a youth to his/her goal. The one-page Goals Worksheet is for staff to help youth identify their goals and break them down into achievable component and can assist in the development of the support plan with the resident and prepare the resident to speak up at the support team meeting. Guidelines for safe ways for youth to include trauma-related goals would be helpful, such as "Understand anger from the past that I can't control" or "Figure out why someone telling me 'No' reminds me of things in the past."

At the time of the site visit, these guidelines for writing effective goals did not appear to be implemented yet at Taberg, but they were making efforts to improve support plans. Consistently strong support plans—including building from the Integrated Assessment, clear goals based on the resident's aspirations with the addition of staff expertise, and all team members' interventions (not just clinicians) stated specifically--is being monitored to determine full compliance.

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

PARTIAL COMPLIANCE

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

Consistency in support plans at Taberg is being monitored to determine full compliance.

The QAI review commended Taberg for the frequency and regularity of clinicians and Youth Counselors meeting with youth.

On Site Observations Regarding Paragraph 53a-f (3/13)

The MH Monitor observed two Taberg support team meetings. [redacted]s a 15-year old who was placed on the Taberg mental health unit in 11/12 (her offense was pulling a fire alarm--false report). She had multiple placements and psychiatric hospitalizations, including [redacted] and being hospitalized while she was at [redacted]. She was removed from home by DSS for [redacted], [redacted] and a lack of parental supervision; she and her sister, who fought frequently, were described as "running the streets and having sex at a young age with men" and polydrug and alcohol use. Both parents had limited cognitive abilities and mental health diagnoses. Between 3/12-12/12, on three administrations of the WISC she had FS IQ scores of 73, 66 and 61, with extremely low verbal comprehension (although reportedly her IEPs had been for ADHD). Her initial Taberg diagnoses were PTSD, Bipolar Disorder, ADHD, Oppositional Defiant Disorder, Conduct Disorder, and Mild Mental Retardation. The clinical contact notes reveal that [redacted] had to change therapists in January when a female therapist who saw her several times a week resigned and was replaced by a male therapist who then had to take considerable leave. [redacted] told one of the Monitors that she had requested a female therapist and her male therapist told her she could not have one. [redacted]'s Integrated Assessment was brief, but included a trauma history. [redacted]'s Integrated Treatment Plan (3/19/13) reflected a significant decrease in self-injurious behavior; Risperidone had been discontinued. IQ and achievement testing had been done by the psychologist, and her safety plan and IIP reviewed. Goal #1 No longer exhibit self-injurious behavior. Decrease impulsive and self-injurious behavior by learning DBT and problem solving skills. Goal #2: Graduate HS and become a nurse or veterinarian. Attend and participate in all educational programming. Family Goal: Successfully working through the unresolved issues connected with her placement outside family home. Family sessions to address loss and separation issues from her living independently. Her family goal may reflect a problem: she and family may believe she is going to RTC as a stepdown to home, but OCFS staff seemed to be planning RTC followed by a foster home. This is an important issue if she has previously gone AWOL trying to get home. Does [redacted] see her goal as stopping self-injury, and what is motivating this trauma-related goal? A dilemma is that her borderline intellectual functioning would make it difficult to graduate from high school and continue to college to become a nurse or vet—is it the job of the facility to make her more realistic at age 15? The psychiatrist continued to monitor her after psychiatric

medication was discontinued. In the 10 weeks prior to the site visit, [redacted] had 11 individual therapy sessions, most of which occurred in the first month with a therapist who left. Her new therapist also documented three special precautions evaluations, and one had also been done by her former therapist. Early in the 10 weeks, her former therapist described a call to her mother about inappropriate phone conversations that upset the resident, but there was no later documentation of therapist contact with her family. She had weekly sessions with the psychiatrist in the first month, and every other week subsequently. During the same 10 weeks, she participated in seven DBT groups and six Triad groups. She also had weekly individual sessions with her YC. She had a CSE (IEP) meeting and two support team meetings; in preparation for the 90-day support team meeting, her CST visited her once and made two telephone contacts, with a follow-up call after the meeting. [redacted]'s 120 day support team was convened by her YC, with her therapist, nurse, and teacher; her CMSO and DSS worker had driven down from Watertown; her mother, father and grandmother had driven from their home; the BBHS psychologist was on the phone. It was the first support team planning for her release in 6-8 weeks, and she had discussed with them the House of Good Shepherd RTC near her family (DSS has custody—and is likely to until she is 18--but she is close to her family). Prior to the arrival of [redacted] and her family in the meeting, her YC expressed concern that her family had brought her 20-year old boyfriend to the facility and said he was her cousin; he was denied entrance and was waiting in the car; the nurse revealed a comment that morning that suggested [redacted] knew her parents were bringing him. [redacted] talked about the success of specific steps in her safety plan, and her YC said he would revise her IIP to reflect them. They reviewed her goals: #1 To reduce self-injurious behavior. [redacted] was commended for stopping scratching herself (previously 6-10 times/month) and instead using the DBT technique of snapping a rubber band. It came as a surprise to the team when she said, "Sometimes I still scratch a little but don't show anyone." The nurse said the psychiatrist had gradually decreased her Risperidal and it had just been discontinued, so [redacted] is no longer taking psychiatric medication. Her therapist indicated that the psychiatrist had changed her diagnosis from Bipolar to Conduct Disorder. His explanation that she had a cluster of personality disorder traits on Axis 2 was confusing. She commented, "I had a breakdown last night." She was commended for talking to staff, and she said to her YC "I like to talk to you. You're different. You listen. You understand me." The nurse said she was proud of [redacted] for talking to her about her self-injurious feelings and is going to help her continue to do so. #2 To be on her own. She said she wanted to graduate from high school and become a nurse or a vet. Putting this goal into the context of her current academic achievement and making a specific plan for what she will complete at Taberg and what she wants to complete academically while at RTC was not discussed. Her therapist brought up her AWOL history as an obstacle to being accepted by the RTC, and she said, "I haven't tried to climb the fence." She was commended for participating in group and individual treatment. When [redacted] was asked about her goals in leaving, she said, "Not hurting myself. Not hurting others. Going to school. Think about myself and don't take on others' worries because it traumatizes me and brings up the past." Her DSS worker said her permanency plan is independent living, her CMSO said she was eligible for an intensive care manager, and her father commented, "We never got any services." Then the professionals on the team engaged in a discussion about the technicalities of a 6-month OCFS commitment and a DSS placement before independence and how the referral to the RTC would be made (this

would have been done better by phone/email not in the presence of [redacted] and her family). Her father said, "Her sister did well at the [redacted]." Her therapist asked about family issues, and her father said they do not want [redacted] to have contact with her sister, although she requested release by her sister's birthday in late April. She went on to say that she "needs only four people in my life—my parents and grandmother" and one other whose picture was in her safety plan (and might have been her sister or her boyfriend). Her therapist proposed family counseling, some by phone and some in person including traveling with [redacted] to the CMSO office to meet with her family; the CMSO was supportive of this. After she and her parents left, staff debated length of stay, her YC saying that officially Taberg is a 4-6 month program, others disagreed saying that it remains a 6-9 month program, and that [redacted] should not have to leave by 6 months. Her therapist questioned how much mental health progress [redacted] could make given her being mildly mentally retarded like her parents and her difficulty understanding connections between the past and present, between her feelings and behavior. Participants acknowledged that the support team meeting, while a good example of in-person involvement of CMSO and DSS and her family (and BBHS on the phone), had been affected by the team being upset by her family's attempt to sneak her boyfriend into the building and lacked the open, fluid discussion they strive for in team meetings.

[redacted]'s Integrated Assessment was completed on 9/14/12 and was a thorough report. Instead of quoting reception or other assessments at length, the Integrated Assessment pulled information from various sources into a clear statement of strengths, vulnerabilities, and history. Her special medical needs due to diabetes and obesity were also summarized. Her two-line trauma history include absence of her father, victim of mother's neglect (about which little is known), mother's substance dependence in the past, and multiple out-of home placements (elsewhere these are described as including five psychiatric hospitalizations for aggressive outbursts and homicidal threats). The Reception diagnosis (Conduct Disorder, Mood Disorder, Rule Out expressive language disorder and learning disorder) was given. Under Diagnostic formulation, a Taberg diagnosis is not given. Instead, she is described as socially and behaviorally younger than her chronological age of 13, struggling significantly with social interactions and that her angry outbursts are like a tantrum of a younger child. More accurate understanding of her inability to regulate her emotions and her limited ability to establish peer relationships is recommended. A weakness of the Integrated Assessment is that her current reading and math skills at the 4th grade level are listed, she does minimal work in 6th grade, and reception's report of the possibility of a language disorder or learning disorder should have resulted in a Taberg referral for testing and for eligibility determination for special education services and an IEP. [redacted]'s Integrated Support Plan (3/20/13) indicated a psychiatric medication change (Seroquel and Abilify were discontinued and Clonidine started) and that her Safety Plan and IIP were reviewed. In the 10 weeks prior to the site visit, [redacted] had 15 individual therapy sessions, three of which also included her mother on the phone. These were well-documented, including describing the therapist's efforts to support the girl who had many worries about going home. She had once a month sessions with the psychiatrist. During the same 10 weeks, she participated in six DBT groups with another clinician and six Triad groups. She also had nine individual sessions with her YC, including documentation of a 28-day hold due to a rule violation that she acknowledged was to sabotage her release. Her

mother married [redacted], and [redacted] was upset to hear her mother and stepfather arguing when she was on the phone. [redacted]s high anxiety about release was noted, and the team planned to help her see that services she will get at home are similar to what she received at Taberg. That she had two major rule violations and three restraints in the previous month was noted as a decrease from her last support team. It was reported that although [redacted] could verbalize her goals and DBT skills, she was having trouble applying them. Her diagnosis is Mood Disorder, Conduct Disorder, and borderline and histrionic personality traits. She had two goals in her support plan: Goal #1 Improve anger management, which involved "Do not get any level IIs or IIIs by utilizing safety plan." The supports to assist her with this goal were weekly psychiatric sessions, weekly individual therapy, and family therapy with DBT skill practice, individual counseling with YC, and completing her school assignments. Goal #2 Improve interactions with peer group which involved "Use mindfulness to notice when she is 'trying to be liked.'" The same interventions as Goal #1 were listed. Her family goal was: She and family will have set limits and communicate them clearly. Her most recent psychiatric contact note (3/21/13) indicated she had a good family visit and then became very agitated with a panic attack which was characterized as "pre-discharge anxiety." Her weight had decreased 70 pounds, and the laboratory was "checking thyroid functions." Her diagnosis was Panic Attacks, Mood Disorder, and Conduct Disorder. Her symptoms were irritability and worthlessness. She was prescribed Effexor, Intuniv, Lamictal, and Trazodone.

The two observed support teams showed Taberg staff with strong relationships with residents communicating effectively with family and CMSO. Aspects of support teams requiring improvement are (a) continuing to strengthen individualized goals and specifying ways each staff can help the resident meet their goals; (b) incorporating the Integrated Assessment findings into the team discussion and support plan; and (c) making connections between the resident's goals at Taberg and success in the community.

Instead of a formal curriculum for teaching staff how to complete the new JJIS support plans, OCFS is providing in-person system walk-throughs and continued coaching by BBHS. JJIS Support Plan Coaching facility staff has begun with clinicians, YC's, teachers, and medical staff to guide them through the new form. On 2/1/13, the new Integrated Support Plan was released in JJIS. On 2/21/13 BBHS Director of Treatment Services and the JJIS clinical coach had their first coaching session at Taberg; they sat in on a support team and provided the clinicians feedback about the meeting and walked them through creating a support plan on JJIS. The coaching team will return to Taberg to do the same with case managers, teachers and medical staff.

A Taberg practice not seen at the other DOJ facilities is a staff member (usually a YDA) posted outside the door during therapy even when the clinician's office is on the unit because Taberg clinicians are not certified in restraint techniques. This notifies everyone that the youth is seeing the clinician (which reduces privacy) and sends a message that youth are likely to require restraint. Of course, it is important that clinicians feel safe, but clinicians in other facilities are not certified in restraint techniques and see residents in their offices with staff nearby but not outside the door.

The QAI review of Taberg surveyed 10 youth and 7 said they had a support plan, 7 said they helped developed their goals, 8 said they attend support team meetings and 3

said their parent/caregiver participated in their support teams. The QAI review of Taberg found that the Integrated Support Plans reviewed were not based on the Integrated Assessment and not specific. The QAI review of Taberg found that in the reviewed records the Integrated Support Plans were not documented and updated monthly and did not contain consistent progress notes from team members. The QAI review of Taberg raised concerns about a lack of family contacts and documentation of family involvement in support team meetings.

FUTURE MONITORING

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

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

The MH Monitor will continue to review psychiatry coverage.

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

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

COMPLIANCE

OCFS is using Innervisions, led by the substance abuse clinician, for substance abuse prevention education at Taberg. OCFS is looking for a new program on total well-being including substance abuse education.

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

PARTIAL COMPLIANCE

OCFS is using Triad for substance abuse treatment at Taberg.

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

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

On Site Observations Regarding Paragraph 54a-b (3/13)

The substance abuse clinician appeared to be fully integrated on the Taberg team, providing individual therapy for several residents as well as substance abuse groups on

each unit using the Triad curriculum designed for girls. He completes the AADIS assessment of substance abuse with each resident at admission. He actively participated in Mental Health Rounds and support teams, commenting on residents' development of DBT skills not just in a substance abuse context. He has focused on improving unit teamwork.

The MH Monitor observed an instructive substance abuse group at Taberg.

Most of the Taberg residents had a history of substance abuse. Substance abuse was noted in Integrated Assessments, but not reflected in some support plans.

The long-term importance of effective substance abuse treatment and its integration into the support plan and the efforts of all staff with a resident is exemplified by [redacted], a 16½-year old at Taberg since 11/12. Her Integrated Assessment described [redacted] as the only child of [redacted] immigrants who work long hours in the store they own. Her father used excessive corporal punishment and she had a conflicted relationship with her mother because she used alcohol, did not attend school (although she has college-level skills) and got into fights. She was placed in a [redacted] residential program for violating probation and then at Taberg for violating the conditions of her release. Trauma was described vaguely; how it affects her behavior, including substance use, was not described. [redacted]'s Integrated Support Plan was weak, having one vague goal and making no connection between trauma and behavior. Although her primary diagnosis was substance dependence, no substance-related goal was included in her support plan. Despite a long-term history of severe family problems making it unlikely that she could successfully complete high school while living at home, family treatment was not included in her support plan. Decreasing anger and increasing trust were objectives stated by staff, but not put in the context of culture, her family, past trauma, substance abuse, and her self-harming behavior and recent suicide watch. Her diagnosis was Conduct Disorder (by history), Polysubstance dependence, R/O PTSD. Goal #1 was "To return home" with the objective of decreasing anger, and the interventions were individual therapy, weekly counseling, and school encouragement. Goal #2 was blank with an objective of increasing trust in others. In the previous month, she had engaged in self-injurious behavior and made suicidal statements, had two major rule violations and two restraints and previously been on suicide watch. She will likely require considerable assistance to identify the skills and the support necessary to avoid relapse in the community.

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

The QAI Report commended the Taberg substance abuse clinician and found that residents were attending a weekly TRIAD substance abuse group and an Innervisions psychoeducational group every other week, the substance abuse clinician administers the AADIS drug/alcohol screen for all youth as they arrive, and progress notes indicate a connection between DBT skills and substance abuse issues.

FUTURE MONITORING

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

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

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

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

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

COMPLIANCE

The Continuity of Care Plan complies with 55a.

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

PARTIAL COMPLIANCE

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

The Discharge Plan (still being developed) will be reviewed for compliance with 55b.

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

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

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

COMPLIANCE

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

On Site Observations Regarding Paragraph 55a-c (3/13)

The MH Monitor reviewed the one-page Mental Health Continuity of Care Plan for a girl who was released after six months in 2/13, shortly before her 15th birthday. She had been admitted to Taberg in 8/12 and was there at the previous site visit. A month after she arrived, Taberg staff submitted an OCFS form "Youth with No Family Resource" indicating that she had been raised by her maternal grandmother, her parents remained in [redacted] and [redacted] and her grandmother and extended family were no longer willing to care for her. Nevertheless, she was discharged to her grandmother on Staten Island, a B2H referral was made and an appointment date with a provider for mental health counseling, family therapy and substance abuse treatment was listed on the Continuity of Care Plan; because she was not taking medication, no appointment with a psychiatrist was made.

The Transition Plan screens comply in part with the Settlement Agreement by including information about all aspects of the youth's services in the community. However, two important functions of a Transition Plan are: (1) Providing specific guidance for a resident's family, school and other providers about her needs and how each of them can support her distress tolerance, self-calming and interpersonal effectiveness skills (including how, specifically, she can make use of her Safety Plan and other New York Model skills in the community); and (2) Identifying her team in the community to help the young person reach her goals and giving each team member (youth, family, OCFS staff, service providers) the telephone number and address of each person/service on the youth's community support team. A transition plan should define how a resident's treatment plan and gains in the facility will continue in the community: if, for example, one of a youth's goals in the facility was "Learn how to manage frustration," then in the last support team meeting before re-entry, important supporters in the community would have been present or on tele/video conference so they understood their role in helping the youth tolerate frustration in the community. Just as the youth and everyone on her team at the facility use her support plan to assess progress and refine supports, OCFS should help the youth, her family and service providers be able to rely on her transition plan as her support plan in the community. All the residents in the four DOJ facilities are receiving individual therapy and individual counseling and are participating in DBT and Sanctuary groups and most are participating in substance abuse treatment groups. The Settlement Agreement wording does not limit the need for a continuity of care plan to youth prescribed psychiatric medication; it includes all residents with the terms "mental health issues" and "receiving substance abuse treatment" in the facility. The Settlement Agreement wording "referrals to mental health *or other* (emphasis added) services when appropriate" requires continuity of care planning for almost all OCFS residents because most residents receive treatment in the

facility to meet their mental health and substance abuse needs. This could include, in addition to referrals to therapy, medication management and substance abuse treatment on the Continuity of Care plan, referrals to B2H services, YAP services, mentoring services, and educational services. Referrals for these services are important for transition plans for all youth, not just those requiring medication management in the community. Some residents have a goal of discontinuing psychiatric medication before they are discharged, and they might be at greater risk of return to the facility than those residents who have a Continuity of Care plan for follow-up by a mental health provider in the community. Through the New York Model OCFS has implemented the integrated assessment and integrated support plan, and hopefully, a revised Discharge Plan format could become an integrated transition plan that includes all elements of a youth's successful re-entry to the community without violating HIPAA.

QAI commented on varied involvement of CMSOs in re-entry services, with Taberg staff doing most of the arrangements instead of some CMSOs. In one videoconference support team observed by QAI, the CST was unaware of the youth's progress prior to the meeting, the CST had not engaged with the youth or her mother before the meeting and the CST was in and out of the videoconference. QAI commended the role of the Parent Advocate in the videoconference in supporting the youth's mother in discussing future plans with her daughter and the team. The QAI review commended the collaboration among Taberg's clinician, the CMSO psychologist, and BBHS administration to identify a more appropriate program for another resident with a low IQ.

FUTURE MONITORING

The MH Monitor will review Discharge Plans in JJIS.

The MH Monitor will review Discharge Plans and Continuity of Care plans of recently released residents.

IV. DOCUMENT DEVELOPMENT AND QUALITY ASSURANCE

56. Document Development and Revision. Consistent with paragraph 68[2] 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.

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[2] 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.

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

PARTIAL COMPLIANCE

COMMENT: A positive element of the monitoring process has been the creation and implementation of the Quality Assurance and Improvement (QAI) Bureau. The Monitors received the *Pilot Program Review: Taberg Residential Center* (Draft) (also referred to as the QAI Review of Taberg) before the monitoring visit and then had an opportunity to discuss its contents and findings before the Taberg monitoring visit. Again, the Quality Assurance and Improvement (QAI) Bureau has produced an excellent report, identifying many of the same issues observed by the Monitors. The Monitors also appreciated the change in the format of the report, especially the tracking of an individual youth's indicators over time and across placements.

The Monitors met with QAI staff members to discuss the FLRC report. Attendees included David L. Bach, QAI Director; Sandra Carrk, Project Manager; Lori Clark, QA Specialist; Diane Deacon, Assistant Deputy Counsel; Myra DeLuke, QA Specialist; Edgardo Lopez, Settlement Agreement Coordinator; Denis Passarello, QA Specialist; and Monique Thomas, Assistant Counsel. The QAI activities have become an important resource for understanding the nature and extent of Home Office involvement in various Settlement Agreement paragraphs. The quality of the QAI pilot reports has been excellent; the reports have been thorough and informative.

QAI has developed the first parts of a quality assurance strategy that could lead to an expedited finding of compliance for the Protection from Harm paragraphs. In its efforts to assist the facility in the appropriate use of physical restraint interventions, QAI proposed the development of restraint metrics that would be linked to graduated restraint safeguards and action plans. More importantly, the QAI initiatives recognize the paradigm shift that occurred in juvenile corrections nearly two decades ago and are consistent with generally accepted professional standards. These critical and yet-to-be-developed performance metric restraints safeguards require more review, but they have the potential to change the monitoring strategies in such a way as to expedite agreement among the parties about compliance with various Settlement Agreement paragraphs.

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: As stated earlier, the monitoring visit selected Restraint Packets for review that were not part of the QAI review process. It is likely that QAI would have raised these issues if Restraint Packet 387594 had been part of its analysis. These recommendations for additional Home Office consideration are intended as safeguards or procedural mechanisms to ensure that certain classes of behaviors by staff and youth receive an additional level of evaluation. These represent behaviors that could be become increasingly problematic over time.

First, two Restraint Packets involved confrontations and restraints that occurred in the youth's room. In both situations, there was no video to substantiate allegations of

assaults or abuse by staff or youth or both. Even with a full understanding of CPM and OCFS policies and procedures, these Restraint Packets suggested the need for a review of (a) when it is appropriate for staff to unlock a youth's room door and enter his/her room and (b) when it is appropriate to conduct a physical restraint in a resident's room.

Second, the filing of an assault complaint against a youth with a history of mental health problems that results in a New York State Police arrest and transfer to county jail represents a situation where the youth's behavior may warrant criminal charges, but the purpose of the commitment of the youth to Taberg is treatment of problems that sometimes manifest in violent behaviors. The transfer of a mental health youth to county jail for the safety and protection of the youth or staff along with the role that treatment staff play in this decision warrants Home Office discussion and review.

57. b. create or modify and implement corrective action plans to address identified problems in such a manner as to prevent them from occurring again in the future.

COMMENT: No corrective action recommendations exist as a result of the Taberg visit.

V. SUMMARY

Taberg has a good and experienced staff, but it continues to endure lapses in continuity in programs and services. The changes of the resident population, the improvements related to unauthorized CPM techniques, the mitigating of leadership and supervisory transitions, and the slowing variations in restraints (measures of harm and threats of harm) have resulted in intermittent progress toward compliance. Taberg looks to sustain acceptable levels of outcomes and services that argue for compliance and withstand mere technicalities and temporary failures to comply.

Leadership and middle management staff appeared overworked. Again, while it is a common characteristic of juvenile facility staff in these positions to have too many things on their plate, Taberg staff will benefit from a quick filling of the Assistant Director positions. This should be a priority.

The relationship between Mental Health and Protection from Harm becomes clearer with the full integration of the New York Model. To the extent that all staff are contributing to New York Model concepts and the strengthening of the youth's ability to maintain emotional regulation, safety issues related to Protection from Harm should improve. A disconnect remains in the smooth and effective implementation of the New York Model on the mental health unit (Opal) in the form of the lack of accountability of OMH staff. Most minimally effective mental health facilities do not have dual standards or dual expectations regarding the job responsibilities of licensed clinicians. A uniform approach is needed here for improved program effectiveness for youth.

The monitoring of Taberg began in early February 2012; and in the 13 months since then, the Monitoring Team completed two additional monitoring visits. Over this period of time, there have been substantial changes at Taberg, moving from a facility troubled by instability and staff and leadership problems to a facility poised to emerge as a quality girls residential treatment program.